Washington State Department of Health

CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS

Communication Network Meeting

July 14th, 2022

We honor native land, people, and experience

I acknowledge that I am speaking to you from the traditional lands of the Duwamish and Coast Salish people. I honor and thank their ancestors and leaders who have been stewards of these land and waters since time immemorial.

Please share the people you honor of the land you are occupying in the chatbox
Native-Land.ca | Our home on native land (native-land.ca)

CYSHCN Team

Monica Burke, PhD

CYSHCN Program Director

Sarah Burdette

CYSHCN Process Improvement Specialist

Bonnie Burlingham, MPH

CYSHCN Epidemiologist

Nikki Dyer

CYSHCN Family Engagement Specialist

Khimberly Schoenacker, RDN, CSP, CD

CYSHCN Nutrition Consultant

Renee Tinder, MPH

Behavioral and Adolescent Health Consultant

Agenda

Time	Topic	Presenter
9:00-9:10	Welcome, Agenda, Program Updates	Sarah Burdette
9:10-9:50	CIIBS Program	Michelle Hoffman
9:50-10:30	MCO Care Coordination	Kathleen Donlin, Tammy Parvin, and Iana Bezman
10:30-10:40	**BREAK**	
10:40-11:20	The 360 Platform: Helping Families Identify and Navigate Resources	Stefanie Robinson and Kemi Akinlosotu
11:20-11:55	Resource List and Family Voice	Shayla Collins
11:55-12:00	Final Questions and Closing Activities	Sarah Burdette
12:00-12:10	**BREAK**	
12:10-1:00	Networking and Collaborative Discussions	Facilitator: Sarah Burdette

Updates

Family Engagement

Nikki Dyer has returned from Maternity leave!

Behavioral and Adolescent Health

Working on Pediatric Mental Health Care Access Grant-Supporting Adolescent & Families Experiencing Suicidality-Fall Timeline

Nutrition-Training Module for community cooking programs supporting life skills for those with disabilities.

Trach-Trach/ Vent and Type 1 Diabetes workgroup meetings continue

WIC Office hours continue to be available for CYSHCN Nutrition support

Process Improvement

Project Accelerate- through Patient-Centered Outcomes Research Institute (pcori) Washington state accepted into national CYSHCN Care Coordination enhancement program

Manual and training Webinar coming at the end of the Summer!

General Updates

Interviews for new CYSHCN Communication Team Member

Washington State
Autism Center of Excellence (COE) Certification Training

Prior to the training, the course "Identifying and Caring for Children with Autism Spectrum Disorder: A Course for Pediatric Clinicians" offered through AAP will be required. Details can be found on the Medical Home website found below.

To register online, visit https://medicalhome.org/coe or click on the link below:

Register Now

Please register no later than Monday of the training week you want to attend

Email for information:

Kate Orville, MPH; Director, Washington State Medical Home Partnerships for CYSHCN, University of Washington.

orville@uw.edu

CENTER OF EXCELLENCE (COE) certification allows eligible providers to diagnose autism spectrum disorder for pediatric patients with Medicaid

NOTE: You must complete the autism learning modules from the AAP and attend the live Zoom training to obtain certification

Presenters:

- **Gary Stobbe, MD:** Attending Neurologist, Seattle Children's Autism Center; Director, UW Medicine Adult Autism Clinic
- **Jim Mancini, MS, CCC-SLP:** Speech-Language Pathologist, Director of Project ECHO Washington
- **And additional topic experts!**

Choose Your Live Zoom Training Date:

Friday September 23, 2022, 8:30 a.m. to 4:30 p.m. OR

Friday December 9, 2022, 8:30 a.m. to 4:30 p.m.

The COE training focuses on current research and thinking regarding the evaluation, treatment and continuing care for autistic individuals throughout the life span including:

- Screening, evaluation and diagnosis
- Differential diagnosis and co-occurring diagnoses
- Diagnostic evaluation models
- Treatment options including accessing Applied Behavioral Analysis (ABA)
- Accessing community and state resources
- Documentation, billing codes and orders
- Lived experience perspectives from autistic and family advocates
- Advice from current community COE clinicians
- ECHO Autism Washington and other follow up support
- Connect with regional partners
- Q & A

IDD AUTISM RESOURCE NAVIGATION ECHO

The purpose of **ECHO Intellectual and/or Developmental Disabilities (IDD) Resource** is to provide evidence-based resources, services, and information for those who provide navigation support for **individuals with IDD and/or Autism.**

WHEN:

Every third Wednesday of the month, starting Feb 16th
8:30 am – 10:30 am via zoom
You can register anytime. Recording of past session(s) will be provided.

WHAT YOU GAIN:

Learn, share, and apply knowledge:

- What to do while you wait
- Getting started
- Cultural Humility for life-long learning
- Parent and caregiver readiness
- Neurodiversity
- Navigating Early Intervention
- State & Federal resources
- Therapies and interventions
- Behavioral Health services
- Challenging behaviors
- Crisis services
- Transition to adulthood / lifespan
- And other vital resources, information, and supports

WHO IS ENCOURAGED TO ATTEND?

- Care Coordinators
- Social Workers
- Clinical Supervisors
- Parent, Self, and Peer Advocates
- Healthcare Workers
- Clinicians and Providers
- Anyone who supports IDD and ASD community

TRAINING TEAM:

Sennie Rose,
ECHO Program Coordinator
University of Washington

Katrina Davis,
Family Resource Specialist and Parent co-advocate
Case Manager Seattle Children's Emergency Department
University of Washington-CHDD

Ronald San Nicolas,
Asst. Teaching Professor, Simon Family Endowment Autism MSW Fellowship Coordinator and Parent co-advocate

Shayla Collins,
UW LEND Mentor, Arc of King County Board Member, Odessa Brown Children's Center Mindfulness and Compassion Program Facilitator and Parent co-advocate

Kate Orville,
Medical Home Partnerships Project for Children and Youth with Special Health Care Needs, public health and community-based systems consultant, UW CHDD, and Parent co-advocate

Tariq Karmy-Jones,
Autistic Self-Advocate

TO REGISTER FOR IDD ECHO:

Click https://redcap.link/registrationIDD

QUESTIONS?

Contact Sennie Rose at echoiddd@uw.edu

ECHO is an acronym that stands for Extension for Community Healthcare Outcomes. ECHO is a virtual, interactive program that accelerates knowledge and information sharing through an "All Teach, All Learn" framework.

Transforming Lives

Children's Intensive In-Home Behavioral Support (CIIBS) Program

Updates and Resources-ComNet July 14, 2022

Michelle Hoffman CIIBS and SSP Program Manager;
Developmental Disabilities Administration

Washington State Department of Social & Health Services
Transforming lives

- Updates on CIIBS Program
- Common Resources for CYSHCN with IDD
- Questions

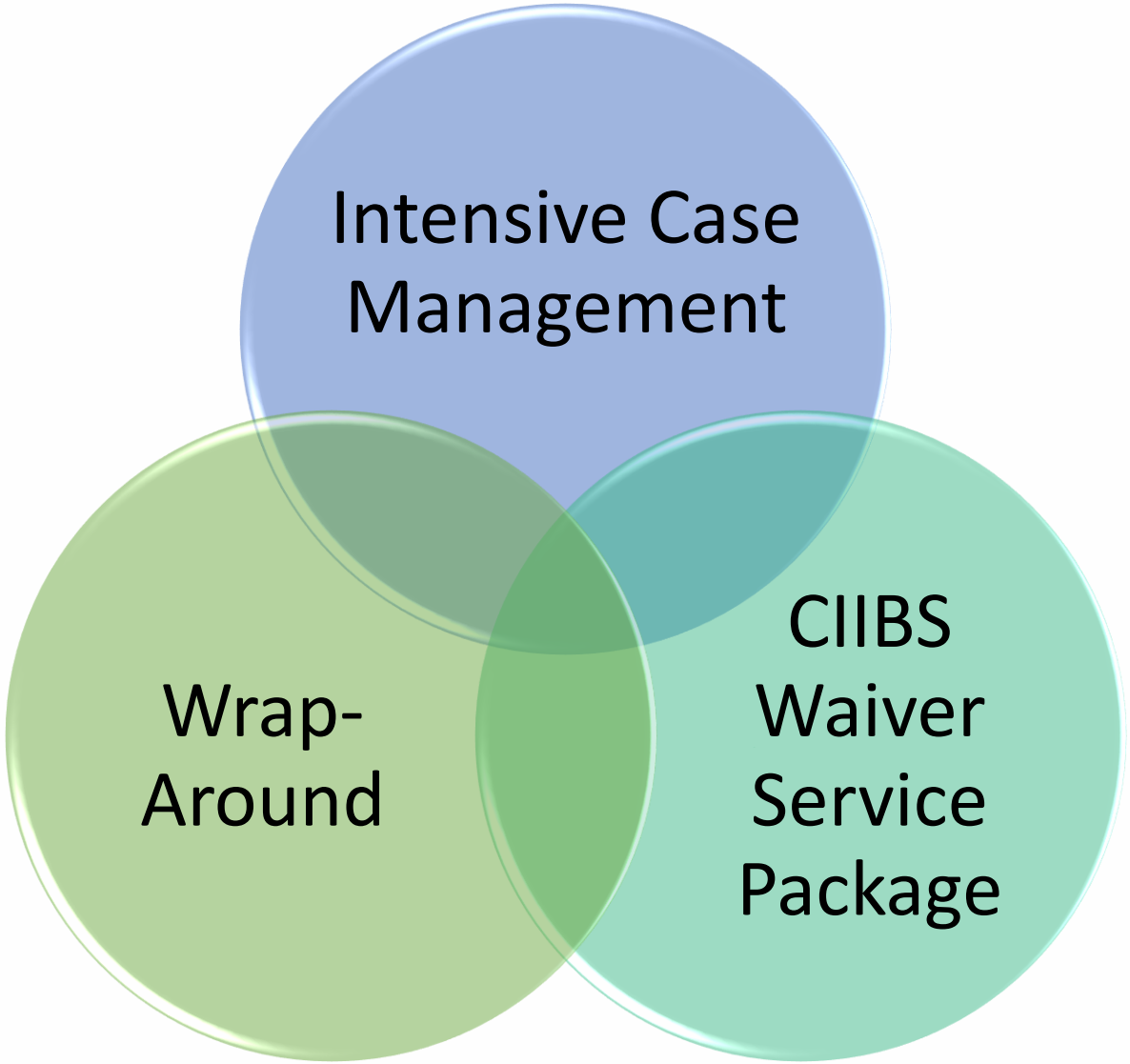
What is CIIBS?

