HB 1477 SUBCOMITTEE REPORT 2023

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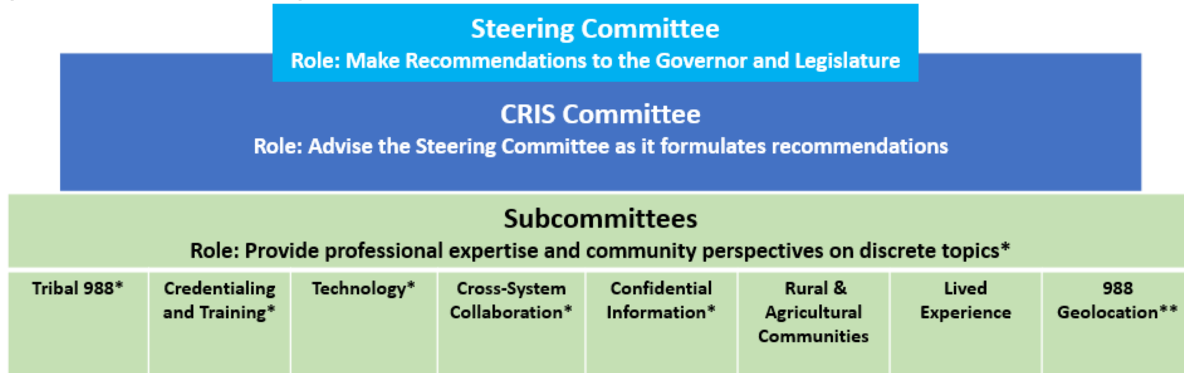
Subcommittee Report Overview

This *2023 Subcommittee Report* includes a compilation of all HB 1477 subcommittee meeting summaries in 2023. Subcommittees convened to share perspectives and expertise to inform the development of CRIS and Steering Committee recommendations for the 2023 Committee Progress Report. The Lived Experience and Tribal 988 Subcommittees met monthly; and the Rural & Agricultural Communities Subcommittee convened approximately three times; the Technology Subcommittee met twice to advise on state agency work on the technology platform. Note: The Credentialing and Training Subcommittee, Cross-System Crisis Response Subcommittee, and Confidential Information Subcommittee were convened in 2022, please see the 2022 Subcommittee Report for meeting summaries. These Subcommittees may be reconvened in 2024 to provide further input as needed.

As part of the CRIS and Steering Committee structure, eight subcommittees provide professional expertise and community perspectives to inform the development of recommendations for an integrated behavioral health crisis response and suicide prevention system (see Figure A).[1] The Subcommittees are comprised of members of the CRIS, state agency representatives, and broad stakeholder members with professional expertise and community perspectives on discrete topics of focus.

Figure A. HB 1477 Steering Committee, CRIS Committee, Subcommittee Structure



Below is high-level overview of the charge of each Subcommittee:

1. ***Confidential Information Compliance and Coordination –*** To examine and advise on issues related to sharing and protection of health information.

2. ***Credentialing and Training Subcommittee –*** To inform workforce needs and requirements related to behavioral health system redesign components outlined by HB 1477.

[1] For further information about the HB 1477 Committees, please see the CRIS webpage: https://www.hca.wa.gov/about-hca/programs-and-initiatives/behavioral-health-and-recovery/crisis-response-improvement-strategy-cris-committees

3. ***Cross-System Crisis Response Subcommittee –*** To examine and define complementary roles and interactions of specified crisis system stakeholders, including mobile rapid response crisis teams, designated crisis responders, law enforcement, emergency medical services teams, 911 and 988 operators, public and private health plans, behavioral health crisis response agencies, nonbehavioral health crisis response agencies, and others needed to implement HB 1477.

4. ***Lived Experience –*** To provide diverse lived experience perspectives into the development of the Washington behavioral health crisis response and suicide prevention system.

5. ***Rural and Agricultural Communities –*** To provide rural and agricultural community perspectives into the development of the Washington behavioral health crisis response and suicide prevention system.

6. ***Technology Subcommittee –*** To examine and advise on issues and requirements related to the technology and platform needed to manage and operate the behavioral health crisis response system.

7. ***Tribal 988 –*** To examine and make recommendations with respect to the needs of tribes related to the 988 and crisis response system.[2]

8. ***Geo-location –*** To examine privacy issues related to federal planning efforts to route 988 crisis hotline calls based on the person's location, rather than area code, including was to implement the federal efforts in a manner that maintains public and clinical confidence in the 988 crisis hotline.

[2] Note: The Tribal 988 Subcommittee is facilitated through the Tribal Centric Behavioral Health Advisory Board to align and build upon existing work already underway to improve the crisis response system for tribal populations. Meeting materials can be found through the TCBHAB website: https://drive.google.com/drive/folders/1PPgc9Vreb2v7gbna4Hg52Rn3ytCI78hM.)

HB 1477 Lived Experience Subcommittee – February 13th Meeting

Meeting Summary

Monday, February 13th, 2023, 1:00 pm to 3:00 pm

Zoom

TOPIC	DISCUSSION
Welcome, Introductions, Review Meeting Agenda	• HB 1477 Steering Committee member Bipasha Mukherjee welcomed everyone to the meeting and introduced the agenda. Bipasha also highlighted that the next CRIS meeting will be held on February 15th 3-6pm. This meeting agenda and Zoom link are available on the CRIS webpage - https://www.hca.wa.gov/about-hca/programs-and-initiatives/behavioral-health-and-recovery/crisis-response-improvement-strategy-cris-committees .

Discussion: Lived Experience Perspectives on Crisis System Gaps	• Puck Kalve Franta (CRIS member representing lived experience) introduced this agenda item and the importance of lived experience perspectives on crisis system gaps.
	• Matt Gower (Washington State Health Care Authority) presented HCA's current work to expand Mobile Crisis Response resources and develop best practices and standard team staff compositions (including clinician, peer, and supervisor). He encouraged feedback from the group, especially around current system gaps. Additional questions for feedback include: 1) Is the MCR team composition appropriate, 2) Should we consider any other models or services for MCR? 3) What should we consider a service area (regional level, county level)? 4) How should we prioritize expansion (factors to consider)?
	• Subcommittee discussion included:
	  ○ **Crisis stabilization beds for individuals in jail**. Some individuals have been waiting almost a year, despite the federal requirement of a bed within seven days. This topic of conversation may need to be further addressed in future meetings.
	  ○ **How to address the fear of police engagement when individuals call the 988 line.** How do we address concern among individual who will not call 988 due to fear that the police will show up and cause further damage? Support is needed around messaging, and clear communication and protocols for when police will be involved.

TOPIC	DISCUSSION
	○ **Support needed for crisis response staff representing populations served.** An example was given of a call center with only one staff person who identifies as transgender, who is being assigned all of the calls from people who identify as trans. These calls may be triggering and increase the emotional burden of the responder, underscoring the importance of crisis system workforce support. ○ **Crisis response staff with shared language and cultural backgrounds as the populations served.** People want to ensure that the person responding to them understands their perspectives. This includes language, but also life experience. Work is needed to support development of a peer workforce that includes people with diverse backgrounds. ○ **Geographic concerns.** Why would calls get routed to a county outside of where the caller is calling from? ○ **Crisis Team disciplines.** Teams should be comprised of people with lived experience as well as clinical staff.
Legislative Update – Current bills relating to Washington Behavioral Health Crisis System	• Kristen Wells (participating in the Lived Experience Subcommittee planning group) introduced this agenda topic and proved background around her own lived experience and the legislative process. • Dakota Steele (HCA) presented slides: 101 on the legislative process and overview of current bills. Topics included how to get to the main page of the Washington State Legislature; Things that you can do on the legislature main page; How do you learn about House committees; How do you learn about the Senate; How do you learn more about a specific bill?; How do you learn more? The ombuds position was explained, including the name transition from ombudsman to Behavioral Health Advocates. • *Subcommittee discussion:* ○ **Definition of Behavioral Health Advocate.** The Subcommittee discussed the definition of the Behavioral Health Advocate. • The Washington National Alliance on Mental Illness (NAMI) is tracking specific bills relating to behavioral health. The link below provides a summary of the current bills: https://www.quorum.us/spreadsheet/external/lbTTouNtbOUVFzyYmGEJ/

TOPIC	DISCUSSION

Open Discussion and Closing Statements	• Discussion centered around protocols for designating voluntary vs. involuntary services, as well as the continued need to consider how to make mobile crisis response teams inclusive and appropriate. Questions remain as to how crisis response can be wholly inclusive and accessible when called upon by the people seeking support.
	• Specific issues raised include:
	  ○ **Geographic access.** Concerns around the types and amount of services rural communities are receiving.
	  ○ **Engagement of diverse communities.** The ongoing concern was raised that not all stakeholders are being included in the conversation about how to improve the system.
	  ○ **Assisted Outpatient Treatment (AOT).** AOT was highlighted, including its role in a crisis situation. Senate Bill 5130 discusses AOT further.
	  ○ **House Bill 1134.** This bill includes several updates to HB 1477 passed last session. Further advocacy is needed for this bill.
	• Lived Experience members may also contact CRIS project manager, Nicola Pinson, for follow up questions or requests for resources (Nicola Pinson, npinson@healthmanagement.com).

HB 1477 Lived Experience Subcommittee – March 13th, 2023 Meeting

Meeting Summary

Monday, March 13th, 2023, 1:00 pm to 3:00 pm

Zoom

TOPIC	DISCUSSION
Welcome, Introductions, Review Meeting Agenda	• HB 1477 Steering Committee member Bipasha Mukherjee welcomed everyone to the meeting and introduced the agenda. Bipasha also highlighted that the next Lived Experience Subcommittee meeting will be held on April 10th-6pm. This meeting agenda and Zoom link are available on the CRIS webpage - https://www.hca.wa.gov/about-hca/programs-and-initiatives/behavioral-health-and-recovery/crisis-response-improvement-strategy-cris-committees . • The group took a moment of silence for a Lived Experience Subcommittee member who passed away last month, Diana Cortez Yañez. Bipasha shared highlights from Diana's work as a speaker and educator in suicide prevention. Diana's website is: https://dianacspeaks.com • Maire Fallon, the newest Lived Experience representative serving on the CRIS Committee, introduced herself and shared about her lived experience. • Puck Franta Kalve introduced themselves as a member representing lived experience on the CRIS Committee. Puck as worked with LGBTQ+ communities for over 20 years. • Kristen Wells introduced herself as a member of the Lived Experience Subcommittee planning group. Kristen shared her lived experience and highlighted Washington Speaks as resource for support sharing your experience with the CRIS and Steering Committee. Please reach out to Nicola Pinson (CRIS project manager, npinson@healthmanagement.com) if you would like to be part of a Live Experience group training to give each other support and feedback for sharing personal stories.
Presentation 1: 2023 Legislative Updates	• Amber Leaders, the Governor's Senior Policy Advisor on Behavioral Health, Aging, and Disability, joined to share a legislative update on current bills addressing behavioral health crisis response in Washington. The first day of the 2023 Washington legislative session was 1/9/2023, and the last day of session is scheduled for 4/23/23. March 8th was the last day to pass bills out of their house of origin, and bills that passed are now being heard in the opposite house. • **HB 1134-** Addresses HB1477 adjustments; establishes a new type of community response team through grant programs funded by 988 tax dollars; Allows the Washington Department of Health to use 988 funds to support co-location programs; Includes agricultural community supports; Supports development of crisis response training standards. This bill has

TOPIC	DISCUSSION

	passed out of the House on a strong vote and has been referred to the Senate Health and Long-Term Care committee.
	• **SB 5120-** Establishes 23-hour crisis relief facilities, that are open 24 hours, 7 days a week, to both walk-in and drop-offs. This bill passed out of the Senate and has moved to the House Health Care and Wellness committee.
	• **HB 1004-** Focuses on installing signs near bridges to deter jumping and give 988 information. Has passed out of the House and has been referred to the Senate Transportation Committee.
	• **SB 5555-** Establishes new professions of certified peer specialists, and certified peer specialist trainees to be certified by the Department of Health. Directs the Health Care Authority to develop training and examinations. This bill passed out the Senate and was referred to the House Health Care and Wellness committee. A public hearing is scheduled on March 15th.
	• **HB 1541 (Nothing About Us Without Us)-** Increases access and representation in policymaking for people with lived experience. Includes lived experience membership requirements for statutory entities. Requires reports of the efficacy of membership requirements and requires the creation/distribution of educational materials on best practices to support meaningful engagement. This bill passed out of the House and was referred to the Senate State Government and Elections committee.
	
	Committee Discussion
	• Highlighted importance of attention to question about focus on youth forensic diversion efforts?
	    o Noted that there is currently legislation addressing adult forensic diversion. Appreciated this is an important point about the need for attention to this issue for the youth and juvenile system as well.
	• Chat: Are services going to be funded throughout the state including Central Washington?
	    o Yes, all of the 988 work is focused on equitable funding throughout Washington.
	• Chat: Senate Bill 5130 relating to Assisted Outpatient Treatment passed the Senate over to the House.
	• Bipasha highlighted summary of potential ways to participate in the legislative session, including emailing your representatives on any issue or comments on specific bills (support, oppose, neutral), testify for a bill. Two bills discussed today (5555-peer specialists, 5120-23-hour crisis receiving centers) have public hearings this week if you are interested in testifying.

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Presentation 2:
 	
Overview of Someone to Come" crisis response models (Rapid Response, Mobile Crisis Response, Co-response)
	• Matt Gower (Washington Health Care Authority) introduced himself as person with lived experience as well as professional working to improve Washington's behavioral health crisis response system. Matt presented an overview of crisis response models, defining the different types of mobile response teams. Today's focus is on the "Someone to Come" part of the crisis response service continuum. At a very general level, there are two general models for crisis response: Mobile Crisis Response Teams and Co-Response Teams. Matt reviewed a high-level overview of each of features for each of these teams (noted that features may vary for specific teams).
	• **Mobile Crisis Response:** Managed by the Health Care Authority and designed based on best practices established by the Substance Abuse Mental Health Service Administration (SAMHSA). Key features:
	  o Dispatched by regional crisis lines/988
	  o Requested by the person in crisis
	  o Teams are comprised of behavioral Health professionals and peer support
	  o Response timeframe standard is currently 2 hours for emergent calls, with a goal of reducing that to within 1 hour
	  o Some teams provide transportation (currently working on ability of teams to provide transportation)
	  o Provide crisis stabilization services and can link individuals to crisis prevention services.
	• **Co-response Teams:** managed by local entities across the state and comprised of first responders (including law enforcement, fire, and emergency medical services) and human services professionals (such as behavioral health professionals, social workers, community health workers, or peer support workers).
	  o Dispatched by 911, fire, and police
	  o Requested by first responders
	  o Response timeframe is the same as the speed of the local first responders.
	  o The teams provide a way to response to respond to crisis calls involving safety risk, medical issues, and emergent needs requiring a quick response; the teams also respond to frequent users of the 911 system to address chronic issues not limited to crisis calls.
	  o Often provide transportation.
	  o Teams often provide proactive crisis prevention services to people who are often in crisis, and some teams provide crisis stabilization support.
	• A key issue with the current system is the multiple doors of entry (e.g., 911, 988, regional lines) and that responses vary depending on the number a

TOPIC	DISCUSSION
	person calls. With 988, Washington is working to promote calls to 988 and a standardized response across the state depending on person's needs. • Matt reviewed additional crisis response programs, such as the Recovery Navigator Teams, Youth Mobile Response and Stabilization Services, and Designated Crisis Responders. In development are Older Adult Mobile Crisis Response Teams, Tribal Mobile Crisis Response Teams, and 1477 Mobile Rapid Response Crisis Teams.

Presentation Discussion	• Subcommittee Member Discussion: request for perspectives on legislative update, the "someone to come" presentation, or any other thoughts and experiences you are comfortable sharing.
	    o Shared experience as person with lived experience providing crisis support for others and feeling overwhelmed about inability to connect people to the resources they need. Looking for more resources to learn.
	        ▪ Emphasized that the system is complex and confusing. Recognized that the goal of the 988 work is to create better system in Washington.
	        ▪ Current regional Ombudsman are available to help navigate resources: www.obhadvocacy.org. At a future meeting, can learn more about the Ombuds resources in Washington.
	    o Reiteration that police can sometimes make a crisis situation worse, and that sometimes people that really need to be in a mental health facility end up in jail.
	        ▪ Situations where people relapse or further decompensate when Designated Crisis Response (DCR) arrives along with officers in uniforms and all of their protective gear as back up.
	        ▪ Situations where people call in crisis and end up going to jail rather getting mental health services. This makes it extremely frustrating for the person in crisis and they lose faith in the system. Calling for help should be a connection to safety, not to jail.
	        ▪ Shared experience as a Veteran with suicide attempt where situation led being met by officers at his home and led away in handcuffs.
	    o People are not able to get services when they have reached out, leading to further mistrust and confusion in the system.
	        ▪ Question about what is provided during the crisis response. Highlighted importance for response to co-occurring mental health and substance use disorders, as this is common. Noted the concern that not every emergency response provider carries NARCAN.

TOPIC	DISCUSSION
	▪ Chat: https://www.npr.org/2023/02/18/1157556969/narcan-fda-over-the-counter • Matt provided overview of mobile crisis response approach to provide intervention, safety planning, and connect to stabilization. Mobile crisis response teams generally do not currently carry NARCAN. • In some cases, there are NARCAN vending machines available for free. • Chat: Co-occurring has been a lacking resource for a long time especially for our youth. ▪ For people in crisis, important to recognize that basic needs (e.g., safety, medical care, housing, food, clothing, transportation, spirituality, etc.) are part of a person's crisis. These basic needs are part of the picture of making people in crisis feel safe and whole. From personal experience, if this kind of support had been provided, would have avoided the level of crisis they encountered. This kind of support can support and empower families be their best selves. Support among subcommittee members for recognizing the role of lack of resources as a role for people in crisis. ▪ Highlighted importance of legal support for people with mental health issues and experiencing crisis. This is important to help ensure that the mental health issues are addressed and not held against them. Noted the Capital Recovery Center resources (https://www.crcoly.org/) has peer support and justice advocacy resources. ▪ Highlighted experience as a mother of a son with substance use disorder and in crisis. Effort to seek help resulted in a list of psychologists, with the first appointment available in 7 months. Even with expertise in how to navigate the behavioral health system, still couldn't access care. ▪ Chat: I also learned about the "ghost networks" the hard way, and I did bury my child after services failed him. I don't know if the 988/CRIS has any role in culling insurance rosters to stop this practice of "ghost networks" as a way to appear to serve clients when there is nothing there. ▪ Chat: experience as NAMI facilitators is that neither of these crisis response models are really happening in Seattle/King County. Parents/families are calling in crisis, and we get to talk to the Crisis line person or maybe a DCR, but response can be 1 month away.

TOPIC	DISCUSSION
	▪ Chat: I am not finding this type of response for those in crisis in King County. Maybe I am not connecting the correct way. I get a lot of confusion or refusal from Medics or Police and 1+ month for crisis team. Basically unhelpful. I have had EMT ask me - what is a Designated Crisis Responder report and who are Designated Crisis Responders? ▪ Chat: I agree that this is why 988 is important because first responder departments on the ground are limited in their knowledge on which services to call during a crisis. They share what they traditionally know. If anything there is a list somewhere online but no one really has time to dig during a crisis. ▪ Chat: Noted importance that Mobile Crisis to do its part in making good partnerships with stakeholders and community partners so they know how to collaborate and create access to needed resources when they are made aware of someone in crisis. ▪ Chat: What about when crisis doesn't come out because it doesn't meet their definition of crisis and then we call EMS and they tell us that it is not their job/ position. ▪ Chat: My daughter has contacted 988 twice in the past month while I was also on a video chat with her. The first time was a positive experience with my daughter and the crisis counselor developing a plan to help her move back away from the that suicide "ledge" that she had found herself. The second time she contacted 988, while I was also on video chat and the suicide thoughts had gotten much more powerful, the crisis counselor (who was a different person) responded to her in a "you got this, bruh" manner. The second experience was not helpful to my daughter at all. My daughter felt that the first time she contacted 988, she was connected with an older person and the second time she was connected with a younger person. My daughter has a SMI that she was diagnosed with at 8 years old. She is now 22 and was more knowledgeable about next steps than the second crisis counselor that she was connected with. She didn't need someone treating her like a "bruh" and telling her to think positively. Can there be better training provided to the crisis counselors that respond to people using 988? o Crisis service jobs don't pay well. ▪ Chat: Paying mental health crisis responders a good wage would help.

TOPIC	DISCUSSION
	▪ Chat: I've been a certified peer counselor for 2 years and have not taken a job in that field due to the low wage and the confusion on what my role would even be. ▪ Chat: I have seen multiple job listings on Indeed for Peers that have wages from $18 to $24 and hour. I understand it is much more expensive to live on the West Side. But, I do see multiple jobs on that sight for CPC's Just an FYI. ▪ Chat: Just my experience, but I have applied for multiple peer jobs and crisis response teams, and the process was horrendous. I didn't take the jobs due to a lack of info or lack of knowledge on their part to even answer my questions… ▪ Chat: Peers are concerned if DOH gets involved with peer certification the certificate will be priced out of reach . The price of certified counselor has gone from 305 to 800 a year. o Question of who 988 is helping. Shared perspective that their crisis doesn't fit int the "buckets" mentioned in the 80 page National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit. The report says: 1) anyone, anytime, … and 2) substance abuse/use disorder and mental health / mental illness. It seems like WA is gearing to only those with mental health issues or suicide prevention. o Chat: I suggest 1) that families should have a support person who can calm them down. After the family is supported and calmer coach them as to what to say to the 988 call center next time e.g. tell the call center that the person has a mental illness diagnosis (if they do), tell the call center if the ill person is afraid of police or if the family anticipates that the ill person will be submissive (or confrontational if that is true). Etc, etc. - give as much info as possible to inform the responders who/what they are going into. The current system alienates the family especially with HIPAA laws. Yet how can the state do this without the help of the family? 2) All police/firemen should be required to take crisis intervention training ("CIT"). Police do so much better if they have been trained in CIT. For example, the last time the police came the lead introduced himself "Hi, I'm Mike". This was so helpful to decelerate the situation vs. one time years ago when the mentally ill person was tazered and criminalized. o Chat: I am here as the mother of an adopted 33 year old daughter with fetal alcohol spectrum disorder and schizoaffective disorder. She is a frequent user of the 988 number and ultimately ends up going to the ER and being hospitalized if there is a bed. (She has had over 50 ER visits since 2004). There are undiagnosed folks on our streets, jails and prisons so fetal alcohol spectrum disorder is a public health issue.. as it is estimated that one in 20 individuals are prenatally exposed so

TOPIC	DISCUSSION
	please support HB 1168 which would provide prevention, diagnostic, treatment and support services for persons who experience prenatal substance exposure. o Overall appreciation for creating space to for people to share their lived experience. o Emphasis on taking action and pursuing policy change
Open Discussion and Closing Statements	• This section of the agenda blended with discussion above. • Lived Experience members may also contact CRIS project manager, Nicola Pinson, for follow up questions or requests for resources (Nicola Pinson, npinson@healthmanagement.com).

HB 1477 Lived Experience Subcommittee – April 10th, 2023 Meeting

Meeting Summary

Monday, April 10th, 2023, 1:00 pm to 3:00 pm

Zoom

TOPIC	DISCUSSION

Welcome, Introductions, Review Meeting Agenda	• HB 1477 Steering Committee member Bipasha Mukherjee welcomed everyone to the meeting and introduced the agenda. Bipasha also highlighted that the next Lived Experience Subcommittee meeting will be held on May 8th, from 1-3pm. This meeting agenda and Zoom link are available on the CRIS webpage - https://www.hca.wa.gov/about-hca/programs-and-initiatives/behavioral-health-and-recovery/crisis-response-improvement-strategy-cris-committees .
	• Subcommittee members and presenters introduced themselves on chat.
	• Kristen Wells shared Washington Speaks information as a resource providing support to individuals to share their lived experience. Please reach out to Nicola Pinson (CRIS project manager, npinson@healthmanagement.com) if you would like to be part of a Live Experience group training to give each other support and feedback for sharing personal stories at a CRIS or Steering Committee meeting.
	• Kristen shared an overview of presenters invited to share different perspectives on the youth crisis response system during the first portion of the meeting.
	    o Sherry Wylie, Youth Mobile Crisis Team Administrator for the Washington Health Care Authority
	    o Kashi Arora, Mental & Behavioral Health/ Community Health & Benefit, Seattle Children's Hospital
	    o Cole Devlin, Prior regional representative of youth in mental health services
	    o Jasmine Martinez, Children's Long-term Inpatient Program (CLIP) Family Liaison
	    o Michelle Karnath, Statewide representative for parents of children in mental health services
	    o Others: Lived Experience planning group members (Bipasha, Puck, Marie, and Kristen)
	• Recognized the complexity of the youth system and different perspectives and system entities that may be involved (e.g. youth perspective, parent/caregiver perspective, sibling perspective, special populations, schools, foster system, juvenile justice, hospitals, service providers, and others).

Presentation 1: Youth Mobile Response & Stabilization Services (MRSS)	• Sherry Wylie (HCA) provided an overview of HCA's work to expand crisis response services for youth and adolescent populations. Sherry also shared that she is a person with lived experience. o Sherry provided context around the current limited access to youth crisis response services in Washington.

