CRISIS RESPONSE IMPROVEMENT STRATEGY COMMITTEE MEETING SUMMARY

Tuesday, February 27, 2024; 1:00 pm to 4:00 pm
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

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ATTENDEES

COMMITTEE MEMBERS

Aleesia Morales, Tacoma Fire Department
Amber Leaders, Office of Governor Jay Inslee
Anna Nepomuceno, National Alliance on Mental Illness (NAMI) Washington
Bipasha Mukherjee, Crisis Line Volunteer
Claudia D'Allegri, Sea Mar Community Health Centers
Connie Chapman, Washington Department of Veterans Affairs
Darcy Jaffe, Washington State Hospital Association
Dillon Nishimoto, Asian Counseling and Referral Service
Fennec Oak, Fennec Oak Counseling
Jane Beyer, Washington State Office of the Insurance Commissioner
Jan Tokumoto, Frontier Behavioral Health
Kashi Arora, Community Health and Benefit, Seattle Children's
Kimberly Mosolf, Disability Rights Washington
Kristen Wells, Valley Cities Behavioral Health Care
Larry Wright, University of Washington School of Social Work
Levi Van Dyke, Volunteers of America Western Washington
Linda Grant, Evergreen Recovery Centers
Michael Robertson, Certified Peer Counselor
Michele Roberts, Washington State Department of Health (DOH)
Michelle McDaniel, Crisis Connections
Puck Kalve Franta, Access & Inclusion Consultant
Representative Tina Orwall, Washington State House
Robert Small, Premera Blue Cross
Teesha Kirschbaum, Washington State Health Care Authority (HCA)

COMMITTEE MEMBERS ABSENT

Adam Wasserman, State 911 Coordinator
Joan Miller, Washington Council for Behavioral Health
Justin Johnson, Spokane County Regional Behavioral Health Division
Krystina Felix, The Kalispel Tribe
Michael Reading, Behavioral Health and Recovery Division, King County

Representative Tom Dent, Washington State House
Ron Harding, City of Poulsbo
Senator Judy Warnick, Washington State Senate
Senator Manka Dhingra, Washington State Senate
Summer Hammons, Treaty Rights/Government Affairs

AMERICAN SIGN LANGUAGE (ASL) INTERPRETERS

Caryl Williams Love
Amber Bahler

COMMITTEE STAFF

Betsy Jones, Health Management Associates
Nicola Pinson, Health Management Associates
Brittany Thompson, Health Management Associates
Chloe Chipman, Health Management Associates (Leavitt Partners)
Jamie Strausz-Clark, Third Sector Intelligence (3Si)
Michael Anderson-Nathe (Anderson-Nathe Consulting)

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 meeting technology and expectations for committee members and public observers. CRIS Committee member Linda Grant welcomed everyone. She shared her experiences with crisis work and detox programs in Washington, highlighting contributions from individuals with lived experience. She noted she is pleased and excited to see changes in the behavioral health field, encouraging CRIS Committee members to continue to look at challenges and solutions.

Jamie then introduced the new CRIS Committee member: Kristen Wells, representing lived experience.

MEETING OBJECTIVES AND AGENDA

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

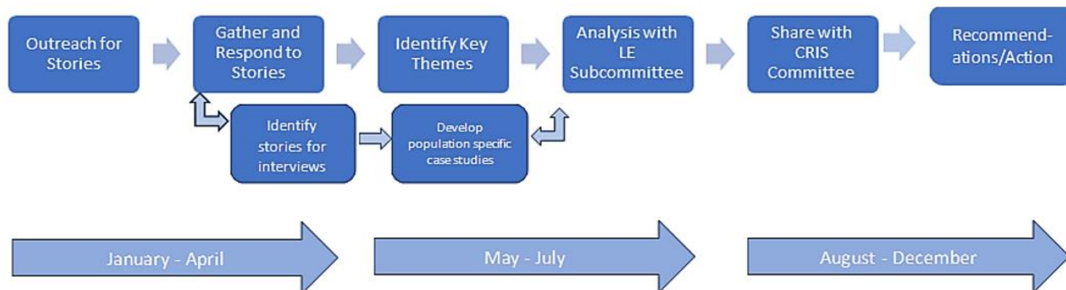
1. Ground our work in the personal stories and experiences of people who encounter the crisis response system.
2. Articulate potential performance metrics for the crisis response system.
3. Confirm action items and next steps.
4. Hear public comment. (Note: Due to lower sign-up numbers, the comment period was shortened. Public comments are welcome in written form at any point throughout the process and may be submitted to HCAprogram1477@hca.wa.gov.)