- The Children's Intensive In-home Behavior Support (CIIBS) program is one of DDA's five Home and Community Based Service Waivers (HCBS)

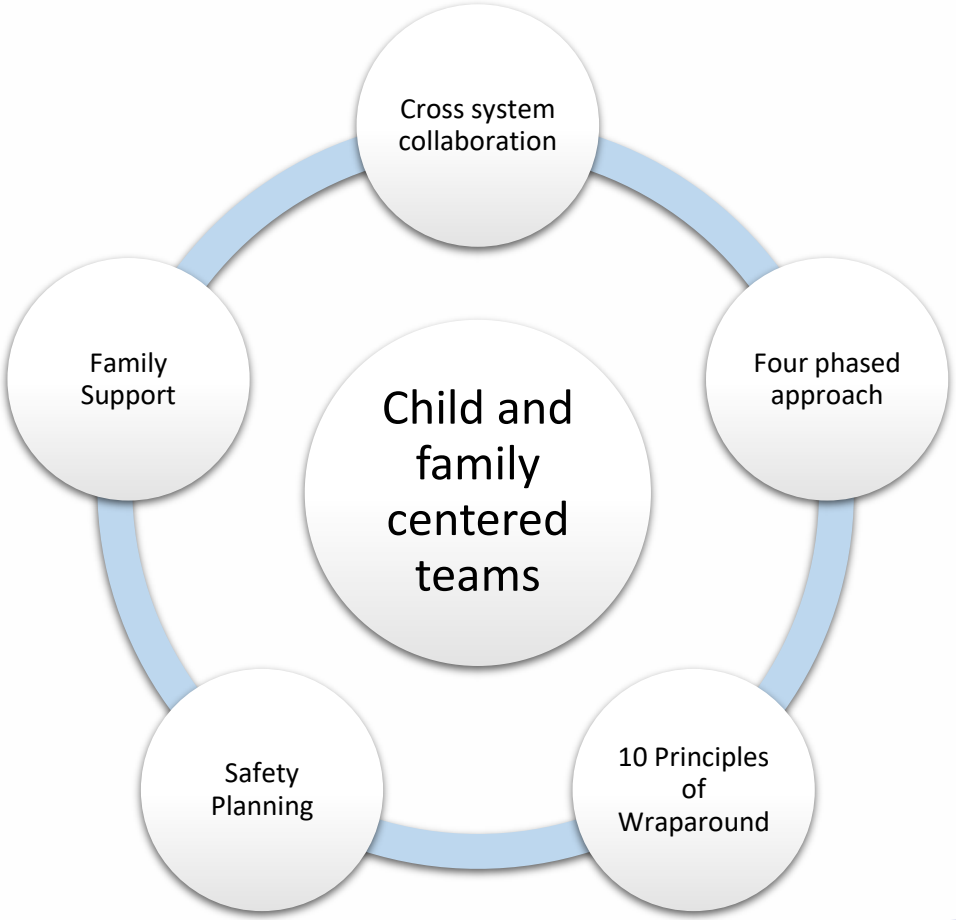
- The CIIBS waiver supports children and youth who are at high or severe risk of out of home placement due to concurrent high behavioral and habilitative needs by providing increased case management support in a wraparound program format.

- Participants receive wraparound supports along with their DDA services so they may continue living successfully at home with their families and within their communities.

Components of the CIIBS Model-overview



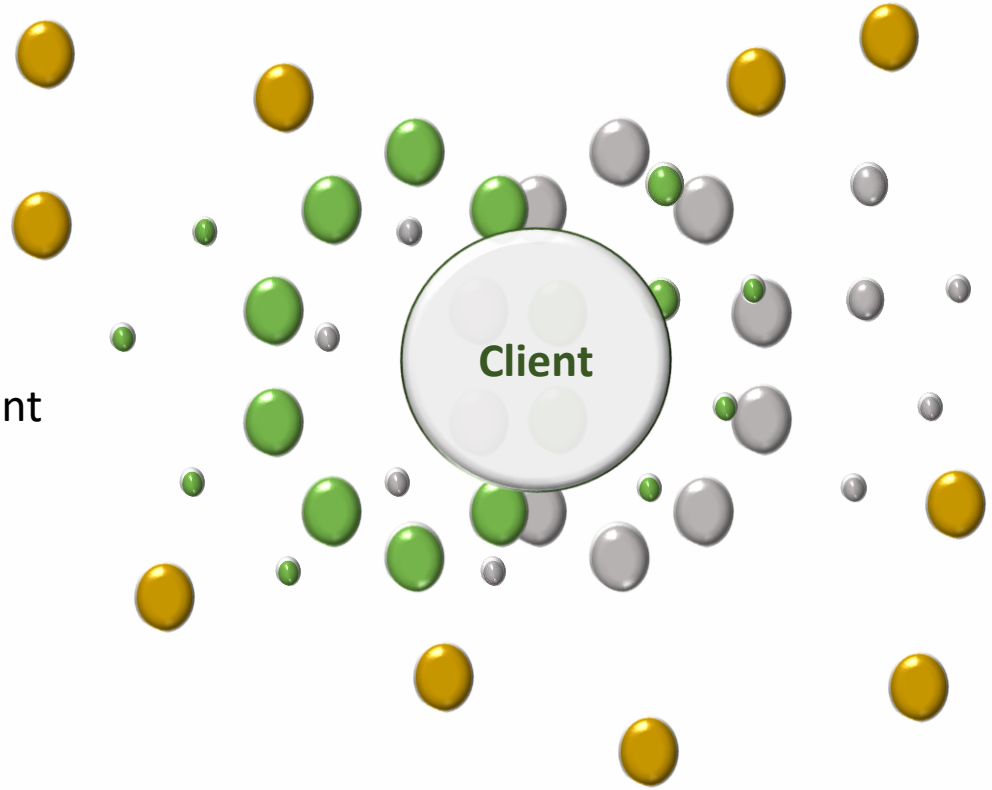
Children's Intensive In-Home Behavioral Support (CIIBS) Waiver-Wraparound



Children's Intensive In-Home Behavioral Support (CIIBS) Waiver-Intensive Case Management

EPSDT/State Plan

- WISe
- ABA
- Evaluation and treatment
- Therapy



Waiver Services

- Staff and Family Consultation
- Stabilization
- Specialized Habilitation
- Equine/Music Therapy

Children's Intensive In-Home Behavioral Support (CIIBS) Waiver

Supports youth ages 8 - 20 at risk of out-of-home services due to challenging behaviors. The model uses wraparound planning and family-centered, strengths based approaches. Services include:

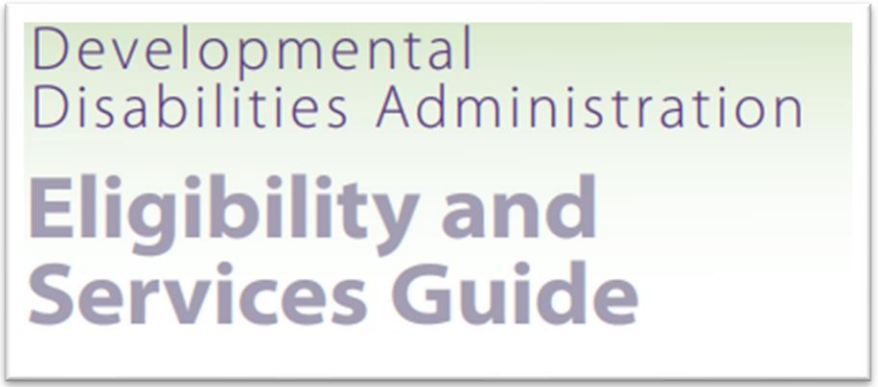
- Specialized Habilitation
- Staff/Family Consultation
- Specialized Clothing
- Therapeutic Adaptations
- Equine Therapy
- Music Therapy
- Assistive Technology

Who is eligible for CIIBS?

To be eligible for the CIIBS waiver, individuals must first be an eligible client of the Developmental Disabilities Administration

Informing Families

https://informingfamilies.org/reasons-to-apply-for-dda-services/



https://fortress.wa.gov/dshs/adsaapps/about/factsheets/DDA/DDA%20Eligibility%20and%20Services%20Guide.pdf

DDA Eligibility – How to Apply

Service and Information Request or return the information listed below:

