Children & Youth with Special Health Care Needs

Washington State Department of Health

www.doh.wa.gov/cyshcn

COMMUNICATION NETWORK MEETING

July 14, 2022

CYSHCN Communication Network Purpose:

Provide for exchange of information among those programs and entities that serve children with special health care needs and their families and facilitate an opportunity to learn more about statewide policies, programs and issues critical to this unique population.

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Attendees

Due to continued social distancing requirements enacted by Governor Inslee, Communication Network will be conducted entirely in an online format.

Attendee	Phone	Email Address
Alicia Skelly, Infant/Toddler Program Director		
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Angela Witt, WWVDN, P2P		
Annette Estes		
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Derek Steele		
Emily Castor, Innovative Services NW		
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Attendee	Phone	Email Address
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Jennifer Quintanilla		
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Attendee	Phone	Email Address
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MarSue Chagnon, Providence Inland MRFB		
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Melanie Abella		
Melissa Lindstedt, Encompass		
Melissa Martin, Clark County Public Health		
Michelle Hoffman, DDA		
Molly Corvino, NE Tri County Health District		
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Stefanie Robinson		
Stephanie White, NE Tri County Health District		
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Vicki Guse		
Zahra Roach		

Guests:	
Michelle Hoffman, CIIBS & SSP Program Mgr DDA	
Kathleen Donlin, Tammy Parvin, & Iana Bezman, HCA	
Stefanie Robinson, COO Prime Foundation & Kemi Akinlosotu, AS360 Program Coordinator	
Shayla Collins, Continuing Education Specialist @ UW Center for Child & Family Well-Being	

Children and Youth with Special Health Care Needs (CYSHCN) Program Update

www.doh.wa.gov/YouandYourFamily/InfantsChildrenandTeens/HealthandSafety/ChildrenwithSpecialHealthCareNeeds.aspx

Staff Updates

Nikki has returned from maternity leave. Renee is working on PMHCA grant with an early fall timeline for full implementation. Sarah is involved in Project Accelerate, a technical assistance opportunity on best practices in patient centered outcomes research. A manual and training webinar should be coming by the end of the summer around care coordination. Interviews have been held for the CYSHCN Communications and Early Childhood Consultant, hire date anticipated soon.

Katrina Davis, Family Advocate and Case Manager at UW CHDD, shared information (flyer in slides) on the IDD Autism Resource Navigation ECHO

Child Health Intake Form (CHIF) Database

Our program has received ongoing feedback about the many challenges and barriers our contracted partners have experienced with the CHIF reporting system over the past two years. Based on this feedback, our program has decided to **end the current CHIF platform on July 31st, 2022**. We intend to rebuild an improved reporting system that aligns the competing and intersecting needs of affordability, usefulness, and accessibility for our partners and our CYSHCN program. Our timeline is to have the new web-based system live by **July 31st, 2023.**

As our CYSHCN program begins to build out the new system, we are committed to bringing in diverse partner groups to inform the rebuild design process. We are inviting our partners to join a coalition group to collectively determine the type of CHIF data and the type of reporting platform that would be most useful to your work. Please reach out to Sarah Burdette and Bonnie Burlingham to learn about becoming part of the rebuild team. We would love to hear from you.

Washington Statewide Leadership Initiative (WSLI) and DOH Family Engagement

For more WSLI or DOH Family Engagement information, contact Nikki Dyer at 360-236-3536 or nikki.dyer@doh.wa.gov.

CYSHCN Program Nutrition Updates

Khim is working on a community cooking program supporting life skills for those with disabilities. Modules will be posted on our website soon. She is also part of two workgroups focusing on Type 1 Diabetes and trach/vent populations.

For more information, please contact Khimberly Schoenacker at 360-236-3573 or khimberly.schoenacker@doh.wa.gov.

CSHCN Rule (Washington Administrative Code-WAC) Update

For more information, contact Monica Burke at 360-236-3504 or monica.burke@doh.wa.gov.

Essentials for Childhood (EFC)

For more information, contact Marilyn Gisser at 360-236-3503 or see www.doh.wa.gov/efc.

Universal Developmental Screening (UDS)

For more information, contact Marilyn Dold at Marilyn.dold@doh.wa.gov.

MCH LHJ Contracts Updates

For more information, please contact Mary Dussol at 360-236-3781 or mary.dussol@doh.wa.gov.