TOPIC	DISCUSSION
	▪ ED's remain the primary access point for youth and caregivers. Families must wait for medical clearance in the ED, often 10-18 hours. Some youth may be admitted to inpatient care, and the majority of youth are discharged home without supports in place. ▪ There are a handful of adolescent inpatient units in the state ▪ There are a limited number of Children's Long Term Inpatient Beds (CLIP facilities) with long waitlists ▪ WISe services face increasing demand and don't replace youth mobile response teams – separate program and both 24/7/365 ▪ 23-hour crisis relief centers offer an additional access point for families and youth, adolescents for voluntary, walk-in behavioral health services. Reduces Emergency Dept. use for BH needs ▪ Currently there is a limited number of youth teams and MRSS service delivery in WA. o Sherry provided an overview of Washington HCA's work to expand youth crisis response services based on the Mobile Response and Stabilization Services (MRSS) model. This model is based on SAMHSA best practices for the youth crisis service continuum, including "someone to talk to", "someone to respond" and "a safe place to be." o Key System of Care partners that could connect youth to the MRSS model include: Schools, primary care providers, parents, eds, inpatient units, Behavioral health providers, juvenile justice or Division of Children Youth and Families. o Mobile Response and Stabilization Services include: ▪ Initial Response (up to 3 days of crisis intervention) *all payors • Family or youth define the crisis, in person response, at home, school, community • Developmentally appropriate engagement, crisis de-escalation, assessment • Keep youth in homes, safety planning, securing the home, increase supervision ▪ Stabilization in-home (*up to* 8 weeks of intensive, in-home services) • Intervention and stabilization phases are distinct but must be connected • In home, schools, community. In person 24/7 access to treatment team • Link families with natural and community supports, arts, activities, parent groups

TOPIC	DISCUSSION
	• Care coordination and warm handoffs to existing systems of care and clinical supports when clinically appropriate
Presentation 2: **Panelists: Personal and Professional Perspectives on Youth Mental Health Services and Youth Crisis**	• Cole Devlin: WISe Therapist for Y Social Impact Center, works with trans teenage foster youth specifically. o Mobile response is important in the new service model for youth. o Utilizing lived experience is valuable because there is still a lot of stigma around getting help. o Minimizing stigma while building services is crucial. o High fidelity wrap around services give youth what they need, and result in less crises and use of crisis services overall. o Recovery based models help clients feel like they are right in the middle of the solution. o Emphasized appreciation for the sharing of peer perspectives through this Subcommittee. o Where youth and parent perspectives on service needs conflict, Cole emphasized the importance of opening conversations between youth and parents making progress to hear each other. • Kashi Arora: Mental and Behavioral Health Program Manager on the Community Health Team at Seattle Children's Hospital. o Works on community facing efforts related to mental and behavioral health. o Emergency departments are currently the primary point of access for youth in crisis. Ideally, EDs should be a place where the decision is whether the person needs to be admitted or not (physical or mental health situations). However, with lack of system resources, EDs have had to take on more and have varied levels of resources. Children's hospitals have more youth focused services and supports, but adult hospitals may not have that same level of support for youth. o Highlighted that there were crisis levels of kids coming to ER for Mental Health in 2019. Data being used to compare baseline is erroneously comparing 2023 to 2019. Data should be compared to 2018, or earlier to see baseline data. If comparing to 2019, we are comparing to what was already a crisis. • Jasmine Martinez: Program Manager for A Common Voice Cope Project, Center of Parent Excellence. Also Children's Long-Term Inpatient Program Family Liaison o Jasmine shared lived experience living with complex Post-Traumatic Stress Disorder and being removed from their parent's home by the law in high school. o Jasmine is a parent of a child with intensive behavioral health inpatient and outpatient service needs. Recognized that a lot of shame comes

TOPIC	DISCUSSION
	along with having to access care for your child, especially outside of the home. o Shared parent's perspective on the Emergency Department. How does a parent know when to go for help? Conflicting advice about when to take youth to ED. Jasmine would take their child to the ER, discharged four days later, not eligible for the psychiatric and behavioral medicine unit (PBMU) and there are no other resources to provide support. This is the space of in-between. Child is not safe at home, but not acute enough for ED, and inpatient has a 6 month wait list. Where do we go? Had MRSS existed for her family, this could have been a helpful resource for their family. • Michelle Karnath: Family lead for the Family Youth System Partner Round Table (FYSPRT). o Lived experience with son with mental illness. o Has accessed crisis services through both public and private insurance. o Struggled with getting a diagnosis for her child, which made it hard to get services. o Lives in a semi-rural area and crisis team would not come to her house. Had to make an appointment for next day, and they still couldn't find her house. Crisis isn't by appointment only. o People who live in rural communities are often told that it isn't cost-effective to provide crisis services to their areas, but those people deserve the same services as their city-dwelling counterparts. o Currently work in a specialized unit within juvenile justice system with youth with BH diagnosis and they and they may be struggling in many areas. Unit provides wrap-around services. o Echoed the thoughts that Jasmine shared around feelings of shame, both internally, and from the community. • Kristen Wells o Sister had serious emotional disturbances. Kristen's experience as a sibling was difficult, because of the lack of support. o She also struggled with how much support her parents needed to support her sister, and how her own needs sometimes got left to the wayside. o She gives a point for people to remember that it's not just the caregivers sometimes, that other people (especially children) need support in crisis situations too. • BIPOC community: acknowledged that people reached out to were not able to join to share their experience due to the trauma experienced with the system. Kristen acknowledged the important perspectives from this community regarding the needs for system change.

TOPIC	DISCUSSION

Discussion and Questions Raised	*Subcommittee Discussion*
	• Acknowledged the courage it takes to share personal lived experience and recognized contributions from people in this meet to share their experience.
	• Shared that sometimes feels like the people who make the decisions are not the people who are experiencing the problems.
	• Emphasis that peer work is invaluable in this work, and that peers need to be truly involved in all aspects.
	• Parents or caregivers are under a large amount of stress and may not be at their best selves. Anger sometimes is only there to mask fear, or frustration, or anxiety about engaging in services.
	  o Getting treatment for a child can turn into an identity. By the time parents meet someone who can help, they are not at their best, so starting the conversation with compassion. The parent is often experiencing such a crisis that their cognitive functioning is impacted.
	• Sometimes parents aren't believed. It becomes the parent voice vs. youth voice. Team effort is needed to see all sides. Sometimes the youth's voice who is actively delusional doesn't match perspective that parent is sharing regarding the situations that have led to the crisis.
	• Conflict between who to trust is rooted in a lack of trust in parents. A lot of families experience that the system is built to not trust the family, and the history of what has happened to that family.
	  o Suggestion for a standardized form to show how the family got to the point of crisis? Form could be state-endorsed and that may trusted more.
	• Parents struggle with stigma, as well as people trying to tell them how to parent their children.
	• We need to be aware that many of the agencies people are supposed to turn to for help are based in institutional racism. More representation is needed for youth who are black indigenous and people of color (BIPOC).
	• Emphasized that services that people of color get are different. Team sent to a specific situation were preoccupied with what the youth had, rather than what the youth needed. That youth ended up not getting care they needed until they joined the military, where the youth's behaviors were noticed. Emphasized so many gaps in the system for people of color.
	• Behavioral health is not a choice. It is a brain illness.
	• There seems to be more gaps than structure in the system. This is not limited to mental health – the theme of gaps is across the system, including social determinants of health. The gaps create intensive burden of parents to be essentially social workers is large.
	• A lot of decisions are made from information that comes from a centralized location. We should ensure that we have a broad scope of the state of Washington. The counties are vastly different and have different needs.

TOPIC	DISCUSSION
	• Those in the youth system will end up in the adult system if they are not properly cared for. • Not in my backyard (NMBY) is a bigger barrier to appropriate care than anyone is talking about. It is difficult to site facilities; communities will often rally against having a facility in their area. • What about situations where the youth and the caregiver are not on the same page? Or situations where the youth and caregiver do not see eye to eye? o Goal is to facilitate interaction between youth and caregiver, push past the discomfort and provide the wraparound services that youth needs. • Is there data showing the significance of having people with lived experience; do they improve services? How is lived experience being used in these processes? Are the voices being used? These are important questions that can be a topic of a future meeting. • Suggestion for a way to set up a hub where information can be entered and accessed by all members of the care team. • Highlighted the need to bridge the gap between being "not sick enough" and being in an active crisis. • Chat: Nobody can be their authentic self or speak their truth if they are in a crisis stage of a severe mental illness. When the brain that is driving the thoughts and behaviors isn't working correctly, an outside intervention is sometimes necessary to preserve life and safety. The tension of when to listen to the ill person and when to listen to the family requires understanding that not every walking, talking being is capable of choice. Sometimes they are too sick. • Chat: Working in a low barrier family shelter, we see a wide variety of behaviors some situational. Many parents struggle because of the stigma or others telling them how to parent the child with behavioral issues. As a parent with an adult child with RAD I can empathize with my families, but how do I convey safety in seeking help vs avoiding stigma for seeking help? looking for others perspective. • Chat: For years, I have been asking for some sort of hub that can be shared by families and providers. The idea is that families only need to enter the information once and then all care team members can access that hub and add their own information to help aid in tracking services, crises, and any other pertinent information. I created a paper version for my children's care. Now they are young adults and maintain their own paperwork. This process is exhausting for families. There needs to be a better way. • Chat: Part of the problem with the term "behavioral health" is the implicit bias that behavior is a choice. When behaviors result from brain-based illness conditions they are not choices. That bias is pervasive. • Chat: A crisis is an expression of the failure of the system to serve unmet needs. • Chat: When I first started treatment they said I was not sick enough for services. it took me being hospitalized numerous times to get help.

TOPIC	DISCUSSION
	• Chat: "proactive vs reactive". . . "PLEASE help me help our son BEFORE blood is on his hands and he has to live with that trauma. . . if he survives it AT ALL" I cried that out SO many times in trying to get my child much needed services (ages 5-15, in three different states). • Chat: I am definitely going to say that the ER/ Hospitals are lacking the resources more than anything in our communities. There should be Social Workers, Alcohol and Drug Counselors, and Mental Health Providers with offices in the buildings. Not to mention on staff with Emergency Response workers and Police Departments. Bio social and psychological model is treating the whole person. Many homeless people are discouraged to get their health needs met because of the stigma that they are there to try and get pain meds etc. • Chat: es, many parents/families who attend NAMI support groups in Seattle are advised early to keep a journal, to record what their FM is doing, what we tried, what appointments and hospitalizations occur, what meds were prescribed/changed, when DCR's were called, when they did /did not come out, etc. Family members even show up in hospital ER's or admitting areas to ask that they pass upstairs to the docs a "one-pager" so that the most important info is not missed. • Chat: Re: regions, 100%. I started on the CRIS when I was in Yakima - I'm in Seattle now, but have tried to access care in Spokane, Yakima, Bellingham, Olympia. Definitely keeping regional variations in mind.

Closing Statements	• Bipasha introduced Anna Nepomuceno to talk about King County Prop 1
	  ○ Tax levy for funding 5 new mental health facilities (one for youth).
	• Hope for Troubled Minds
	  ○ A collection of letters expressing love for care and gratitude for life, despite what can be debilitating brain illness.
	  ○ Hope for Troubled Minds: https://docs.google.com/forms/d/e/1FAIpQLSc7kwnnLexNM0KkmtU7xRnsdbUq7sXwdcEUyg6dXP_A0k-Gzg/viewform?
	• Next meeting is May 8th, from 1-3pm.
	• Lived Experience members may also contact CRIS project manager, Nicola Pinson, for follow up questions or requests for resources (Nicola Pinson, npinson@healthmanagement.com).

HB 1477 Lived Experience Subcommittee – May 8th, 2023 Meeting

Meeting Summary

Monday, May 8th, 2023, 1:00 pm to 3:00 pm

Zoom

TOPIC	DISCUSSION
Welcome, Introductions, Review Meeting Agenda	• HB 1477 Steering Committee member Bipasha Mukherjee welcomed everyone to the meeting and introduced the agenda. Bipasha also highlighted that the next Lived Experience Subcommittee meeting will be held on June 12th, from 1-3pm. Meeting agendas and Zoom links are available on the CRIS webpage - https://www.hca.wa.gov/about-hca/programs-and-initiatives/behavioral-health-and-recovery/crisis-response-improvement-strategy-cris-committees. • Kristen Wells shared Washington Speaks information as a resource providing support to individuals to share their lived experience. Please reach out to Nicola Pinson (CRIS project manager, npinson@healthmanagement.com) if you would like to be part of a Live Experience group training to give each other support and feedback for sharing personal stories at a CRIS or Steering Committee meeting. • Laura Van Tosh invited people to attend a Mental Health Policy Roundtable, on May 17th, from 2:00-4:00pm. The event will be facilitated by Kevin Black, a senior staff counsel for Senate Committee Services within the Washington State Legislature, and will focus on a review of behavioral health legislation passed this session. For those unable to attend, a recording will be made available after the event. A link to the event is here: https://us02web.zoom.us/j/82286496104?pwd=VnE1aGc4U1lNREVTSHZ6dnpYTng3dz09
Crisis Response Dispatch Protocols: Washington Health Care Authority overview of the draft Crisis Response Dispatch Protocols and request for Lived Experience Subcommittee input	• Betsy Jones (Health Management Associates), Project Director for the CRIS Committee, provided an overview of the formation of a CRIS workgroup to review and provide feedback on the draft Crisis Response Dispatch Protocols developed by the Washington Health Care Authority (HCA). The Crisis Response Dispatch Protocols workgroup is comprised of approximately 14 members, including 3 members representing lived experience (Michael Robertson, Kristen Wells, Puck Franta). A summary of the workgroup's feedback and changes made to the Dispatch Protocols will be provided at the June 20th CRIS meeting. The Dispatch Protocols will be incorporated into the Crisis Response Best Practice Guidelines developed by HCA and due July 1, 2023. The protocols may also be updated as changes to the crisis system are made. • HCA is also seeking feedback from the Lived Experience Subcommittee at this meeting. Matt Gower (HCA) shared a one-page overview of the Crisis Response Dispatch Protocols. The protocols outline crisis response approach based on five levels of crisis acuity. The intent of the protocols is to standardize protocols for how and when to dispatch crisis response resources.

TOPIC	DISCUSSION

	Subcommittee Discussion
	• Where would calls be coming in aside from the call center?
	  o The protocols are intended for calls to the 988 call centers as well as the regional crisis lines.
	• What does the training around this protocol look like? There is some concern that the protocol quick-glance worksheet is too busy, and too confusing.
	  o There will be training around using the tool, as well as putting it in a different format (colors, font, etc.) to make it easier to use. The current version is in draft form.
	• How is this going to be implemented in areas where the crisis system is understaffed, or not available at all?
	  o The protocols will be implemented as work is also undertaken to expand the crisis system. Recognition that there are current gaps in access to services that need to be addressed.
	• Particularly thinking about the red stage of the quick glance guide, we need to identify areas where time is the most important factor. How much time is spent up front when you call 988 before you get to someone? How fast does 988 identify if you are in the red box, and how fast are they connecting you to 911?
	  o Noted time to reach a person if calling 988. The up-front 988 dial pad options take 53 seconds to get through, which is unfortunately controlled at the federal level through Vibrant.
	  o Call centers are highly trained and able to get calls to 911 timely.
	• The term gravely disabled has been noted to be offensive. Language should be person-first.
	  o The term “gravely disabled” is part of the Involuntary Treatment statute in Washington law. While we can request that that law be changed to include person-first language, in real life, we encourage people to share terms they prefer.
	• Noted that one call may float across many of the different domains on the quick-glance page.
	• There is some confusion around the terms co-response and dual response, which may need more clarification.
	  o Dual response would include response by both mobile rapid response crisis team and law enforcement and/or emergency medical services. By contrast, a co-response team would include a single team of comprised of first responders and behavioral health professionals.
	• When people have bad experience with crisis teams, if an evaluation prompts a panic attack, could the crisis team mistakenly think they are in a worse situation than they are actually are?

TOPIC	DISCUSSION
	◦ Key pieces is training in emotionally thinking. Crisis team tries to pull person out of panic-brain. Crisis team will know how to deescalate both a person in panic and themselves. • Is this going to be pilot tested across a few organizations? ◦ Yes, HCA is planning to test extensively. Table-top exercises are up next and after publishing, the protocols will be pilot tested to ensure that the guide works.
Behavioral Health Crisis Response and First Responder Collaboration: Overview of Behavioral Health Crisis Response & First Responder Collaboration Workgroup and request for Lived Experience Subcommittee Input	• Betsy Jones (Health Management Associates) provided an overview of the formation of a CRIS workgroup to develop recommendations regarding collaboration between behavioral health crisis response and first responders (fire, emergency medical services, and law enforcement). The workgroup's recommendations will be brought forward for consideration by the CRIS and Steering Committee. The Crisis Response & First Responder Collaboration Workgroup includes approximately 17 members, including 3 members representing lived experience (Brittany Miles, Marie Fallon, Puck Franta). A summary of the workgroup's recommendations will be brought forward at the June 20th CRIS meeting. • Provided opportunity for subcommittee members to share feedback regarding collaboration between fire, police, and emergency medical services (first responders) and behavioral health crisis response. *Subcommittee discussion* • The open-endedness of this discussion is very appreciated, especially as thoughts and questions come up after the meetings. • Addressing insurance coverage as an issue would be appreciated. The medical bill after someone experiences a crisis can be re-traumatizing. • Primary care is a crucial part of crisis care. Delivery of services makes a big difference. Typically, the fire department doesn't know who is going to deliver care; their primary focus is to get you to the place where you will get care. Peer support is also crucial in a crisis. • There is a caregiving group for people with intellectual and intellectual disabilities. There are 850,000 people who are unpaid caregivers in their homes for members of their families. These caregivers can go into crisis themselves. What kind of resources do the crisis teams have to keep people from being institutionalized? ◦ We need to have a conversation about people who are neurodivergent and individuals with disabilities. We need to be able to support people and their caregivers. • Are paramedics going to be trained in trauma-informed care?

TOPIC	DISCUSSION
	○ We do not have an answer to this, specifically, but there is agreement that trauma-informed care is critical in a crisis response. Many hospitals do provide trauma-informed care, but more is needed. ○ Section 11 of E2SHB 1134 talks about developing regional training collaboratives that may in the future provide trauma informed training for a wide range of professionals and community members. Right now the bill calls for an assessment of how this could be done. • There is an opportunity to reinforce effective safe practices. Clarity is needed around the rules of crisis, because people can end up with post-traumatic stress disorder after a crisis. For example, what are the protocols, what are the police supposed to do? Police also need to be trained on how to interact with families of people who are in crisis.
Crisis Stabilization Services ("A Place to Go"): Washington Health Care Authority overview of current landscape of crisis stabilization services and request for Lived Experience Subcommittee input on key gaps and priorities	• Matt Gower and Sherry Wylie (HCA) provided an overview of current crisis stabilization services in Washington, including Crisis Stabilization Units, 23-hour centers, peer respites, withdrawal management, inpatient evaluation and treatment, and crisis stabilization services for youth offered through the Mobile Response and Stabilization Services (MRSS) model. *Subcommittee Discussion* • Very grateful for peer respite. • Is peer respite option for adults only? Any insurance type and uninsured? Any restrictions on who can go there for support? ○ It is up to a commercial plan to agree to cover a peer respite. Uninsured or underinsured including people with commercial insurance can be covered by BH-ASOs, although resources are limited. ○ Eligibility is up to the respite center, but they are meant to be low barrier and accept people where they are at. • MCO = Medicaid only? ○ Yes MCO (managed care organization) is Medicaid only in this context. • Wow, the youth model sounds amazing! Why is the adult system facility based and doesn't offer the options available to youth? ○ This is definitely something that some groups are doing advocacy around. • Noted interest in evidence/data that shows the value of investing in the 8 week in-home support for youth to support advocacy around expanding this approach. • Note questions about youth services: Which agencies will provide that in-home support for youth? What demand levels are you forecasting by region? Where will capacity come from in the system in terms of providers, etc? • Noted better access to mental health services in some areas if you're on Medicaid.

TOPIC	DISCUSSION

Open Discussion and Questions Raised	*Subcommittee Discussion*
	• We have a number of stakeholders as part of this call. Individuals with psychiatric disabilities, family members, people who have been in crisis themselves, etc.
	• All of the acronyms are messy. What are those entities at the top of the system and what do they do? How do they make the crisis system function?
	• When looking at where are services are going to be in the future, Walla Walla wasn't there. Will these services be provided in the future, where people live, how do we make that happen?
	  o Expansion is in the works. The Department of Commerce is receiving proposals from entities to open new facilities.
	• Consider outreach to community groups to talk about what it would look like to start their own program. There are a number of people who are underserved or marginalized who could potentially head up a program, but they may not have the social skills, mentorship, confidence, etc..
	• Commercial health insurance: behavioral health services know that you are better off if you are on Medicaid. For example, some people who are not on Medicaid can't access psychosis services. What is the data that makes the case for this? Would love to understand the market side of this problem.
	  o Noted that House Bill 1688 requires commercial plans to cover emergency services (roughly translates to crisis services). Self-funded plans can opt in.
	• People like to use the word marginalized. These are intentionally marginalized communities. We won't get to a place where these communities will be demarginalized until we address as a society as a whole. We have communities who have never been involved in the system. If we are going to talk about demarginalized, we need to stop stepping over the dead bodies and do an autopsy of the intentional marginalization, structural and administrative racism. We like to say it, but we're not demonstrating it. We're not going to address any of this until we realize we have a cooccurring approach they need to have addressed. Constructs are in place that will prevent us from solving the problem.
	• Behavioral health is not separate from social justice issues.
	• I moved off of Medicaid into Molina Marketplace. I live in Tacoma and they couldn't find a mental health provider who would take me as a new patient. We tried for a year and then I got care from an online provider in California. I decided to change from my small primary care provider into the UW system. It did not improve my access to mental health care. I was denied access because the department was focused on institutional care. After elevating the issue I was accepted but told that I can't get the therapy my doctor recommended because I didn't meet the criteria of being violent. I agree we have a system that promotes crisis not stabilization.

TOPIC	DISCUSSION
	• I wish the crisis system was set up so people could build and tailor their own crisis system response before they are in crisis. Having a treatment plan would help prevent bad experiences with the crisis teams. • We need to track what we know will be valuable. • People are tired of repeating their stories over and over again. • A survey would give the person control over what and how much they share.
Closing Statements	• Bipasha provided a recap of the meeting, and Marie Fallon offered her thanks and appreciation for the conversation and the participation of the attendees in the discussion. • Next meeting is June 12th, from 1-3pm. • Lived Experience members may also contact CRIS project manager, Nicola Pinson, for follow up questions or requests for resources (Nicola Pinson, npinson@healthmanagement.com).

HB 1477 Lived Experience Subcommittee – June 12th, 2023 Meeting

Meeting Summary

Monday, June 12th, 2023, 1:00 pm to 3:00 pm

Zoom

<table>
<tr><th>TOPIC</th><th>DISCUSSION</th></tr>
<tr><td>Welcome, Introductions, Review Meeting Agenda</td><td>

HB 1477 Steering Committee member Bipasha Mukherjee welcomed everyone to the meeting and introduced the agenda. Bipasha also highlighted that the next Lived Experience Subcommittee meeting will be held on July 10th, from 1-3pm. Meeting agendas and Zoom links are available on the CRIS webpage - https://www.hca.wa.gov/about-hca/programs-and-initiatives/behavioral-health-and-recovery/crisis-response-improvement-strategy-cris-committees.
Kristen Wells shared Washington Speaks information as a resource providing support to individuals to share their lived experience. Please reach out to Brittany Thompson at Health Management Associates (CRIS project coordinator, bthompson@healthmanagement.com) if you would like to be part of a Live Experience group training to give each other support and feedback for sharing personal stories at a CRIS or Steering Committee meeting.
Sherry Wylie (HCA) shared slides highlighting opportunities for people with lived experience to get involved, including some opportunities that come with stipends. This information, including links and contact information, has been posted to the CRIS webpage as part of the meeting slides.

Children and Youth Behavioral Health Workgroup

Youth and Young Adult Continuum of Care (YYACC) subgroup
Prenatal – 25 Behavioral Health Strategic plan subcommittees

Center of Parent Excellence (COPE)
Washington State Community Connectors (WSCC)
A Common Voice COPE Project
SPARK – Students Providing and Receiving Knowledge
The Mockingbird Society
Youth Move National

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<tr><td>Legislative Update</td><td>

Megan Celedonia (988 Coordinator, Governor’s Office) provided a legislative update and overview of her role.