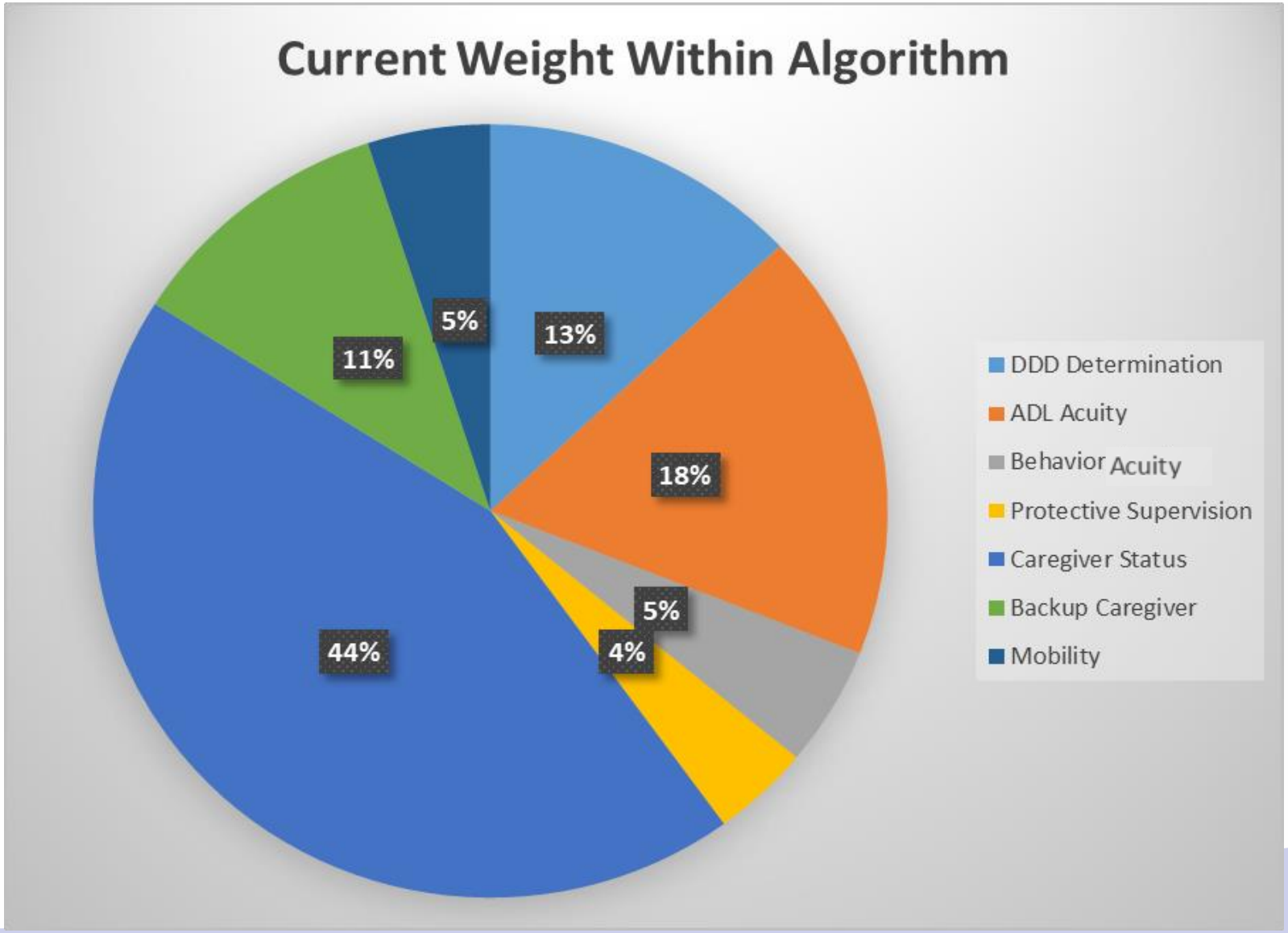
- Request for DDA Eligibility Determination (14-151)
- Notice of Privacy Practices for Client Confidential Information (03-387)
- Consent (14-012)
- Documents that support evidence of a developmental disability,
  - Educational records
  - Psychological records
  - Medical records
- DSHS Forms and Publications

Eligibility Requirements

- Between the ages 8-17 (served until 21st birthday)
- Behavior acuity level is high (WAC 388-828-5640)
- Your caregiver's risk score is medium, high, or immediate (WAC 388-828-5300)
- Live with the family
- Family agrees to participate fully in the program

Algorithm Score Distributions

Caregiver Status is a big driver of the CIIBS algorithm



Who is eligible for CIIBS?

The child or youth must meet CIIBS waiver criteria in the CARE Assessment

- Meet ICF-IID Criteria
- Live in the family home
- Trigger the CIIBS algorithm for high or severe risk of receiving services out of their family home
- There must be an habilitative need for a waiver program
- There must be waiver enrollment capacity

The child or youth must meet additional regional and state criteria

- Regions prioritize their CIIBS requests with a recommendation to HQ for approval or denial, based on criteria in RCW 71A.24
- The must not have an open CPS allegation or a substantiated finding within the last 12 months
- Family must sign an agreement indicating they are interested in participating in the program, and plan to engage in the wraparound process

Role of Regional Staff

- Multi-step process
  - Case Manager determines that the individual is CIIBS eligible in the algorithm by completing a CARE assessment
  - A referral is made to the regional CIIBS coordinator if the family requests to be considered for the CIIBS program
  - The CIIBS Coordinator meets with the family to provide overview of CIIBS and a wraparound model
  - A regional recommendation is made to Central Office for approval or denial

Child and Family Team Meetings

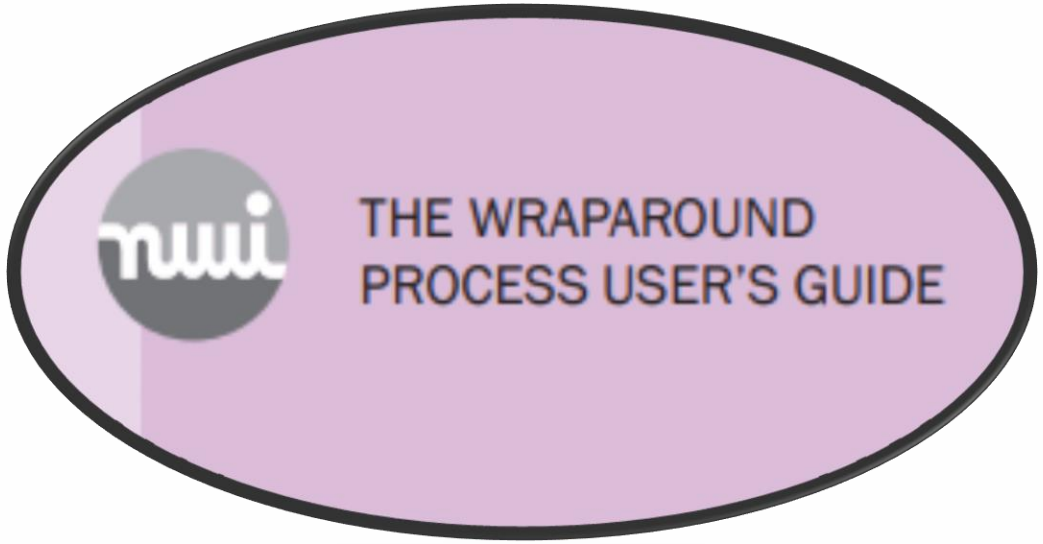
- Start with a Family Vision and a strengths-based approach
- Address unmet needs and crises, leveraging strengths and coordinating treatment needs, waiver needs and informal supports
- Plan for intentional and supported transition to adult services or less restrictive supports when appropriate.

CIIBS Uses a Wraparound Model

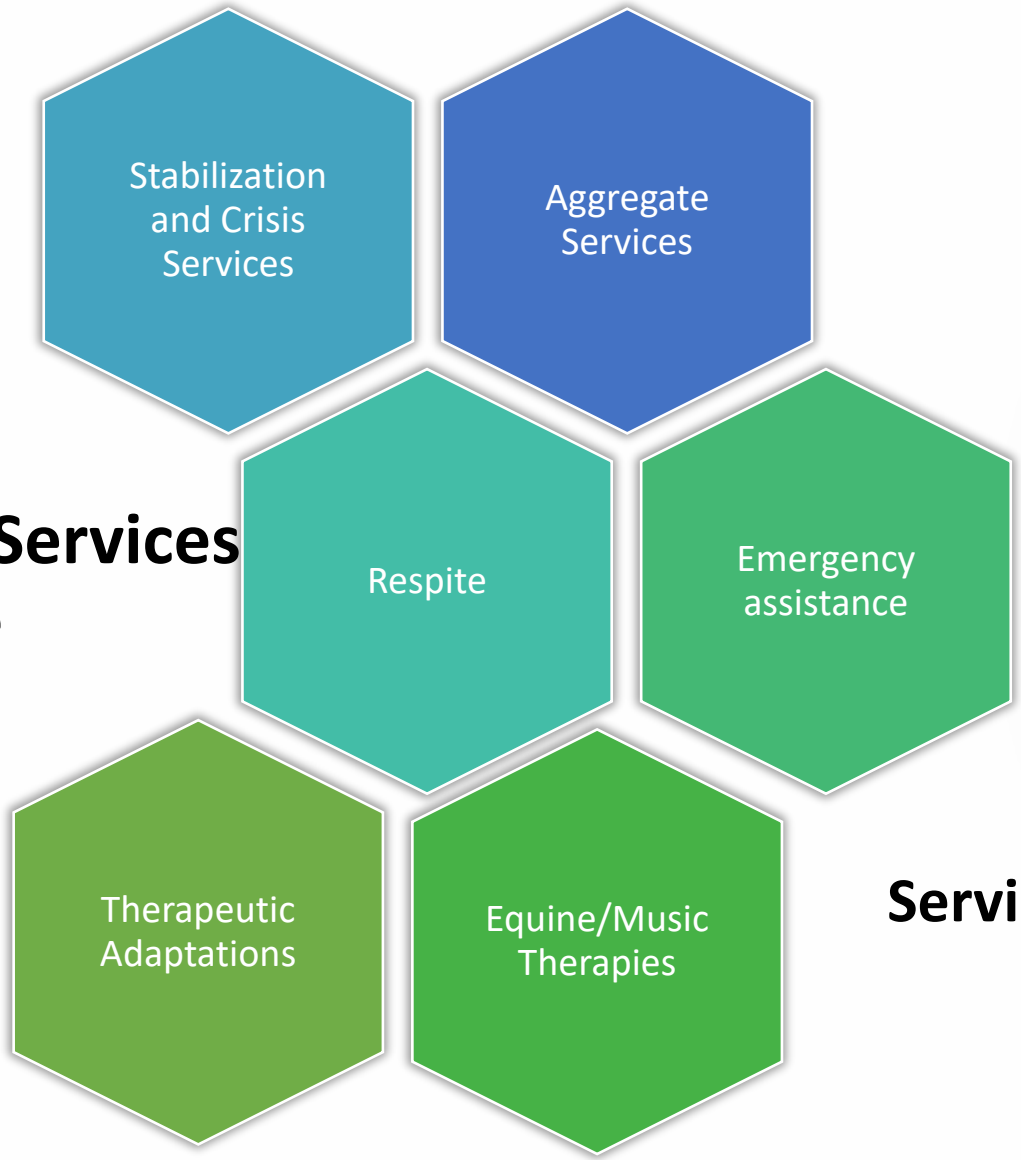
- Wraparound provides whole family support for children and youth with high support needs related to intense behaviors
- The goal of a Wraparound model is to prevent out of home placement
- Wraparound is an evidence based model demonstrating positive outcomes for children, youth and families with very high support needs placing them at risk for out of home placement
- Wraparound uses a unique structure to facilitate child and family centered conversations within a cross systems team-based approach