Guest Presentations

CIIBS Program

Michelle Hoffman, CIIBS and SSP Program Manager Developmental Disabilities Administration

Children's Intensive In-Home Behavioral Support (CIIBS) Program--only children's specific waiver

Updates: The CIIBS program supports youth ages 8-20 at risk of out-of-home services due to challenging behavior. The program uses wraparound planning and family-centered strengths-based approaches and its services include: specialized habilitation, staff/family consultation, specialized clothing, therapeutic adaptations, equine and music therapy, and assistive technology. There are 3 components to the CIIBS program which include: Intensive Case Management, Wrap-around, and the CIIBS Waiver Service Package. The CIIBS case manager has 18 clients they support, a smaller caseload than other programs. The CIIBS Waiver-Wraparound has a high emphasis on cross system collaboration using a 4 phased high-level approach with families to plan around their values. It focuses on the 10 principles of wraparound, including safety planning & family support--all around a child and family centered team (family values statement). There has been a shift to a strengths-based approach, working with families to understand what their larger goals are and what do you want things to look like for their life. CIIBS offers intensive case management that coordinates across all systems: working with clients EPSDT/state plan (WISe, ABA, evaluation & treatment, Therapy); Waiver Services (staff & family consult, stabilization, specialized habilitation, equine/music therapy). There are a lot of informal supports for case managers to develop and this work is all happening at team-based meetings.

Who is eligible for CIIBS:

- Must be DDA eligible. (Michelle shared the following resources: Informing Families website: informingfamilies.org/reason-to-apply-for-dda-services and the DDA Eligibility and Services Guide (DDA homepage/eligibility). The DDA Eligibility and Services Guide is available for download.
- Between the ages 8-17; behavior acuity level is high; caregiver's risk score is medium, high, or immediate; live with the family; & family agrees to participation
- Must have a care assessment & meet CIIBS waiver criteria:
    - 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
    - Must be an habilitative need for a waiver program-learning skills need vs treatment need
    - Must be waiver enrollment capacity
    - Must meet additional regional and state criteria:
    - Regions prioritize CIIBS requests w/recommendation to HQ for approval or denial, based on RCW 71A.24
    - Must not have an open CPS allegation or substantiated finding w/in last 12 months
    - Family must sign an agreement indicating they are interested in participating in program & receive wraparound service

Eligibility: caregiver status is a big driver of the CIIBS algorithm—44% weighted

Wraparound model: provides whole family support; uses a phased based approach and makes the CIIBS unique compared to other waivers that DDA administers; the goal is to prevent out of home placement using a unique structure to facilitate child & family centered conversations w/in a cross systems team-based approach

Waiver Service Package includes: Stabilization & Crisis Services; Aggregate Services; Respite; Emergency Assistance; Therapeutic Adaptations; Equine/Music Therapies

Components of Waiver Services package: Emphasizing family engagement and support; skill development and habilitation; and accessibility and accommodation

The desired outcomes of CIIBS are that children remain in family home, the family's confidence is increased, behaviors are decreased, there is an increase in skill development, and the family vision is achieved.

Regional staff are involved in multi-step process: case manager determines eligibility; a referral is made to the CIIBS coordinator; coordinator meets with family to provide overview of CIIBS and wraparound model; regional recommendation for approval or denial is made to Central Office

Child and family meetings start w/a family vision and use a strengths-based approach. They see to address unmet needs and crises, leverage strengths and coordinate treatment needs, waiver needs and informal supports. They plan for intentional and supported transition to adult services or less restrictive supports when appropriate.

Questions: Take from recording

SARAH WILL DO FAQ with all questions/answers put in chat

MCO Care Coordination

Kathleen Donlin, Tammy Parvin, and Iana Bezman, Health Care Authority

Medicaid Managed Care Organizations-Care Coordination

Medicaid Managed Care provide preventive, primary, specialty, and ancillary health services. The goals of Medicaid Managed Care are to improve access to care and to have an improvement in health plan, performance, health care quality, and outcomes. Its advantages are there is care coordination and guaranteed access to a primary care provider. There are 5 Medicaid Managed Care plans in WA contracted to deliver Integrated Managed Care (IMC): Amerigroup, Community Health Plan of WA, Coordinated Care of WA, Molina Healthcare of WA, and United Healthcare

Differences between Medicaid delivery systems—Integrated Managed Care (IMC), Behavioral Health Services Only (BHSO), Fee For Service (FFS)

MCO-BHSO-FFS: FFS original Medicaid benefit; MCOs provide service coverage at 2 different levels: Integrated Managed Care: covers physical & BH medically necessary services under that MCO; Behavioral Health Services Only (BHSO): plan covers certain BH services (MH & SUD) as contracted to the MCO; Both IMC & BHSO Apple Health clients also have some services covered through FFS

