Crisis Response Improvement Strategy – High-Level Workplan July 2022 Status Updates	Status Update
Objective 1: Place to contact – National Suicide Prevention Lifeline crisis centers can effectively receive and respond to 988 calls, chats, and texts in a manner that is culturally responsive and tailored to meet the needs of diverse individuals and families across all ages, and deliver services according to national best practices, standards, and guidelines.	
• Objective 1.1. Appropriate technology is in place for 988 calls to be answered by National Suicide Prevention Lifeline crisis centers. (Per Federal legislation and Washington's HB 1477)	• Current NSPL crisis center technology is in place for launch. DOH working with NSPL crisis centers to assess NSPL technology needs.
• Objective 1.2. National technology system is in place to support text and chat services in Washington State.	• Volunteers of America of Western Washington is accredited for, and currently provides, NSPL text and chat services.
• Objective 1.3. Standardized process flows between 988 National Suicide Prevention Lifeline crisis centers, regional crisis call centers, crisis services, and 911 are established and there is a plan for implementation.	• Two 2-day work sessions held with 988 call centers, 911, and Regional Crisis Lines. • Cross System Subcomm. to inform process map future state.
• Objective 1.4. Appropriate National Suicide Prevention Lifeline crisis center staffing levels are in place to respond to the volume of calls, text, and chat associated with 988.	• DOH distributed funding to NSPL centers to expand staffing. • DOH awarded SAMHSA grant. Contracts with crisis centers will support capacity to develop and coordinate a student internship and follow-up programs.

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• Objective 1.5. 988 National Suicide Prevention Lifeline crisis center staff have skills to provide services that are person- and family-centered, culturally responsive, and trauma-informed.	• Credentialing and Training Subcommittee reviewed current NSPL staffing and training requirements and in process of developing recommendations.
• Objective 1.6. Establish standards for designation of Crisis Call Center Hubs; establish expectations for crisis call centers to provide high-quality crisis intervention services, triage, care coordination, referrals, and connections to individuals contacting the 988 crisis Lifeline. Standards will be in accordance with national requirements and best practices (SAMHSA and Vibrant Emotional Health).	• CR-101 memo for proposed rulemaking is being drafted in response to the E2SHB 1477 requirements of DOH. DOH is on timeline.
• Objective 1.7. Crisis Call Center Hubs have access to state-of-the-art Crisis Call Center Hub technology that is interoperable with 911 and Vibrant's National Unified Platform, adheres to forthcoming national requirements, complies with data privacy and security laws (including text and web-based data sharing), has a disaster preparedness plan, and is able to dispatch mobile teams, identify bed availability, schedule and conduct follow up and community service referrals, and support all system partners in navigating the crisis system.	• HCA developing Section 109 Technical and Operational Plan for submission in October, with review and input by Technology Subcommittee. Information is being gathered from multiple sources (e.g. WA NSPL crisis centers, system partners and providers, other states, vendors).

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Objective 2: Someone to come – Mobile crisis response teams are available 24/7 and positioned to quickly travel to the locations of individuals to deliver best practice care that is culturally responsive, tailored to the needs of diverse individuals and families across all ages, and reduces the need for unnecessary ER visits and arrest.	
• Objective 2.1. Mobile rapid response crisis teams are connected to the Crisis Call Center Hub technology in a manner that maximizes clinical best practice, efficiencies, and interoperability.	• HCA developing Section 109 Tech/Op Plan (see Objective 1.7).
• Objective 2.2. Clear protocols are established to guide mobile crisis teams in a manner that maximizes clinical best practice and safety in a variety of settings, including support for voluntary processes over involuntary, reserving involuntary processes only in extreme situations. Protocols are developed on how crisis teams work with law enforcement, emergency departments, and other system partners.	• HCA seeking feedback on draft Mobile Crisis Team guide based on SAMHSA best practices and adapted for Washington. • Process Map work sessions future focus on dispatch and response.
• Objective 2.3. There is equitable access to mobile response team services across the state that are accessible within designated timeframe standards established.	• HCA distributed $38 million in legislative proviso funding to expand adult and youth mobile crisis teams. • Conducting analysis of Medicaid claims and encounter data to identify current service utilization and gaps. Engaging CRIS discussion of future state system goals and gaps.
• Objective 2.4. Mobile crisis team staff have skills to provide services that are person- and family-centered, culturally responsive, trauma informed and non-coercive.	• HCA is working on adapting best practice models to reach all of

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	Washington by making models focused on rural areas, tribes, and HCA is looking into more adaptions to work with local cultural needs. • HCA seeking feedback on draft Mobile Crisis Team guide based on SAMHSA best practices, • HCA is working on incorporating bachelor level clinicians and researching models to train crisis responders, • Credentialing & Training Subcommittee to review and inform.
• Objective 2.5. Mobile crisis teams are multidisciplinary and include peer and family support.	• Same as above. • HCA has developed a crisis peer training to assist peers in understanding their role, developing resiliency and selfcare, and finally orienting them to service models