Megan’s position at the 988 Hotline & Behavioral Health Crisis System Coordinator in the Governor’s Office was created in HB 1477 (2021) and extended in HB 1134. Megan oversees statewide implementation of 988 and cross-agency collaboration between DOH and HCA. Megan’s position is specific to 988, while Amber Leaders focuses on Washington behavioral health services overall.
Bills reviewed: (slides are available on the CRIS webpage)

HB 1134 – 988
SB 5120 – Crisis Relief Centers

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TOPIC	DISCUSSION
	▪ HB 1004 – Installing Bridge Signs ▪ SB 5555 – Peer Specialists ▪ HB 1541 – Nothing About Us Without Us (did not pass) *Subcommittee Discussion* • Note that even though HB 1541 did not pass, there is some work in the interim and people who ae interested in helping may contact Laura Van Tosh at lauravantosh56@gmail.com • Concern about how to ensure that lived experience voices are heard, and hope that when panels and committees are assembled, peer voices are considered. • Question about whether the facilities are being planned to be low-stimulating, so as to create a difference from the harsh clinical feel of emergency departments. o The delegation of Washington representatives that went to Arizona observed their processes and found there was a lot of thought into the environment and making it less harsh and more calming. o DOH is planning for draft rules for the Crisis Relief Centers established under SB 5120; note that the bill creates a facility type, not funding for new facilities. • Comment that peer voices are so important, and so are the voices of families. A peer on a committee doesn't mean family voice is present, and vice versa. o Kristen Wells shared that her mother is the executive director at WA State Community Connections, before that she was a parent partner. Kristen's sister is trained as a certified peer specialist as well. She emphasized how important it is to have all types of voices.
Washington State Health Care Authority (HCA) Role in the 988 Buildout, and Incorporating Lived Experience Input	• Matt Gower, from Washington State Health Care Authority (HCA), provided an overview of HCA's role in 988 and the behavioral health crisis response system. Topics included funding sources, crisis services, and how the system operates. o HCA's role in the crisis system re-design project includes crisis services (expansion and program development), operational infrastructure (regulations and oversight), funding (federal and state) and a technology platform. o HCA's scope of work does NOT include 988 call centers and hub designations, oversite of commercial plans, 911/Public Service Access Points, First Responders, Veteran services, or state hospitals and long-term care. HCA works with partners for these workstreams. *Subcommittee Discussion & Chat* • **Chat Request:** "Can someone at HCA develop a list of who is responsible for discharge from each of the various levels of inpatient care under the ITA?" • **Chat Response:** "This is part of our 988 plan--that a crisis leads to a person being enveloped by the system and not abandoned. Discharge planning is a huge gap"

TOPIC	DISCUSSION
	○ "Absolutely. Discharging from an inpatient facility is a time of increased risk, transitional support is very important as people return to their community." ○ "And the status quo often means discharge to nothing, maybe an uber to a shelter. 988 will fail to pivot toward a recovery-based system without a huge change in discharge planning" ○ "What role does HCA have in oversight of discharge planning? Do they have responsibility to track what happens next?" ○ "Some people are being discharged with a tent." • **Chat:** "I am a parent who has supported and advocated for my children (now adults) during their journeys with serious mental health needs. There was no crisis stabilization/response while they were growing up. 911 was the only option. I founded Family Alliance for Mental Health, coordinate Wraparound with Intensive Services and our Family Youth System Partnership Round Table. All in Thurston and Mason counties. I believe strongly in patient rights, utilizing least restrictive environments, family involvement and reduced reliance on Designated Crisis Responders. I also believe there needs to be greatly increased monitoring of inpatient psychiatric hospitals/facilities." • **Question:** "Future lived experience efforts. Peers were engaged in DOH Rules for peer respite. How will this occur with facilities?" • **Question:** "What is the goal for each regional crisis line? Quota, for example?" ○ Response: Current metrics are to answer calls within 30 seconds and be open 24/7. They are in the process of creating stronger metrics. • **Question:** Are you looking for people with lived experience from each hub? Note that in some areas, people with lived experience aren't received well. ○ Response: Working on re-tooling outreach. They are working to make sure they reach and hear from people they don't usually hear from. • **Question:** Is there military/veteran peer presence today? ○ Comment: I just would like to share what I shared to the Steering Committee about an issue with the veteran crisis line when some vets call 988. A veteran in crisis I helped could not reach 988. There have been dropped calls. • **Chat:** Some places go with providing housing first. Independence Center in St. Louis owns lots of transition housing units. I'm grateful for what is offered in Thurston county for individuals with mental health needs but it is not readily available. • **Chat:** I support an overall strategy for peer engagement. That currently does not exist. • **Question:** Is there coordination with the Behavioral Health Advocates across the state?

TOPIC	DISCUSSION
	• **Question:** Is there sense of a clash with some first responders with keeping co-responder teams active that 988 may do away with? • **Chat:** Observation: a lot of absorption today. Let's plan on a solid 2 hour meeting for input someday.

Workgroup updates	• Crisis Response Dispatch Protocols Workgroup
	  ○ **Purpose:** This group reviewed and provided input into draft crisis response dispatch protocols that have been developed by HCA and partners. The protocols are intended to standardize guidelines for when and how to dispatch crisis response resources. The dispatch protocols will be part of the Crisis Response Best Practice Guidelines due by July 1, 2023. The Guidelines will be continuously updated to incorporate changes. The 15 members met May 4th and 17th
	• Behavioral Health Crisis Response & First Responder Collaboration Workgroup
	  ○ This group includes members representing lived experience and is focused on developing recommendations to address barriers to appropriate, effective, equitable, and safe collaboration between first responders (fire, police, and emergency medical services) and behavioral health crisis response.
	  ○ As a request to the Lived Experience subcommittee, a survey was distributed, asking people:
	    ▪ "What is getting in our way of having an appropriate, effective, equitable and safe collaboration between fire, police, and emergency medical services (first responders) and behavioral health crisis response?"

Open Discussion and Questions Raised	*Subcommittee Discussion*
	• **Comment:** We need to look at discharge planning, or lack thereof. We can't just hear it on a call like this and not have a place to put it, and have place to follow up. Does Disability Rights of WA have anyone on this call, and what would their response be?
	• **Chat:** DRW has a report named all or nothing at all and talks about discharges to the street.
	  ○ https://www.disabilityrightswa.org/new-report-all-or-nothing-ending-washingtons-dependence-on-involuntary-civil-commitment/
	• **Question:** more productivity here with peers with lived experience? It's hard to get a viewpoint of the whole project.
	  ○ Matt does feel like the lived experience is one of the most productive committees, and he is on many of them.
	• **Question:** In regards to retention, do we feel like we're getting somewhere?
	  ○ There is still a lot of time (18 months) for Lived Experience voices to be heard. The Lived Experience subcommittee was intentionally left as an

TOPIC	DISCUSSION

	open committee, as opposed to the other subcommittees, which are closed.
	  ◦ Several CRIS positions open right now (LGBTQ+, University center of excellence, and first responder co-responder programs).
	  ◦ **Chat:** The meetings are one thing, but the work that needs to be done between meetings is a lot!
	• **Chat:** FYI: Medicaid Managed Care Organizations are subject to the following requirement: 7.17. Required Reporting for Admission, Discharge, and Transfer (ADT) Notifications. The Contractor will require the use of interoperable Health Information. Technology (HIT) to create and send admission/discharge/transfer notifications. (ADTs) to providers, facilities, or practitioners on behalf of Enrollees admitted to. Inpatient Psychiatric Hospitals and Units that have access to HIT/EHRs.
	  ◦ See the complete Medicaid managed care requirement here: https://www.hca.wa.gov/assets/billers-and-providers/ahimc-medicaid.pdf
	• **Chat:** When I mention it to people or leadership, the common response is "There's a lot pieces."
	• **Chat:** It's very challenging to follow. I'm just glad at least peers at the decision table are brought to the table more than I have seen before at this level.
	• **Chat:** We worked hard to get a lived experience vote on the Steering Committee, and I agree that it would be great to have this opportunity in more places beyond the CRIS!
	• **Comment:** When we talk about evaluating involuntary treatment facilities for efficacy, it's a bizarre experience. It's like evaluating a parachute as people are falling out of airplanes. This work is about repairing parachutes.
	• **Comment:** Surveys/requests for input should be distributed before the meeting to get more stakeholder engagement.

Closing Statements	• Bipasha provided a recap of the meeting. • Next meeting is July 10th, from 1-3pm. • Lived Experience members may also contact Brittany Thompson, for follow up questions or requests for resources (bthompson@healthmanagement.com).

HB 1477 Lived Experience Subcommittee – July 10th, 2023 Meeting

Meeting Summary

Monday, July 10th, 2023, 1:00 pm to 3:00 pm

Zoom

TOPIC	DISCUSSION
Welcome, Introductions, Review Meeting Agenda	• HB 1477 Steering Committee member Bipasha Mukherjee welcomed everyone to the meeting and introduced the agenda. Bipasha highlighted that the next Lived Experience Subcommittee meeting will be held on August 14th, from 1-3pm. Meeting agendas and Zoom links are available on the CRIS webpage - https://www.hca.wa.gov/about-hca/programs-and-initiatives/behavioral-health-and-recovery/crisis-response-improvement-strategy-cris-committees. • Kristen Wells shared Washington Speaks information as a resource providing support to individuals to share their lived experience. Please reach out to Brittany Thompson at Health Management Associates (CRIS project coordinator, bthompson@healthmanagement.com) if you would like to be part of a Live Experience group training to give each other support and feedback for sharing personal stories at a CRIS or Steering Committee meeting.

Your Experience Engaging With CRIS	• The Lived Experience Subcommittee Planning team posed the following questions for the subcommittee:
	    ○ What has engaging in this process been like for you?
	    ○ What helps you to (continue to) show up?
	    ○ Are you feeling respected, heard, seen when you share?
	    ○ What are you hoping we will accomplish through these meetings?
	    ○ What themes have you seen emerge across these meetings that agencies should strongly consider when building out the BH crisis response system?
	    ○ What might help you feel better about this process?
	• These questions were also shared via a survey in the chat. This survey was shared after the meeting as well, and sent directly to the Lived Experience Subcommittee listserv.
	
	Subcommittee Discussion
	• Participants highlighted the importance of having people with all types of lived experience be part of the conversation. Including people with lived experience in substance use disorder.
	    ○ Should include more people who have gone through certified peer counselor training.
	• Dual diagnosis was discussed as an important issue to address. For example, treating attention deficit/hyperactivity disorder (ADHD) helps with SUD.
	    ○ HCA has been working with the Developmental Disabilities Administration to compile resources and training around working with

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	people who have a dual diagnosis, especially diagnoses that include intellectual or developmental disability. o There is major concern about the nationwide shortage of ADHD medication. Not having these medications can cause people to go through withdrawal and could exacerbate other issues. Fear of inpatient situations is also a concern because it can often be more traumatizing. ▪ Some pharmacies aren't taking out-of-town prescriptions and online pharmacies have stopped filling prescriptions. ▪ Medication mismanagement is a huge problem. There is an understanding that these medications have to be controlled to prevent misuse, but "the challenges of that control of them come down so hard on the consumers that need to access those meds." ▪ "It just feels like we're trying to fight drug addiction by punishing disabled people. And that's really hard because then I think it makes those disabled people more susceptible to getting into drug addiction because they're not able to access their regular meds. And so then they're more likely to turn to less legal, straightforward methods, and then they're likely to get screwed over by that system and harmed by that system. It feels really challenging to try to navigate that." ▪ **Question:** why is there such a shortage? • Answer: Self-research on internet, given with caveat to take this with a grain of salt, and to do some research on their own. The U.S. Drug Enforcement Administration (DEA) opted to not raise the amount of medications that manufacturers could make. COVID also had an effect; more diagnoses, but DEA is skeptical that those people do have ADHD. ▪ **Question posed to legislators:** Can we look into this, and maybe provide some education around this topic? • **Chat:** I am wondering if somehow someone can get connected to Governor Inslee to talk to him about the nationwide med shortage? Can the CRIS committee be informed about this shortage? something needs to be done. The shortage has been going on for over a year now. ▪ **Chat:** Those concerns about overdiagnosis from online prescribers feels like that same stigmatization that we see frequently that folks are just med-seeking. • **Chat:** Eye Movement Desensitization and Reprocessing (EMDR), Dialectical Behavior Therapy (DBT), and even Cognitive Behavioral Therapy (CBT) are

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	evidence-based to work but are incredibly difficult to access due to insurance barriers and provider shortages. These also lead to crises that are predictable and preventable.
	• BH as a medical issue. People should be treated as a whole person, not compartmentalized.
	  o The visit to AZ was mentioned. AZ model is a wholistic approach; includes mental health, substance use, medical, etc. If the medical is more than they can handle, the facility can transfer an individual to an emergency department, but only 2-3% of patients need transfers. The individual is also not just discharged, they come back to the facility for more wrap-around services. They are trying to create the no-wrong door approach, so people don't get shuffled around and their experience is more healing.
	• **Chat:** This is strictly from my perspective! I continue to encourage the use of the 988 system and regional systems, however we still see within our community people struggling to even connect. I understand we have multiple people seeking consultation through a crisis but they disengage because they are put on hold or told someone will call them back? What can we do or say that would encourage to use these systems.
	  o **Response:** Short-staffed, but legislators are doing what they can to open doors reasonably without compromising standard of care, education, etc. Based on criteria that they are able to live in area they work, and responsive to burn-out. Deep need for people to fill in, and peers could be a place for that.
	• **Chat:** Agree! Any behavioral health receiving facility needs to respect and be able to provide for physical health needs as well. In my family experience this did not happen and there was no way to get it resolved. More accountability is needed.
	• Even with access to Mental Health, there are still major barriers.
	  o One participant used to take Xanax for his major depressive disorder, and even though Xanax works for him, his insurance would not continue to cover. They put him on Propranolol and Gabapentin. He ended up losing roughly 20 pounds. As he also has an eating disorder, they wanted to put him on an anti-psychotic to help him gain weight instead of giving him therapy. He used to be able to access Xanax through back-door methods, but he can't do that anymore because there is the fear of developing a fentanyl addiction. "I'm being forced to be pigeon-holed into a system that doesn't work for me or access the system that works for myself and develop a fentanyl addiction."
	  o He knows of a therapeutic model called Eye Movement Desensitization and Reprocessing (EMDR) that works very well for him, but the insurance wants to keep him in Cognitive Behavior Therapy (CBT). So, he's paying $200 a month and none of his needs are being met.

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	◦ "Long story short, there seems to be a disconnect between patient and provider." ◦ "I feel like I keep hearing this run about people not being trusted, and I think that that's what it comes down to, and I think that that's really important thing to recognize." ◦ **Chat:** call the insurance commissioner and talk to them. • Sometimes it takes multiple years for doctors to correctly diagnose something, and in the meantime, people are struggling with medications that might not work, or they might not be able to get the medication that does work because providers are afraid to prescribe it. • People with behavioral health needs present themselves differently than people without behavioral health issues. People in behavioral health crisis do not present as calm, harmonious. More training is needed on how to interact with people in a behavioral health crisis and not read that as a form of resistance. • Going through recovery and only getting treated for SUD and not for MH, creates an environment where people are likely to return to use. Self-medication is dangerous and could lead to more overdose deaths. ◦ "I'm really thankful to be in this this group in this process to see you guys work because you guys all care." • Mental health is from young to old, everyone needs to be considered. • **Chat:** The triage for mental health in Spokane closed due to people not accessing that service, so I have been told. • **Chat:** Yes people are turning to other means to medicate due to cost association or lack of access to. • **Chat:** I have recently become a peer support councilor for our local behavioral health therapeutic court. My experience is that our Department of Behavioral Health (DBH) is so full that when you are new in the system it's incredibly long to get an intake and then make an appointment for meds. How can we fix this issue. • **Chat:** I've heard from the Office of Behavioral Health Advocacy that medication mismanagement is the number one consumer complaint in WA State. Medication mismanagement has a huge correlation with cause of crisis, so it's very relevant to the CRIS work. Getting the right meds to begin with, keeping an Rx with insurance barriers, getting refills, side effects and medication interactions...these can all lead to crisis, yet medication management is getting worse not better. • There are a lot of services that are only available to people depending on how they access insurance, which means that if you are on Medicaid there's some services you can get. But people on private insurance plans can't access those same services, and vice versa which is problematic. There are a lot of types of therapy and types of medication and types of services that would be beneficial to

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	a lot of people. But if you get insurance one way or another way, you can't necessarily access them, which is also problematic.
	• **Chat:** That's another issue recovering addicts deal with on a daily basis being denied medication because you are an addict.
	• **Chat:** Or misdiagnosed and mismedicated…. My ptsd [post traumatic stress disorder] and anxiety presented as adhd as a child and that misdiagnosis has followed me since childhood....
	• **Chat:** I have lived experience. I am in recovery bhc grade also have a son that passed away from suicide almost 7 yrs ago. 1 yr later I couldn't cope with his loss and then attempted suicide myself. Thank God, I didn't succeed.
	• **Chat:** I refused inpatient out of fears. I was fortunate to have an amazing support group but this was through the Veterans Affairs (VA), I felt attacked by community providers 7 years ago. So yes things are changing but we get stuck in the old ways.
	• Something the CRIS could do is provide information regarding hiring.
	  o Regionally
	  o National Suicide Prevention Lines
	  o Regional Crisis Lines
	• Reflection on the question "What might make you feel better about this process?"
	  o At the beginning of each meeting, reflection on how the comments from the previous meetings were organized, shared with the CRIS committee and how they might have influenced any of the decision-making processes. This could include whether someone is collecting training topics for the 988.
	    ▪ This is something we can put into a deeper conversation to understand.
	• Mothers of the Mentally Ill founder gets a lot of emails from people who are engaged with many aspects of the system. One story that came to them is about a young adult who has been trying to help a roommate with a severe psychotic disorder for many years. The roommate has been in and out of numerous involuntary hospitalizations and lacks insight into their illness because of the nature and severity of their psychotic condition. The person trying to help is struggling to keep their roommate out of jail and out of the hospital. This person has said that the people who answer the 988 call line have become a barrier to helping their roommate and the DCRs. In the past, the person was able to call directly and share information about their roommate's condition, and a relationship was developed. Information was stored, and the crisis lines had information about what had happened. Now, they're talking to VOA and they have to start from scratch every time they call. No development of relationship or understanding of how a crisis is evolving. This person may be willing to talk to the CRIS.

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	◦ The lack of records in 988 has been brought up in many of the subcommittees. How do we make sure the people showing up on the scene has all of the information they need to treat the person who needs it. ◦ At some point, 988 will be a robust hub. It will be able to coordinate more at the system level. Hopeful that incentives in HB 1134 for higher reimbursement for rapid response leads to more community-based care and less police involvement. ▪ **Chat:** That is the #1 issue for myself. how many times do we need to disclose our stories. It took me 20plus years to get where I felt safe to share it. ◦ Direct access to DCRs is 206 263 9200. We need to have a call with the 988 NSPLs. They should be answering these questions directly. We also need information about NSPLs and RCLs in WA and how that will function with support of DOH and HCA. • Substance Use and Recovery Services Advisory Committee (SURSAC) community notes that smoking devices were given out during COVID in order to reduce the harm of people using contaminated needles during the needle shortage. • **Chat:** I have had serious thoughts to suicide. Acting on my thoughts once. I have lost close friends to suicide. I have been active in suicide prevention for 23 years at Martin Hall Juvenile Detention Faculty. I have seen way too many youths as young as 10 years old that end up at my place and they should have been admitted to mental heath issues. I have seen a ton of the good, bad and ugly in the mental health services. I am also the Chair for Prevent Suicide Spokane Coalition. I try to attend as many of these meetings along with Cris and Steering Committee meetings. I was on the training and credentials committee. I love how invested Rep. Tina Orwell has been to HB 1477. I have seen and heard it all. Thank you for giving us a voice. • **Chat:** Link to crisis lines by county https://www.hca.wa.gov/assets/program/county-crisis-line-phone-numbers.pdf • **Chat:** I am still finding people that do not know about 988. Just yesterday. I would love to see more some commercials on tv • **Question in Chat:** Is there a flyer for 988 that can be posted? ◦ Lots you can download or order from the Substance Abuse and Mental Health Services Administration (SAMHSA) • **Chat:** Yes, violence is a requirement for involuntary intervention, yet people who reach that threshold are commonly denied care having symptoms that are "beyond the scope" of the hospital. A terrible catch-22 • **Chat:** Just wanted to say hello!! I recognized quite a few faces and I'm so glad to find you all here. This was my first meeting. I've just landed at Stilly Valley Health

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	Connections which serves north Snohomish County. I look forward to this opportunity! • **Chat:** SeaMar was funded to open up the first youth crisis receiving center in our state. Co-located with Youth detox and youth SUD treatment • **Chat:** 2/3 of sub disorders are from trauma • **Chat:** I wrote an op/ed piece published July 1 in the Seattle Times about fixing the system. Feel free to read and reach back to me with any questions, jerri.clark@momi-wa.org. https://www-seattletimes-com.cdn.ampproject.org/c/s/www.seattletimes.com/opinion/the-mental-health-system-that-failed-my-son-is-fixable/?amp=1 • **Chat:** HCA peer support webpage - includes how to become a certified peer counselor https://www.hca.wa.gov/billers-providers-partners/program-information-providers/peer-support
Open Discussion and Questions Raised	Analogies for the work we do: • We maximize our impact by doing a relay. Racers take turns turning the track and no one person ever runs the full length or time of the race. This allows exceptionally long races like the RAGNAR, which is 200 kilometers. Another example is Relay for life, which is 24 hours long. None of us can successfully do this work alone. It takes all of us coming together to share our experience, insights, and education to improve the system. • Choirs maximize their performances by using staggered breathing. When it is impossible for one singer to hold an extremely long note, the singers take short breaths at different times to make it sound like the note is continuous. If we each take a step back when we need to take care of ourselves, we know there are still others there doing the work. • We work, we rest, we take turns, we do it together. *Subcommittee Discussion* • Often, when kids are in crisis, they are violent, and in those cases, they need to be taken care of and listened to. Sending them to the Juvenile Detention center is not the place for that. A program where those kids are embraced instead of turned away is something people want to see more of. o Martin Hall is a juvenile detention facility that serves 10 counties and 2 tribes, for kids who need short term facilities. There are other facilities that house kids for longer. Families come in and parents don't know where else to go. Kids have mental health issues and end up in long-term facilities. Those facilities do have treatment, but it's still not the right place for most of these kids. • DOH will be raising more awareness of 988 with social media, community campaigns, etc. • Someone working as a peer and their agency doesn't know what to do with them. This person is cleaning rooms, which is not what they signed up for.

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	• Why don't we have a mental health clearing house that compiles the various things that are going on. HCA has a calendar, but not everyone knows what things are going on. Especially for peers, a centralized place to look for work would be helpful. We need a centralized, user-friendly database with all services in Washington.
Closing Statements	• Bipasha provided a recap of the meeting. • Next meeting is August 14th, from 1-3pm. • Lived Experience members may also contact Brittany Thompson, for follow up questions (bthompson@healthmanagement.com).

HB 1477 Lived Experience Subcommittee – August 14th, 2023 Meeting

Meeting Summary

Monday, August 14th, 2023, 1:00 pm to 3:00 pm

Zoom

TOPIC	DISCUSSION
Welcome, Introductions, Review Meeting Agenda	• HB 1477 Steering Committee member Bipasha Mukherjee welcomed everyone to the meeting and introduced the agenda. Bipasha highlighted that the next Lived Experience Subcommittee meeting will be held on September 11th, from 1-3pm. Meeting agendas and Zoom links are available on the CRIS webpage - https://www.hca.wa.gov/about-hca/programs-and-initiatives/behavioral-health-and-recovery/crisis-response-improvement-strategy-cris-committees. • Kristen Wells shared Washington Speaks information as a resource providing support to individuals to share their lived experience. Please reach out to Brittany Thompson at Health Management Associates (CRIS project coordinator, bthompson@healthmanagement.com) if you would like to be part of a Live Experience group training to give each other support and feedback for sharing personal stories at a CRIS or Steering Committee meeting.

Presentation and Discussion: Synthesis of Recommendations Relating to "Someone to Come" in the Crisis Service Continuum	• Michael Anderson-Nathe, an HMA partner and facilitator reviewed the Synthesis of Gaps and Opportunities document that was shared in the last CRIS meeting. Specifically, Michael focused on where the Lived Experience Subcommittee feedback has been incorporated throughout the document. A video recording of this overview is provided on the CRIS webpage here: https://www.youtube.com/watch?v=PPqHy_jdj-Y. Key points highlighted included:
	  ○ **Lived Experience Subcommittee "Breadcrumbs":** the HMA project team created a "breadcrumbs" tool to document the process incorporating input from Lived Experience Subcommittee meetings to inform CRIS and Steering Committee recommendations. The tool is a spreadsheet that documents comments made during subcommittee meetings (without identifying names of individuals) and indicates where those comments are incorporated into the "Synthesis" of system gaps and opportunities, as described below.
	  ○ **Someone to Come: Synthesis of Gaps and Opportunities:** Michael reviewed the "Someone to Come: Synthesis of Gaps and opportunities" table that was shared with the CRIS in July with additional themes that were identified by the Lived Experience Subcommittee. As illustrated in the breadcrumbs document, there was a lot of alignment between Lived Experience Subcommittee comments and the gaps and opportunities identified by the CRIS and Collaboration Workgroup. Additional themes identified by the Lived Experience Subcommittee that were not already

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	reflected in the CRIS and Collaboration Workgroup synthesis are highlighted in BLUE text in the table. Additional Synthesis documents are being developed for "Someone to Call" and "A Place to Go." • Lived Experience Subcommittee input is requested to ensure key priorities are reflected in the Synthesis documents. These documents are working drafts and being used as a tool to bring together committee input to serve as the foundation for recommendations to include in the CRIS 2024 Progress Report. Questions that you may consider: a. Is there anything missing from the Synthesis documents? b. Is there anything that needs to be strengthened or further clarified? c. Do you feel your input is reflected? • **Chat:** This is a shoutout to [name removed] who keeps the system honest on how the voices of the LE folks are being incorporated in the CRIS process. Thank you. • **Question:** what is the meaning of "bread crumbs?" o This is the term that the team is using to describe the document in which we track input from the Lived Experience subcommittee and how that has been incorporated into the Synthesis document. • **Chat:** I would ask the following: 1) Provide honoraria for peers who will do a good job with this project. • **Question:** I would need to review documents before I can comment. o Comments are welcome. Please send to Nicola Pinson (npinson@healthmanagement.com) or Brittany Thompson (bthompson@healthmanagement.com) • **Chat:** I am concerned with how and who can comment with the parameters set before us. • **Chat:** I appreciate this bread crumb document; transparency is so great! • **Chat:** I am completing a similar project for an out of state location. They are paying an hourly rate and providing plenty of follow up time. • **Chat:** I haven't read this document... and I can't see it here (bad eyes, and the dog ate my glasses) So please forgive if this is addressed somewhere. But something that I see as a potential gap with MRSS is the lack of infrastructure around intensive resources for children with complex co-occurring IDD/ mental health that make them a danger to self and others. When the "Someone Comes" my lived experience was being told by CPS that all my neurotypical kids would be removed if my disabled child kept harming them, since there was nowhere for my disabled child to go to get services. our infrastructure currently doesn't include any longer-term residential resource than CLIP. this will be problematic for trying to keep chronically violent kids in homes that also have other siblings living at home. Our current model is to send all those kids out of state far from their support systems (which I find really inappropriate). So, our infrastructure will need built out to include resources for that demographic.