Who are Children & Youth with Special Health Care Needs (CYSHCN): individuals under 19 who are any one of the following:

- eligible for SSI under Title XVI of SSA
- 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
- receiving services through a family-centered, community-based, coordinated care system that receives grants funds under Section 501(a)(1)(D) of Title V of the SSA

Detect and connect CYSHCN as soon as possible: collaboration between Title V MCH programs and Medicaid includes confidential data sharing; CYSCHN are identified by an indicator in Provider One System that informs providers and MCOS that child may need increased supportive services. The Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) benefit provides preventative and enhanced service coverage for youth 20 and under. Medically necessary services identified w/in EPSDT are covered by this program that are not covered under the state Medicaid plan.

There are different roles for the CYSHCN coordinator and the MCO care coordinator but there are shared job functions (slide 20). Care Management is an umbrella term that includes care coordination (CC) and case management (CM). Slide 21 describes these differences (i.e. CC=short term needs, CM=longer term needs).

Care management overview:

- collaborates w/other existing teams (DDA, DCYS, Schools, Community Supports)
- enhances or supplements current efforts & eliminates duplication of work
- is a partner at the multidisciplinary table
- Assists w/follow up on treatment team recommendations
- Work w/insurance companies
- Includes transitions of care from one level to another

How to request care coordination: email to client's MCO; specify CYSHCN Request for Care Coordination--links to each MCO on slide 23

Tips for requesting care coordination from MCO-be specific; please discuss w/client/parent/guardian prior to referral and get consent; be specific with client information including name, DOB, and Provider One number; communication between MCO and CYSHCN team is critical

Health Homes:

- Who is eligible: active on Medicaid including dually eligible; have a PRISM risk score of 1.5 or greater; has one chronic condition and at risk for a 2nd; all ages eligible
- 6 Health Home services: 1)comprehensive care management; 2)care coordination; 3)health promotion; 4)comprehensive transitional care; 5)individual & family support; 6)referral to community support & social support services

CYSHCN-MCO care contacts updated every 6 months; request from DeeAnn Smith @ HCA DeeAnn.Smith@hca.wa.gov

QUESTIONS: What does HCA see as the role for the CYSHCN coordinator versus the MCO care manager? (especially in light of DOH requesting LHJs move away from enabling services like family navigation): Dual roles; CYSHCN have more boots on the ground; MCO care coordinators and what they can provide; CYSHCN work in concert w/MCO CC; CYSHCN know the specific local resources

RE: Health Homes- for children who do not qualify due to lower PRISM score, what is the process for referral/eligibility for Health Home (are exceptions available?): not aware of any exceptions, every child w/Medicaid w/an MCO is eligible for care coordination; PRISM score based on health system utilization; still reach out regardless of PRISM score

IS there a more simple way to refer to a CYSHCN?: Local CYSCHN should be the door/gatekeeper and should be able to help w/facilitation process for services

The 360 Platform: Helping Families Identify and Navigate the Resources They need, when They Need It

Kemi Akinlosotu, AS360 Program Coordinator and Stefanie Robinson COO, Prime Foundation

If someone in need googles "behavioral health resources WA" 2.38 billion responses will appear

360 vision: seek to build an interactive curated platform targeted at life's greatest challenges to alleviate the burden for those in need. Platform has potential to give families and individuals a clear path and immediate access to resources, training tools, and community forums; resources can be accessed early and often and are readily available, reliable and helpful.

The 3-step 360 platform approach: assess (leverage diagnostic tools to support users in narrowing their specific needs); curate (leverages a verified list of resources, programs, and providers to curate applicable options based on responses); connect (provides community forums to foster discussion and support across those w/lived experience facing similar challenges)

Platform in action: AS360 in soft launch w/SCAC & UWAC

Stephanie gave a demo of the BH360 prototype; geared towards parents & caregivers; targeting a Fall 2023 launch

ASD360 has launched and is available to the general public: www.as360.org

- Assessments available on site--6 of them; parents able to fill out assessments and site automates results; resources populated based on answers and type of assessment taken
- Find resources near me: look for different services, by insurance, language spoken, age group, and address
- HB1800 Parent Portal is mentioned (BH360)

Question: is this a free tool for families: YES!