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Objective 3: A Place to go – A broad range of walk-in and crisis stabilization services are accessible, culturally responsive, tailored to the needs of diverse individuals and families across all ages, and provide all individuals with a no-wrong door access to mental health and substance use care and crisis stabilization services.	
• Objective 3.1. Crisis stabilization providers are connected to the Crisis Call Center Hub technology in a manner that maximizes clinical best practice, efficiencies, and interoperability.	• HCA developing Section 109 Tech/Op Plan (see Objective 1.7).
• Objective 3.2. Clear protocols are established to guide crisis stabilization providers that maximizes clinical best practice and safety in a variety of settings. Protocols are developed on how crisis facility providers work with law enforcement, emergency departments, and other system partners.	• HCA is currently working on standards for in home stabilization services provided by mobile crisis teams or follow up teams. • HCA is working on developing standards and programmatic framework for facilities.
• Objective 3.3. There is equitable access to a broad range of walk-in and crisis stabilization services across the state, and individuals are connected to ongoing care. These services will include peer-run services and peer-run respite centers.	• Conducting analysis of Medicaid claims and encounter data to identify current service utilization and gaps. Engaging CRIS discussion of future state system goals and gaps. • Department of Commerce is opening an RFP to fund the building of several new facilities across the state. There is a set aside for youth-based facilities. Another funding round that

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	opened on June 7th will fund the construction of peer respites. • HCA is exploring the funding of these models to ensure they are fully and stably funded. • HCA is developing 23-hour models to provide walk-in support to people to avoid needing to go to an emergency department or other behavioral health crisis system for support.
• Objective 3.4. Crisis stabilization provider staff have skills to provide services that are person- and family-centered, culturally responsive, trauma informed and non-coercive.	• HCA is looking at other state's models and trainings to develop a proposed curriculum to meet these goals. • HCA has developed a training for peer crisis workers.
• Objective 3.5. Standardized process flows are developed for coordination with law enforcement and there is a plan for implementation.	• HCA is working with co-responder and law enforcement groups to develop a plan for implementation.

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Objective 4: Pre- and Post-Crisis Care – Services immediately upstream and downstream of crisis events are culturally responsive, tailored to diverse individuals and families across all ages, and accessible to all and support individuals and families to avoid cycling in and out of the crisis system.	
• Objective 4.1. Pre- and Post-Crisis Care providers are connected with Crisis Call Center Hub technology in a manner that maximizes clinical best practices, efficiencies and information sharing to support next steps for the person's transition to follow-up non-crisis care.	• HCA developing Section 109 Tech/Op Plan (see Objective 1.7). • NSPL crisis centers' current resource/info management is in place and DOH and HCA are assessing other opportunities and efforts.
• Objective 4.2. Services such as next day appointments, post-hospitalization and post-crisis services, warmlines, peer and family supports, and navigation supports are culturally responsive and developed to address the needs of diverse individuals and families across all ages to avoid whenever possible situations from escalating and to not cycle in and out of the crisis system.	• HCA is working with OIC and providers to make necessary connections for post-crisis care. • HCA is developing proposals for implementing statewide warm lines to serve various populations and meet them where they are. • HCA is coordinating with recovery navigator and family navigator programs to integrate them into the crisis system.

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• Objective 4.3. Expanded use of community education programs or campaigns are used to educate the community about where and how to access services.	• DOH and HCA are developing a communication plan that will educate stakeholders and partners as resources become available.
Objective 5: A statewide crisis system is designed, administered, and monitored with oversight that ensures equitable, efficient, and person-centered behavioral health crisis system that demonstrates quality outcomes and performance.	
• Objective 5.1. A vision and principles for the crisis system is developed and drives administrative oversight and local operational and clinical practices across the state.	• Steering Committee approved Crisis System Vision and Guiding Principles developed by Ad Hoc Workgroup on Vision with input from multiple subcommittees.
• Objective 5.2. Sovereign tribal authorities – crisis system is designed in a manner that respects the existing processes and governing bodies of tribal governments to address tribal behavioral health and crisis system needs and gaps.	• Engaging Tribal Roundtables and Consultation Process for Section 109 Tech/Op Plan and HB 1477 Steering Committee Recommendations.
• Objective 5.3. System partners – including individuals and family members with lived experience, first responders, emergency, crisis and community providers, government, and managed care plans – collaborate to design, implement, and oversee an effective and equitable behavioral health crisis system.	• Engaging input by CRIS and Subcommittees into system vision and design.
• Objective 5.4. Cross-system metrics are developed in collaboration with system partners that allow for crisis system transparency and oversight through report disseminated and improvement strategies implemented. Metrics include satisfaction ratings by individuals, family members, and system stakeholders.	

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• Objective 5.5. Shared data is developed to evaluate overall crisis system performance and support performance improvement across the system.	
• Objective 5.6. Appropriate levels of braided funding (including Medicaid, Medicare, commercial, local and other dollars) are available to support a high functioning system, include sufficient access to crisis lines, mobile teams, and walk-in and crisis stabilization services as well as and prevention and post crisis services.	• Engaging Provider Cost Workgroup to conduct cost modeling study to estimate crisis service costs to inform budget recommendations.
• Objective 5.7. Recommendations related to behavioral health workforce needs by each region across the state are developed. These recommendations include minimum licensure, education, and training requirements for staff delivering crisis services, as well as strategies to support the existing workforce and recruit new staff.	
• Objective 5.8. Reimbursement approaches incentivize a highly-coordinated system of care across system partners that results in quality outcomes and supports provider viability and sustainability.	
• Objective 5.9. Statewide minimum standards of operational and clinical practices are developed that foster use of best and promising practices while also allowing for tailored implementation at the local level.	