PERSONAL STORY

CRIS Committee member Kristen Wells introduced Ashley Albert to share their personal story and experience with Washington's crisis response system. Ashley is an advocate and community leader, helping others with similar experiences become decision-makers in their own healing and recovery. Her mom experienced substance use disorder, and Ashley was in foster care from ages 9 to 18, being cared for by her grandmother. Ashley experienced suicidal ideation, post-traumatic stress disorder, and depression. During her childhood, she spent time in juvenile detention facilities and mental health facilities. At 23, she was asked to voluntarily agree to foster care for her children. Her children were later adopted, and she was the first parent in Washington State to legally enforce and modify an open adoption agreement. Ashley has been in recovery for seven years. She emphasized that going through the foster care system and adoption system in Washington is a crisis experiences and noted discrimination she experienced as a woman of color. Ashley now works to help other families, particularly families of color, to better navigate the system. She encouraged the CRIS Committee to consider trauma-informed opportunities for families in the foster care and adoption systems. Ashley has also partnered with the Washington State Coalition Against Domestic Violence to share her book on owning your story and claiming your power (available at: https://wscadv.org/resources/your-story/). Kristen thanked Ashley for sharing with the group, noting that her story can help the CRIS Committee members to consider the trauma that can be caused by systems.

DISCUSSION: State Agency and Lived Experience Subcommittee Updates

Kristen provided an update on the Lived Experience Subcommittee project to gather lived experiences stories of Washington's behavioral health crisis response system to inform system improvements. Based on feedback from the CRIS Committee and Lived Experience Subcommittee, the stories project will seek stories about lived experiences from all populations interested in sharing their experience with any part of the system. The first phase of the project will be a general call for people who have engaged with any aspect of the behavioral health crisis system within the last two years. The project will also identify themes and patterns and leverage demographic information to identify missing communities for further outreach. The second phase of the project will identify stories for interviews. The project will then share stories and themes gathered with the full CRIS Committee and focus on the development of recommendations for system changes needed. The stories may also assist in drafting a Crisis System Consumer Bill of Rights, as identified in the CRIS Committee's 2023 recommendations. The group will continue to report back on progress and request feedback and support from the CRIS Committee.



Committee Discussion

- Anna Nepomuceno noted that NAMI Washington would be interested in supporting the project. NAMI WA has 20 affiliates across the state and can leverage those partnerships to identify individuals that can share their experiences.

CRIS members received the CRIS February Newsletter with state agency and committee updates in advance of the meeting and were given the opportunity to ask questions.

- How are rulemaking process updates selected? For example, the most recent newsletter provided updates on rulemaking processes for the crisis contact hub centers, the 23-hour crisis relief centers, and peer support. However, there are several other rulemaking processes occurring, such as efforts related to agency affiliated counselors which relates to crisis workforce issues.
    - Michele Roberts (WA DOH) noted that the DOH team works to include updates related to crisis system work, particularly rules and laws that are being passed that require rulemaking directly related to CRIS Committee work. The team can discuss updates to confirm additional updates that should be added.
- What is the timeline for executing the contract to conduct work under the award the state received from the National Association of State Mental Health Program Directors? Additionally, are there any other stakeholders that will be engaged in the work beyond the Lived Experience Subcommittee, specifically the psychiatric hospitals and units as places that have the beds listed in the registry?
    - Teesha Kirschbaum (HCA) shared that HCA plans to speak with additional stakeholders including behavioral health providers, emergency departments, first responders, the hospital association, Behavioral Health – Administrative Services Organizations (BH-ASOs), and others as HCA gets into the process. HCA is getting the contracts executed with the organizations supporting the work, after which the timeline may become clearer.
- Are youth/minor beds within the scope of the bed registry program?
    - HCA will address this comment in the next newsletter.
- Is there a timeline for bringing HCA's work to develop mobile response team endorsement standards forward to the CRIS Committee for input? The newsletter notes that these endorsement standards are due by April 1.
    - Teesha will follow up with the HCA team on next steps to communicate work on the mobile crisis team endorsement standards.