Resource List and Family Voice

Shayla Collins, Continuing Education Specialist at UW Center for Child, and Family Well-Being

Shayla has two children, ages 11 & 9, one w/physical disabilities and one w/an autism diagnosis at age 2/1/2.This resource list came from navigation of trying to find out everything she could to help her children and support their needs. Shayla found that the "100 days packet" given out by providers was very overwhelming and cumbersome, felt like "homework" and not helpful. She did her own research and was able to share with "support group" of parents; started documenting all the available resources, kept them in her phone, kept building it up with a hope to diminish some of the pressure on families. Eventually she brought her list to Kate and Sophie to publish to the larger public and "Shayla's List" was born.

Shayla shared list and went through resources: list included in attachments

Feedback and additions are welcome to the list. The goal is to include as many resources as possible to reduce the burden on families of navigating available resources.

Health Plan Updates

Amerigroup-Washington

Jackie Matter

www.amerigroupcorp.com

[Coverage Area Includes: All Counties except Adams, Chelan, Clallam, Clark, Cowlitz, Douglas, Ferry, Grant, Kittitas, Lincoln, Okanogan, Skamania, and Wahkiakum]

No updates at this time.

Community Health Plan of Washington (CHPW)

www.chpw.org

[Coverage Area Includes All Counties except Clallam, Columbia, Garfield, Jefferson, Klickitat, Lincoln, Mason, Skamania, and Whitman]

No updates at this time.

Coordinated Care
Sherry Bennatts and Azka Bashir

www.coordinatedcarehealth.com

Molina Healthcare of Washington
Mary Blakeman and Margaret Whaley

www.molinahealthcare.com

No updates at this time.

UnitedHealthcare
Cindy Spain and Mandy Herreid

www.uhc.com

[Coverage Area Incudes: All Counties except Clallam, Cowlitz, Garfield, Pend Oreille, San Juan, Skagit, and Whatcom]

No updates at this time.

Partner Updates

Washington State Parent to Parent Network
Tracie Hoppis

Washington State Medical Home Partnerships Project for CYSHCN
Kate Orville

www.medicalhome.org

A flyer for the Autism COE Certification Training was attached to Sarah's email. The target audience for this training are primary care physicians, psychologists, and those qualified to diagnose and prescribe, but the group recognizes the importance of the support from public health professionals that are involved in this work and so all are eligible to attend. Dr. Wendy Stone is hosting a training for early intervention providers on play-based intervention (flyer in slide presentation).

University of Washington CSHCN Nutrition Project at CHDD
Mari Mazon, MS, RDN, CD and Sarah Harsh, MS, RDN, CD

University of Washington – Center on Human Development and Disability (CHDD)

Nutrition Training Contract http://depts.washington.edu/cshcnnut/
Mari Mazon, MS, RDN, CD and Sarah Harsh, MS, RDN, CD

Washington State Fathers Network (WSFN)
Louis Mendoza

www.fathersnetwork.org

Family to Family Health Information Center (F2FHIC)
Jill McCormick

www.familyvoicesofwashington.com

No updates at this time.

Open Doors for Multicultural Families
Hodan Mohamad

www.multiculturalfamilies.org

No updates at this time.

Washington Autism Alliance & Advocacy (WAAA)
Arzu Forough

www.washingtonautismadvocacy.org

No updates at this time.

Office of Superintendent of Public Instruction (OSPI)
Nicole Klein, Health Services Program Supervisor

www.k12.wa.us/HealthServices/default.aspx

Seattle Children's Hospital
Paula Holmes

www.seattlechildrens.org

No updates at this time.

Lifespan Respite Washington (LRW)
Linda Porter

www.lifespanrespitewa.org

No updates at this time.

WithinReach
Chris Gray

www.withinreachwa.org

No updates at this time.

State Updates

Department of Children, Youth, and Families
Early Support for Infants and Toddlers (DCYF-ESIT)

Lori Holbrook

www.dcyf.wa.gov/esit

DSHS, Developmental Disabilities Administration (DDA), Waiver Unit
Kari Freer

No updates at this time.

DSHS / DDA, Medically Intensive Children's Program
Doris Barret

DSHS, Fostering Well-Being Care Coordination Unit (FWB CCU)
Autumn Wade and Amanda McCleskey

DSHS / ALTSA, Kinship Care and Lifespan Respite
Rosalyn Alber

www.dshs.wa.gov/kinshipcare

No updates at this time.

DOH Screening and Genetics Unit
Nini Shridhar

www.doh.wa.gov/YouandYourFamily/InfantsChildrenandTeens/HealthandSafety/GeneticServices.aspx

No updates at this time.

Health Care Authority
No updates at this time.

Attachments

- Agenda (PDF) (wa.gov)
- Meeting presentation slides (PDF) (wa.gov)
- Meeting recording (youtu.be)

Next Meeting

October 6, 2022

Virtual Meeting