

MEETING SUMMARY

CRISIS RESPONSE IMPROVEMENT STRATEGY COMMITTEE MEETING SUMMARY

Tuesday, November 16, 2021; 1 to 4pm

Zoom

*[Meeting Agenda, Slides and Recording are available on the CRIS webpage:
<https://www.hca.wa.gov/about-hca/behavioral-health-recovery/crisis-response-improvement-strategy-cris-committees>]*

ATTENDEES

COMMITTEE MEMBER

Adam Wasserman, Washington State Emergency Management Division
Amber Leaders, Office of Governor Jay Inslee
Bipasha Mukherjee, Volunteer
Caitlin Safford, Amerigroup
Cathy Callahan-Clem, Sound Health
Darcy Jaffe, Washington State Hospital Association
Darya Farivar, Disability Rights Washington
Dillon Nishimoto, Asian Counseling and Referral Service
Heather Sanchez, American Lake Veterans Affairs
Jan Tokumoto, Frontier Behavioral Health
Jane Beyer, Washington State Office of the Insurance Commissioner
Jennifer Stuber, UW School of Social Work & Co-Founder Forefront Suicide Prevention
Jessica Shook, Olympic Health and Recovery Services
Joan Miller, Washington Council for Behavioral Health
Justin Johnson, Spokane County Regional Behavioral Health Division
Kashi Arora, Community Health and Benefit, Seattle Children's
Katherine Seibel, National Alliance on Mental Illness Washington
Keri Waterland, Washington State Health Care Authority
Kimberly Hendrickson, Poulsbo Fire CARES program
Levi Van Dyke, Behavioral Health Volunteers of America Western Washington
Linda Grant, Evergreen Recovery Centers
Senator Manka Dhingra, Washington State Senate
Melissa Hurt Moran, The Kalispel Tribe
Michael Reading, Behavioral Health and Recovery Division, King County
Michael Robertson, Peer Kent (Peer Washington)
Michele Roberts, Washington State Department of Health
Michelle McDaniel, Crisis Connections
Puck Kalve Franta, Access & Inclusion Consultant
Ron Harding, City of Poulsbo
Summer Hammons, Treaty Rights/Government Affairs
Representative Tina Orwall, Washington State House
Robert Small, Premera Blue Cross

COMMITTEE MEMBERS ABSENT

John "Bunk" Moren, Sea Mar Community Health Centers

Tom Dent, Washington State House

Judy Warnick, Washington State Senate

SPEAKERS/GUESTS

Jim Vollendroff

Cathy Callahan

COMMITTEE STAFF

Betsy Jones, Health Management Associates

Brittany Thompson, Health Management Associates

Jamie Strausz-Clark, Third Sector Intelligence (3Si)

Lauren Baba, Harborview Medical Center

Liz Arjun, Health Management Associates

Madeline Grant, Harborview Medical Center

Mark Podrazik, Health Management Associates

Mark Snowden, Harborview Medical Center

Michael Anderson-Nathe, Michael Anderson-Nathe Consulting

Nicola Pinson, Health Management Associates

Suzanne Rabideau, Health Management Associates

WELCOME, INTRODUCTIONS, AND TECHNOLOGY REVIEW

Jamie Strausz-Clark (3Si) convened the meeting and reviewed use of Zoom features to ensure understanding among meeting participants regarding use of Zoom technology for the meeting and expectations for committee members and public observers.

Representative Tina Orwell began the meeting with an introduction and a welcome. Amber Leaders, Office of Governor Jay Inslee, offered a land acknowledgement, recognizing that she is a guest on tribal lands and honoring tribal ancestors and leaders as stewards of these lands. Each CRIS Committee member introduced themselves and noted what their representation group on the CRIS committee is. Next, the committee staff introduced themselves and gave their roles on the project.

MEETING OBJECTIVES AND AGENDA

Jamie then reviewed the meeting agenda and objectives for each agenda item. This meeting of the Washington Crisis Response Improvement Strategy Committee had five objectives:

1. Continue laying the foundation for collaboration.
2. Review themes and findings from the comprehensive assessment of the existing behavioral health and crisis response system and provide input on systems issues and gaps.
3. Provide written update on Subcommittee formation.
4. Confirm action items and next steps.

5. Hear public comment. Jamie provided an overview of the public comment process to occur at the end of the meeting. Public comments are also welcome in written form at any point throughout the process and may be submitted to HCAprogram1477@hca.wa.gov.

PERSONAL STORY

Steering Committee member Bipasha Mukherjee introduced both speakers for personal stories. Jim Vollendroff and Cathy Callahan both shared their personal stories of experience with the crisis response system. Recordings of these stories are available on the CRIS webpage as part of the November 16 CRIS meeting recording.