DISCUSSION: Performance Metrics for the Crisis Response System

Jamie introduced the discussion on performance metrics for the Washington's crisis response system. This topic will be a focus area for the CRIS Committee in 2024. At this meeting, the Committee will concentrate on identifying potential performance metrics aligned with Washington's behavioral health crisis response system vision and guiding principles (see below). As an example, Jamie facilitated group discussion with

the Committee regarding potential performance metrics aligned with the guiding principle: *People in crisis experience timely access to high-quality, coordinated care without barriers*. Specifically, Jamie engaged CRIS Committee input on the following questions:

- What does this guiding principle mean in practice?
- How might we measure whether this is happening?

Following this group exercise, Committee members were divided into breakout rooms to discuss the meaning and metrics for the remaining guiding principles (see below). **Attachment A** (at the end of this document) includes a summary of CRIS member input on the meaning and potential metrics for Washington's behavioral health crisis response guiding principles.

Washington's Vision and Guiding Principles for Crisis Response and Suicide Prevention

Vision: 988, Washington's Crisis Response: building understanding, hope, and a path forward for those in need, where and when they need it.

People in crisis experience:	The Crisis System is intentionally:
▪ Timely access to high-quality, coordinated care without barriers ▪ A welcoming response that is healing, trauma-informed, provides hope, and ensures people are safe ▪ Person and family centered care ▪ Care that is responsive to age, culture, gender, sexual orientation, people with disabilities, geographic location, language, and other needs	▪ Grounded in equity and anti-racism ▪ Centered in and informed by lived experience ▪ Coordinated and collaborative across system and community partners ▪ Operated in a manner that honors tribal government-to-government processes ▪ Empowered by technology that is accessible by all ▪ Financed sustainably and equitably

Approved by the HB 1477 Steering Committee, May 2022

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BREAKOUT DISCUSSION: Performance Metrics for the Crisis Response System

CRIS Committee members were divided into three breakout rooms to discuss potential metrics for measuring the extent to which each guiding principle is being fulfilled. Jamie facilitated the same activity in the main room with community members. The discussions focused on the following questions:

- What does this guiding principle mean in practice?
- How might we measure whether this is happening?

Breakout Room 1 reviewed the following guiding principles:

- People in crisis experience a welcoming response that is healing, trauma-informed, provides hope, and ensures people are safe.

- The crisis response system is intentionally grounded in equity and anti-racism.
- The crisis response system is centered in and informed by lived experience.

Breakout Room 2 reviewed the following guiding principles:

- People in crisis experience person- and family-centered care.
- The crisis response system is coordinated and collaborative across system and community partners.
- The crisis response system is operated in a manner that honors Tribal government-to-government processes.

Breakout Room 3 reviewed the following guiding principles:

- People in crisis experience care that is responsive to age, culture, gender, sexual orientation, people with disabilities, geographic location, language, and other needs.
- The crisis response system is empowered by technology that is accessible by all.
- The crisis response system is financed sustainably and equitably.

The Main Room with the community members reviewed the following principles:

- People in crisis experience care that is responsive to age, culture, gender, sexual orientation, people with disabilities, geographic location, language, and other needs.
- The crisis response system is centered in and informed by lived experience.
- The crisis response system is coordinated and collaborative across system and community partners.

Committee Discussion

Attachment A (at the end of this document) includes a summary of CRIS member input on the meaning and potential metrics aligned with Washington's behavioral health crisis response guiding principles.

ACTION ITEMS AND NEXT STEPS

Next steps and action items for the meeting:

- HMA to synthesize and summarize CRIS discussion of potential performance metrics aligned with the Washington's crisis response system vision and guiding principles.
- DOH and HCA to provide additional rulemaking updates in the upcoming newsletter, as relevant.
- HCA to provide updates on the award for bed registry in the upcoming newsletter, as relevant.
- HCA to provide updates on the endorsement of Mobile Response Teams plans in the upcoming newsletter and/or CRIS meetings, as relevant.