Enrolling and Participating on the CIIBS Waiver

Wraparound is a phased based approach and makes the CIIBS unique compared to other waivers that DDA administers



Waiver Services Package



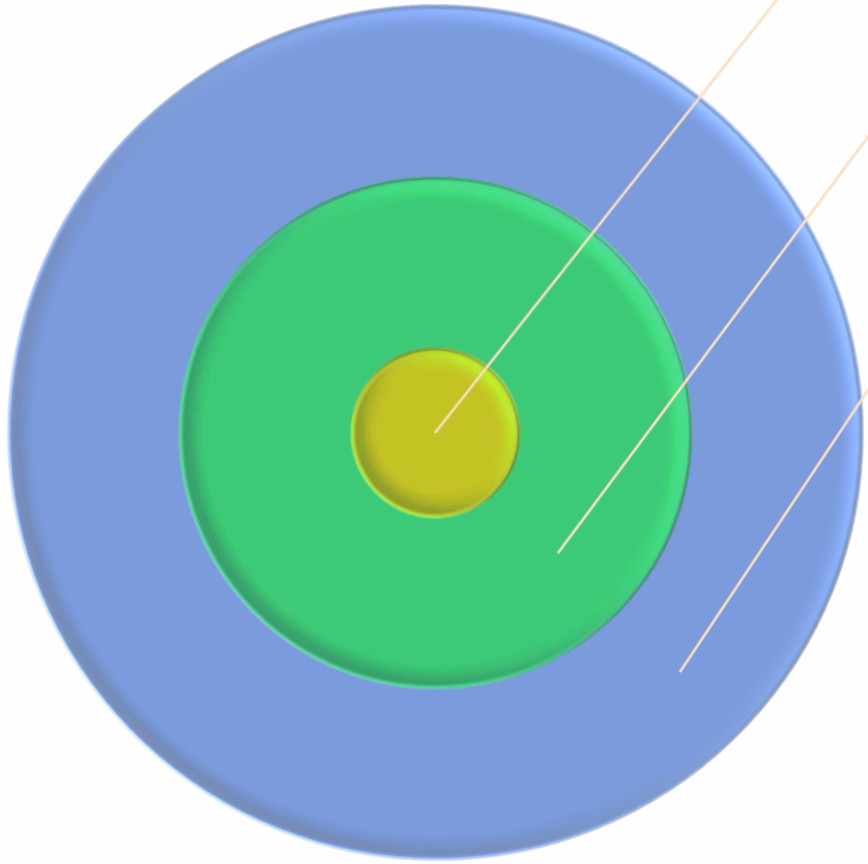
- Rules and Resources
  - WAC 388-845-0225
  - Fact Sheets and Handouts
    - CIIBS Waiver Fact Sheet
  - Informing Families Video

Services Budget Categories

What Services Are Available on the CIIBS Waiver?

Service	Yearly Limit
Assistive technology **Environmental adaptations** Nurse delegation Specialized clothing Specialized equipment and supplies **Specialized habilitation** **Staff and family consultation** Transportation **Vehicle modifications**	$15,000 per year for any combination of services
Respite	Limits determined by the DDA Assessment
Stabilization Services and Risk Assessment	Limits determined by the Person Centered Plan
Emergency Assistance	$6,000 per year
Music, Equine, Peer Mentoring* Person Centered Plan Facilitation*	$5000 per year for a combination of services
Therapeutic Adaptations	One time up to $15,000 every 5 years

Components of the CIIBS Model-Waiver Services Package

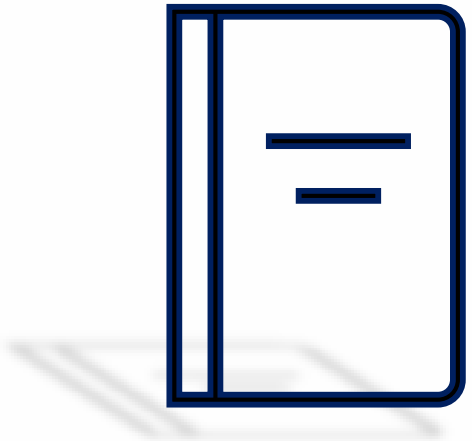


Emphasizing family engagement and support

Skill development and habilitation

Accessibility and Accomodation

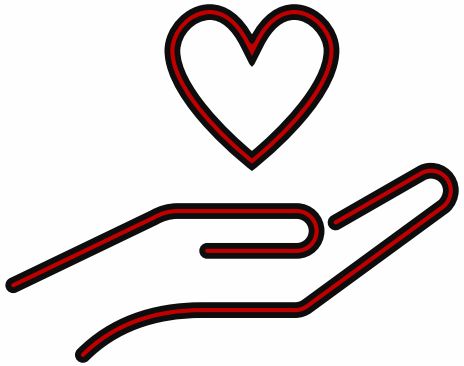
CIIBS Services Resources



CIIBS Waiver Brochure

Available in 9 language translations

DDA Programs and Services Fact Sheets



Care Provider Bulletins and Information

Desired Outcomes

- Children remain in the family home
- Increase family confidence
- Decreased behavior
- Increase in the development of skills
- Achieving the Family Vision

Additional Sources of CIIBS Information

Authority:

- Chapter 71A.24 RCW | Intensive Behavior Support Services
- Chapter 388-825 WAC | DDA Service Rules
- Chapter 388-845 WAC | DDA Home and Community Based Services Waivers

Publications:

- CIIBS Fact Sheet

DDA Policies:

- Policy 4.06 | Children's Intensive In-Home Behavioral Support
- Policy 5.14 | Positive Behavior Support


QUESTIONS

Medicaid Managed Care Organizations

Care Coordination

Washington State Health Care Authority

Goals of Presentation

- Differences between Medicaid delivery systems-Integrated Managed Care (IMC), Behavioral Health Services Only (BHSO) and Fee-for-Service (FFS)
- Children and Youth with Special Health Care Needs (CYSHCN) and the MCO connection
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)-how it relates to CYSHCN
- Provide an understanding of care coordination through the Medicaid Managed Care Organizations (MCOs)
- What is Care Coordination through MCOs and how to request on behalf of individuals and families
- Health Homes (HH) and the Care Coordination connection

Medicaid Managed Care

Medicaid Managed care is a prepaid, comprehensive system of medical and behavioral health care delivery. It includes preventive, primary, specialty and ancillary health services

- Goals of Medicaid Managed Care
  - Improve access to care
  - Improvement in health plan, performance, health care quality, and outcomes are key objectives of Medicaid Managed Care
- Advantages to Medicaid Managed Care
  - Care Coordination
  - Guaranteed access to a primary care provider

Medicaid Managed Care

Five Medicaid Managed Care plans are contracted with the state to deliver Integrated Managed Care (IMC) to provide physical and behavioral health:

- Amerigroup
- Community Health Plan of Washington
- Coordinated Care of Washington
- Molina Healthcare of Washington
- UnitedHealthcare

* Coordinated Care of Washington is also contracted as the single managed care plan to serve the integrated foster care contract statewide, including foster children and youth, adoption support, and alumni of foster care

Washington State Health Care Authority

MCO-BHSO-FFS

Medicaid benefits are provided on a Fee for Service (FFS) basis or through managed care plans provided by one of five contracted Managed Care Organizations (MCO). Managed Care plans provide service coverage at two different levels – **Integrated Managed Care (IMC)** and **Behavior Health Services Only (BHSO)**

- IMC plans cover medically necessary services including physical and behavioral health
- BHSO plans cover certain behavioral health services (mental health and substance use disorder treatment) as contracted to the MCO.
- Both IMC and BHSO Apple Health clients also have some services covered through FFS

Who are CYSHCN?

- Individuals under 19 years of age who are any one of the following:
  - Eligible for Supplemental Security Income (SSI) under Title XVI of the Social Security Act;
  - Eligible for Medicaid under Section 1902(e) (3) of the Act;
  - In foster care or another out-of-home placement;
  - Receiving foster care or adoption assistance; and/or
  - Receiving services through a family-centered, community-based, coordinated care system that receives grant funds under Section 501(a) (1) (D) of Title V of the Social Security Act

Detect and Connect

- ✓ Collaboration between state Title V MCH programs and Medicaid includes confidential data sharing requirement with HCA's Medicaid program
- ✓ CYSHCN are identified by an indicator in the Provider One System
- ✓ Informs providers and the MCOs that these children may need care coordination and other supports and services