TOPIC	DISCUSSION

	• **Chat:** Also, if the child is violent at CLIP placement they will be discharged. So frustrating.
	• **Chat:** This document is the product of a lot of group conversations, what we are doing here is in effort to do what Laura is mentioning, to broaden and deepen the feedback we're getting to make sure everyone here is heard.
	• **Chat:** Absolutely, Laura - that's another thing we're doing here, trying to figure out the best ways to use our voices to provide feedback that will be heard.
	
	Subcommittee Discussion
	• There is a recommendation that whenever the work is done, it be brought back to the larger group to share the results of the overarching issues brought up.
	• Bipasha reminded attendees how the CRIS process works. House Bill 1477 (2021) set up the CRIS Committee as an advisory body to the Steering committee. There are also numerous subcommittees, all of which HMA is a part of. HMA synthesizes each meeting to bring a cohesive set of information to the CRIS Committee and Steering Committee.
	  ○ People should feel free to reach out to Steering Committee members directly to provide further perspectives.
	  ○ Bipasha reminds the attendees that the goal of these meetings is to connect people directly to the people making the decisions.
	• Subcommittee member story: Our member is currently involved in helping a family in one region of the state with a frustrating and evolving crisis. The young person involved has been threatening to harm themselves, as well as their landlord, and causing property damage on a large scale. This person's family has called the crisis line dozens of times in the last two weeks, but the Designated Crisis Responders (DCRs) won't evaluate the person because they barricade themselves in their apartment and won't let them in. The DCRs are unable to do an evaluation on someone who won't volunteer for that evaluation. This is contradiction in the system. The Involuntary Treatment Act requires that someone be dangerous in order to be treated involuntarily. People are getting bounced around from 988 to 911 to police to mental health.
	  ○ This may need a deeper conversation about what exactly the law entails, and who is executing that law.
	• **Chat:** In my area they've broken the door to get to my family member multiple times, to provide help.
	  ○ This was in Olympia, and this involved the fire and police departments. The DCR came multiple times, but there was more response from police and fire. The police stopped coming, but before they did, they were always respectful and kind. The fire department was right across the street, so it was easier access as well.
	• **Chat:** I want to talk about alternatives to forced treatment. We need to give this equal time at the very least.

TOPIC	DISCUSSION
	◦ Response in **Chat:** of course voluntary treatment should ALWAYS be the priority. AND when someone is just too sick, we need to protect human rights and save people before someone dies. • **Chat:** So much friction between police versus crisis responders versus DCRs. Everyone wants someone else to take the problematic cases. • Question from **Chat:** To what extent does the Steering Committee have interactions or reports on the federal level of 988? For example, does the tech subcommittee report to the CRIS committee and then the steering committee about a technical concern to 988 main suicide line system/Vibrant health? ◦ Steering Committee members receives general updates. Agencies are responsible for system oversight and implementation. ◦ Out of state technical assistance is being provided at the King County level with active involvement in the Crisis Levy work. I am participating with other peers. I request we revisit issue of consensus. It matters that we negotiate this when it comes to making larger decisions. It's happening elsewhere, why not among peers? • **Chat:** It's the "we need a social worker" like, person to do follow through as the system tosses it around • **Chat:** the hardest thing is that every DCR responds differently and that is frustrating. • **Chat:** I have experienced this numerous times in Clark county - more than any other (especially when it comes to DCR) • **Chat:** I think it could be a problem with the people in these positions? Like there are people who don't give up easily because they are devoted to supporting and those who just do the work of checking the box • Question in **Chat:** Also, one of the past meeting, HCA shared CRIS is not extensively marketing 988 to the public since we are still building it? Is this correct? This response to my question about not many first responders or mh professionals know what is going on here at the CRIS and the overall work and process of 988. There's more awareness this year with different entities. ◦ Washington has not started actively marketing 988 and the system is still in development; current marketing is being led by SAMHSA. ◦ I know if you go to 988 website you can download posters and other merch to post places you work or go. ◦ https://www.samhsa.gov/ ◦ The weekly Crisis Jams are also a good resource. https://talk.crisisnow.com/learningcommunity/ • **Chat:** We have a lot of new peers entering the field with varying degrees of knowledge and awareness of peer values that have existed for decades (40 +years). It goes to the quality of training well beyond getting credentialed as a peer specialist.

TOPIC	DISCUSSION
	○ A conversation I've been wanting to have in this space is about our values, because I don't know that we will find consensus here necessarily - but if we articulate what different people expect our rights to be in the 988 process, we can at least assess who/how/if those needs are being met. ○ But lack of agreement with precedent doesn't mean people are wrong. ○ And "lived experience" doesn't equal "peer." And does "peer" still mean what it used to mean? Not to a lot of people. • **Chat:** The DCR's work differently in the 9 counties I work with. It gets frustrating that it gets so hard to get someone retained unless they are evaluated in Spokane County. This is due to resources. This is why the youth ends up at our detention facility. Very SAD. • **Chat:** The DCRs that I know don't feel confident speaking up about their org's requirements/guidelines because the field is small for such specialized positions. • **Chat:** Fire department helped to temporarily fix door the last time. • **Chat:** People with psychotic disorders have gotten this sick for centuries. We need to admit as a system that we need a plan for the very rare and uniquely dangerous cases when someone needs life-saving, involuntary care. • Question in **Chat:** Is there a list of the organizations on the crisis line subcommittees (I don't know the correct name for that one) ○ https://www.hca.wa.gov/about-hca/programs-and-initiatives/behavioral-health-and-recovery/crisis-response-improvement-strategy-cris-committees#members ○ https://www.hca.wa.gov/assets/program/cris-subcommittee-member-list.pdf • **Chat:** Behavioral Health urgent care facilities that are low stim and that also have medical staff would help reduce some of the need for emergency responders. • **Next Steps:** The HMA project team will: ○ Follow up to share Synthesis documents of gaps and opportunities across the crisis service continuum (Someone to Call, Someone to Come, A Place to Go) for review and feedback from the Lived Experience Subcommittee. ○ Feedback may be provided by email or verbally during upcoming listening sessions. The HMA team will follow up by email to provide materials for review and further details regarding listening session dates. ○ HMA will provide mailed copies of the documents for review upon request. ○ Please email requests for mailed copies, questions or feedback to Nicola Pinson (npinson@healthmanagement.com) or Brittany Thompson (bthompson@healthmanagement.com)

TOPIC	DISCUSSION

HCA Agency Request Legislature	• Matt Gower, from HCA, shared the latest version of the HCA Agency Request Legislation. The legislation focuses on liability protection in general for crisis responders and crisis facility workers. This was prompted by HB 1477 creating mobile rapid response crisis teams, but not providing liability protection when they respond. HCA is pushing for liability protection to reduce barriers for the crisis responders going out to provide services.
	
	Subcommittee Discussion
	• **Chat:** My "'what if they intentionally do harm?" worry is addressed by something like "but they'll still be in trouble if they're trying to do things wrong"
	    o "Act or omission" so you can't get in trouble for something you didn't do, as well as did
	• Question in **Chat:** Has Disability Rights of Washington reviewed and/or commented? How about the new OBHA?
	• **Chat:** "other needed crisis services" is pretty broad
	    o It doesn't specify just mental health/substance/behavioral health crisis
	• **Chat:** "What would a reasonable person do" is sorely missing from so many areas of our system, so if that's what this can promote I totally approve. EG: The example I gave earlier in this meeting (the VERY ill woman whom no one will intervene to save) highlights how what a reasonable person would think necessary is so often NOT what happens.
	• **Chat:** I can see where in the current system people look at me and go "you're fat, you're a risk" and this removes that being as reasonable of an argument
	    o (not that my being fat actually makes me a risk, but we're dealing with folks' bias and risk aversion)
	    o Similarly, I was told "you're too thin and young to have a stroke". They sent me home with migraine meds and hours later I had a full blown ischemic stroke...that could have been prevented had their bias and lens been different.
	    o Living in a co-op with 20 other people though, I do notice how "reasonable" is its own value
	    o . . . these translate in mental health all.the.time - especially with severe mental illness (psychotic disorders).
	    o Yeah. 'We have beds but not for you.'
	• **Chat:** I can't even tell you how many time we have been in the ER waiting for 9 hours plus for clearance. Then when we get to the mental health side, they then remove all of the possible harmful things to the person. This has been so frustrating. Then you add in the mental exhaustion on top of a mental health crisis.
	    o If they are "too much of a risk," that is when they need care! Exactly!
	    o Yeah, it's hard when our last line of care then has barriers

TOPIC	DISCUSSION
	• **Chat:** As someone who has worked in Community Mental health in the past this legislation is helpful and over due • **Chat:** I know in Snohomish County the DCR would usually have law enforcement with them when the go to assess someone ○ Yeah, different county by county • **Chat:** Preventative care is still a foreign concept. Even just the barriers to therapy alone and only authorizing therapy when there is signs of a problem is a misconception that needs to be dismantled. Mental health care is seen as a luxury tied to dollars, which aligns with hesitancy for our people to call for help with the 911 system. Dollars. Bottom line.
Closing Statements	Analogies for the work we do: • We maximize our impact by doing a relay. Racers take turns turning the track and no one person ever runs the full length or time of the race. This allows exceptionally long races like the RAGNAR, which is 200 kilometers. Another example is Relay for Life, which is 24 hours long. None of us can successfully do this work alone. It takes all of us coming together to share our experience, insights, and education to improve the system. • Choirs maximize their performances by using staggered breathing. When it is impossible for one singer to hold an extremely long note, the singers take short breaths at different times to make it sound like the note is continuous. If we each take a step back when we need to take care of ourselves, we know there are still others there doing the work. • We work, we rest, we take turns, we do it together • Bipasha provided a recap of the meeting. • Next meeting is September 11th, from 1-3pm. • The HMA team will follow up with Synthesis documents for review and further detail regarding opportunity to provide input during listening sessions or in writing, as detailed earlier. • Lived Experience members may also contact Brittany Thompson, for follow up questions (bthompson@healthmanagement.com).

HB 1477 Lived Experience Subcommittee – September 11th, 2023 Meeting

Meeting Summary

Monday, September 11th, 2023, 1:00 pm to 3:00 pm

Zoom

TOPIC	DISCUSSION
Welcome, Introductions, Review Meeting Agenda	• HB 1477 Steering Committee member Bipasha Mukherjee welcomed everyone to the meeting and introduced the agenda. Bipasha highlighted that the next Lived Experience Subcommittee meeting will be held on October 16th, from 1-3pm. Meeting agendas and Zoom links are available on the CRIS webpage - https://www.hca.wa.gov/about-hca/programs-and-initiatives/behavioral-health-and-recovery/crisis-response-improvement-strategy-cris-committees. • Brittany Thompson from Health Management Associates (HMA) provided an overview of Zoom. • Kristen Wells shared Washington Speaks information as a resource providing support to individuals to share their lived experience. Please reach out to Brittany Thompson at HMA (CRIS project coordinator, bthompson@healthmanagement.com) if you would like to be part of a Lived Experience group training to give each other support and feedback for sharing personal stories at a CRIS or Steering Committee meeting.
Presentation and Discussion: HB 1477 Committee Recommendations & Incorporating Lived Experience Input	• Nicola Pinson, from HMA, gave a short presentation on the status and next steps for the Synthesis of Gaps and Potential Opportunities documents that have been the focus of past meetings. Currently, there are four (4) documents, Someone to Call, Someone to Come, Somewhere to Go, and an overarching Systemwide Issues document. These have been widely shared for CRIS and subcommittee input as working drafts and will serve as the foundation for recommendations to include in the HB 1477 Progress Report that is due in January of 2024. Lived Experience Subcommittee input is incorporated throughout these documents; Additional input provided through the listening sessions or in writing as also been incorporated. • Representative Tina Orwall gave updates from her perspective as well. She acknowledges how difficult this work is, because it is systems change. She also added that the voices of community is what grounds the work and ensures improvements are moving in the right direction. She finished by reiterating that we're building system that is trauma-informed, and people are going to feel like they are heard and seen, and they will feel safe. • Megan Celedonia shared perspective on how Washington has created a pivotal opportunity to think through how to envision the future of an improved behavioral health crisis system in WA and envision the future. *Subcommittee Discussion*

TOPIC	DISCUSSION
	• Question from chat: Is there a process for tracking how many voices of lived experience contributed through listening sessions, etc. and ensuring there is diversity among those voices? o Answer: While we do document attendance in listening sessions and lived experience meetings, we recognize that there are voices missing. Bipasha asks participants if they have ideas of ways that HMA could improve attendance. Also, she notes that some organizations have data that could be shared/mined to help with the process. • Chat: Thanks for supporting system change and person-centered services. This is incredibly important work. • Chat: I keep coming to these types of meetings, hoping for change not really expecting it. DOH has known about problems for a long time, and talk about change, but nothing changes. Heard it so often but doesn't really think it's going to happen. Keeps coming, and is hopeful, but not expecting anything. For example, when she was getting her license, she would call different places, and get different answers, which makes it hard to keep the faith. • Comment: It takes a long time to change a habit, even as one person, even a moderate habit. Change takes time. • Chat: Hanging on to the hope, as hard as it is • My email is elaina.perry@doh.wa.gov. If I can't address your comments/concerns directly, I will find who can!
Presentation and Discussion: Washington Department of Health (DOH) and Health Care Authority (HCA)	• The Washington Department of Health (DOH) presented on their role in the 988 project, and how they work with the Washington Health Care Authority (HCA). Elaina Perry (DOH) and Matthew Gower (HCA) introduced their teams and provided and overview of each agency's role and key areas of work to improve Washington's crisis response system. • Chantel Wang (DOH) gave a presentation on public health marketing, including an activity, as well as an update on the upcoming 988 campaign that DOH is working on. • Please see the meeting slides for further details on presentations and ways to get involved. *Subcommittee Discussion* • Chat: I'm glad there are examples of places where you can walk in to a neighborhood behavioral health urgent care. My family member in Missouri accessed one and got their meds adjusted so they could keep their new job and avoid inpatient. I am hoping we can get to where this becomes a reality with more choices than hospital emergency rooms. I support home and community based services and want to see our state move forward. I appreciate all the work being done.

TOPIC	DISCUSSION

	• Chat: I have felt the same way at times. I've been engaging in more National conversations recently, which has really helped adjust my perspective toward gratitude because as much work as we still have to do, our behavioral healthcare system is doing a lot of things really well, compared to all the other states. In case you were wondering, my lens is as a mom of 8 and family advocate. Thank you for keeping on "keeping on" despite occasional fatigue and discouragement!
	• Chat: 988 is amazing. we are putting the number on our agency t-shirts advertising my business
	• Chat: I have a 988 t-shirt. I agree they are amazing.
	• Question in chat: May I ask where is the community listening session, and for whom?
	    o Answer: rules-processing link- https://doh.wa.gov/licenses-permits-and-certificates/facilities-z/behavioral-health-agencies-bha/rules-progress
	• Chat: I am doing another QPR training.
	• Chat: My hope is to increase options/choices and decrease reliance on DCR/more restrictive environments. Also to shine a light on the sham due process when individuals are detained.
	• Chat: I am holding a forum on his topic this month on dreaming up new systems that would be alternatives to inpatient hospitalizations
	• Chat: that's exciting! I'd love to help bring additional family voices to these conversations if that would be helpful. richellemadigan@wsccsupport.org
	• Chat: do you talk about how gambling can lead to suicide looking like auto accidents?
	• Chat: Rep. Chris Stearns and I work closely together. We serve on the Regulated Substances and Gambling committee. We toured VOA last week. We are talking about suicide prevention as it relates to gambling addictions. We may be able to do more to promote 988 in the casinos.
	• Chat: Michele Roberts: Happy to help with any follow-up and connections for the Department of Health. michele.roberts@doh.wa.gov
	• Chat: Appreciate the 'not breaking it' -- there are regional strengths!
	• Question from chat: So will families be calling 988 in crises where a DCR or police help is needed?
	    o Answer: continue for now to call what is working for you. Nothing has changed much as of right now, as the teams are still working on the integration. Calling 988 will hopefully get you the right response.
	• Chat: We're asking for families who appear at NAMI Family Support groups, and don't know who to call for help.
	    o Answer: If they are new, 988 is the place to start- 988 will be able to navigate these needs.
	    o Answer: There are casino ads on buses .. why not 988 on buses. It is extremely expensive but maybe the state could make a deal?

TOPIC	DISCUSSION

	• Chat: It would be great to also loop in feedback from family orgs. could be a great way to include a more broad and diverse representation of lived experience.
	• Chat: Great point, Richelle! Do you have any specific orgs in mind? We can cross-check Chantel's outreach lists to make sure they are included.
	• Chat: Washington State Community Connectors. FYSPRT (regional and statewide), COPE project participants
	• Chat: When is this 988 marketing campaign expected to go live?
	  ○ Answer: end of November
	• Question: Is this different from the ads/marketing that the 988 suicide crisis line Facebook currently has? This is more for WA state, since that is national? Do you work with the federal 988 suicide prevention line to glean ideas?
	  ○ Answer: This is different in that the focus will be tailoring the media for WA state residents.
	• Question from chat: OSPI?
	  ○ Answer: Office of Superintendent of Public Schools (OSPI)
	  ○ Answer: Definitely OSPI and school districts
	• Chat: Yay on the compensation!!!!
	• Chat: For anyone interested or for those who have any questions/concerns, please feel free to reach out! Chantel.Wang@doh.wa.gov
	• Question from chat: Before we leave can I get the link to the Community Listening Session?
	  ○ Answer: rules-processing link- https://doh.wa.gov/licenses-permits-and-certificates/facilities-z/behavioral-health-agencies-bha/rules-progress
	• Chat: Vanessa.Saavedra@doh.wa.gov for 988 crisis contact hubs rulemaking workshops.
	• Question from chat: Will we have access this recording?
	  ○ Answer: HMA will look into trimming the recording and do so if possible.
	  ○ Answer: The meeting summary and slides will be available here: https://www.hca.wa.gov/about-hca/programs-and-initiatives/behavioral-health-and-recovery/crisis-response-improvement-strategy-cris-committees
	• Question from chat: Is there any way for organizations to get involved in the earlier steps- like during the stakeholder process?
	  ○ Answer: Yes, DOH has been reaching out to as many organizations as possible, but they don't have a set contact for many organizations. If you think an organization should be involved, please send recommendations to Chantel.
	• Chat: COMPREHENSIVE HEALTHCARE Yakima WA Paul Nagle-Macnaughton
	• Chat: I shared comments earlier to say why I keep coming back. System change is slow and can be frustrating but that's the reason to keep showing up. To keep sharing our voices.

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Question from chat: regarding CHWs and licensing or cert as MH specialists: is there anyone on the panel who knows anything about that?
Answer: Elaina can point to the proper division, or suggests that we invite them to future meeting.
Chat: The Workforce and Rates Subcommittee of CYBHWG is where those conversations are happening
Chat: Children and Youth Behavioral Health Work Group and subgroups: https://www.hca.wa.gov/about-hca/programs-and-initiatives/behavioral-health-and-recovery/children-and-youth-behavioral-health-work-group-cybhwg
Chat: https://public.govdelivery.com/accounts/WADOH/subscriber/new
Chat: Thanks for making these meetings so open and accessible.
Chat: Oh good. That's all I do all day. Collaboration!

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<tr><td>Presentation Activities</td><td>
Chantel Wang, from DOH gave an in-depth presentation on public health marketing, which included some activities. The first activity was to review an advertisement that missed the mark. She gave the example of the Kylie Jenner Pepsi advertisement, which depicts rioting being stopped by Kylie Jenner presenting the police with Pepsi. Chantel talked about why this advertisement missed the mark, how it made her feel, and asked for participants to share similar feelings on advertisements. The second activity included showing two (2) advertisements and garnering people's reactions. The first advertisement was for pens specifically marketed to women, and the second showed a police car following a car, with a note on driving under the influence, specifically in regards to marijuana.

Activity one

Chat: no one looks like me
Chat: Suicide "prevention" ads that just tell you to get help when there isn't any
Comment: the last few years, more people of color are featured more, but why weren't they included before?
Chat: it has but they still miss the mark...Its like a box check to them
Chat: We have a loooong ways to be actually including everyone.
Chat: Data are clear that ad campaigns do nothing to change suicide statistics
Chat: There have been some really confusing naloxone ads on Pandora lately. They are super uncomfortable and not very uplifting to instill hope
Chat: The way suicide/crisis and mental health has more connotation and empathy toward one group. Reinforces that other cultural groups that already deal with internal stigma that it doesn't exist with them or "truck it through"

Activity 2

Pen slide:
Chat: like it's for kids

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TOPIC	DISCUSSION
	◦ Chat: super uncomfortable, and I feel like the pink tax will be at play too where they cost extra ◦ Chat: I find it insulting…. A pen is a pen. Colors do not represent gender ◦ Chat: Exclusion? ◦ Chat: Placement of that left pen is …. ◦ Chat: good pens are smaller so I can use them ◦ Chat: Why shouldn't men be able to use these pens too if they like them better than other pens? ◦ Chat: not a fan. plastic cheaply made pens in stereotypical "girl" colors. a pen is a tool, and the need for tools is not gender-specific. this is uncomfy • Car Slide: ◦ Chat: Feels threatening and also doesn't use language that anyone in my generation uses (to my knowledge). ◦ Chat: It focuses on punishment rather than safety ◦ Chat: Isn't reefer a refrigerator? 😆 ◦ Chat: Seems meant for intimidation. Could flip it to the positive and yes, old term used ◦ Chat: It is a word I recognize from my youth ◦ Chat: Interestingly the Legislature discussed how police could tell if drivers who are driving strangely because of THC use; harder to tell compared to alcohol. ◦ Chat: I wouldn't use that language either. Reefer stems from the psychedelic drug era and the rifts between generations. War on drugs? Stereotypes people with that terminology. May have been off with my history of the origins of the term reefer, but I think of that era when I hear of it. Feel free to fact check.
Closing Statements	Analogies for the work we do: • We maximize our impact by doing a relay. Racers take turns turning the track and no one person ever runs the full length or time of the race. This allows exceptionally long races like the RAGNAR, which is 200 kilometers. Another example is Relay for Life, which is 24 hours long. None of us can successfully do this work alone. It takes all of us coming together to share our experience, insights, and education to improve the system. • Choirs maximize their performances by using staggered breathing. When it is impossible for one singer to hold an extremely long note, the singers take short breaths at different times to make it sound like the note is continuous. If we each take a step back when we need to take care of ourselves, we know there are still others there doing the work. • We work, we rest, we take turns, we do it together. • Bipasha provided a recap of the meeting.

TOPIC	DISCUSSION
	• Next meeting is October 16th, from 1-3pm. • Lived Experience members may also contact Brittany Thompson, for follow up questions (bthompson@healthmanagement.com).

HB 1477 Lived Experience Subcommittee – October 16th, 2023 Meeting

Meeting Summary

Monday, October 16th, 2023, 1:00 pm to 3:00 pm

Zoom

TOPIC	DISCUSSION
Welcome, Introductions, Review Meeting Agenda	• HB 1477 Steering Committee member Bipasha Mukherjee welcomed everyone to the meeting and introduced the agenda. Bipasha highlighted that the next Lived Experience Subcommittee meeting will be held on October 16th, from 1-3pm. Meeting agendas and Zoom links are available on the CRIS webpage - https://www.hca.wa.gov/about-hca/programs-and-initiatives/behavioral-health-and-recovery/crisis-response-improvement-strategy-cris-committees. • Brittany Thompson from Health Management Associates (HMA) provided an overview of Zoom. • Kristen Wells shared Washington Speaks information as a resource providing support to individuals to share their lived experience. Please reach out to Brittany Thompson at HMA (CRIS project coordinator, bthompson@healthmanagement.com) if you would like to be part of a Lived Experience group training to give each other support and feedback for sharing personal stories at a CRIS or Steering Committee meeting. *Subcommittee Discussion* • Question in Chat: I had this link shared through an email newsletter. I just wanted to make sure it's ok for me to attend as a member of the public to be a fly on the wall. ○ Answer: Yes, these meetings are open to the public, and there are often people who join just to listen in, though we always appreciate participation.
Presentation and Discussion: DOH -- Crisis Response System Technology Platform User Experience	• Elaina Perry, from Washinton Department of Health (DOH) presented work being led by DOH and HCA to take a people-centered approach in developing the technology to support the crisis system. DOH and HCA are asking that members of the public help them with the development of system user 'personas' that will be used to influence the design of the new statewide technology supporting the crisis response system, and to develop communication and training plans as the new system is developed and rolled out. Elaina presented a draft call-taker persona and engaged a series of questions for feedback from the Lived Experience Subcommittee members. (Note: the term 'persona' is defined as an approximation of a segment of users who might use the 988 technical platform. Some personas may reflect a narrow population of users, while other personas sometimes referred to as 'archetype' personas may be more broad in their descriptions.) DOH is documenting the feedback gathered during the Lived

TOPIC	DISCUSSION

	Experience Subcommittee meeting, as well as offering opportunity to complete a survey by October 26th to inform the development of 'personas' for 988 call takers, supervisors, and callers. This information will be used to inform the technology system Request for Proposals (RFP) and ensure a person-centered approach to development of Washington's crisis system technology platform. Please see meeting slides available on the CRIS webpage for further background on this work.
	