ICE MELTER

What—if any—lifestyle changes you’ve made in the last 20 months to cope with the pandemic do you think you may want to retain, even as life returns to “normal?”

DISCUSSION

COMPREHENSIVE ASSESSMENT OF THE BH AND CRISIS RESPONSE SYSTEM—KEY THEMES AND GAPS

Mark Podrazik, of Health Management Associates led a brief presentation on the details of each of the 9 key themes identified in the report, with various subthemes.

1. AVAILABILITY OF THE CONTINUUM OF SERVICES

- 1.1 The manner in which funds are distributed can impact the continuum of services available for those who are Medicaid eligible and those who are not Medicaid eligible.
- 1.2 The number of Crisis Lines varies across regions.
- 1.3 Mobile Crisis Teams are present in every region, but the availability (turnaround time) can vary across the state. Crisis Stabilization Units are not available in some parts of the state and not easily accessible in many parts of the state.
- 1.4 Preventative services and programs such as warmlines and walk-in clinics are not consistently available across the state.
- 1.5 Crisis Respite programs, including Peer Respite, are not funded in all regions.

2. UTILIZATION OF SERVICES

- 2.1 The volume of crisis calls (controlled for population size in each region) varies across regions.
- 2.2 Mobile crisis team utilization and responsiveness varies greatly across regions.
- 2.3 The rate of involuntary placements also varies across regions of the state.
- 2.4 There continues to be an over-reliance on inpatient psychiatric beds because preventative or other diversion services are not consistently accessible.
- 2.5 The Single Bed Certification process continues to be in place which allows for care of the psychiatric patient in the absence of a community alternative.

3. ACCOUNTABILITY FOR THE PROVISION OF CRISIS SERVICES

- 3.1 For Medicaid clients, the scope of what the BH ASOs deliver under crisis services narrowed. The Medicaid MCOs took over responsibility for more of the crisis services
- 3.2 For non-Medicaid clients, however, the scope of what the BH ASOs deliver under crisis services did not narrow. In other words, the BH ASOs offer some crisis services to non-Medicaid clients but not to Medicaid clients.
- 3.3 There appears to be different interpretations across the state as to where responsibility of crisis services to Medicaid clients begins and ends between the BH ASOs and the MCOs.
- 3.4 The BH ASOs no longer have real-time data on crisis encounters for Medicaid members for all crisis services in the continuum.

- 3.5 Alternatively, the MCOs do not have all information on their Medicaid clients related to crisis services due to varied levels of tracking and reporting by the BH ASOs to the MCOs.
- 4. FINANCING OF CRISIS SERVICES**
- 4.1 Payments to BH ASOs from the HCA for non-Medicaid clients are based on historical payments and not necessarily on preferred outcomes such as diversion to lower levels of care, when appropriate.
- 4.2 Payments to MCOs from the HCA for Medicaid clients are made on a per member per month (PMPM) basis. There is variation of this PMPM at the regional level, usually because of differences in historical utilization. That is, higher-cost services in the past will drive a higher PMPM.
- 4.3 Payments to BH ASOs from the MCOs for Medicaid clients and the services under BH ASO responsibility are often paid out in advance but later reconciled on a per service basis. Therefore, in order to maximize the initial revenue received, there is an inherent bias to deliver more costly services.
- 4.4 The BH-ASOs often pay their local crisis providers based on capacity for 24/7 availability (“the firehouse model”). Other providers are usually paid directly by the MCO on a per service or per day basis. Providers that may deliver services across the continuum can be reimbursed differently by MCOs and BH ASOs.
- 5. PERSON, FAMILY, AND COMMUNITY-CENTERED APPROACHES TO DELIVERY OF CRISIS SERVICES**
- 5.1 In some regions, services are often rendered in a more, not less, restrictive setting due to lack of alternative options for less-restrictive settings for those in crisis.
- 5.2 Further, the options for individual and family empowerment (e.g., respite, warm line, drop-in) are limited in many regions. This can limit the ability to proactively prevent a crisis and results in a higher reliance on the crisis system itself.
- 5.3 Significant variations in the crisis service continuum and resource restrictions exist in rural communities.
- 5.4 Person-centered, culturally responsive, and trauma-informed approaches are inconsistently applied across the state.
- 5.5 Although peers are used in many settings in many parts of the state, there appears to be consensus that peers can be leveraged even more.
- 6. COLLABORATION IN THE DELIVERY OF CRISIS SERVICES**
- 6.1 Since the implementation of integrated managed care, there is not a coordinated effort between the HCA, the MCOs and the BH ASOs to track the follow-up of clients after a crisis-related event.
- 6.2 The lack of real-time information to providers across the continuum of services can impede more cohesive collaboration.
- 6.3 There are some promising collaborative efforts underway today that should be explored further to leverage across the crisis system.
- 6.4 There is variation across MCOs and BH ASOs in the levels of collaboration and support of community initiatives
- 7. CRISIS SERVICES WORKFORCE**
- 7.1 Recruitment and retention of behavioral health practitioners impacts the access to and availability of crisis services in Washington.
- 7.2 Peer support specialists are under-utilized in many portions of the crisis service continuum.
- 7.3 Regulations and licensure requirements can serve as an additional impediment to crisis service delivery.
- 7.4 Behavioral health workforce training and standards are varied across regions.
- 8. USE OF TECHNOLOGY IN THE PROVISION OF CRISIS SERVICES**
- 8.1 Call centers are using state-of-the-art call management systems to route crisis calls.
- 8.2 Call centers have the ability to report call metrics.