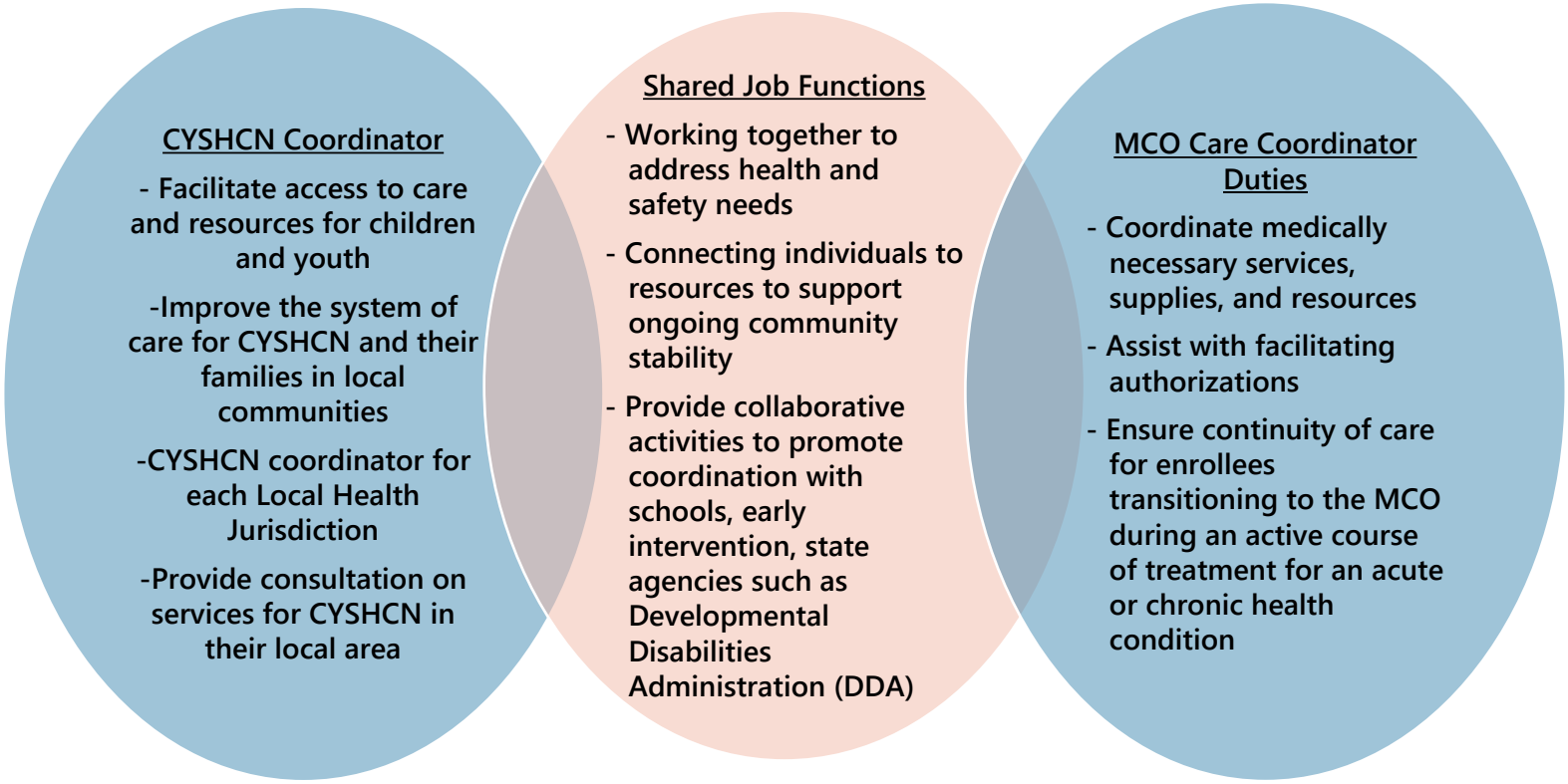
Washington State Health Care Authority

CYSHCN Health Services under the Medicaid EPSDT Benefit

- Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) benefit provides preventative and enhanced service coverage for aged-20 and younger
- Medically necessary services identified within EPSDT are covered by the program even if the services are not otherwise covered under the Medicaid State Plan
- The right care to the right child at the right time in the right setting

Washington State Health Care Authority

Roles and Responsibilities | *Comparison*



Care Management Overview

***Umbrella term that includes care coordination and case management**

Care Coordination (CC)

- Focus on short term or intermittent needs
- May be provided by unlicensed/nonclinical staff
- Access to care/services addressing social needs
- Improve clinical outcomes
- Increase self management skills
- Voluntary

Case Management (CM)

- Focus on longer term support (approx. 3-6 months engagement)
- Provided by licensed/clinical staff
- Assist members in managing complex healthcare needs
- Goal setting based on individual's priorities
- Integrated care planning with member consent
- Voluntary
- CM services are voluntary, and we must have member/guardian consent to provide CM

Care Management Overview

- Collaborates with other existing teams to effectively manage complex needs of individuals or populations.
  - DCYF, DDA, Schools, Community Supports, etc.
- Community providers also do case management services for members.
- Strives to enhance or supplement current efforts and eliminate duplication of work.
- Is a partner at the multidisciplinary team table.
- Assists with follow up on treatment team recommendations.
- Can work with other insurance companies to coordinate care.
- Includes transitions of care from one level of care to another.

Requesting Care Coordination

Send a secure email to the client's MCO to request care coordination.

- Emails from local health jurisdiction identify the sender as a public health employee and are HIPAA-compliant

Specify [CYSHCN - Request for Care Coordination] in the subject line and provide the following information within the request:

- Individual's name
- Individual's ProviderOne ID (9-digit number ending in "WA")
- Individual's date of birth
- CYSHCN's Coordinator's name and contact information
- Details about the individual, including current services (if known) and the reason for the request for care coordination

- Client or legal representative's contact information

  - ✓ Indicate that the client or their representative requested care coordination
  - ✓ Indicate if the MCO should contact the CYSHCN Coordinator prior to contacting the individual or their representative

Requesting Care Coordination

Use the following links to request care coordination from a client's Apple Health managed care plan

- Molina: MHW_PediatricCM@MolinaHealthCare.com
- CHPW: CareMgmtReferrals@chpw.org
- CCW: CareManagement@coordinatedcarehealth.com
- UHC: WA_CareCoordinationRequests@uhc.com
- Amerigroup: cmrefwash@amerigroup.com

Care Management Overview

***Umbrella term that includes care coordination and case management**

Tips for requesting Care Coordination

- Be Specific- what kind of help are you seeking?
- Please discuss with client/guardian prior to referral and get consent prior to referral (if possible).
- Be specific with client information, name, DOB and Provider One number
- Communication to and from MCO and CYSHCN team is critical.

By providing this information the MCO will be able to determine the best course of action

Washington State Health Homes Program and Care Coordination

Who is eligible

- Must be active on Medicaid includes dually eligible (Medicaid and Medicare)
- Have a PRISM risk score of 1.5 or greater
- Has one chronic condition and is at risk for a second
- All ages are eligible

The six Health Home Services

- Comprehensive care management
- Care Coordination
- Health Promotion
- Comprehensive transitional care
- Individual and family support
- Referral to community and social support services

Washington State Health Care Authority

Requesting Assistance/Resources

- List of CYSHCN-MCO Care Contacts, updated every six months
- Request the list from Smith, DeeAnn (HCA) DeeAnn.Smith@HCA.WA.GOV
- Utilize request for Care Coordination from the MCOs (previous slides)
- HCA MC Programs hcamcprograms@hca.wa.gov
- Health Home email box HealthHomes@hca.wa.gov

Questions?

Questions?

HCA Managed Care Programs
hcamcprograms@hca.wa.gov

Washington State Health Care Authority

Thank You!

- Kathleen Donlin, RN
- Iana Bezman, RN
- Tammy Parvin, RN

Washington State Health Care Authority

Washington State Department of Health

10 MINUTE BREAK

Return by 10:40

The 360 Platform

Helping families identify and navigate the resources they need, when they need it.

AGENDA & INTRODUCTIONS

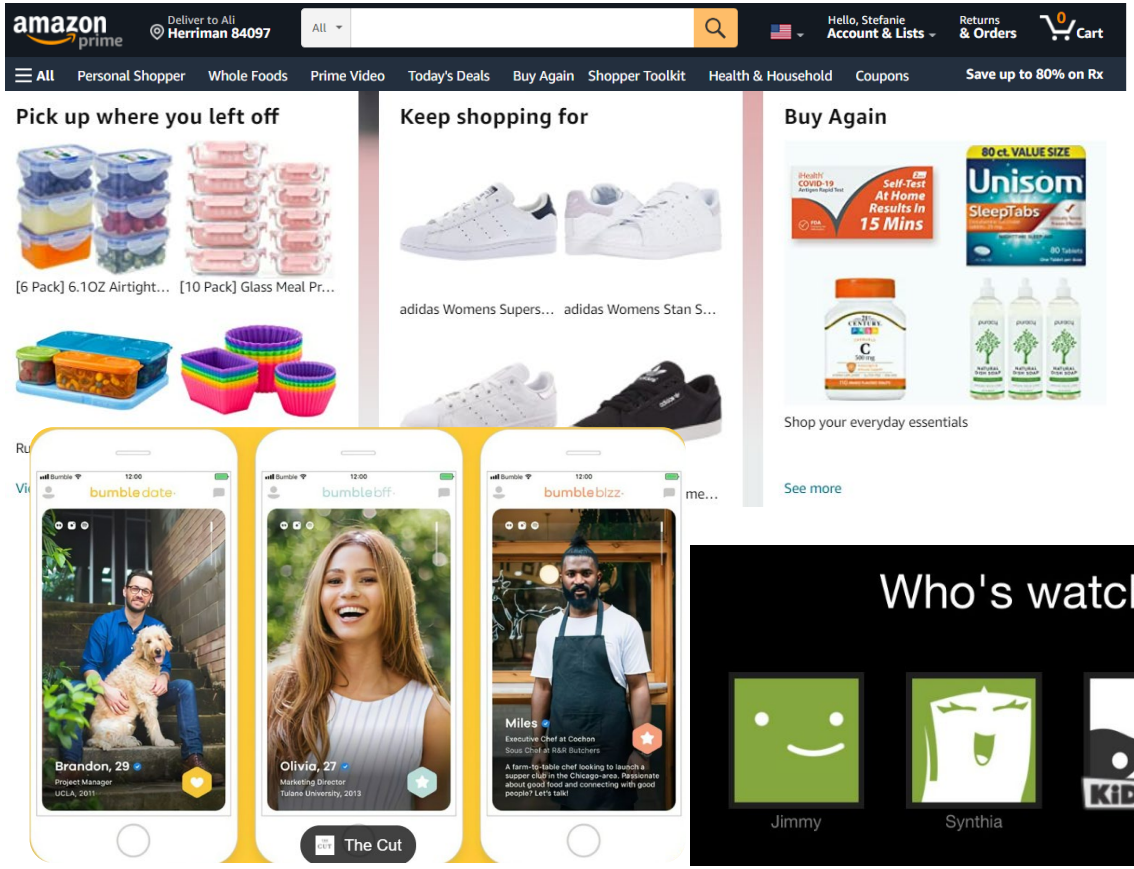
TOPIC	OBJECTIVE
Platform Introduction	• Technology as a catalyst for helping communities • The 360 vision
AS360 + BH360 Deep Dive	• Platforms currently under development • Progress to date • Deep dive on site capabilities and goals
The 360 ROI for Washington State	• Build requirements to bring the 360 platforms to life • Helping services across the state move from reactive to proactive • How to get involved

Kemi Akinlosotu
AS360 Program Coordinator

Stefanie Robinson
COO, RPrime Foundation

PLATFORM VISION

TECHNOLOGY ENHANCES CONSUMER EXPERIENCE



- Technology advances (Artificial Intelligence, Machine Learning) have dramatically changed the consumer experience
- This technology underlies most day-to-day decisions and alleviates many common challenges
- While successful at helping with shopping, knowing what to watch, and even dating, life's hardest challenges have yet to take advantage of this enhanced experience

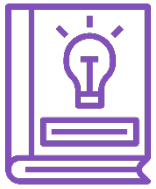
TECHNOLOGY ENHANCES HUMAN EXPERIENCE

What if this personal, highly curated, easily navigable approach to life's greatest challenges?

