TREATMENT SALES TAX THURSTON COUNTY, WA ADVISORY COMMITTEE

Meeting Minutes: Friday, September 20, 2019

Date	Time	Location	Preparer of Minutes
9/20/19	8:30-11:30am	PHSS Building, Olympia	Pam Gant

Attendance			
Committee Members		**TST Staff**	**Others**
Joe Marmo Jim Stanton Bob Jones Wendy Tanner Marilyn Roberts Skip Steffen	Absent Gina Thompson Glenn Dunnam Chanita Jackson	Carrie Hennen Pam Gant	Athena Grijalva Christina McVeigh Donna Obermeyer Mariel Macauley Gary Enns Mike Fenton Jackie Yee Gretchen Thaller Liz Davis Lori Montoya Whitney Pearsall Tricia Wiltse Amy Martin Laura Vogel Kristy Dees Pam Hartman Beyer Heidi Williams Robin Campbell Robyn Martin Christy Peters Tonia McClanahan Katie Alderson

Agenda Item	Notes
Welcome & Introductions	▪ *This program showcase focused on TST-funded programs serving youth and families. Programs were asked to reflect on their TST data and complete a brief presentation template in advance of the meeting.* ▪ *Housekeeping announcement*: All programs have 10 minutes for their presentations; TST staff time-keeper will provide 4 minute and 1-minute warning to keep the program showcases on schedule; TST staff encourages leaving 3-4 minutes for questions; all additional questions can be written down and passed to TST staff to discuss at the end of the presentations ▪ *Introductions:* Name, agency, and which programs you are associated with
Program Showcases	*Notes below capture basic points of discussion; please also see accompanying slide presentation and TST Data Dashboard for more complete information presented by each program.*

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	Wraparound with Intensive Services, *Heidi & Athena* ▪ Program has grown 3x larger in the last few years to due to high need for program in the community; there is a one-year waitlist for *non-Medicaid* youth (182 youth served YTD 2019, including Medicaid youth) ▪ TST helps pay for *non-Medicaid* eligible youth to enroll in Thurston County (6 slots total) ▪ Team-based planning processes with therapist, psychiatrist, family members, youth, certified peer counselors, and more- help and support family and the youth in their own goals for the program **Children's Mobile Crisis,** *Heidi* ▪ Crisis responders respond within 2 hours to crisis ▪ 37% of youth served YTD have been *non-Medicaid eligible* (142 youth served in Q2-2019 alone) ▪ A lot of youth seen through mobile crisis have not had any behavioral health services prior to crisis services and are referred to treatment services as deemed appropriate (72% successful exit rate in Q2 includes youth who transfer to a treatment provider or complete stabilization services with the mobile crisis team) ▪ Transition to Managed Care Organizations (MCO) may change the reimbursement rate for crisis stabilization services for up to 14 days of care **Steps to Wellness,** *Athena & Christina* ▪ Services include immediate crisis intervention and consultation for youth at Rosie's Place (drop-in shelter) with therapist; therapist creates a safe place and primary concern is youth safety ▪ Program cannot currently bill Medicaid because services offered are considered engagement and outreach services ▪ Program presented as a vital connection/service to reduce the youth homelessness population ▪ Therapist helps de-escalate youth interactions with law enforcement by providing advocacy and working with Olympia Police Department Crisis Response Unit ▪ Capacity and number served is largely dependent on the time of year, as cold weather increases the number of youths at the shelter and warmer weather decreases the number of youth at the shelter (Q1- 38 youth served, Q2- 23 youth served) **Youth Outpatient Treatment,** *Jackie & Amy* ▪ Program receives referrals from many places in the community, including Juvenile Court (and detention), community providers, schools, parents, and self-referrals by youth ▪ There has been an increase in the number of middle school youth (11-12 years old) accessing substance use services in 2018

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	▪ Tobacco use and vaping has increased among youth; program is trying to create an intervention focused on vaping only ▪ 35% of youth served are *non-Medicaid eligible* (158 youth in Q2-2019) ▪ Upcoming challenges include changes to discipline protocol at schools and possible funding changes *inside* detention after MCO transition **Multisystemic Therapy,** *Tricia* ▪ MST program has 35 years of research to guide practice and changes to programming and serves youth ages 12-17 years old ▪ Program provides individualized treatment and treatment can take 3-5 months ▪ Between January 2016 and Sept 2019, 41% of youth had substance use as a goal upon entering MST (72/177) and 87.5% of those youth saw a reduction in substance use after program completion (UW follow-up survey). ▪ 18% of youth are *non-Medicaid eligible* that are served by MST (46 youth served in first six months of 2019) **Nurse Family Partnership,** *Gretchen & Liz* ▪ Clients engaged through NFP are extremely reluctant to engage in behavioral health treatment due to trauma and previous experiences- nurses actively work to encourage clients to receive counseling services ▪ Program currently has a substantial waitlist ▪ Program has difficulty finding behavioral health treatment availability when client *is* ready to engage with treatment ▪ Increased successful exit rate in Q2 possibly attributed to the quality assurance initiatives by the program (93% in Q2 up from 62% in Q1 and 68% in 2018-Q4) **Juvenile Court & Detention Transitions***, Athena & Mariel* ▪ JCDT program provides brief mental health assessments (CANS, ASAM) and referrals to behavioral health treatment for youth in Thurston County detention ▪ Program operates at the very early stages of coordination of care ▪ Recent challenges include increased special population youth (such as autism and traumatic brain injuries) and decreased number of youths detained in detention (through legislative changes and seasonal changes when school is in/out of session) ▪ Program staff provides a warm hand-off to treatment providers, which may contribute to the high engagement with treatment rate (100% in Q2, 67% in Q1, and 78% in 2018-Q4) **Juvenile Justice Behavioral Health Alternative,** *Mike, Genevieve, Robyn* ▪ Program has been running for two years now; program staff are still working on protocol/structure, connections to community and referrals, and sustainability through reflective evaluation and consultation