- 8.3 The BH ASO region-based crisis lines are not connected electronically to the three Lifeline call centers.
- 8.4 Health information technology platforms are not being utilized (e.g., bed registry, available outpatient appointments, client-specific ED use or other history) by the call centers or by providers to assist in coordinating and delivering services.
- 8.5 The information flow of services used by Medicaid clients before, during, and after a crisis event between BH ASOs, MCOs, and individual providers is fragmented and inconsistent. Where it occurs, the information is not in real-time.

9. OUTCOMES FROM THE DELIVERY OF CRISIS SERVICES

- 9.1 There is little data collected today at the system level to assess the effectiveness of crisis service delivery (e.g., mobile team response time, diversion to less restrictive care, measures to assess prevention of crisis services).
- 9.2 There is limited fidelity monitoring to determine if Washington’s crisis delivery system aligns with national best practices.
- 9.3 Information to assess individuals’ or families’ experiences with care is limited.
- 9.4 Service utilization data is not being aggregated and analyzed at the statewide level to drive improvement.

INTERACTIVE BREAKOUT GROUPS

CRIS Committee members were divided into 5 breakout groups to discuss the key themes, using the following questions:

1. What are your initial impressions of the key themes?
 - Are they comprehensive enough?
 - Did any of these themes surprise you, and why?
2. What are we missing?
3. Which—if any—of these themes do you relate to based on your own personal and/or professional experience and why?

REPORT-OUT FROM BREAKOUT ROOMS:

Below is a high-level summary of key issues raised during the breakout groups. The project team is developing a tracking tool to provide CRIS members will updates regarding how feedback and comments are being addressed.

- Themes are missing information about first responders, follow-up services, peers, and services available through commercial insurance system.
- Provider perspective is limited.
- Information about the unique services provided for and used by children and youth is needed.
- More clarity is needed around where behavioral health services end and where crisis services start.
- Recognition of the complexity of the crisis services delivery system. If the system is confusing for us, it must be more so for the people trying to use the system
- Recognition of issues around equity (and the quality of care therein) and cultural sensitivity are needed.
- Crisis system data needs to be outcome driven as well as operational.
- The themes are deficit related and not focused also on the positives.
- Upstream services and wrap-around services should also be a focus of the comprehensive assessment. We can have a better crisis response system overall if less people need to use it.

- Theme 9 could be seen as a goal for the CRIS Committee.
- Shared definitions will be important to the committee’s work. Include a Glossary in the report to ensure common shared definitions (including what is the “Crisis System”)
- There are many barriers to communication across different parts of the system.

NEXT STEPS

CRIS Committee members were asked to submit written comments between November 16-November 30th on the themes identified and discussed at the meeting. The project team will incorporate the CRIS member feedback into the report, as appropriate. CRIS members will also be invited to submit comment on the final report. CRIS member comments will be combined into a companion document to the report.

Amber Leaders from Governor Inslee’s office announced the launch of a new Blue Ribbon Commission focused on the intersection of the behavioral health and criminal justice created through an executive order in Spring 2021. The Blue Ribbon Commission will include members of the community, various state agencies and 3 members of the CRIS committee. The CRIS committee will soon have the opportunity to consider who should represent CRIS on the committee. The link to the executive order is:

https://www.governor.wa.gov/sites/default/files/exe_order/eo_21-03.pdf

PUBLIC COMMENT PERIOD

Jamie Strausz-Clark opened the public comment period: 10 people signed up for public comment, and 6 members of the public commented. Individuals were allowed two minutes to provide comment. For individuals with additional comments or time needed, Jamie highlighted the opportunity to submit public comment via email to: HCAprogram1477@hca.wa.gov.

MEETING ADJOURNED