The use cases are endless, and potential for positive change is immense.

EXAMPLE USE CASES

Healthcare Needs



Education

Mentorship + Entrepreneurship

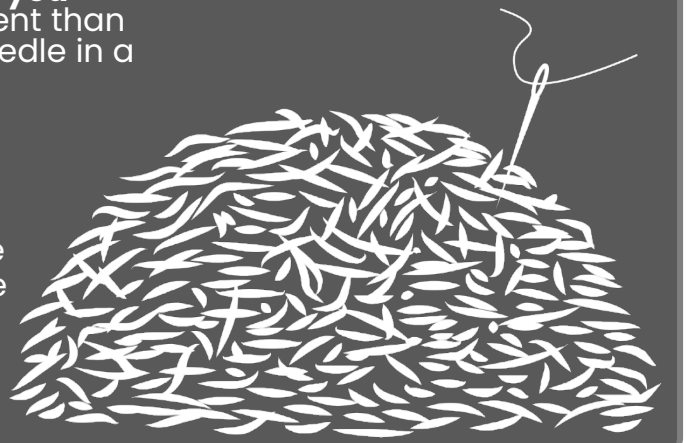
Rehoming (refugees, military, etc.)

EXAMPLE CHALLENGE

If someone in need googles, "Behavioral Health Resources Washington" **2.38 BILLION** results will appear.

Finding access to the right kind of care, **when you need it** is no different than searching for a needle in a haystack.

How can we bring coherency and enhance accessibility to the resources we have for our communities?



THE 360 VISION

We seek to build an **interactive** curated platform targeted at life's greatest challenges to alleviate the burden for those in need.

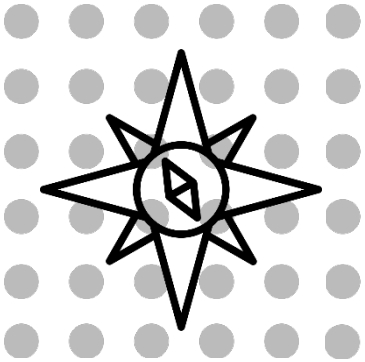
We can see a day when…

- Families and individuals have a clear path and immediate access to resources, training tools, and community forums for a variety of challenges they may face
- Resources can be accessed early and often enabling a transition from a reactive to a proactive state
- Resources, services, and information are readily available, reliably helpful, and customized for your unique needs
- The 360 platform is informing structural changes to enhance system offerings for communities across the country
- Families have peace of mind knowing services and opportunities exist for their children through every stage of their lives through to adult independence
- Seamless transition can occur between 360 platforms providing robust support for life's greatest challenges

PLATFORM OVERVIEW

360 PLATFORM APPROACH

Our three-step approach to providing support can build community and momentum to helping others solve problems across a variety of challenges.

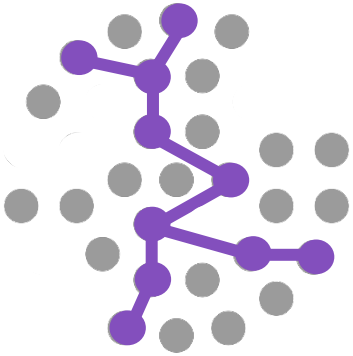


ASSESS

Leverages diagnostic tools (where appropriate, clinically validated) to support users in narrowing their specific needs.

CURATE

Leverages a verified list of resources, programs, and (where appropriate) providers to curate applicable options based on responses to the diagnostic tools.



CONNECT

Provides community forums to foster discussion and support across those with lived experience facing similar challenges.

BACKGROUND: THE 360 PLATFORM

The 360 platform is a cloud-based software program that leverages best-in-class technologies for a comprehensive support system across a variety of challenges.

We intend to leverage this framework to enable **connection and access to curated resources** to serve individuals and strengthen communities.

Cloud Based

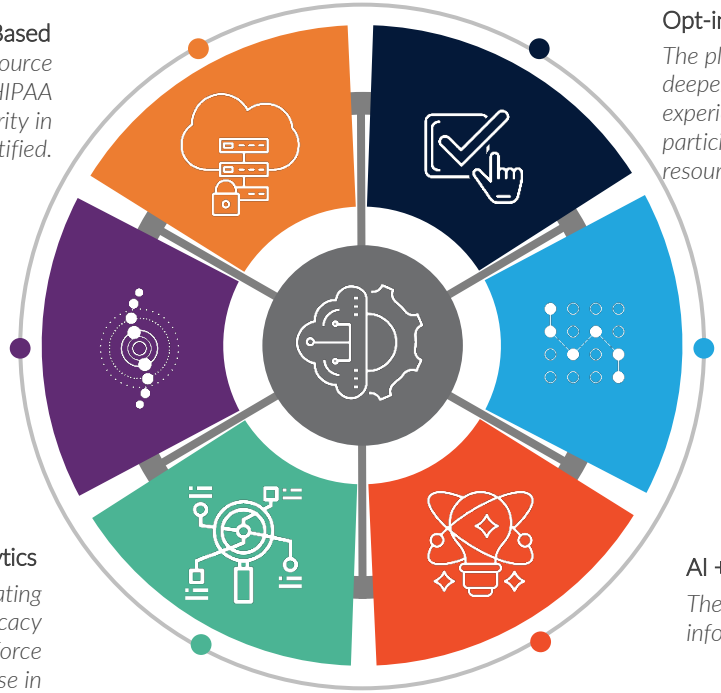
The system is cloud based to minimize technology resource oversight and ensure longevity in the product. All HIPAA regulations are applied as appropriate to ensure security in patient data – both identifiable and de-identified.

CRM Backbone

The platform includes a CRM profile for all users the opt-in to participation. Feedback will follow up with participants to encourage long-term engagement and inform efficacy of resources. A CRM based approach enables a transition from reactive to a proactive future state.

Research + Analytics

De-identified data is collected across participants, creating opportunities for data collection and analytics for advocacy and research use. Over time, data collection can reinforce and strengthen community systems to best serve those in need.



Opt-in Participation

The platform allows for patients and families to opt-in to a deeper engagement. Participation enhances the experience by providing curated resources. Declination to participate will still enable access to all information and resources.

Curated Information + Resources

The system curates resources that best align with outputs of the assessment tools. This enables individuals and families to find and access the right information to support their needs.

AI + Machine Learning

The system leverages AI to pull in and maintain current information about resources, programs, and providers.

360 PLATFORM IN ACTION

IDEATION	PLANNING + BUILD	E	PILOT	LAUNCH	EXPAND
• Socialize idea with subject matter experts • Build consensus / identify potential partners • Understand market need	• Onboard appropriate partners + SMEs • Identify technical needs for build • Extensive interviews of target customer(s)	• Share with partners, SMEs, and potential funders • Continuously gather feedback for iterative build to pilot • Identify pilot partners, define success measures	• Launch with targeted partners for customer feedback • Monitor site analytics to determine fit / need alignment with build • Determine funding for subsequent launch	• Formal launch to targeted community for use (almost all cases will be PNW) • Begin to identify potential expansion opportunities for subsequent phases of work	• Expand capability internal to site and/ or to other geographic locations • Strategy will vary depending on platform

BH360

BH360 PROTOTYPE LAUNCHED 05.17

AS360

AS360 IN SOFT LAUNCH WITH SCAC AND UWAC

BH360: PRODUCT ROADMAP

WE ARE HERE

PROTOTYPE

- **Screening capability** across 11 disease types (anxiety, attention difficulties, autism*, depression, disruptive behaviors, eating difficulties, elimination, mania, psychosis, substance use, suicidality, trauma) to narrow resource information
- Educational resources about depression including different types, **common signs, evidence-based treatments** for your child, etc.)
- Awareness resources including advocacy information, **how to find the right provider and a printout to bring to your potential therapist to help evaluate** if they are a good fit for your needs
- Connection and links to external sites rich with information for deeper dives
- **Providers within a geographic range** of the users choosing with their **specialties of focus** listed and **if they accept insurance**
- **Community forum** (depression only)

PILOT

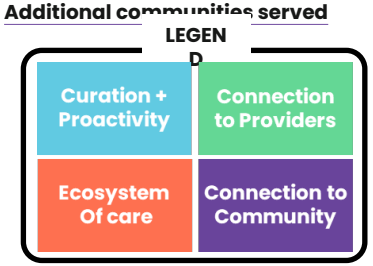
- Educational resources (**all 11* disease types**) – common signs, evidence-based treatments and interventions, etc.
- **Ability to "register"** and input personal data to store and use for personal need
- Analytics engine to generate **insights on users, provider fit, and efficacy of information** provided
- Advocacy resources including **how to find the right therapeutic approach and therapist** for your child
- Ability to complete a form that is generated and sent to potential providers for an **appointment request**
- Ability to **survey users** on provider fit (net promoter like score), and efficacy of resources accessed on the site
- **Community forums** (all disease types and care provider types)

BH360 1.0

- **Enhanced curation** given additional data in the system, with data and feedback gathered thus far, resources will be more acutely tailored to fit the users need
- Automated ability to **add new providers**, ongoing
- **Search functionality** within community forums
- Incorporation of **feedback from users** in the pilot phase