	Subcommittee Discussion
	
	Overarching question: What are your reactions about this call-taker archetype persona? What are outliers or exceptions we should be aware of?
	• Question in chat: can you explain what you mean by outliers/exception?
	    o Answer: Aspects of today's persona that may not align with the majority of all call takers. For example, people in this role typically have a Bachelor's degree but some outliers hold a Master's.
	• Question in chat: How useful will she be (no shame, no blame) for being able to help callers)? Then extended to how much care will the call-takers be receiving, or how many people will be available to not overburden call-takers, so that the callers can get the help they really need?
	    o Answer: Washington's 988 Lifeline crisis centers are funded to staff at appropriate levels to answer calls without a rush to get the callers off the line. Calls take as long as is needed to support callers. Additionally, 988 Lifeline crisis centers also have implemented creative ways to support call-taker wellness and support for managing secondary trauma.
	• Chat: A challenge or pain point could also be lack of resources because of rurality/region-specific barriers
	• Chat: There is no mention of the hours worked. I assume that this program will be a 24/7 rotation. Having a set schedule and working overnight should be considered
	• Chat: Part of context: how they feel about their supervisory relationship, their compensation and benefits. That will likely impact how they show up.
	    o Agree. I've felt really frustrated that I can't offer ongoing services to folks who call sometimes either because the system does not exist or we do not have a exhaustive comprehensive place to go look for resources.
	• Chat: Another pain point could be workforce shortages... Call takers taking many calls and receiving calls from people who have been waiting on hold in crisis
	• Chat: There's allusion to compensation in "long-term goals" but does this person feel well-compensated for the trauma she is experiencing?

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Chat: Being paid adequately is enough is very important AND beyond that it’s important to not burn out staff because that helps them be fully there for the caller.
Chat: not true
Comment: Member shared recent experience with 988 that was not helpful. Her teen son was experiencing a behavioral health crisis. She called 988, first time ever calling. Got in contact with someone and told story, call-taker gave her regional crisis line number to contact for in-person response. Child was breaking and throwing things, so she asked call-taker to transfer her, but she was put on hold for over 30 minutes. She ended up calling RCL herself, and then had to tell her story again, after waiting 20 more minutes. Then, there were no referrals to a counselor. She asked what she should do next time, and they said that she should call again and hopefully she will get through sooner, but if there’s violence, then she should call 911. Her family was not helped in any way from that whole experience.

Chat: UGH, UGH, AND MORE ugh!!
Chat: Horrible response. I am so sorry.
Chat: This isn’t the first time I’ve heard this [kind of] story. @Rep. Orwall 33 I think we heard very similar things when we had that listening session in January, didn’t we?
yes we should do a joint meeting with the three call centers
Chat: Best practice with youth is to send a team out in person to reduce any contact with law enforcement or transport to the emergency department.
Chat: Thank you for sharing your truth. I hope that things have settled down for your son now and that we can move to resolve these delays in service.
Question in Chat: Can you tell us what county you live in?
Answer: Grant County
Chat: I live in Grant County and have not used 988 but this makes me less likely to call 988 in crisis
Chat: This is very troubling. And adds trauma on top of the crisis. It makes my heart hurt. Just out of curiosity- I’m wondering from which county she was calling.
Chat: I failed to attend any of the feedback sessions (I was giving up), but I STRONGLY would like part of data collected: what are the satisfactory or unsatisfactory outcomes that the "individual in crisis" (SAMHSA language) experienced?
Question in chat: Elaina do we have or plan to have the capacity for this tech to hop over into substance/co-occurring worlds?

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TOPIC	DISCUSSION
	▪ Answer: Yes, this system will look to better connect across the continuum so they aren't broken apart. ▪ Chat: Rep. Orwall is exactly right: what do we do in the interim (while we wait for the complete tech system to be put in place). o Chat: Families should not have to tell their stories over and over to get help. I can confirm we have a youth team in Grant County. o Chat: https://kidsmentalhealthwa.org/ has regional resources for connecting youth with mental and behavioral health services. Richelle, your regional program should be able to help connect you with a provider. ▪ Chat: "should be able to" o Chat: Rep. Orwall … I am getting the impression that the agencies are playing tug-of-war for control over what's going on ?? Just reading between the lines ▪ Chat: I think less that and more that privatization makes coordination really hard o Chat: Catholic Community Services has youth teams in three of our regions for context. o Chat: I understand that this current legislation does not focus on prevention. What current or future prevention efforts are being considered, if any? o Chat: Solutions is are important, but from so many experiences and the stories showcase is that there isn't even empathy. I know it a dangerous and difficult ask but if these calls are able to showcase empathy and improved clarity of processes. This would at least make callers feel like we aren't just calling a helpline robot. ▪ Chat: I have been on several calls where I've had people be very sad and supportive that they aren't able to provide me with resources or direction - that feels a little better in the moment but all in all it's still an issue. ▪ Chat: Yes we should not be providing empty "empathy". Why hopefully there is a clear improvement on the transfer and handoff on top of improving those connections o Question in Chat: Anyone who works at a crisis center-how does the internal functions on your shifts look like? For example, when you are taking calls, how do you communicate with colleagues about each call in real time? ▪ Answer: I can answer this one for you in detail via email if you'd like to share! Apologies, trying to focus on conversation at hand.

TOPIC	DISCUSSION
	▪ Chat: No worries. I work the NAMI Helpline and we use a live chat system. o Question in Chat: Do you track the abandoned calls and rates at which point callers give up? ▪ Answer: Yes! We do by center. 6-8% of calls are abandoned. o Chat: As all involved behavioral health: Stop Pretending SUD Is an "oh by the way" item. it is 1A or 1B o Chat: For clarity, CCS Youth Crisis Teams are in three counties in Western WA - another agency is in Grant Co where Richelle was calling from ▪ Chat: That agency is Renew Behavioral Health, that's who operates the crisis call center where I live. o Chat: I am the mother of the 36 year old woman with schizophrenia that is decompensating and has been in psychosis for months and mobile crisis and police have been called multiple times and haven't done anything despite her gravely disabled behavior. The mobile crisis team never arrives soon enough to see her in absolute active crisis mode and she barricades herself in her apartment. Many tenants have contacted the landlord about her screaming and bizarre behavior with threats. [An email was sent] about my situation. My daughter would never call for herself. She suffers from anosognosia and needs involuntary treatment. I'm going to have to file a Joel's Law petition with the court because mobile crisis has done nothing. I'm a long time member of NAMI and many support groups. It's inhumane how difficult it is to get my daughter help. Despite multiple calls to crisis and police. She has only been helped through incarceration and that is a terrible and traumatizing method to get help. Then she gets released without a proper plan that keeps her medicated. She will not take medication unless she's forced. And she needs help getting services. She cannot manage her own life. But once she's medicated she can work and function very well. • Comment: Representative Time Orwall was asked to reflect on the story. Representative Orwall stated that her heart aches because it was a painful story to hear, and that we can use this as a reminder that the implementation of 988 is very complex. She emphasized the importance of coming together as a system to see how to quickly address things that need to change and highlighted that we are trying to figure out the separateness of 988 and 911 and how to get those systems to work together. We also need short term answers while we are building the bigger system. • Comment: One more factor is that there are no counselors to refer people. That's also part of expanding the system. We need enough people to staff referrals.

TOPIC	DISCUSSION
	• Comment: Unfortunately, the story shared isn't that uncommon. Another problem is that parents get screened out 2-3 times and have to keep calling back. • Comment: From the perspective of someone working inside peer network, we need to explore redefining peer services and what they look like and what the function of peers are. Peers have great training, but what they didn't see was the magnitude of behavioral health and substance abuse as it stands right now. So, the workforce needs to be improved, and the training needs to be made more applicable. We don't just need a body answering the phone, we need viable solutions and the ability to troubleshoot on the spot. Being trauma informed is just not enough. If we are going to re-vamp, we need to look at how people are compensated. • Comment: in regards to the barrier of not being able to ask a person's age; a part of calling 988 is being able to press x if you are a member of a certain community (LGBTQIA+, tribal, etc.), so commenter is wondering why age cant be made a part of that menu. o Response: not at local level, but the Federal level there are restrictions. It's a balancing act between getting a caller to a person as fast as possible and having an inclusive line. • Comment: if lifeline and the 988 folks could work out the age factor, the call could just go straight to youth crisis lines. *Overarching question: 2) Do you think there any difference in services requested based on identifiable characteristics (youth, parents, people calling from healthcare facilities, agricultural community members, students calling from school, people calling for general resources like housing, rural callers, or others)?* • Chat: The level of support that 988 callers receive depends on their zip code. Rural callers face challenges receiving assistance due to a lack of resources. When I called for a parent in crisis who lived in Tri-Cities, I was rerouted to 911. Dispatch redirected the call to a police officer who said their hands were tied due to "liability concerns". • Chat: Longer transport times... If in the story I shared with you from last week, someone DID send a crisis team, it would have take them at least 20-30 minutes to drive to my rurally located house. So, it would have been 30 minutes to get a crisis counselor, and then another 30 mins for someone to get here. Knowing that fact, may be why the regional center said if there's violence, to call 911 (they would get here quicker) • Comment: Considering the stories we've heard so far, it seems like parents are hoping for a quick response when they call. • Comment: We often tag "parents" as being parents of youth, but there are parents of adults who need to make use of the system as well.

TOPIC	DISCUSSION

	• Question: Video calls with crisis line workers; can we expand upon that?
	  o Answer: There is national ASL video calls, which is not yet handled in the state, but that's an accessibility feature that is coming.
	• Comment: Another accessibility challenge is language. We have a lot of people in Washington who don't speak English, or don't speak English as a first language. There are 250 translated languages, but we all know that talking toa translator isn't the same as talking to someone who speaks your language.
	
	Overarching question: 3.) What current accessibility challenges should we know about as we design the future systems? And 4.) What are some specific challenges or needs for callers who are part of marginalized populations (e.g., Native & Indigenous, LGBBTQIA2S+, Rural, People with Disabilities, Veterans and others)?
	• Chat: 4. As a child of immigrant Viet parents. I know one of frequent and messy need is having youth being the caller on parents (parents who often don't speak English). So we have multiple parties who are vulnerable and don't know the systems calling for help. This transcend just immigrant families of course, as so many children are force to support a parent in crisis. But just wondering how if this is being noted
	• I don't know if this would be possible but if you are calling in with a crisis related to gender specific traits it can be difficult to connect with a specific gender. Such as a female rape survivor connecting to a male crisis responder.
	  o Answer: Yes, our call centers can and have accommodated that ask once brought forward by the caller.
	  o Question in chat: To clarify, they can ask gender?
	  o Answer: Yes - the 988 Lifeline crisis centers have had callers ask for a non-male call taker and the centers have worked to accommodate that ask (usually by pulling in a shift lead/supervisor). It is not a pre-set button to push but can be received when asked.
	  o Chat: But they have to know to ask.
	  o Chat: Yes, it is not an option to select it up front but would you suggest that it be a reminder for counselors/call takers that they offer up in scenarios where it has been previously applied (domestic violence/gender-based violence survivors)?
	• Chat: Thank you guys for listening. I'm sorry to HCA for cutting into your time. As much as my 988 experience was frustrating and unhelpful in the moment, I'm grateful that experience happened to me (vs someone else not in this work, or with other additional barriers) so that we could have this rich conversation and work to fix the broken places that contributed to what I experienced. I have to jump off a little early for a care coordination meeting for one of my children. If anyone wants to reach me, my email is

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	richellemadigan@wsccsupport.org. Thank you all for your passion in this work, and for hearing me today. 🌻 ○ Chat: Absolutely no sorry needed, Richelle. What you brought up was courageous and needed to be heard. I'm sorry for your experience and it will not be set aside/forgotten.
Presentation and Discussion: HCA shared updates, including the progress from the 988-Regional Crisis Line Workgroup, crisis service actuarial efforts, and a recently awarded SAMHSA grant.	• Matt Gower, from HCA gave updates on a few things HCA has been working on. HCA is currently undergoing some actuarial work and doing research on how the teams are operated and where gaps in funding might exist. Another update involves the workgroups that are being held with the Behavioral Health: Administrative Services Organizations and call centers to better transition from Regional Crisis Lines to 988, and how to improve integration. The last update was that HCA received grant funding from SMHSA to set up Community Crisis Response Teams. The teams are volunteer driven and coordinated through an app. *Subcommittee Discussion* • Chat: What a fabulous model Matt described (Community Crisis Response) 👏 ○ Chat: I love this model so much!!!
Presentation and Discussion: HMA to share update on process to prioritize recommendations for the January 1, 2024 Committee Progress Report.	• Nicola Pinson with HMA gave updates on the process of compiling all the recommendations into the synthesis documents to present to the Steering Committee. Nicola gave a recap of the work that has been done so far to bring recommendations together from the CRIS and all the subcommittees. The synthesis documents work to compile the gaps they've been hearing about from the subcommittees, as well as potential actions/opportunities identified to further organize the gaps. The gaps were then organized into the three core pillars of the crisis response, Someone to Call, Someone to Come, and a Safe Place to Be. The synthesis documents were shared on the September 19th CRIS meeting, and the attendees of that meeting took place in a sticker activity, where they placed dot stickers next to the priorities that they wanted to elevate to the Steering Committee. HMA is currently working to further consolidate and classify those recommendations. • Bipasha shared a data summary about the sticker exercise. There were 104 options to vote on. She offered to take LE feedback to the next CRIS Steering Committee meeting. *Subcommittee Discussion* • No comments or chats regarding this topic.
Open Discussion	• Comment: confused because she got a survey from HCA about adolescence and fentanyl crisis, but the instructions aren't clear. There are numbers, but it doesn't

TOPIC	DISCUSSION
	say what those numbers mean. Feedback that it needs to be more explicitly stated. o Chantel Wong knows who is running the survey, and will send email address to them to get in contact and explain. o Chat: I just opened the survey and it says "Rank the following (as it pertains to time and effort, and resources):" • Comment: Another way to get information is to ask directly when the call is answered. Some people may be more comfortable giving information ahead of the time that a call is answered by a person, while other people may be more comfortable giving that information a person. • Chat: There are been large increases in the text and chat line too. I think many youth use this option versus calling but VOA can share more information. o Comment: you have to give some information before text is routed. Name and concern is asked at the loading page. • Question in Chat: Chat screens for age, correct? o Answer: When you chat into 988, demographics are included self-reported including age, zip code, name/alias, gender identity, primary concerns, etc. https://988lifeline.org/chat/ • Comment: Bill last year put incentives in place for a more rapid response to calls. The first 18 months was technical assistance, trying to understand how teams needed to be created to respond to calls more rapidly. Behavioral health also partnered with the fire department, which is working well in Spokane. The rapid response teams ae a voluntary opt-in, but the hope is that more parts of the state will participate and the data/information that comes out of that work will further inform steps forward. Rapid response is important, but the crisis relief centers are also an important piece. There are two receiving centers in Pierce county, and there have been meetings with local law enforcement, etc., to make sure everyone know the centers are there and available. There will also be youth beds coming in the future, co-located with youth detox and youth substance use. • Comment: There has also been talk of co-response teams, not just the police, but with fire department, EMTs, etc. • Chat: Currently lived experience persons in the crisis workforce and pay scale and training is tantamount to having an EMT out in the field with a COSTCO first aid kit for minimum wage. I only use EMT as an analogy. • Comment: Pay scale has not been figured out correctly, and that needs to be revisited. Formal training around mental health, substance use, etc. should be required for EMS and fire department. • Chat: HCA is working to support EMS/Fire training around behavioral health needs and crisis, as well. • Chat: We are working with UW to develop BH crisis specific training for EMS/Fire to improve their response

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	• Comment: the current peer training doesn't talk very much about how to deal with crisis. The training seems to focus on doing scheduled appointments in a clinic, which isn't always the type of work a lot of peers end up doing.
	• Question in chat: What is the lived experience participation in that training development?
	  ○ Answer:
	• Chat: We will be building this out once we can get a contract in place, but we will ensure we are at the table to inform it
	• Question in chat: Do you mean peers at the 988 level too, Bipasha?
	  ○ Answer: Yes.
	• Chat: The change will be slow to materialize in trainings because the contractual facilitation has been signed and shook and no one facilitating is willing to not be the "go to" for newer training and methodology.
	• Chat: doing outreach is different very day not only with the peer you are outreach it the environment around you. it a lot about feeling safe on a outreach.

Closing Statements	Analogies for the work we do: • We maximize our impact by doing a relay. Racers take turns turning the track and no one person ever runs the full length or time of the race. This allows exceptionally long races like the RAGNAR, which is 200 kilometers. Another example is Relay for Life, which is 24 hours long. None of us can successfully do this work alone. It takes all of us coming together to share our experience, insights, and education to improve the system. • Choirs maximize their performances by using staggered breathing. When it is impossible for one singer to hold an extremely long note, the singers take short breaths at different times to make it sound like the note is continuous. If we each take a step back when we need to take care of ourselves, we know there are still others there doing the work. • We work, we rest, we take turns, we do it together. • Bipasha provided a recap of the meeting. • Next meeting is November 13th, from 1-3pm. • Lived Experience members may also contact Brittany Thompson, for follow up questions (bthompson@healthmanagement.com).

HB 1477 Lived Experience Subcommittee – November 13th, 2023 Meeting

Meeting Summary

Monday, November 13th, 2023, 1:00 pm to 3:00 pm

Zoom

TOPIC	DISCUSSION
Welcome, Introductions, Review Meeting Agenda	• HB 1477 Steering Committee member Bipasha Mukherjee welcomed everyone to the meeting and introduced the agenda. Bipasha highlighted that the next Lived Experience Subcommittee meeting will be held on December 11th, from 12-2pm. Meeting agendas and Zoom links are available on the CRIS webpage - https://www.hca.wa.gov/about-hca/programs-and-initiatives/behavioral-health-and-recovery/crisis-response-improvement-strategy-cris-committees. • Brittany Thompson from Health Management Associates (HMA) provided an overview of Zoom. • Kristen Wells shared Washington Speaks information as a resource providing support to individuals to share their lived experience. Please reach out to Brittany Thompson at HMA (CRIS project coordinator, bthompson@healthmanagement.com) if you would like to be part of a Lived Experience group training to give each other support and feedback for sharing personal stories at a CRIS or Steering Committee meeting. • Availability Poll: a poll was delivered during the meeting to gather attendee feedback on best time to continue the Lived Experience Subcommittee Meetings. Final time to be determined.
Presentation and Discussion: Draft 2023 Committee Recommendations & Lived Experience Perspectives	• Kristen Wells, a member of the Lived Experience Subcommittee planning group, shared an overview of the 988 journey so far. She talked about the three call centers that have gone live, the Native and Strong Lifeline, multiple bills that have been passed, and the two past CRIS Committee progress reports as well as the current report in progress. She also noted that there have been 18 Lived Experience Subcommittee meetings with Department of Health (DOH), Health Care Authority (CHA), the Governor's office, and legislators. Kristen also highlighted key legislation that has been passed, included HB 1134, SB 5120, HB 1004, and SB 5555. *Subcommittee Discussion* • Chat: https://www.hca.wa.gov/assets/program/fact-sheet-facility-based-crisis-stabilization.pdf • Chat: elaina.perry@doh.wa.gov & Vanessa.Saavedra@doh.wa.gov • Chat: Also forgot to say: thank you to all of the Lived Experience Subcommittee participants who gave us such helpful comments in the 23-hr crisis center rulemaking process and the 988 Crisis Call Center Hubs rulemaking workshops! • Chat: tina.orwall@leg.wa.gov & manka.dhingra@leg.wa.gov

TOPIC	DISCUSSION
	• Chat: For sb5555 do we have clarity on what this license will do. Is this going to be a expanded license or a replacement. I know the biggest complaint from my team the new barriers create and having to train for a new license which we do not enough supervisor staff to train. Thank for you all your work. • Chat: Is the Work Force and Rates subcommittee a better place for those questions? • Chat: I am willing to help in any way needed. I can share my experience as well. Myouker@cccscorp.com. I want to add that I have attended most committee meetings the last few years. • Chat: DOH license you can bill Medicaid. DOH license is voluntar
Presentation and Discussion: Lived Experience Subcommittee Work Ahead in 2024	• Bipasha provided overview of the 2023 CRIS and Subcommittee process to develop recommendations for the 2024 Progress Report. Nicola Pinson (HMA) provided an overview of the draft Committee Recommendations that will be included in the Progress Report. These Recommendations are organized and consolidated into eight (8) domains, discussion around each is listed below. *Subcommittee Discussion* • For those interested, here's the link to the draft committee recommendations document: https://www.hca.wa.gov/assets/program/cris-committee-draft-recommendations-20231101.pdf **1. Vision for Washington's crisis response and suicide prevention system** Michael Robertson, a member of the Lived Experience Subcommittee shared with the meeting how the Vision was developed. He discussed the importance of not only focusing on the individual experiencing a crisis, but the support system of that individual. We also need to be aware of how family-centered care is necessary and pertinent, but also to remember that not everyone is able to get family-centered care. The community should be the safety net for some individuals. *Subcommittee Discussion* • Chat: Well said Michael--a HUGE problem in the current system is the bias to "protect people" from those who love them. • Chat: DEI - Diversity, Equity and Inclusion **2. Equity** Nicola Pinson, of HMA, and Puck Franta, of the Lived Experience Subcommittee, provided an overview of the eight (8) recommendations that fall under this category. *Subcommittee Discussion* • Comment: the DOH Equity and Social Justice team is looking into these issues, and these issues are being tracked.

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	• Chat: My concern right now is that individuals and organizations that have had interface with 988 are losing or have lost trust in its efficiency and reliability. The military community is a prime example. In the words of a long time veteran service representative, "It doesn't work." It will be helpful though to increase the representation of communities we are not hearing from and what is happening on the ground with that community. I know we've discussed such matters, but it's a significant barrier. • Chat: I've heard from some BIPOC communities that there is a fear that calling 988 will lead to loved ones being thrown in jail or shot and killed by police. • Comment: workgroups have been looking at serving many different communities, for example people with developmental or intellectual disabilities. • Comment: Expanding on the fact that people are afraid to call 988 because they are afraid of the police response. We don't need to do research about that, because we already know. There isn't enough emphasis on this. This fact is implied, but it needs to be blatantly there. There are ways to allow for police to be there without looking like the full police presence. • Chat: military have a valid fear of losing security clearance when reaching out for help • Chat: Also, I don't think the call drops with the Veteran crisis line has been resolved. It's hard to say because the recent feedback I received was that it's not been fixed. Bridging the gaps between Vibrant or whichever organization facilitates the national veteran line on letting them know there is an issue or at least to confirm that it is being worked on. • Chat: those in healthcare are afraid of reaching out doctors, nurses etc. • Chat: I don't know if in the name of equity and if this is considered part of crisis response in the ED when people with physical medical needs get to keep their belongings v people with mental health needs have all their possessions taken from them and are often placed in a locked room for hours. If this is outside of the CRIS scope and more of a department of health arena please let me know. There doesn't seem to be solutions for this. • Comment: DOH has invested in diversity, equity and inclusion for 988 lifeline crisis centers. They are also working with 911 public safety access points to transfer call better. • Comment: what rights does the state think that callers have? Informed consent? If people aren't calling because they are afraid that police will be deployed non-consensually, then that's something we need to work on. • Comment: there is an intersectionality between criminalization and what happens in a crisis situation. The threshold for involuntary treatment is gray,

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	because its only when there is an imminent threat, or an active situation of a crime being committed.
	
	3. Services
	Nicola Pinson discussed the recommendations that fall into the Services Domain, including making sure crisis response service being made available in all regions so that people have access to care whenever and whenever.
	
	Subcommittee Discussion
	• Comment: A piece missing from Recommendation 10 is substance use.
	
	4. Quality and Oversight
	This recommendation focuses on holding the system accountable and speaks to building trust in communities while demonstrating outcomes.
	
	Subcommittee Discussion
	• Comment: Call center hold times is a piece of data and reporting that can have a big impact on services that people get.
	
	5. Cross System Collaboration
	Recommendations in this Domain, which include collaboration between people in behavioral health work and first responders, as well as bringing partners together to create regional plans and protocols.
	
	Subcommittee Discussion
	• Comment: Another resource that stands out is 211, which is where people ca turn for other help. Cros-system should support every aspect of a person's life.
	• Chat: I live in rural eastern WA. internet can be iffy
	  ○ Chat: Tahuya has internet challenges too (Mason county).
	  ○ Chat: I'm in downtown Seattle and my service keep dropping out, so 🤷‍♀️
	• Chat: It makes Telehealth tough sometimes too
	• Comment: Curious about cross-system protocol between entire system. It's important to have consistent protocols across entire system. We also need consistent behavioral health crisis training. We're still hearing about law enforcement implementing "excited delirium", and people are concerned that this is still being promoted among training for law enforcement.
	
	6. Staffing and Workforce
	Recommendations in this domain focus on expanding a diverse workforce and engaging behavioral health providers and first responders in trauma-informed care and youth-informed trainings to minimize harm and build trust.