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	▪ Staff are extremely hands-on to encourage engagement and treatment follow-up with youth and family; program tries not to "terminate" any youth from the program, but instead works to find solutions and flexible strategies (graduation rate 100% in first six months of 2019, only two youth terminated in the last 2 years) ▪ There has been a significant reduction in the *criminal* caseload over the last two years, but the type of cases and youth are often more complex and very different from one another, requiring further flexibility in services and programing offered. ▪ All youth are assessed pre- and post- participation (at exit) for mental health and substance use improvement (100% improvement for mental health in all youth in the last year, 75% reduction in substance use in all youth in the last year) **Equine-Assisted Youth Peer Support,** *Mike & Kristy* ▪ Previously a TST-community grant program transferred to a Juvenile Court contract ▪ Program offers a 6-week recovery support with peer counselors and support; youth engage in highly metaphorical lessons during horsemanship training ▪ Changes in the intensity of youth backgrounds may affect the data (program initially started with only youth with civil cases, but now youth with criminal cases are also participate in this program)- individual outcome measures have decreased improvement rates since program inception (anxiety, mood disturbance, crime/delinquency, substance use, suicide risk) ▪ Possible interrater reliability concerns with pre-CANS (to determine eligibility, conducted by the JCDT program) and post-CANS (conducted 5-weeks after youth begins the EAYPS program) **Domestic Violence Case Coordinator**, *Katie* ▪ Case coordinator monitors the treatment requirements and engagement of clients with domestic violence cases (specifically monitors substance use and mental health treatment)- cases are civil, not criminal ▪ DV treatment is not funded by health insurance companies (or TST), making it difficult for clients to engage in their court ordered treatment ▪ Data collection and reporting for TST began in Q1 of 2019 and has yet to show trends to comment on; however, 21 TST-eligible clients were served on the caseload in Q2 alone **Family Recovery Court,** *Laura & Robyn* ▪ FRC is a voluntary specialty court specifically for parents with substance use/chemical dependency needs; participation can be 12-18 months and each participant receive extremely intensive case coordination and management

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	▪ Program helps coordinate education, counseling, transportation, employment assistance, and other services necessary to help achieve reunification with children ▪ Participants come from trauma-intensive backgrounds and the program is incorporating more trauma-informed policies, languages, and lens to their program such as strength-based or sensitive language (e.g., "discharged" rather than "terminated") ▪ Current challenges include adequate/appropriate housing, low enrollment rate for fathers, and the program nearing capacity (which may result in a waitlist)
General Discussion	**Vaping** ▪ Gretchen and Liz presented the current Public Health & Social Services Department approaches to address vaping prevention and the health effects of vaping **Non-Medicaid youth: Access to care, wait times, MCO transition** ▪ Programs that serve non-Medicaid eligible youth need to further analyze their funding allocations going forward to address the need ▪ Positions within programs that provide coordination, outreach, or support may not be reimbursed/funded beginning Jan. 1st with the transition to Managed Care Organizations ▪ Programs need to get together to discuss planning and partnerships to smoothly handle the transition to MCO ▪ The Behavioral Health Organization is transitioning into an Administrative Services Organization (ASO) and the State has mandates about ASO priorities (such as crisis) - this pulls money away from other services such as programs involving detention ▪ Barriers to access for non-Medicaid youth with private insurance include co-pays and other financial hardships for families or specific requirements that are not met o Addressing this issue would require action by the Office of the Insurance Commissioner **Blank Check Exercise (Around the room in 8 minutes):** What would you do with $300,000 for additional programming with TST funds? ▪ Create programming for clients that are not eligible for NFP ▪ Recovery school program ▪ Expand services for non-Medicaid eligible youth, and retain detention services ▪ Add additional drop-in shelter programming and services ▪ Provide more specialized treatment services that insurance or Medicaid do not fund for JJBHA participants; develop more internal youth behavioral health groups for this population (Aggression Replacement Therapy, Step Up) ▪ Fund additional providers to serve more clients in all services

Agenda Item	Notes
	▪ Provide Domestic Violence treatment scholarships ▪ Trauma-informed alternatives to Urinalysis testing

Next Meeting:
Friday, October 18, 2019, 8:30-11:30am (Public Health & Social Services Building, Olympia)