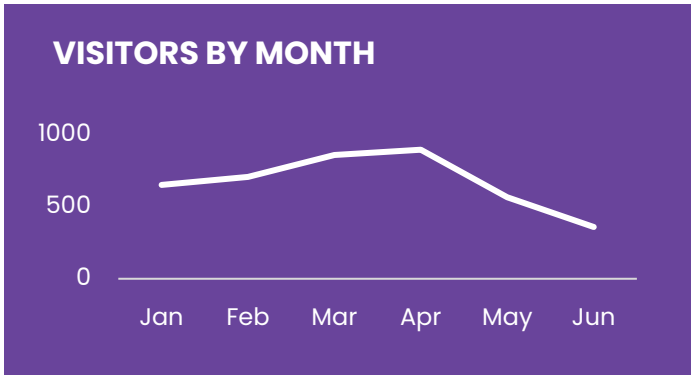
BH360: FUTURE

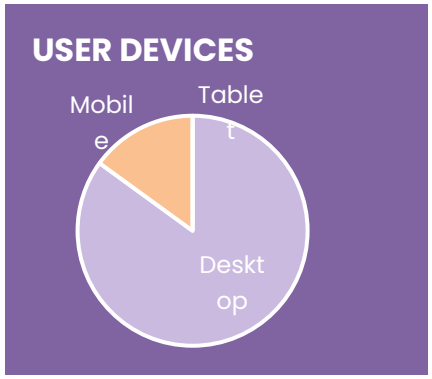
- Curated providers by user demography (if desired) using scores and data gathered, ongoing
- **Longitudinal tracking** of participants, assists in moving from reactive to proactive
- Educational resources for those post-diagnosis
- Ability to build a document repository including milestones to **log information** + share with providers
- Ability to **share documents** with "team" child
- Ability to connect to other platforms for monitoring interventions, etc. (e.g. Manatee)
- **Additional communities served**

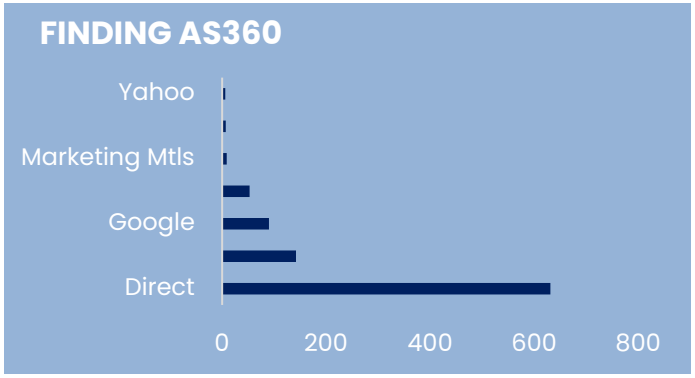


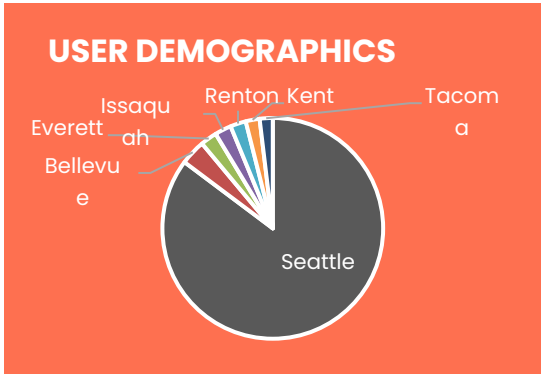
Feb – mid May → **June – ?** → **Targeting: Fall 2023**

AS360: PRODUCT PROGRESS



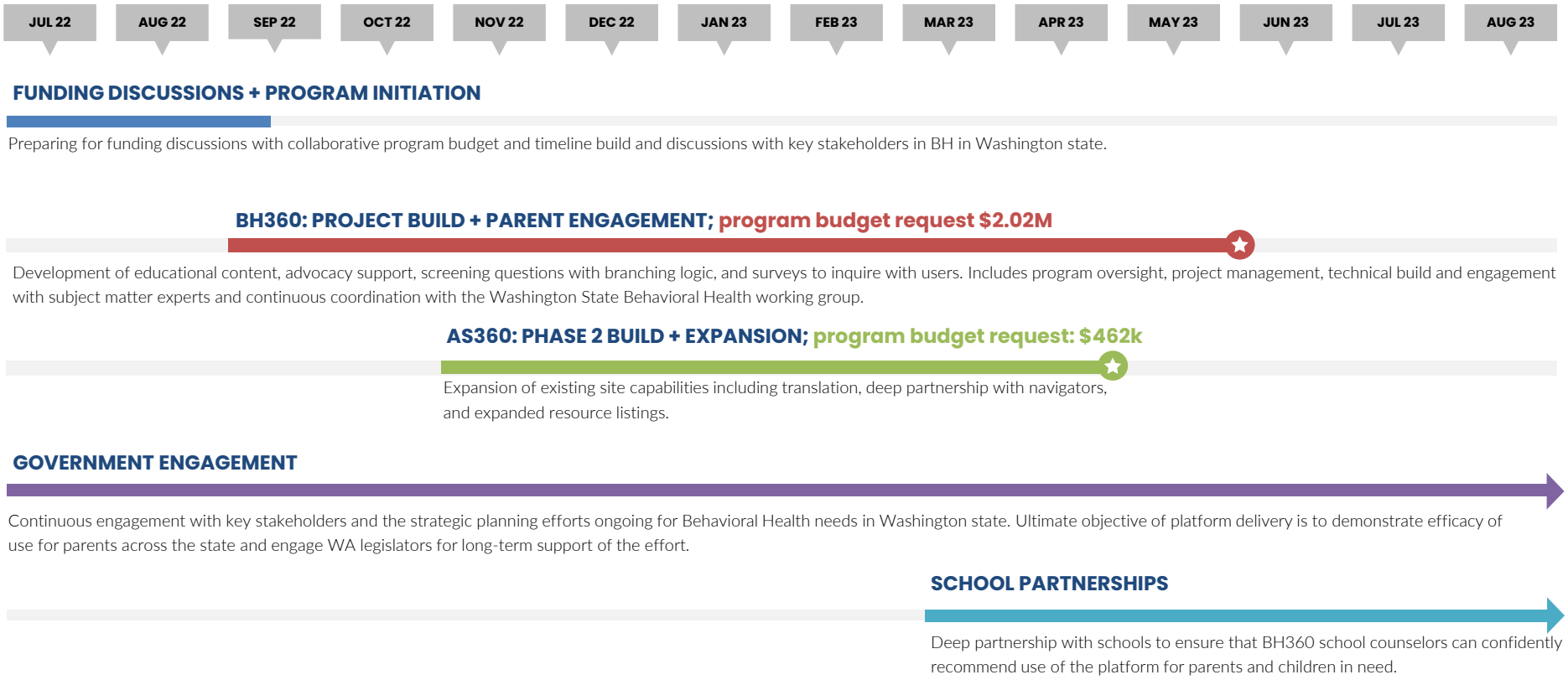






360 PLATFORM: NEXT STEPS

360 PLATFORM BUILD TIMELINE



360: GETTING IT RIGHT

Our platform will alleviate the burden on families in Washington state and provide a much-needed strategic model for the nation.

Our step-wise approach ensures we are achieving desired impact before expanding platform capabilities.

1 BH360

EFFECITIVE RESOURCE: INDIVIDUAL ENGAGEMENT

Our tool will first and foremost demonstrate efficacy for families in need.

2 AS360

AUGMENTING WORKFLOWS: COUNSELOR ESSENTIAL TOOL

The platform must enhance existing workflows for those most closely connected to families in need. For BH360, school counselors are often front lines in early identification of behavioral health needs.

3

ECOSYSTEM ENGAGEMENT: A NECESSARY RESOURCE ACROSS THE STATE

Connecting the ecosystem across the state for resources partnered with insights on efficacy and areas of need generates highest opportunities for impact.

4

EXPONENTIAL IMPACT: NATIONWIDE APPROACH TO SUPPORT

With demonstrated impact in Washington, the platforms can seamlessly expand for national engagement to support families in need across the country.

360: STEPPING INTO IMPACT

THE 360 ROI

Integrating our services in Washington state, we aim to demonstrate that our tools are supporting families with **early identification and intervention** of behavioral health needs in their children. We believe that with the right tools and information families can mitigate larger and sometimes fatal circumstances.

Initial partnerships with schools and navigators will help us validate the tool's efficacy in a way that can be iterated upon to ensure our ultimate platform delivers greatest impact for families and communities in need.

CONNECTING THE ECOSYSTEM

Identifying and accessing appropriate medical care should not be a privilege for only those who can afford to take time off to figure out what is best for their family after receiving a diagnosis.

A NEEDED RESOURCE

Our existing systems are not adequately supporting the volume of demand for behavioral health services, particularly in children. Families have wisdom from lived experiences, and this platform will help them connect with one another.

EQUITABLE ACCESS

We have developed user surveys that will query families about the efficacy of the information we provide, resources we link to, and the providers they connect with. Data collected real time will help us learn and adjust our workflows; enhancing the opportunity to align families with the greatest possible match for resources given their need.

LONGITUDNAL ENGAGEMENT

Monitoring a child's progress with our screener over time provides unique views on children struggling with behavioral health challenges longitudinally. This helps a parent track their child's response to interventions leveraged and services accessed. Use of this de-identified data can be leveraged for research in an area of great need.

SHIFTING TOWARD PROACTIVITY

Data provided by our users can be deidentified and aggregated to provide a unique view on behavioral health needs across the state. Monitoring these trends over time will provide insights into what pockets across our state or age specific populations are in highest need of support, enabling us to move to greater levels of proactivity for behavioral health services. These trends will generate insights about needs and gaps for systemwide improvements.

MOVING FORWARD

As we continue to build out the 360 platforms, we will need input from many key stakeholders.

WANT TO GET INVOLVED?