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	Subcommittee Discussion • Chat: there are a severe shortage of mental health providers, I believe it is going to get worse before it gets better • Comment: There might be an area where there can be a cultivation of community members who can interface with 988 system providers to create more trust and a sense of safety. • Chat: The peer workforce has PEOPLE …. But the pay isn't livable. o Chat: Absolutely, the pay differential between peers and other behavioral health staff is ridiculous. • Chat: Related to youth callers-NAMI Helpline recently started the Teen & Young Adult HelpLine. If a caller is a teen or young adult, they can select that option on call or text. If any individual, including this group, is in crisis, we can do a Columbia suicide assessment and transfer them to 988. This is national. I don't know if Teen Link, more locally to us in WA state, has a similar transfer system. • Chat: People get into the training and aren't aware that your income bracket is equal to the menial workforce and sometimes lower • Chat: state has known about the problem for years, did nothing until we are now in a crisis, mental health and SUDP's • Chat: can make more money at MCDonalds than in some mental health jobs • Chat: Absolutely we need to play people so they can support themselves at any job they are working full time at. • Comment: Great Rivers Behavioral Health Region just launched a request for proposal for youth crisis teams. An aspect that they've implemented is that any team who isn't working is supposed to be out in the community, doing outreach to bridge the gap and explain what 988 does. Hopefully, this will correct those negative experiences that people have had while calling 911 and having police intervention. • Chat: Agreed on the workforce priorities, Bipasha. Our centers and the HCA have a few activities around improving some of these pieces (training items and barriers to entering the field). -- I meant the 988 Lifeline centers **7. Technology** HCA and DOH are leading work to establish a technology platform, and has engaged input in 2023 from the CRIS, Lived Experience Subcommittee, and other Subcommittee to inform the development of the Request for Proposal that will be released next year. *Subcommittee Discussion* • No discussion here

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	8. Funding and Cost Estimates Recommendations focused on expanding funding for the system, including additional funding to rural areas and enabling payor blind crisis services, so that there is access to services regardless of insurance status. *Subcommittee Discussion* • Chat: payer blind is important • Question in Chat: What about funding to have placements for patients? o Answer: • Chat: so I find people also don't like to ask for any help because what happens after do they go back to the street or are they in transition housing tiny home or shelter or even housing are they now on the street. do they have support when the emergency is kinda not an emergency' • Chat: Yes [we heard story] about being on hold for 30m and having to tell her story 4 times and by the time she got to the person the immediate crisis had shifted. • Chat: No this system is more than broken it breaks people. • Chat: Thanks Bipasha for representing Lived Experience. You are doing such a great job. Thanks Puck For your dedication. Your ideas and experience brought to all the meetings are valuable.
Closing Statements	Analogies for the work we do: • We maximize our impact by doing a relay. Racers take turns turning the track and no one person ever runs the full length or time of the race. This allows exceptionally long races like the RAGNAR, which is 200 kilometers. Another example is Relay for Life, which is 24 hours long. None of us can successfully do this work alone. It takes all of us coming together to share our experience, insights, and education to improve the system. • Choirs maximize their performances by using staggered breathing. When it is impossible for one singer to hold an extremely long note, the singers take short breaths at different times to make it sound like the note is continuous. If we each take a step back when we need to take care of ourselves, we know there are still others there doing the work. • We work, we rest, we take turns, we do it together. • Bipasha provided a recap of the meeting. • Next meeting is December 11th, from 12-2pm. • Lived Experience members may also contact Brittany Thompson, for follow up questions (bthompson@healthmanagement.com).

HB 1477 Lived Experience Subcommittee – December 11th, 2023 Meeting

Meeting Summary

Monday, December 11th, 2023, 12:00 pm to 2:00 pm

Zoom

TOPIC	DISCUSSION
Welcome, Introductions, Review Meeting Agenda	• HB 1477 Steering Committee member Bipasha Mukherjee welcomed everyone to the meeting and introduced the agenda. Bipasha highlighted that the next Lived Experience Subcommittee meeting will be held on January 22nd, from 1-3pm. Meeting agendas and Zoom links are available on the CRIS webpage - https://www.hca.wa.gov/about-hca/programs-and-initiatives/behavioral-health-and-recovery/crisis-response-improvement-strategy-cris-committees. • Health Management Associates (HMA) provided an overview of Zoom. • Kristen Wells shared Washington Speaks information as a resource providing support to individuals to share their lived experience. Please reach out to Brittany Thompson at HMA (CRIS project coordinator, bthompson@healthmanagement.com) if you would like to be part of a Lived Experience group training to give each other support and feedback for sharing personal stories at a CRIS or Steering Committee meeting. • Availability Poll: a poll was delivered during the meeting to gather attendee feedback on best time to continue the Lived Experience Subcommittee Meetings. Final time to be determined.
Presentation and Discussion: DOH and HCA Year in Review and Look Ahead	• Elaina Perry, from the Department of Health (DOH) highlighted 2023 work led by DOH that incorporated input from the Lived Experience Subcommittee. This included: planning for the 988 awareness campaign, rule-making regarding crisis contact hub designation and 23-hour crisis stabilization facilities, and development of user-profiles for the technology platform. Matthew Gower, from the Health Care Authority (HCA) gave updates key areas where the Lived Experience Subcommittee has informed HCA efforts in 2023, including development of the Best Practice Toolkit and dispatch protocols. Please see meeting slides available on the CRIS webpage for further detail. *Subcommittee Discussion* • Question: What is the difference between geo-location and geo-routing? ○ Answer in Chat: Geo-fencing: caller's phone pings cell towers to triangulate general location to better inform system of where to route their call (to which call center) to best provide services if needed. Geo-routing: the term Vibrant uses for the same concept as geo-fencing. Geolocation: precise location of caller for the purposes of dispatching mobile crisis response if necessary.

TOPIC	DISCUSSION

	• Comment: The Native and Strong Lifeline goes by zip code and is only available to those have a Washington Zip Code. Geo-routing would help connect people with services available to them in WA.
	• Question: is there a plan for ensuring that there is community and family voice in the data collection. It is important that the burden of data collection doesn't fall on the providers, so that there isn't an incentive to miss things accidently.
	    o HCA: requirements for data collection vendor include objective way to gather feedback.
	    o Question in chat: What particular vendor are we talking about here?
	        ▪ Answer: The technology platform.
	• Chat: Something we know we need to collection information on regularly are the outcomes of crisis system contacts from the perspective of the recipients of those services.
	• Chat: The RFP will be for the Enhanced Crisis Call and Response System (including the Call Center Platform and Behavioral Health Integrated Client Referral System).
	• Chat: The question is, who is responsible to collect information on how the 988 system is working? It feels like HCA is trying to put that off as a "contractor problem"
	• Chat: last time I had a bad experience, I called 988 first. Since it was so clunky and took forever, this time i called the RCL instead. I still got transferred multiple times. Today i heard a 988 ad on the radio. It was so conflicting to hear because on the one hand, I was excited that the info is getting out there... But if people call and have the experiences I have, they will not trust the systems to meet their needs and they won't call back.
	• Chat: Every health care provider agency and hospital uses a "customer satisfaction survey." why is this so hard?
	    o Chat: Because we don't know if those surveys are effective or worth our time, and this needs to be
	    o Chat: I've been told by people who work for hospitals that those surveys are very important to administrators.
	• Chat: I had an experience when calling crisis center, someone showed up at my home but left and never called back. After 3 hours I called and was told person was too scared to come in to the house but did call police. Waited another 1 1/2 hours, no show by police but did receive a phone call from police office indicating pt not meeting ITA criteria. Why couldn't the crisis center staff wait for police and both could have come.
	• Question in Chat: Is there a "how did your call go" survey after you contact 988?
	    o Once the new tech platforms are implemented I think these will be more available.

TOPIC	DISCUSSION
	○ Also worth noting Vibrant controls a lot of what contact centers can and cannot do in this regard. Most have a quality control process, but I don't their exact process
Presentation and Discussion: Hopes and Expectations for When We Call 988	• Bipasha introduced agenda topic and goal to engage input from the Lived Experience Subcommittee regarding their current experience of contacting 988 and their hopes for an ideal system. Further discussions are planned for 2024 around this topic. To start off this discussion, representatives from each of the 988 contact centers joined the meeting to share information about what to expect currently when someone contacts 988. • Guest speakers from the three 988 centers in Washington introduced themselves. ○ Tonya Stern, Service Director for Frontier Behavioral Health. ○ Diane Mayes, Clinical Director for 988 Services at Crisis Connections. ○ Courtney Colwell, Director of 988 Services at Volunteers of America. • Courtney walked through what happens when a person calls 988, including the education requirements of call-takers, and the types of questions asked of callers. Courtney also shared information about a pilot program called the Mental Health Crisis Call Diversion Initiative, partnered with South Sound 911, where a 988 counselor is co-located at the 911 center. This pilot is working to divert behavioral health crisis calls from the 911 system to a 988. They had 413 calls fully diverted from 911 to 988 in 80 work days. *Subcommittee Discussion* • Question in chat: How many of the more local/county specific mobile crisis dispatch options have limited business hours? Most, a few, none? ○ Answer: varies by region, but for Mobile Crisis teams in Spokane County, the child youth family mobile crisis team is 24/7, 365 days. For adults in their county, there's another crisis response that is not 24/7, but goes evenings during business weeks, and 8-8 on Saturday and Sunday. • Question in chat: a "crisis responder being pulled from whatever they are doing"... What does it look like when the "whatever they're doing" is already responding to another crisis call? Do they try to simultaneously respond to 2 crises? I'm asking that question because the responder I got yesterday let me know that she was on a current crisis call and wouldn't be able to leave to our house for 2-3 hours. ○ Answer: Rural counties have 24 hour coverage, but there's only usually one person on call. If there is no back-up, the respondent has to prioritize which call has the highest risk. ○ Chat: That sounds like "if there's not a crisis responder available they will be told to go to the ER" ○ Chat: It feels like a "luck of the moment" system. I guess I will continue to guide families to call 988 ahead of time to ask questions in order to

TOPIC	DISCUSSION
	design emergency plans. They need to be able to reasonably predict what's going to happen and what might be possible BEFORE they are in the throes of an actual crisis. o Chat: And I honestly think that these positions need to be *over*staffed to work, to not have people burning out. ▪ Chat: Definitely. In the role I fill I *always* have a backup and that is necessary for my team to be available at all times. I can't imagine ever being the only person available. ▪ Chat: And people having to be doing other work while they wait for calls… Sounds terrible. • Question in chat: Is there a resource guide that allows for comments/updates? When i worked for the crime victim hotline, having the updateable guide was a huge help because it allows us to add notes like "only accepting ___" or "only open during ____" o Chat: When I was calling recently I was given a bunch of different referrals by different responders, often with contradictory information to each other and further contradictory to what we were told on the phone and online. I agree with the most common “this won’t work because” of “it’s hard to keep up to date,” but I’m sorry if the state is funding these programs there needs to be a central location where the state can see what they are doing, what their availability is, etc. o Answer: We have expanded youth teams significantly from 4 to 13, and counties covered from 5 to 17. They are building up capacity now. Mobile response and regional youth crisis lines (wa.gov) o Answer: https://www.hca.wa.gov/assets/program/mrss-youth-team-map.pdf • Chat: What if we made everybody eligible for the supports they needed. I just (last night) got someone into temporary housing through the end of the year, waiting on them getting an actual stable home, and… this morning they learned that DSHS is no longer going to fund the program that has been allowing them to work and to provide for their family. • Question in Chat: I'm sorry, I am a little confused, are the mobile crisis response teams housed under 988 or are they separate entities? o Answer in chat: A lot of them are separate entities, often dispatched by the regional crisis lines instead of the 988 hub, which is why a warm handoff or referral is sometimes needed. • Chat: Google sheets is an excellent tool for sharing resources among work groups because you can click a column or row and "reorganize" as needed for each caller. Reorganize meaning, clicking "by county" and then "hours available" or clicking the "peer support" column and being able to not only see all the

TOPIC	DISCUSSION

	platforms and programs that offer peer support, but be able to reorganize so that "online 24/7" is at the top......
	• Chat: The plan is for the 988 entities when they become HUBS and dispatch the clinical teams in response to the small response of contacts that need outreach.
	• Chat: Do we track data on a county-by-county basis regarding the availability, response times and outcomes for responders such as mobile crisis, DCRs etc.? If we can't measure, we can't get better.
	• Question in chat: Is there a platform/webpage/app for 24/7 crisis, with no barriers? I'm thinking something similar to heypeers.com? but 24/7 rather than scheduled groups?
	• Chat: Hey everyone my name is jocelynn I have over 20 years of lived experience living with a mental health condition and multiple crisis situations. I just wanted to say that I live in Walla Walla WA and there is a serious need for crisis services. The crisis team is so short staffed that we can not even get the crisis team to come to peoples houses when they are in a crisis. if people have a crisis, they have to go to the ER to get any help from the crisis team.
	• Chat: Equity FIRST breeds accessibility which births logistic and geographic efficiency…..
	• Chat: Like if heypeers had a baby with discord or reddit?
	• Chat: Thanks for the map. In Thurston/Mason I give out the 360-480-5721 number for youth/families and 988 for parents. The Family Alliance site has all of that info. 988 and the former 10 digit number for the helpline has always been amazingly helpful for my family members. The adult crisis service coordinates with kids crisis for 18 and under in most situations, except for a few times when I've seen co-responders that include law enforcement and then it seems to stay with adult crisis + law enforcement. My family has also had lots of experience with law enforcement and fire fighter response for crisis that has been good
	• Chat: Without equity the idea of creating an efficient platform that serves everyone is folly
	• Chat: Love that work is being done to hold private insurance accountable and have them pay their fair share for crisis services. Thank You!!
	  ○ Chat: I forgot to mention, one of the 3 people I talked to yesterday, referred to herself as a "screener" (and she seemed to be trying to talk me into NOT using mobile crisis because it would take so long) definitely not to fidelity with "just go"
	• Chat: 211 would be great for community resources if agency's would keep their info up to date. Its a great platform and would be an amazing if organizations would do their part. How cool would it be to see three, three digit numbers that handle it all. 911, 988, 211.
	  ○ Chat: HCA I would love it if 988 cross-referenced/managed info with 211
	  ○ Chat: That has been suggested. I think we are exploring how to do it

TOPIC	DISCUSSION
	◦ Chat: I work for Greater Health Now and my big push next year will be to get organizations to update their info. If you havent Play around on the 211 website, it could be really cool. • Chat: FY2024 - SAMHSA (HHS) has budgeted 100 million for mobile crisis response. How and what portion of the money is distributed to WA state from national level funding. ◦ Chat: https://www.samhsa.gov/grants-awards-by-state/WA/discretionary/2023/details • Chat: If i knew how to make an app or webpage, it would be a resource hub that allowed user comments/feedback for each listed resource. And then the rear of the hub would be similar to heypeers.com but more peraonal.... Like if there was a live chat where people could chat or video call with a counselor/peer/mental health professional
Closing Statements	Analogies for the work we do: • We maximize our impact by doing a relay. Racers take turns turning the track and no one person ever runs the full length or time of the race. This allows exceptionally long races like the RAGNAR, which is 200 kilometers. Another example is Relay for Life, which is 24 hours long. None of us can successfully do this work alone. It takes all of us coming together to share our experience, insights, and education to improve the system. • Choirs maximize their performances by using staggered breathing. When it is impossible for one singer to hold an extremely long note, the singers take short breaths at different times to make it sound like the note is continuous. If we each take a step back when we need to take care of ourselves, we know there are still others there doing the work. • We work, we rest, we take turns, we do it together. • Bipasha provided a recap of the meeting. • Next meeting is January 22nd, from 1-3pm. • Lived Experience members may also contact Brittany Thompson, for follow up questions (bthompson@healthmanagement.com).

HB 1477 Rural & Agricultural Communities Subcommittee – February 22nd Meeting

Meeting Summary

Wednesday, February 22, 2023, 2:00 pm to 3:00 pm
Zoom

Attendees

Subcommittee Members

Matt Guettinger, WA Department of Health
Bob Small, Premera Blue Cross
Don McMoran, WSU Skagit County Extension
Jovanna Centre, Comprehensive Healthcare
Lexa Donnelly, Great Rivers BH-ASO
Pam Lewison, JP Ranch/Washington Policy Center
Peggy Needham, Reach Out Walla Walla Suicide Prevention
Sindi Saunders, Greater Columbia BH-ASO
Levi Van Dyke, Volunteers of America
Todd Kimball, Walla Walla County
Tonya Stern, Frontier Behavioral Health
Tori Bernier, Summit Pacific Medical Center

Facilitation Staff

Betsy Jones, Health Management Associates
Nicola Pinson, Health Management Associates
Chloe Chipman, Health Management Associates (Leavitt Partners)
Susan McLaughlin, Behavioral Health Institute

State Agency Staff

Elizabeth Tharp, HCA
Jennie Harvell, HCA
Luke Waggoner, HCA
Wyatt Dernbach, HCA
Maddy Cope, HCA
Kirstin McFarland, DOH
Lonnie Peterson, DOH

TOPIC	DISCUSSION
Welcome, Introductions, Review Meeting Agenda	Betsy Jones, Health Management Associates, reviewed the meeting agenda and objectives. 1. Provide update on January 1, 2023 HB 1477 Committee Progress Report 2. Provide overview of HB1477 Committee focus areas in 2023, including work on the full continuum of crisis response services: 1) A place to call, 2) Someone to come, 3) A place to go, 4) Pre- and post-crisis care

TOPIC	DISCUSSION
	3. Hear update on 988 Lifeline implementation, including work with Native & Strong Lifeline and the Veterans Lifeline. 4. Provide legislative update on 2023 bills relating to rural crisis response 5. Discuss development of a culturally-competent 988 response for rural and agricultural communities 6. Confirm action items and next steps. New members Matt Guettinger (DOH) and Susan McLaughlin (Harborview/Behavioral Health Institute) introduced themselves to the group. Matt Guettinger works is the rural suicide prevention specialist with the Washington Department of Health. Susan McLaughlin is the new director of the Behavioral Health Institute at Harborview.
Committee Updates	Betsy Jones (Health Management Associates) provided a brief update on work of the HB 1477 Steering Committee, CRIS Committee and Subcommittees. On January 1, 2023, the Steering Committee submitted a HB1477 Committee Progress Report to the Governor and Legislature. The report summarized committee progress and recommendations in eight critical areas of recommendations outlined by HB 1477, including feedback from the Rural and Agricultural Subcommittee. A copy of the HB 1447 Committee Progress Report is available on the CRIS webpage. The Steering Committee has identified four focus areas for Committee work in 2023: 1) Crisis system goals and metrics, 2) Crisis system services needed to meet these goals, 3) Funding and cost estimates, and 4) Crisis system infrastructure. The Rural and Agricultural Community Subcommittee is charged to provide rural and agricultural community perspectives into the HB 1477 Committee recommendations. Committee discussions this year will inform the next HB1477 committee report due January 1, 2024. There is also a potential for a one-year extension for CRIS Committee work, as proposed currently by HB 1134. This meeting addresses is focused on "A Place to Call" in the crisis service continuum. Future meetings will look at additional services along the crisis response continuum, including "Someone to Come," "A Place to Go," and "Pre- and Post-Crisis Care."

TOPIC	DISCUSSION
988 Implementation Update	988 Crisis Center representatives, Levi Van Dyke (Volunteers of American Western Washington) and Tonya Stern (Frontier Behavioral Health) provided an update on 988 implementation, including an overview of the Native and Strong Lifeline and the Veteran's line. Levi (VOA) highlighted steady increases in volume across all services (i.e., call, text, and chat) since the transition to 988 in July. This increase is consistent with other centers and across the country since the 988 transition. Volunteers of America operate the Native and Strong Lifeline, which is a 988 dial pad option (#4) for native populations in Washington. The Native and Strong Lifeline launched on November 10, 2022. In December, there were 232 calls, which increased to 383 calls in January. This reflects a substantial call volume for a program focused on a specific population. As familiarity increases, coupled with more information to the public, VOA anticipates the volume will steadily increase. When someone calls into 988, there is front end messaging with dial pad options. The first option is the Veterans crisis line, the second is the Spanish line, the third is for LGBTQ+ Youth and goes to the Trevor Project partnership, and the fourth is the Native and Strong Lifeline, which is unique to Washington state. The Rural and Agricultural Communities Subcommittee has previously discussed concern about the amount of time front-end messaging takes before someone can talk to an actual person. This concern is continually evaluated by SAMHSA with input from stakeholders. There is a balance of supports people to connect directly to an appropriate service while also ensuring a timely response. Tonya discussed regional updates for 988 crisis centers, noting call volume for 988 is not as high as the regional crisis line call volume. Get 3,500 – 4,000 calls a month to the regional crisis lines, whereas the 988 average for the past 6 months was 345 calls, which represents an increase with the implementation of 988. Average length of calls has increased by 2 seconds from 12:14 to 12:16. There is a 5% difference between what Vibrant reports show compared to crisis center systems—anything beyond 5% would require resolving discrepancies. From August – January 2022, the centers answered between 24.5 to 97.8% of incoming calls. Average answer rate is from 11 – 16 seconds. Percentage of incoming calls by rural county: • Spokane County: 88.4 to 93.9% of callers • Stephens County: 1.5 – 4% of callers • Lincoln County: 0 – 6% of callers

<table>
<tr><th>TOPIC</th><th>DISCUSSION</th></tr>
<tr><td></td><td>Ferry County: 0 – 2.3% of callers
Adams County: normally less than 1% of callers
The crisis centers have also filled almost all vacant positions; currently looking for a Diversity Equity and Inclusion (DEI) coordinator still. Several staff have taken the AgriSafe training—one of the staff made a farmworker resource list to share with other crisis center staff to use for calls. There are two staff members that grew up in agricultural farming communities, including the crisis call center trainer, two staff members grew up in rural Washington, and one staff member grew up on a cattle ranch.

Subcommittee Discussion
Has there been any movement toward a dial pad option for the agricultural population?
There are currently several conversations occurring between state representatives and stakeholders. There is also attention to providing specific training to crisis center staff to ensure a culturally-appropriate response to people in rural and agricultural areas. Conversations have included the AgriSafe network and help line. A few states use the help line for people in the agriculture industry and specific training around that. VOA has had some staff go through training from the AgriSafe network, and they are considering expanding to additional staff. Additional dial pad option is a conversation at the state level, which also brings SAMHSA and Vibrant in—requires a lot of stakeholders at the table.
Don McMoran added he has access to AgriSafe Rescue Courses that he can share with the group if anyone is interested.</td></tr>
<tr><td>Discussion: Recommendations to Ensure Access to 988 Lifeline for Rural & Agricultural Communities</td><td>Don McMoran, WSU Skagit County Extension, shared current resources to build upon. When WSU Skagit County Extension received its $7.18M Farmer Ranch Stress Assistance Network Grant, it became responsible for setting a call line up. Developing its own would cost around $4M to start and $2M to maintain, so the team looked to existing call centers, particularly the Farm Aid resource line, to partner. The line functions out of the east coast (MA)—they have a call center connecting callers to someone that understands farm culture and connections within community (e.g., USDA, attorney, CPA, etc.).</td></tr>
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TOPIC	DISCUSSION
	• First the team asked Farm Aid to increase the volume they serve. Call center originally inaccessible for the West—available 8 hours a day, M – F on east coast time. Next asked about putting Farm Aid operators in WSU Skagit County Extension and they agreed. Now there are 2 operators in Burlington, WA, taking calls from 11 am – 7 pm. • Farm Aid does not want to move to a 24/7 hotline, regardless of available funding options. Would potentially partner with another organization to get there. • AgriSafe helpline, WSU Skagit County Extension's partner, has put together the AgriStress helpline specifically for agriculture. Various states have signed on. Cost-wise, it's the best option for 988 moving forward—$200k to add Washington to the helpline. However, not all operators have a farm background, which is problematic if goal is to have operators who have a deep understanding of agriculture. • Another option is for Washington to start its own call center specifically for farmers and farm workers. The call lines would be ancillary to 988 call lines, but there would be a potential to bring them into the 988 call structure. That will be up to leadership; some legislators are interested in going down that road. *Subcommittee Discussion:* • There is a lot of excitement and momentum around these conversations. Looking forward to getting more information and weighing the options to see how we can produce something that will work well. Our representatives are looking to collaborate and want to move the needle quickly. • The dial number is a good approach; it would be helpful to explore that more. Hoping to balance what we want with what is actually available and possible. • The 988 number is picking up steam. First cautioned about it, and continued to use the 10-digit national number. Have since heard 988 is here and working well now. • There is a new state voucher program that provides vouchers for farmers and farm workers to see a certified counselor or therapist. The program uses the WSU psych clinic and telehealth—only has the capacity for 4 people per month, and only one individual is using the voucher currently. This group can share information

TOPIC	DISCUSSION
	about the vouchers and increase capacity moving forward. Reach out to Don or staff for further information. Once visits are used, participants can use their own insurance or pay the small fee (approximately $10 for some). • Are there other places for people to speak confidentially with telehealth folks? How does that work with access? o There is an extension office in every county—could connect participants with an extension office assist with telehealth component. WSU extension also received an $8M grant to increase broadband to rural areas in Washington state. There is progress to get better connectivity to stakeholders. • The Department of Health is working to set up a voucher program as well. Working with comprehensive mental health care in Yakima—offices throughout 8 or 9 towns in eastern Washington. Hoping this will be available soon.
2023 Legislative Update and Rural Crisis Response	HMA to follow up via email to provide legislative update from Megan Celedonia (Governor's Office).
Next Steps & Wrap Up	The HMA team will follow up to schedule the next subcommittee meeting, as well as with legislative update slides. If anyone has questions about bills or other topics, they can reach out to Nicola Pinson (Lead Project Manager) to connect with appropriate staff.

HB 1477 Rural & Agricultural Communities Subcommittee – March 28th Meeting

Meeting Summary

Tuesday, March 28, 2023, 12:00 pm to 1:00 pm

Zoom

Attendees

Subcommittee Members

Cindy Adams, GCBH – ASO Peer Support
Codie Marie Garza, WDVA
Bob Small, Premera Blue Cross
Levi Van Dyke, Volunteers of America
Lexa Donnelly, Great Rivers BH-ASO
Megan Celedonia, Governor's Office
Nicole Davis, Crisis Connections
Peggy Needham, Reach Out Walla Walla Suicide Prevention
Representative Tina Orwall
Sindi Saunders, Greater Columbia BH-ASO
Todd Kimball, Walla Walla County
Tonya Stern, Frontier Behavioral Health

Agency Staff

Allison Wedin, HCA
Eliza Tharp, HCA
Jennie Harvell, HCA
Lena Rubinstein, HCA
Luke Waggoner, HCA
Matthew Gower, HCA
Melanie Oliver, HCA
Robyn Wells, HCA
Ruth Leonard, HCA
Sherry Wylie, HCA
Wyatt Dernbach, HCA
Amira Caluya, DOH
Beth Schuurmans, DOH
Matt Guettinger, DOH

Committee Staff

Betsy Jones, Health Management Associates
Nicola Pinson, Health Management Associates
Chloe Chipman, Health Management Associates
Susan McLaughlin, Behavioral Health Institute

TOPIC	DISCUSSION
Welcome, Introductions, Review Meeting Agenda	Betsy Jones, Health Management Associates, welcomed subcommittee members and reviewed the meeting agenda and objectives. 7. Receive updates on legislation addressing behavioral health crisis response for rural and agricultural communities. 8. Understand current behavioral health mobile crisis response (MCR) system in Washington and work to develop best practices
Legislative Updates	Representative Tina Orwall shared updates on 988 legislation (HB 1134) addressing behavioral health crisis response, including provision addressing needs for rural and agricultural communities. With HB 1477 passed in 2021, Washington is one of only five states that has passed a telecom fee (24 cents per line or prepaid wireless service, increased to 40 cents per line or prepaid wireless service beginning in January 2023) to fund 988 implementation and related initiatives. This session, the legislature will make decisions on what to do with the increased fee amount while developing the four-year budget. Rep. Orwall provided overview of HB 1134 which amends and adds new legislative sections to expand "someone to come" rapid response teams and establishes expected timeframes for response in rural and urban communities. Representative Orwall also noted that Senator Dhingra is working on legislation to support expansion of a "place to go" through the development of 23-hour crisis relief centers. The "someone to come" teams may include expansion of existing mobile crisis rapid response teams and/or new partnerships between behavioral health, emergency medical service (EMS), and fire. Rep. Orwall reiterated that rapid response teams are a non-police response that would include behavioral health centers, mental health professionals, people with lived experience, and transportation (e.g., agency van, EMS, fire). She noted that while about 95% of calls are resolved on the phone, the hope is that the other 5% would receive clinical outreach. HB 1134 also looks at the co-location of 988 staff at 911 call centers to direct mental health calls back to 988.

TOPIC	DISCUSSION

	HB 1134 also creates comprehensive regional training for 988 and other crisis responders, including training that is specific to understanding the unique stressors and needs of rural and agricultural communities. Rep. Orwall highlighted the need for experts to support the development of the training plan, including national experts (e.g., the AgriSafe network).
	
	Rep. Orwall also noted plans to discuss a variety of topics with Vibrant. Before moving forward with adding a dial pad option for rural and agricultural communities in Washington, she hopes to learn about Vibrant's plan at the national level. Levi Van Dyke, VOA noted that adding dial pad options involve a larger conversation with Vibrant, SAMHSA, and other stakeholders.
	
	Subcommittee Discussion
	• To address cultural and language barriers in smaller rural communities, what is the plan to have training available in Spanish?
	    o It will be important to build language considerations into the training. 988 has a Spanish-speaking line dial pad option, but it is noted that there is interest in providing training in multiple language. Additionally, the 988 subnetworks, such as the Spanish, Veterans', and Native & Strong dial pad options, typically have additional training.
	• For Veterans calling 988 that bypass the Veterans' crisis line, how are we identifying callers as Veterans? Would that compromise anonymity?
	    o Callers can choose whether to share this information. There aren't screening questions for callers due to 988 confidentiality standards. Vibrant does have a contract amendment with centers to collect Veterans data, but that is de-identified. Vibrant is looking to determine the number of Veterans bypassing the Veterans' crisis line option and calling directly to a regional crisis center.
	• When callers select the Veterans crisis line option, can they get a next-day appointment from the VA?
	    o Callers that select the Veteran crisis line option are connected to call centers outside of Washington. They are given the

TOPIC	DISCUSSION
	option to opt-in to a call back, which is generally done within the next day, and suicide prevention coordinators will contact them from the local VA. These coordinators are typically social workers or licensed mental health professionals that do a suicide risk assessment and can determine the need for an expedited appointment. Callers that cannot access Veterans benefits or mental health care are referred externally. The Washington VA has peer specialists that can connect these Veterans to resources within the community. • Noted that it may be challenging to balance confidentiality concerns among the rural and agricultural communities while also trying to determine the extent to which rural and agricultural community members are accessing services.
Mobile Crisis Response - Updates	Matt Gower (Washington Health Care Authority) shared an overview of the current mobile crisis response system in Washington and work to develop best practices based on the Substance Abuse and Mental Health Services Agency's (SAMHSA) best practices for crisis response. The SAMHSA best practices are organized around a core continuum of crisis response services including a place to call, someone to come, and a place to go. In Washington, a place to call includes 988 and regional crisis call centers, someone to come includes mobile crisis response, and a place to go includes crisis stabilization facilities, peer respites, and potentially new crisis relief centers that are being proposed through Senate Bill 5120. The Health Care Authority's adult mobile crisis response includes in-person, community-based interventions where they are needed, and typically include multidisciplinary teams that incorporate certified peer counselors paired with a clinician, and utilize other providers when available (e.g., advanced registered nurse practitioner, substance use disorder professional). The teams will also provide community-based, post-crisis follow-up services in preferred locations to promote ongoing stabilization and recovery. HCA noted that youth and tribal crisis response teams are structured to meet these unique needs of each of the populations. The overview today is focused on HCA's model for adult mobile crisis response.

TOPIC	DISCUSSION
	Washington's crisis system has historically served everyone regardless of ability to pay. When the system was initially created, it focused on involuntary services for individuals with the highest acuity needs given the limited system resources. Additionally, resources have been funded at the local level, with no statewide standards, creating variation across the state. The Behavioral Health Administrative Service Organizations (BH-ASOs) are contracted with HCA to administer crisis response services at the local, regional level. Washington is in the process of developing statewide standards and best practices for crisis response services. It is also important to note that funding has never been adequate for a robust crisis response network to serve everyone, which has resulted in individuals in crisis utilizing emergency departments and first responders. Co-response teams (teams comprised of first responders and behavioral health professionals) have since developed to support response to individuals calling 911 or other first responder systems. The crisis system gets a blend of federal and state funding, which impacts who can operate and deliver services. Under the current state plan (which will change soon), only master's level clinicians and psychiatric registered nurses can provide behavioral health services in a mobile crisis team. They can also oversee mental health care providers, including those with bachelor's degrees in the field or an associates degree with 2 years of experience. Behavioral health agencies (BHAs) are the only licensed providers for crisis services under Medicaid, and they must be licensed by Washington's Department of Health. Licensing is open to any organization that can meet the basic requirements; this typically includes community behavioral health agencies, fire departments, and emergency medical services (EMS). As part of the Crisis Response best practices, HCA is working with partners to develop crisis response dispatch protocols that will be used by the future-state Crisis Contact Center Hubs. These protocols provide

TOPIC	DISCUSSION

	a decision tool for the scenarios in which to send different in-person crisis response resources.
	
	Subcommittee Discussion
	• Has HCA considered how it will fund rural crisis providers in their concept? Including considerations for long-distance travel, inclement weather, lack of cellphone coverage and internet access, and language barriers? For example, some rural counties have a high number or majority Spanish speaking individuals. Hard to get an interpreter in middle of the night, may be able to access by phone but not in person. Rural crisis providers need funding to support building teams that can respond in ways state is hoping to meet needs of individuals. Noted that funding using the firehouse model will be important in rural areas.
	  o To address barriers rural areas, HCA is looking at funding to support BH-ASOs to station providers part-time in different areas, similar to an on-call firehouse model. For larger populations in rural areas, HCA is looking at funding part-time staff available during peak hours. Noted the importance of establishing capacity for rural teams to address language and other needs of rural and agricultural populations.
	• Is HCA coordinating with and expanding existing programs into the 988 system? For example, community paramedic programs and trained professionals in fire houses.
	  o Representative Orwall noted that HB 1134 recognizes nature of regional response and the involvement of behavioral health, emergency medical services, fire, and co-responders.
	  o HCA is in the process of engaging first responders and co-responders to determine how they fit in the system at a regional level. Main goal working with community paramedics is to ensure they're available for medical interventions needed as part of a BH response.
	  o The CRIS Committee has been walking through the three different types of crisis response in the state: first responders, co-response, and mobile crisis response. During the March CRIS meeting, the CRIS Committee discussed when to include first responders and behavioral health professionals in response. There will be a CRIS Workgroup to develop recommendations regarding collaboration between behavioral health crisis

TOPIC	DISCUSSION
	response and first responders to bring forward to the full CRIS and Steering Committee. • Matt invited Subcommittee members to reach out if they are interested in providing input into HCA's work to develop the crisis response dispatch protocols. The CRIS committee is forming a workgroup focused on providing feedback on the crisis response dispatch protocols.
Next Steps & Wrap Up	The HMA team will follow up to schedule the next subcommittee meeting in May. If anyone has questions about bills or other topics, they can reach out to Nicola Pinson (Lead Project Manager) to connect with appropriate staff.

HB 1477 Rural & Agricultural Communities Subcommittee – September 25th Meeting

Meeting Summary

Monday, September 25, 2023, 11:00 am to 12:30 pm

Zoom

Attendees

Subcommittee Members

Donald McMoran, WSU Skagit County Extension
Levi Van Dyke, Volunteers of America
Nicole Davis, Crisis Connections
Pam Lewison, Washington Policy Center
Representative Tom Dent
Sara Schumacher, Frontier Behavioral Health (sitting in for Tonya Stern)
Tori Bernier, Summit Pacific Medical Center

Agency Staff

Jennie Harvell, HCA
Maddy Cope, HCA
Matthew Gower, HCA
Melanie Oliver, HCA
Sherry Wylie, HCA
Yen Baynes, HCA
Lonnie Peterson, DOH
Matt Guettinger, DOH

Committee Staff

Betsy Jones, Health Management Associates
Nicola Pinson, Health Management Associates
Brittany Thompson, Health Management Associates
Chloe Chipman, Health Management Associates

TOPIC	DISCUSSION
Welcome, Introductions, Review Meeting Agenda	Betsy Jones, Health Management Associates, welcomed subcommittee members and reviewed the meeting agenda and objectives. 1. Receive updates on progress to implement 2023 legislative and other changes to address behavioral health crisis response in Rural & Agricultural Communities across the crisis response continuum – Someone to Call; Someone to Come; A Safe Place to Be. 2. Receive update on synthesis of gaps and opportunities to improve Washington's behavioral health crisis response service continuum. 3. Understand process to incorporate input from Rural & Agricultural Communities Subcommittee into synthesis documents and next steps to

TOPIC	DISCUSSION
	inform Steering Committee recommendations in the January 1, 2024 Committee Progress Report.

Agency and Legislative Updates	DOH and HCA staff provided updates on agency progress to improve behavioral health crisis response in rural & agricultural communities across the crisis response continuum – Someone to Call; Someone to Come; A Safe Place to Be. These updates included status of new requirements under HB 1134 to strengthen crisis services for rural and agricultural communities.
	• Lonnie Peterson, WA DOH 988 Crisis Systems Manager, provided updates on DOH's 988 efforts specific to rural and agricultural communities, including: standardization of training requirements for 988 Lifeline Centers; planning for the statewide 988 social media campaign. DOH noted that the 988 Lifeline centers are currently providing the following trainings for agricultural communities:
	    ▪ Frontier Behavioral Health and Crisis Connections: AgriSafe Learning Lab hosted by AgriSafe Network for staff to participate in the online "FarmResponse" training
	    ▪ Volunteers of America Western WA: Internal trainings developed to guide callers, specific role-based case studies and resource lists
	  o Matt Guettinger, WA DOH Suicide Prevention Specialist for Rural and Agricultural Communities, highlighted: extension of the rural communities counseling service voucher program; and work to conduct the Agriculture Mental Health Needs Assessment to identify needs and barriers among the farming community regarding access to services to alleviate stress; Contract and collaboration with WSU Skagit-Extension to reduce suicide in the agriculture community.
	• Matt Gower, HCA, provided updates on HCA's 988 efforts.
	  o Developing endorsement standards for rural eastern Washington community-based crisis teams.
	  o Completing and actuarial analysis for crisis services to develop more sustainable funding models for rural services.
	  o Developing service expansion plans to bring more mobile crisis to rural areas.
	  o Received funding to develop a tribal mobile crisis pilot to develop a model of tribal adoption.
	
	Subcommittee Discussion
	• Recent concern from a rural community member continues to highlight the long wait time for 988 callers to connect with a live person. Community member suggested having a live person answer the phone then move the call in the right direction, rather than having the caller wait to select the options.

TOPIC	DISCUSSION
	○ Currently, it takes 41 – 45 seconds to get through the front-end messaging when someone calls 988, and the average wait time to get in touch with a counselor after the call is routed is usually 15 – 20 seconds. Vibrant is piloting a new Interactive Voice Response (IVR) system, where it will take about 30 seconds to get through. This will also have an option for a caller to press "0" to immediately connect to a counselor rather than listening through the dial pad options. Washington can share feedback with Vibrant regarding concerns with the long wait times, but ultimately Vibrant controls the decisions on greeting and time to connect with a counselor. ○ Suggestion to brand around an extension number for agricultural communities (i.e., 988-XX). ○ HCA has a workgroup with call centers to determine how to move calls from regional crisis lines to 988, including where to start to move things to the Hubs that go live in 2026. Will then look at no wrong door approach to get people support faster, and get them from the wrong door to the right resource. A major focus area will also be rural access. Police officers do not usually call 911; they typically use their own special line to get to departments. Plan to build that type of functionality and look at localized numbers. ○ Frontier Behavioral Health has recently done work with consumer advisory boards and received similar feedback around the amount of time it takes to talk to a live person. • Don McMoran shared update that WSU Skagit-Extension was awarded funding through the USDA's Farm and Ranch Stress Assistance Network (FRSAN) to support an AgriSafe crisis line for rural and agricultural communities in Washington, Montana, and Colorado. The grant is for one year, with opportunity to seek additional funding in the future. WSU will continue to provide updates on this work.
Washington Behavioral Health Crisis Response: Synthesis of Gaps & Opportunities	Nicola Pinson, HMA, provided an overview of the summary documents synthesizing gaps in Washington's behavioral health crisis response system, progress to date on addressing these gaps, and potential actions and opportunities to further address these gaps (Someone to Call, Someone to Come, Somewhere to Go). Will be using these documents as working drafts for review and input by CRIS Committee and Subcommittees to ensure perspectives are reflected. The purpose is to serve as the foundation for recommendations to include in the HB 1477 Committee Progress Report due January 1, 2024. Nicola provided an overview of the organization of the documents and key themes for rural and agricultural communities:

TOPIC	DISCUSSION

	SOMEONE TO CALL
	• Gaps:
	  ○ Confidentiality concerns in rural areas are a huge barrier and many rural callers will hang up if they call a line and are greeted with a recording instead of a live person.
	  ○ Limited/inadequate or no access to the internet limits access to services in rural areas (i.e., some areas do not have cellular reception).
	• Opportunities:
	  ○ Ensure that call center staff receive specific training on understanding and interacting with rural/agricultural communities.
	SOMEONE TO COME
	• Gaps:
	  ○ Rural areas are chronically underfunded
	  ○ Rural and agricultural settings are often rugged and can be distant from roads and other access points and may require special equipment, technology, and vehicles to access people, services and locations.
	• Opportunities:
	  ○ Due to geographic limitations and barriers in rural areas, may need to have a greater reliance and partnership with first responders in these areas.
	A SAFE PLACE TO BE
	• Gaps:
	  ○ Some people—particularly those who live outside the I-5 corridor—do not have crisis stabilization services in their local area.
	  ○ Need for adequate services available in all regions (including/especially in rural areas) so that people have access to services – why call if and ask for help if there are not resources to actually help.
	  ○ In some rural areas there is nowhere to go – so people end up in the emergency department and this might deter them from accessing help in the future if they know they have
	• Opportunities:
	  ○ Provide additional funding to behavioral health crisis systems in rural communities. Consider enabling “payer blind” crisis services (i.e., services not just for Medicaid clients or commercially-insured clients).

TOPIC	DISCUSSION
	◦ Ensure there are adequate services available in all regions (including/especially in rural areas) so that people have access to services – why call if and ask for help if there are not resources to actually help? ◦ Develop performance metrics and hold the behavioral health crisis response system accountable. It is important to establish metrics to tell us when rural areas aren't getting level of services urban areas are and then focus on investing and improving services in those areas. ◦ Increase use of telehealth to enable access to care on behalf of persons living in rural communities. ◦ Ensure partnerships with local community resources and experts (especially in rural areas) that can help with training, communications, and outreach (agronomists, community partners, family resource centers) *Subcommittee Discussion* • Noted anonymity is important to the agricultural community. Would need to be their decision whether someone comes to them, otherwise, they may not call. • Most of the stress in agriculture comes from financial issues, whether it's low prices or bad weather that takes crops out. Will need to address those unique pressures in a realistic way with people who are familiar with agriculture. • There has been very little progress in filling the pipeline for mental health professionals and providers since 2015. Some talk about putting together a counselor position that works under a PhD just to increase numbers of professionals/providers. Interested in identifying additional ideas. ◦ Consider connecting with Dean Powers at WSU to discuss capturing agricultural-adjacent kids who don't want to farm but still want to be involved in agriculture. Can think of opportunities to do some sort of counseling through the agricultural department as a major. Noted Dean Powers will be in Mount Vernon on 10/19, as well as hosting other regional events. ◦ WSU Skagit-Extension has a partnership with the WSU site clinic, providing vouchers to anyone in WA that wants to see a certified counselor (including option to go in person on campus in Pullman or do telehealth through the site clinic free of charge for six visits, then about $10 per visit after the sixth).

TOPIC	DISCUSSION
	• Highlighted need for creative solutions to address lack of resources and workforce in rural areas, including a less formal respite locations, such as a fire station, where people in crisis could go to access behavioral health support. • Suggestion to move the following opportunity from A Safe Place to Be to Someone to Call or Someone to Come: Ensure partnerships with local community resources and experts (especially in rural areas) that can help with training, communications, and outreach (agronomists, community partners, family resource centers). • Suggestion to develop peer certification for rural communities. This may be a creative approach to fill the workforce gap where we don't necessarily have counselors available. • Noted that when talking about resources, not only talking about agricultural community but also the rural population of those communities, including farm workers. Everyone in the rural community in need of accessing a resource. • Language access is also an issue. When talking about agriculture, needs to be dual language as well. Ensure Spanish options as the bare minimum. Touch base with farm worker contractors to identify where the bulk of H-2A contracts are coming from (e.g., Cambodia, Vietnam, Jamaica, etc.). Important to cast a wide net when discussing language barriers and cultural barriers for farm worker communities. ○ WSU Skagit-Extension has four Spanish translators, recently added Mixtec, which is mainly spoken in the Oaxaca region of Mexico. • Highlighted WA Department of Commerce webinar regarding Washington's digital equity plan. Webinar is 9/27 from 2 – 3 pm (link here).
Next Steps & Wrap Up	The HMA team to send the synthesis documents and the information about the HCA Digital Equity Forums to subcommittee members. Request to subcommittee members to provide feedback to the synthesis documents by next Friday, October 6th 2023.

HB 1477 Technology Subcommittee – February 23rd Meeting

Meeting Summary

Thursday, February 23, 2023; 2:00 to 3:30pm

Zoom

Attendees

Subcommittee Members

Adam Wasserman, 911 Coordinator
Brittany Miles, Product Management Leader
Callie Goldsby, Washington Department of Health
Kelly McPherson, Washington State Healthcare Authority
Kevin Bromer, Ballmer Group
Levi van Dyke, Volunteers of America
Mary-Sara Jones, Amazon
Paul Arguinchona, Frontier Behavioral Health
Rena Cummings, CHPW, MCO
Rep. Tina Orwall, Washington State House of Representatives
Shawna Ernst, Spokane Police Department
Sriram Rajagopalan, Strategic IT Consultant
Tim Curran, Crisis Connections (Clay Masterson as back up)
Trinidad Medina, Great Rivers BH-ASO

Committee Staff

Betsy Jones, Health Management Associates
Nicola Pinson, Health Management Associates
Chloe Chipman, Health Management Associates (Leavitt Partners)
Susan McLaughlin, Harborview Medical Center – Behavioral Health Institute

State Agency Staff

Amy Pearson, OCIO
Huong Nguyen, HCA
Jennie Harvell, HCA
Luke Waggoner, HCA
Maddy Cope, HCA
Matthew Gower, HCA
Melanie Oliver, HCA
Robyn Wells, HCA
Sherry Wylie, HCA
Wyatt Dernbach, HCA
Lonnie Peterson, DOH
Megan Celedonia, Governor's Office

TOPIC	DISCUSSION
Welcome, Introductions, Review Meeting Agenda	Betsy Jones, Health Management Associates (HMA), welcomed everyone to the meeting and shared the following meeting objectives: 1. Updates on HB1477 committee work 2. Update on information available on the Vibrant Unified Platform 3. Update on the HB1477 Final Technical and Operational Plan 4. Describe process and timeline to develop the draft RFI 5. Provide overview of draft RFI 6. Seek Subcommittee input on the draft RFI New members Susan McLaughlin (Harborview/Behavioral Health Institute) and Maddy Cope (HCA) introduced themselves to the group. Maddy Cope is new to the project and works in the office of health information technology. Susan McLaughlin is the new director of the Behavioral Health Institute at Harborview.
Committee Updates	Betsy Jones (Health Management Associates) provided updates on the January 2023 HB1477 Committee Progress Report and the HB 1477 Final Technical and Operational Plan submitted in October 2022. The HB1477 Committee Progress Report summarized progress in eight critical areas of recommendations outlined by HB 1477, including feedback from the Technology Subcommittee. A copy of the HB1477 Committee Progress Report is available on the CRIS webpage. The HB 1477 Final Technical and Operational Plan was submitted in October 2022. The plan provides an analysis of 1477 technology requirements and lays out next steps for Request for Information and Request for Proposal processes to identify technology vendors. A copy of the Final Technical and Operational Plan is available on the CRIS webpage. The Steering Committee has identified four focus areas for Committee work in 2023: 1) Crisis system goals and metrics, 2) Crisis system services needed to meet these goals, 3) Funding and cost estimates, and 4) Crisis system infrastructure. The Technology Subcommittee is charged to advise on issues and requirements related to the technology and platform needed to operate the behavioral health crisis response and suicide prevention system. State agency partners provide regular updates as the bodies responsible for planning and implementing the technology platform across the system. Committee discussions this year will inform the next HB1477 committee report due January 1, 2024. There is also a potential for a one-year extension for CRIS Committee work, as proposed currently by HB 1134.
Status of Vibrant Unified Platform	Maddy Cope, HCA, provided an update on the status of the Vibrant Unified Platform (Vibrant UP). Vibrant UP hosts monthly public meetings on the first Friday of every month, where they provide vendor demonstrations and updates on technology timelines. Thus far, Vibrant UP has provided a pilot program for a couple of centers.

TOPIC	DISCUSSION

	The calls lack information about Vibrant UP timelines and functionalities, which is a challenge shared by states across the country. Region 10 sent a list of questions to Vibrant UP and SAMHSA (see PDF attached at the bottom of the summary); there has been no response as of 2/23.
	
	Vibrant UP experienced two major 988 outages—one in December 2022, and another in February 2023. The first outage on December 1st was a catastrophic failure of Intrado's system—Intrado is a vendor for call routing. All of Intrado's redundancies failed, causing a national outage for Intrado's customers. As a solution, the calls were routed to national backup centers on December 2nd. Chat, Text, and SMS were still functional. Vibrant UP is still investigating the cause of the outage. Tribal partners and Region 10 states have expressed concerns about the lack of communication from Vibrant UP regarding the outage. Vibrant UP has not provided specific or timely communication on what the failure was, why there was a failure, or plans for future. Two rounds of questions regarding the outage have been sent to Vibrant and SAMHSA; there has been no response as of 2/23. The lack of communication has led to a discussion around concern about using Vibrant UP as potential vendor for 988. There is additional conversation around keeping technology in-state to limit the impact of potential future outages. The second outage on February 13th was specific to the text platform, and there is limited information on the cause or future plans.
	
	HR 498—the 988 Lifeline Cyber Security Responsibility Act—was introduced in January 2023. The purpose is to secure the 988 Lifeline from cybersecurity incidents. The resolution requires the Secretary of the U.S. Department of Health and Human Services (HHS) to coordinate with the CISO of HHS to ensure the 988 Lifeline program is protected. It also compels the Comptroller General to conduct a study evaluating cyber security risks to 988 within 180 days of enactment of the resolution and submit the study to the U.S. House of Representatives and U.S. Senate.
	
	Subcommittee Discussion:
	• 988 outage notifications should also go to State 911 providers because a 988 outage will likely result in an increase in 911 calls as people try to find help.
	• Concerned about Vibrant UP not having communication at least at senior leadership level back to states. Is there any other way to prod them?
	    ○ HCA and DOH have reached out to them in different avenues. Questions may be asked via chat during the Vibrant UP monthly calls, but those are typically more high-level. DOH and HCA will continue to pursue multiple avenues of communication.
	    ○ The FCC has also published a request for comment in response to the December outage, proposing that the vendors would notify SAMHSA, the VA, and NSPLs in the event of an outage.