- **Parents** can provide user feedback and assist in our ability to ensure the tool best meets their needs
- We are looking to partner with **a school** (or many) for BH360 to recommend use of the platform to parents in need
- We will continue to expand the **resource listings** on our AS360 page and are looking for further engagement with programs across the state
- We will require additional funding to bring this vision to fruition and are seeking **investors or grants** to enable our ability to do so

Shayla's List

A menu of resources to support individuals with intellectual and developmental disabilities (IDDs)

~~~ Financial ~~~

Prescription for Diapers

What is it? For children ages 3 years and older, diapers can be covered by medical insurance with a prescription.

How to get it:. You will need an annual prescription for diapers with a diagnostic code of bowel and bladder incontinence. A medical supply company will provide you with the diapers.

Charity Care and Financial Assistance at Washington State Hospitals

What is it? Washington's hospitals are committed to ensuring patients get the hospital care they need regardless of their ability to pay for that care. Charity care eligibility is based on family size and income. Providing health care to those that cannot afford to pay is part of the mission of Washington's hospitals. State law requires hospitals to provide free and discounted inpatient and outpatient care. Each hospital is responsible for maintaining its own charity care program.

How to get it: Reach out to the hospital's charity care/financial assistance program for information on eligibility and to get the application. Below are links to information on the children's hospitals programs:
Seattle Children's Hospital
https://www.seattlechildrens.org/clinics/paying-for-care/financial-assistance/
Sacred Heart Hospital
https://www.hshs.org/SacredHeart/Patients-Guests/Patient-Financial-Services/Patient-Financial-Assistance
Mary Bridge Children's (part of Multicare)
https://www.multicare.org/patient-resources/financial-assistance/

SSI (Supplemental Security Income)

What is it? Supplemental Security Income (SSI) is a federal program that gives payments to children and adults with disabilities who have limited income and resources. The cash payments can be used to meet basic needs for food, clothing, and shelter.

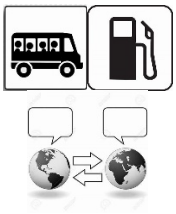
How to get it: Call toll-free at 1-800-772-1213 (TTY 1-800-325-0778) between 8:00 am – 7:00 pm., Monday through Friday.

DDA	***What is it?*** The Developmental Disabilities Administration (DDA) is where people go to get help for in-home, out-of-home, and community-based services. Children who do not qualify for SSI due to family income may still be eligible for DDA services which are based on the child's disability and not family income. ***How to get it:*** Website on how to apply: https://informingfamilies.org/topic/dda-services/ Website where you apply: https://www.dshs.wa.gov/dda
Medicaid Premium Payment Program 	***What is it?*** Medicaid will provide reimbursement for private health insurance coverage when an Apple Health (Medicaid) client has access to private health insurance coverage, such as through an employer or private policy. ***How to get it:*** https://www.hca.wa.gov/health-care-services-supports/program-administration/premium-payment-program
Ben's Fund 	***What is it?*** This is only for children who have a diagnosis of Autism Spectrum Disorder. It is a $1000 grant that can be used for your child's services, technology, therapies, camps, equipment, safety/security, etc. ***How to get it:*** www.bensfund.org

~~~ Transportation ~~~

Disability Parking Placard 	***What is it?*** A parking placard that allows your family to park close to the entrance of medical/dental offices, hospitals, grocery stores, shopping centers, zoos, etc. if there is a medical condition for your child that qualifies. ***How to get it:*** Your child's medical provider needs to write a prescription and the Disabled Parking Application for Individuals. Take both of these to where you get your parking tabs. The Disabled Parking Application for Individuals can be found at this website: https://www.dol.wa.gov/forms/420073.pdf More information can be found at: https://www.dol.wa.gov/vehicleregistration/parking.html

Medicaid (Apple Health) Transportation Services



What is it? The Health Care Authority (HCA) covers nonemergency transportation for eligible clients to and from covered medical appointments through transportation brokers. For eligibility, clients must have a current ProviderOne services card, have no other way to reach your health care appointment, and must ensure that the appointment is covered by your Apple Health program. The most common types of transportation available include: public bus, taxi, wheelchair van, airplane, gas vouchers, ferry tickets, and reimbursement for vehicle mileage.

How to get it: Contact the transportation broker for your county. The transportation broker will arrange transportation that is most appropriate for you. Transportation to health care providers that are outside of your local community will need approval from the transportation broker.
https://www.hca.wa.gov/health-care-services-supports/apple-health-medicaid-coverage/transportation-services-non-emergency#transportation-broker-directory

WA State Ferries

What is it? Reduced fare tickets on WA State ferries.

How to get it: Present identification verifying disability eligibility to the ticket seller when purchasing a ticket. More details at https://wsdot.wa.gov/ferries/rider-information/ada

Public Transportation Reduced Fare Permit

What is it? People with disabilities may ride the bus or train at a reduced rate if they submit an application to their local agency and get approved for a permit.

How to get it: Contact your local public transportation office for information on eligibility and the application.

Orca Card/Sound Transit: https://www.soundtransit.org/ride-with-us/how-to-pay/fares/regional-reduced-fare-permit

Spokane: https://www.spokanetransit.com/files/content/rf-passapplication-final.pdf (includes application) Autism specifically called out

Yakima: https://yakimatransit.org/media/DAR-Reduced-Fare.pdf

~~~ Recreation ~~~

National Parks Pass	***What is it?*** The Access Pass is a free, lifetime pass available to U.S. citizens or permanent residents of the United States that have been medically determined to have a permanent disability (does not have to be a 100% disability) that severely limits one or more major life activities. It provides access to more than 2,000 recreation sites managed by five Federal agencies. **How to get it:** https://store.usgs.gov/pass/access.html#benefits
WA State Parks - Discover Pass	***What is it?*** You do NOT need a Discover Pass for day use access at state parks if you have a disability placard/license plate OR a free state-issued Disability Pass. This program also offers free watercraft launching, trailer dumping and a 50% discount on camping and moorage. ***How to get it:*** https://parks.state.wa.uw/1207/Disability-Pass

This resource list was created by Shayla Collins and is distributed through the Washington State Medical Home Partnerships Project (MHPP). If you would like to share ideas or feedback on this list, please send an email to info@medicalhome.org.

Closing and Next Steps

- Meeting Minutes and Recording will be available in the coming weeks
  - Please send any program updates you would like included in the minutes to Sarah or Renee

Networking Meeting (optional)

Regional Connections and Brainstorming

Then Share Out and group collaboration

Washington State Department of Health

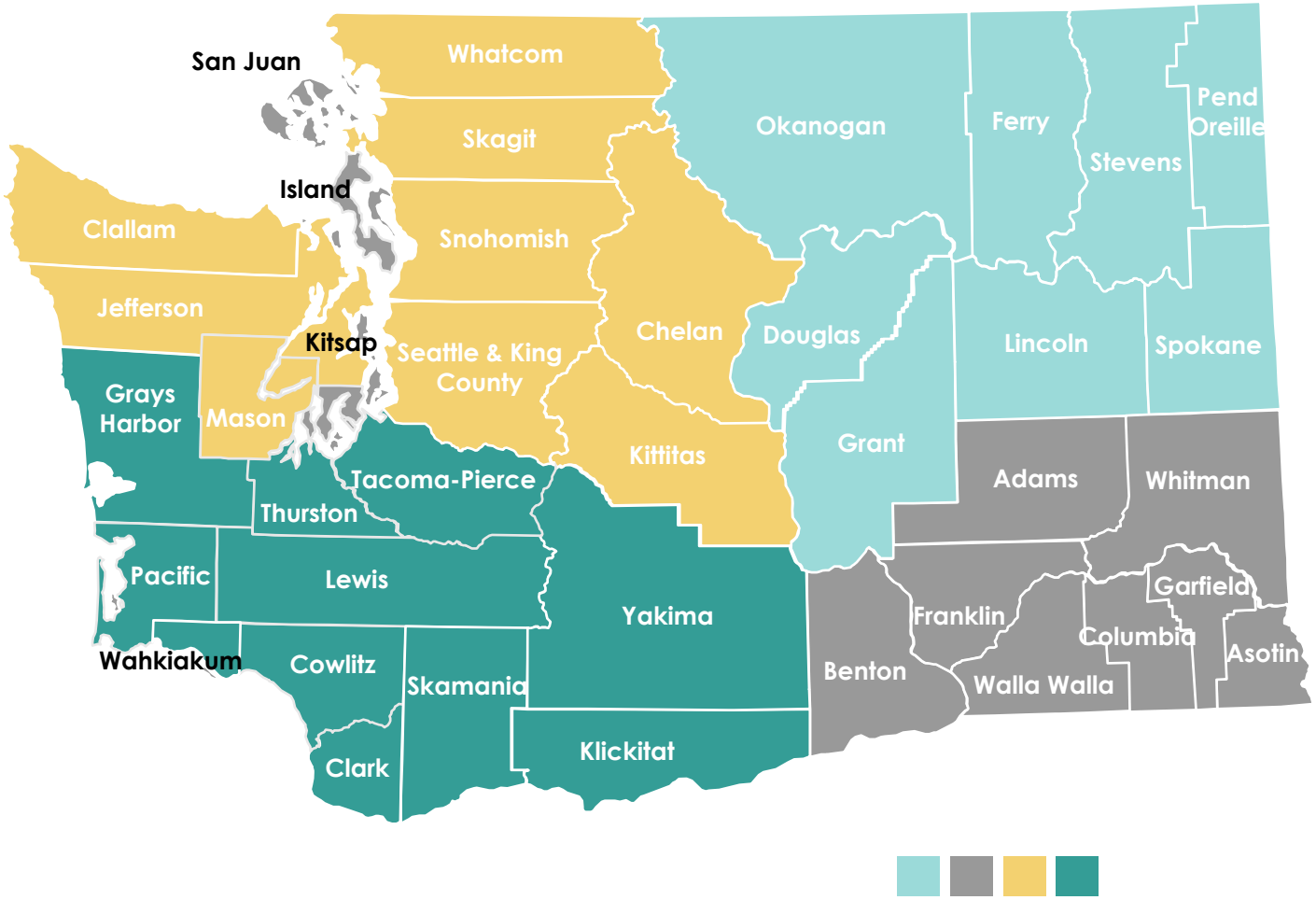
10 MINUTE BREAK

Return by 12:10

Networking Lunch

12:10-12:15	Agenda and Discussion Questions
12:15-12:35	Join Regional Breakout Group: **Networking and Discussion Questions**
12:35-12:55	Rejoin, Regional Share Out, and Group Collaboration via Whiteboard
12:55-1:00	Next Steps and Close Out

Regional Breakout Groups



Regional Group Talking Points

Introductions:

Name, Agency, Duties

What are your **Regional Assets and Capacities?**

AKA: What is going well? What are you proud of?

***Ideas for leveraging your strengths?**

What are your **Regional Challenges and Barriers?**

AKA: What do you see the population you serve struggling with?

What do **you** struggle with when seeking to meet the needs of your community?

***In a perfect world, what would improve your ability to support your community as well as meet the needs of your community?**