TOPIC	DISCUSSION

	• Wondering about the pathway to decide we move forward with Vibrant UP or not. In the absence of info from Vibrant, what does that mean for our process? If we aren't getting information from them, will we make a decision or let it go?
	  o Once vendors respond to the RFI, that will help us determine where vendors stand and who we want to look closer at. Vibrant UP is invited to respond to the RFI as well as any other vendor in the space. Questions and concerns will shape future recommendations regarding needed tools and vendors.
	• Is call routing separate from text and chat routing?
	  o For Vibrant UP, routing for call, text, and chat are on different systems. When we talk about call routing, that refers to phone calls. Text and chat are on a different system.

Subcommittee Input: Draft Crisis System Technology Request for Information (RFI)	Maddy Cope, HCA provided an overview of the draft crisis system technology Request for Information (RFI), and process to develop. The RFI is a broad tool with the purpose of gathering information. It was written such that vendors can respond to any part of the RFI they can meet. This approach encourages different types of vendors to respond. The following have reviewed the RFI and given feedback: Internal HCA/DOH teams, State 911 coordinator, Users (RCLs, NSPLs, MCRs, BH-ASOs), Tribes, Governor's Office, OCIO, HCA AAG, HB 1477 Technology Subcommittee. Technology Subcommittee members received a draft copy of the RFI one week prior to this meeting for advanced review. The draft RFI outlines nine functional requirements needed based on the standards laid out in HB 1477. Sections for each functional requirement details goals of the functionality and questions for vendors to respond to. The nine functional requirements include: 1) Call Center Platform, 2) Responder Dispatching, 3) Resource Directory, 4) Provider Portal, 5) Referrals and Appointments, 6) Manage Consent, 7) Electronic Documents, 8) Bed registry, and 9) Reporting. The technology requirements within the RFI will need to be addressed by all vendors regardless of what piece of the functional requirements they answer, including privacy, security requirements, and standards. The RFI is drafted with the assumption that the state will require multiple systems and vendors partnerships, and that relationships between vendors will be necessary. The timeline, legislation, and regulations are listed as potential constraints. Lastly, risks listed include the multiple components, complexity, and changing requirements. RFI Timeline: HCA and DOH are working to publish the RFI on March 9, pending review processes. They will allow one month for vendors to respond to the RFI, and are aiming to develop recommendations from the RFI to inform the RFP process by mid-June. Discussion Questions: Focusing feedback on functional requirements, Technology Subcommittee members answered the following questions:

TOPIC	DISCUSSION

	1. Is this a complete list of functional requirements that would create a successful platform? Did we miss anything?
	2. Are there any technology/business pieces that we did not address or that are not addressed clearly enough?
	3. Is there anything we need to widen the scope on?
	
	Subcommittee Discussion:
	• For high utilizers, there could be value in being able to reach the same resources regardless of text or phone.
	• System availability management/maintenance piece. Uptime numbers, response timeframe, etc. are critical. Some cursory understanding or verbiage around that could be helpful. General questions on how they manage their system, which could impact overall response.
	• Wondering if we need to ask them about how they transfer to emergency responders as needed. Big part of this—getting not only their own responders, but if they need fire or police support. Could ask about high-level cybersecurity statement so they know it's at the forefront of our requirements. Potentially also a statement about how they ensure privacy.
	  ○ Some of the privacy and security is within the details. Every system that Washington procures must comply to OCIO 1410, where cyber security is addressed. The RFI also asks that respondents provide information on how they will address privacy and security.
	• Is there a role for a system integrator? Should the RFI ask about that?
	  ○ A system integrator is essential to the success of this program. The RFI requests a lead integrator on the state side. Each vendor will work out partnerships to submit one complete system and have a system integrator working with our system integrator and others. The state will oversee the project and any stateside systems and processes with vendor-procured ones.
	• For the workforce side, suggest being more specific about scheduling, capacity management, and include an onboarding piece.
	  ○ Some of the RFI requirements don't emphasize scheduling tools—will need to make a note to add emphasis into the requirement. Some of the designated crisis responders and onboarding are dispatched from regional crisis lines (RCLs). A lot of those things would be handled in the system, not listed as requirements right now. Capability should be there whether we use it or not.
	• We are trying to create these teams to help find all the community-based resources; part of it might be taking them somewhere where they will be assessed by designated crisis responders. We aren't seeing that component in the short-term.

TOPIC	DISCUSSION

	• We want to see 988 follow-up in our state. Knowing whether there was a next day appointment, if the patient attended it, if we need to check on them. It seems like that's really a distinct function we're going to be making.
	• We need to consider the dispatch integration component for future practice, ideally capacity to dispatch and monitor progress electronically. Whether that's integrated within the platform or some type of additional technology. Could be rapid response teams, any type of alternative response teams, or things that are being dispatched from a call center level whether it's 988 or regional crisis lines.
	• Additionally, looking at a long-term system, it is not clear what the provider portal is and how it ties into the referral piece. Is it just an information registration system for providers, or is it the place they go to manage all the referrals and other kinds of things that come to them?
	  o The portal is for any of the providers that can't transfer information through API's. They'll get a login then they can either enter information or get information that they wouldn't get automatically.
	• Is it important for users to be able to enter or modify electronic documents on their own? There is a level of complexity for providers updating documents vs. users updating them. It's unclear if the users need to do that or just providers.
	  o The RFI talks about the ability for systems to support needed functionality for particular document types (i.e., mental health advanced directives, crisis plans and assessments, risk assessments, and safety plans). There are other questions in the RFI responders will address regarding document types. Ideally, where possible, patients would be able to install and modify their own documents.
	• Within the electronic documents management, does that include digital signing for users?
	  o We have a project of the electronic consent management, which would fulfill some of the signing capabilities of the system. We plan to incorporate some of those existing systems and processes.
	• Suggestion to clearly mention there is a requirement to support Vibrant UP. That's fairly well documented and fair to callout that they need to tell us whether or not they support those reporting departments.
	  o RFI lists integration with Vibrant UP as a general requirement. Calling out that reporting is important.
	• Recommend having respondents list additional capabilities in the RFI. That would simplify the assessment of the RFIs rather than having team do heavy lifting. Suggest being more clear so that respondents tell us what their gaps and additional capabilities are.
	  o One of the concluding questions for each functional area is tell us anything else you want us to know.

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<tr><th>TOPIC</th><th>DISCUSSION</th></tr>
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- Are we asking for a list of integrations as part of the RFI? It might be nice to know what other systems the vendors already partner with.
- Is the RFI directed to specific vendors? Or is it open to all vendors to respond?
  - Combination of both. All RFIs and RFPs get posted to our web system where various vendors will routinely check. The big vendors that we have talked to are looking for it, and we plan to let vendors know that it's there and how to find it. We can't specifically send this out to vendors, but we can let them know that it's there

Mathew Gower, HCA, discussed the team's efforts regarding business process mapping. The purpose is to get more insight into how we can better fill gaps with technology solutions and best practices, dispatch protocols, etc. The team is also going to each crisis center site to see how the work is done and observe existing technology. The team has met with VOA and ORHS. The work is important to understanding how to support and build off of existing capabilities. The team is also working to streamline and standardize data reporting to better track mobile crisis teams, services provided by adult and youth teams, and follow-up services.

Subcommittee Discussion:

- Once finished, will the work be shared with the subcommittee?
  - Yes. We are in the process of evaluating the timeline and process for bring this work through subcommittees for input.
- Is there future journey state mapping as part of next steps? What happens once you get the business processes mapped?
  - These efforts were focused on the current state. We will do future-state process mapping as well to determine technology tools needs.
- Can you share more about the timing and timeline for business processes mapping and when you expect to be done?
  - We are finalizing dates with partners. Our goal is to do at least one onsite visit with each of the NSPLs, and potentially RCLs as well; hoping to finish by end of April. This will inform the technology platform.
- Could we get a process map from one of the exemplary state systems (e.g., Arizona or Georgia)? This could inform us and get us to what the future state should be, especially as we get to the RFP stage.
  - This may be a matter of what other states can share. Might also be useful to re-present the information shared previously on other states.
  - HCA noted that the teams working with the NSPL and RCLs are learning a lot. Those key takeaways could be really useful.
  - This could be a simple matter of outreach to see what they have available to help us learn and develop some ideas.

</td></tr>
<tr><td>Next Steps and Wrap Up</td><td>The HMA team will follow up to schedule the next subcommittee meeting as needed.</td></tr>
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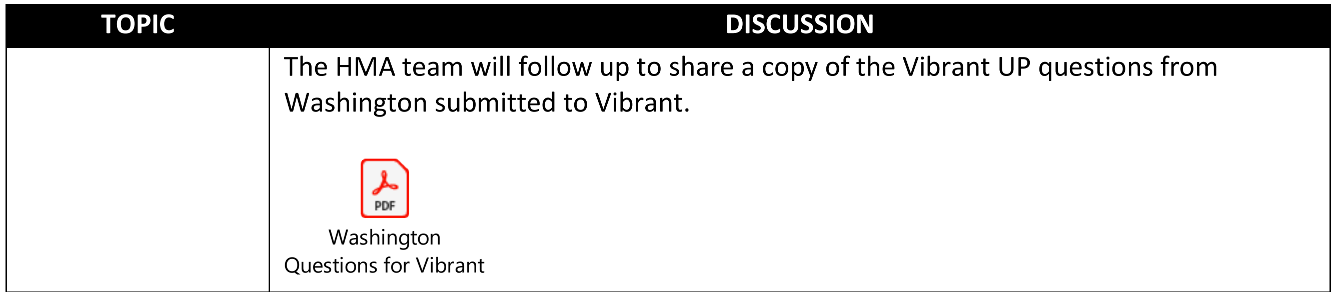

TOPIC	DISCUSSION
	The HMA team will follow up to share a copy of the Vibrant UP questions from Washington submitted to Vibrant. Washington Questions for Vibrant

HB 1477 Technology Subcommittee – August 9th Meeting

Meeting Summary

Wednesday, August 9, 2023; 2:00 to 3:30pm

Zoom

Attendees

Subcommittee Members

Adam Wasserman, 911 Coordinator
Brittany Miles, Product Management Leader
Diane Mayes, Crisis Connections
Kevin Bromer, Ballmer Group
Levi Van Dyke, Volunteers of America
Mary-Sara Jones, Amazon
Michael Reading, King County ASO
Paul Arguinchona, Frontier Behavioral Health
Rena Cummings, CHPW, MCO
Rep. Tina Orwall, Washington State House of Representatives
Shawna Ernst, Spokane Police Department
Sriram Rajagopalan, Strategic IT Consultant
Tim Curran, Crisis Connections (Clay Masterson as back up)
Trinidad Medina, Great Rivers BH-ASO

Committee Staff

Betsy Jones, Health Management Associates
Nicola Pinson, Health Management Associates
Chloe Chipman, Health Management Associates (Leavitt Partners)
Susan McLaughlin, Harborview Medical Center – Behavioral Health Institute

Agency Staff

Adna Trnjanin
Huong Nguyen, HCA
Jennie Harvell, HCA
Kelly McPherson, HCA
Maddy Cope, HCA
Matthew Gower, HCA
Melanie Oliver, HCA
Robyn Wells, HCA
Sherry Wylie, HCA
Wyatt Dernbach, HCA
Cat Robinson, DOH
Elaina Perry, DOH
Sachin Lande, DOH
Megan Celedonia, Governor's Office

TOPIC	DISCUSSION

Welcome, Introductions, Review Meeting Agenda	Betsy Jones, Health Management Associates (HMA), welcomed everyone to the meeting and shared the meeting agenda.
	1. Updates on topics relevant to the Technology Subcommittee
	    a. State Affinity Workgroup
	    b. Status of Vibrant Unified Platform
	    c. HB 1134
	    d. HB 1477 committee work
	2. Receive update on vendor responses to the Technology Platform Request for Information (RFI)
	3. Provide feedback on next steps to inform the development of the Request for Proposals (RFP)
	
	Sachin Lande, new DOH chief system integration officer, introduced himself to the group. Sachin is focused on the technology sector for 988 and has expertise in the telecommunications and healthcare space.

Technology Platform Request for Information (RFI) Update	Sachin Lande, DOH, provided an update on the status of the Technology Platform Request for Information (RFI). The objective of the RFI was to conduct a market scan regarding vendor technical capabilities to deliver a 988 technical platform across the Crisis Care continuum and inform development of RFP recommendations and approach. The RFI requested information on both functional and technical requirements, including:
	- Functional Requirements
	    o Call Center Platform
	    o Responder Dispatching
	    o Resource Directory
	    o Provider Portal
	    o Referrals and Appointments
	    o Consent Management
	    o Electronic Documents
	    o Bed Registry
	    o Reporting
	- Technical Requirements – ideally pre-built, can custom tailor to the state's needs:
	    o Cloud-based solutions
	    o SaaS/Commercial Off the Shelf (COTS) solutions
	    o Distributed computing Architecture
	    o Data Governance
	    o Data Security and System Management
	    o Privacy and Protocols
	    o Tribal Data Sovereignty

TOPIC	DISCUSSION
	RFI respondents were evaluated using a "Four Quadrant" approach, with the quadrants representing four major components of the system. Respondents were assessed based on the solution provided. Quadrants included: 1. Telephony – The management of the call/text/chat routing, dispatching, and integration with existing telephony hardware. This will include interactive voice response (IVR) and Voice over internet protocol (VOIP). 2. Client Relationship Management (CRM) + Referral & Dispatch – CRM handles the intake, account management of the person in crisis and captures all the information for the encounter until the resolution of the crisis. Referral allows the call taker to send the information to a different provider for either follow up, long term care or other services. Dispatch refers to sending the crisis information to response teams to engage the person in crisis. 3. Integration Cross Paths – Includes the integration platform, will facilitate the different systems to exchange data (e.g., Application Programming Interfaces, Electronic data interchange, etc.). 4. Reports and Analytics – Output data from various other components of the system for consumption by operational leadership and other stakeholders. There were 11 total RFI vendor respondents evaluated against the "Four Quadrant" approach, including Accenture, Coastal Cloud, Genesys, iCarol, LinkLive, MTX, Netsmart, Trek Medics International, Twilio, Unite Us, and Visionlink. HCA and DOH teams reviewed strengths, offerings, and evaluated core capabilities. Some vendors were strong across all quadrants, while others had strengths in specific areas. No single RFI response addressed the Crisis Care continuum needs entirely. Demos were set up with a couple of vendors to provide deeper capacities. Cost estimates were not comparable and varied. Timelines also varied, generally estimated to be 5 – 7 years for full implementation. HCA & DOH will continue to coordinate/collaborate; assigned responsibilities for systems are: - Telephony - **DOH** - CRM + Dispatch - **DOH** - Referral & Bed Registry - **HCA** - Integration Cross Paths (e.g., EHRaaS, Provider Portal, FHIR resources for Mental Health Advance Directives, LRAs, and other document types) - **HCA** Next steps are for (i) HCA/DOH leadership to approve for staff to perform analysis on the three architectural options below with a focus on packaged application software, strong data governance, interoperability, and private cloud infrastructure model; and (ii) provide guidance, upon completion of this analysis, on approach: - Vibrant UP + CRM & Dispatch+ Integration pathways

TOPIC	DISCUSSION

	- Best in Class Telephony Chat and Text + CRM & Dispatch + Integration pathways.
	- Next Gen Emergency Services + CRM & Dispatch + Integration pathways
	
	Currently, Vibrant is Washington's telephony approach as a multi-tenant architecture. Washington also has three different National Suicide Prevention Lifeline (NSPL) centers —Crisis Connections, Frontier Behavioral Health, and Volunteers of America Western Washington (VOA)—each with different telephone platforms and different EHRs. The state will need to architect a solution with one single system that can bring together longitudinal data. There are three potential architecture approaches at present.
	- **Option A: Vibrant UP** - Currently functional; all the calls in the state come through Vibrant UP. Vibrant is working closely with Salesforce to build a CRM platform for managing patient data and ensuring data interoperability and governance. Vibrant is also working to build capabilities around bed registry and Mental Health Advance Directives.
	- **Option B: Best in Class** – Washington would create its own system to manage telephony, CRM software, and finally integration touch points. The state would be able to pick and choose what it needs to build in this custom option.
	- **Option C: Next Gen Emergency Services (NENA I3)** – NENA I3 is the backbone; this option would use the same backend infrastructure as 911 for routing calls.
	
	Subcommittee Discussion:
	• The Vibrant system is a national system that is federally funded with separate lines. Washington could benefit from being a part of that. Other options could be a huge cost burden to tax payers when creating a comprehensive system.
	    o Vibrant is a viable, national option. It will evolve and continue to improve moving forward. However, the DOH and HCA teams have noticed discrepancies between Vibrant in-state call data and the data reported by the state's NSPLs. The teams are hoping to look at these variances and determine how to fix them. Have also heard challenges in different states related to data sharing and the ability to report data with Vibrant. The DOH and HCA teams will continue analyzing the Vibrant data on their end to determine next steps.
	    o Representative Orwall noted that Vibrant is working with the Federal Communications Commission (FCC) to route calls differently; this will be resolved in the future.
	• Concerned about routing everything through 911.
	    o The second architecture approach does not use 911. It uses 911's backend infrastructure to route calls. For example, California extended its 911 platform and used an extension to build a separate

TOPIC	DISCUSSION
	o and secure platform for 988. It will be important to have inter-connection between 988 and 911 to transfer calls. • What is the architecture of Vibrant compared to the other options, and what does that mean for the RFI and scope? Does Vibrant provide all the system and integration capabilities to pull everything in and provide longitudinal data? Would like a comparison between a Vibrant and non-Vibrant architecture. o Vibrant is an evolving platform. Will want to ensure the overall architecture is more comprehensive than just the telephony piece—it will include how calls are routed into the state contact centers and to the right agent. Currently in the process of building architecture for Vibrant, but it is difficult to make an assumption on functionalities offered with all of the unknowns. Hoping to receive clarity in September and will provide update at a future meeting. • Regarding the challenges different states are facing related to data sharing and the ability to report data with Vibrant, what is the context? Correct to assume that it would be reduced going with the 911 option? o Currently, when a 988 call has to be transferred to 911, there is no mechanism to share data information. In a future world or "Next Gen 911", there will be a seamless way of transferring information. 911 responders can even transfer to 988. o Rep. Orwall added that 95% of calls are resolved on 988 and very few go to 911; however, we do need a mechanism for sharing. That's why the state is also doing co-location. • If calls to 988 need to be transferred to 911, would the caller have to consent to sharing their data? o There is a need to establish consent management. Future state requirements indicate that the CRM platform will need to have verbal consent. • Vibrant will continue to strengthen over time. This is not just a cost or IT question. If Washington goes away from the Vibrant system, it will need to create a whole new system with Veterans, Spanish, and LGBTQ+ lines. o The way this would be architected in the future is that the routing mechanism will go to the 988 Vibrant system, while Washington has its own telephony network. 988 calls will still go to the 988 contact centers. For example, California uses a next gen network but all calls are eventually routed back to the Vibrant network. Would not be moving completely away from Vibrant; just a new routing piece. • It would be helpful to know more about what California has done and how that could impact the architecture of the system—it seems like they have found a happy medium. Bypassing Vibrant is not a good idea. There is an

<table>
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o Option C represents that happy medium. With the routing mechanism, all 988 calls go to the 988 Vibrant ecosystem, and are brought back into the next gen network. Have discussed with key California technical team members to understand their architecture.</td></tr>
<tr><td>Committee Updates</td><td>Maddy Cope, HCA, provided updates on the status of the Vibrant Unified Platform (Vibrant UP). SAMHSA’s vendor, Vibrant Emotional Health, is in the process of developing the Vibrant Unified Platform (UP) as a comprehensive system for the basic needs for the crisis continuum.

Vibrant UP has been released in stages, currently including volunteer crisis call centers or NSPLs as pilots for the releases. VOA is working on the chat and text pilot, which has been delayed to begin this quarter. For now, and in the near future, states will be able to access the 988 text/chat feature if they utilize the Unified Platform in some capacity. Moving forward, Vibrant hopes to support the ability to integrate and allow for 988 text/chat to be answered by states outside of the Unified Platform.

There are three Unified Platform Package options—Vibrant Standard, Vibrant Extended, and Vibrant Connect—and Washington will determine pursuing future technology procurements and how to integrate with the Unified Platform. To make these decisions, HCA has begun discussions with Vibrant and SAMHSA regarding Unified Platform functionality. Vibrant has expressed interest in having Washington support the development of the specifications for the Unified Platform.

Vibrant has indicated ongoing testing around geo-fencing/routing. To level-set, the following definitions were provided during the call:
• Geo-fencing: caller's phone pings cell towers to triangulate general location to better inform system of where to route their call (to which call center) to best provide services if needed.
• Geo-routing: the term Vibrant uses for the same concept as geo-fencing. We will use this term for the rest of the presentation for clarity.
• Geolocation: precise location of caller for the purposes of dispatching mobile crisis response if necessary.

The 988 state affinity workgroup (SAW) was created in March as a forum for states and territories across the country to connect and share ideas, successes, barriers, advice, concerns, questions, and anything related to 988. The increasing list of attendees includes representatives from 44 states, the District of Columbia, and two territories. Topics covered thus far include funding, risks and barriers, the Vibrant Unified Platform, air-traffic control models for mobile dispatch.</td></tr>
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TOPIC	DISCUSSION

	There are multiple considerations underway for the HB 1134-established Geolocation Subcommittee, including the content for meetings due to the potential crossover with the Technology Subcommittee. There are also federal-level decisions being made at the FCC regarding how to handle caller location and resulting privacy implications.
	
	Regarding the technology procurement process, HCA and DOH staff are obtaining leadership approval for the recommendations on how to move forward with the RFP. Ask for the subcommittee members:
	• Are members of the CRIS Technology Subcommittee interested in reviewing the technical specifications of the RFP?
	  o Reviewers cannot be associated with any potential bidders for the 988 solution
	  o Reviewers will be required to sign an NDA
	  o Commitment:
	    ▪ Participate in an orientation training end of August/beginning of September
	    ▪ After training, review and comment on technical specs ~2 hrs/week for ~10 – 15 weeks
	  o Interested participants should contact: Maddy Cope (madeline.cope@hca.wa.gov)
	  o NOTE: NSPL and RCL members of Tech Subcommittee will also receive a similar request to participate in this review process. HB 1134 requires DOH/HCA to include 988 call centers and designated contact hubs in the decision-making process for technology platform.
	• In the future: When the RFP is published, DOH and HCA will also ask this subcommittee for participants in the review of RFP vendor submissions.
	• Current Opportunity: Engage in the HL7 Patient Empowerment Workgroup to inform and comment on the ballot for an Implementation Guide on Advance Directives in order to better inform the Mental Health Advanced Directives.
	  o HL7 is one of the key Standard Development Organizations that establishes standards for the interoperable exchange and re-use of health care information
	
	Subcommittee Discussion:
	• Understand that 911 has geolocation. If a 988 call is routed through 911 software rather than the Vibrant platform, would that caller be subject to geolocation?
	  o No, it won't track geolocation. There are also masking techniques to prevent information from being shared with the call team. Will share a specific scenario in a future call to walk through the backend system process.

TOPIC	DISCUSSION

	• The geolocation subcommittee will have a heavy emphasis on addressing privacy issues with geolocation.
	• Appreciate the need for standards. Why use HL7 and not Fast Healthcare Interoperability Resources (FHIR)?
	    o HL7 is the governing body, underneath that is FHIR. All data will be exchanged using FHIR R4, which is the latest version. HL7 was used as a nomenclature but will use all FHIR standard resources for all API calls moving forward.
	• How will the group be ready to move onto the RFP if we don't resolve the Vibrant UP question? That is a core part of the RFP.
	    o Yes, we need to be clear about Vibrant UP. Currently doing the deep dive analysis to look at discrepancies.
	• At a high level, DOH and HCA next steps are to present technical architecture overview with specific details around Vibrant UP and determine additional pros and cons, with clear definitive pathways toward a recommended platform. This will drive how the RFP is released. Other topics to discuss in the future include the bed registry and Mental Health Advance Directives piece, and ensuring these capabilities either in-house or elsewhere.
	• Will you hold the RFP until we have the information needed from Vibrant?
	    o Yes.
	• Is there any feedback on the volunteer pilots for the new RFP and Vibrant solutions? Is there a forum where pilot participants provide feedback?
	    o "Vibrant UP Update" is a forum where pilot participants give feedback; it is hosted on the first Friday of every month.
	    o Levi, VOA, noted that the pilot is still relatively new and was delayed, but is hoping to gather data and present at the next meeting. The initial impression is that it's superior to what was in place, but there are still things to work out regarding process and workflow. Overall, it is working and the response has been positive. VOA in Washington does chat and text for the state, is the national backup center for chat and text, and is the chat and text subnetwork center for LGBTQI+ youth subnetwork.
	• Vibrant UP just opened the Spanish line—does VOA support English and Spanish for chat and text?
	    o Levi, VOA, explained that the Spanish line was a separate and specific RFP from Vibrant. Vibrant has had a subnetwork for a number of years, but it hasn't included chat and text until recently. VOA is not involved and hasn't heard which centers are involved.
	• Members discussed the evolution of the system, including actors like Vibrant and the states. Positive headway across the board.

TOPIC	DISCUSSION
Next Steps and Wrap Up	• HMA will reach out to schedule the next Technology Subcommittee as additional updates are available. • Members of the CRIS Technology Subcommittee interested in reviewing the technical specifications of the RFP should contact Maddy Cope (madeline.cope@hca.wa.gov)