PUBLIC COMMENT PERIOD

Jamie reviewed the public comment process and opened the public comment period: no one signed up for public 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

ATTACHMENT A. Summary of CRIS Committee Discussion and Input on system performance metrics aligned with Washington's Vision and Guiding Principles

Guiding Principle	Meaning	Measurement
People in crisis experience timely access to high-quality, coordinated care without barriers.	We determine what "timely" means, depending on the service, and people in crisis receive services in a timely manner.	Identify targets for providing 1) initial, live response and 2) trained behavioral health response for each type of service and measure whether system is meeting these targets.
	Responders know the system, know what services a person in crisis has already received, and are able to provide informed referrals.	Track how many transitions a person makes before they get the service they need.
		Gather client/customer/consumer satisfaction surveys to ask whether people who accessed the system received a "high-quality service" (i.e., they felt the service was helpful, met their needs, and met their expectations for timeliness).
	Youth have access to evidence-based intervention (e.g., Mobile Response and Stabilization Services - MRSS)	Percent or number of youth who accessed the system who were connected to MRSS.
	Translation services are available to anyone who needs them.	Track how often people ask for help in a language other than English, which language, and whether or not they are able to receive that language support.
People in crisis experience a welcoming response that is healing, trauma-informed, provides hope, and ensures people are safe.	People who accessed the system feel like it was valuable for them to use the services and that they benefited from the services.	Gather qualitative feedback from users about how they experienced the system, e.g., whether it felt trauma-informed, healing, and hopeful; whether they would use it again if they had another crisis.
	People who accessed the system see themselves reflected in the people providing services, meaning the providers may have shared identities with the people they are serving and/or lived experience.	Monitor demographics of workforce--including whether they have lived experience (recognizing that there are privacy limits to what we can ask)
	Responses are appropriately matched to the need, e.g., use of first responders is avoided when a behavioral health response is sufficient.	Monitor first responder vs. behavioral health deployments for appropriateness.
	Users know what they are consenting to when they ask for help.	

Guiding Principle	Meaning	Measurement
	The physical environment (i.e., the facility) is well kept and demonstrates care for individuals in crisis.	Physical space assessments
People in crisis experience person- and family-centered care.	The caller (person in crisis and/or family, when appropriate) defines the crisis, resolution, and whether the crisis has been adequately addressed.	Gather qualitative feedback from users about whether they felt centered (e.g., they felt listened to, they agreed with the documentation of resolution, they offered options for resolution, they did not have to repeat their story multiple times, etc.)
	The caller does not need to tell their story multiple times.	
	The caller is able to explore various options for referrals/resolution and determine which is the right fit.	
	People in crisis are listened to when they have a complaint or grievance about the care they received; they are not dismissed.	
	Responders are trained in motivational interviewing.	
	Mental health advanced directives are followed (e.g., providers have access to mental health advanced directives).	Monitor how often individuals/families are asked about advanced directives, whether they were followed, and why.
	Individuals are asked who they want involved in their care.	
	Families are offered support resources, including respite care.	Quotes from families are included in documentation of resolution.
	Support exists for people who need extra help.	
People in crisis experience care that is responsive to age, culture, gender, sexual orientation, presence of disabilities, geographic location, language, and other needs.	The workforce is trained in provide culturally-responsive, welcoming, trauma-informed, and healing care.	
	Call takers are trained to be responsive to age, gender, sexuality, language needs, and/or presence of an intellectual or developmental disability, including neurodivergence.	Number of trainings provided to call takers on needs related to different identities (e.g., sexuality and gender expression, age, neurodivergence etc.)
	The system is flexible and adapts to the needs of the user. For example, people in crisis with intellectual or developmental disabilities are able to access the services they need, even if they need support with communication and/or activities of daily living.	Demographic information about people who received crisis services crossed with outcomes data about whether or not the services met their needs.
	People in crisis receive the level of support that meets the needs/acuity of their crisis.	Measure whether individuals in crisis have a clear treatment plan focused on what is effective/appropriate rather than just what NOT to do.

Guiding Principle	Meaning	Measurement
	People in crisis feel heard and supported after their experience with calling 988.	Client/customer/consumer feedback loop, including but not only a survey.
	Staff at call centers are representative of the people they serve.	Demographic information about call takers compared to the populations they serve.
	Callers have access to language supports.	Data on calls that included use of an interpreter, including completed calls, dropped or incomplete calls, and calls where the requested language supports were not available.
	People are able to access support through texting (because not everyone is able to make phone calls)	Measure use of text/chat
The crisis response system is grounded in equity and anti-racism	The system is aware of where institutional racism exists and how to mitigate.	Conduct organizational audits to identify and address systemic racism.
	There are embedded and ongoing systems to assess and affect equity and racism.	
	People working in the system routinely and consistently receive training in equity and anti-racism, there are clear expectations about participating, and they are compensated to participate.	Track participation in trainings.
	The system values and treats workers equitably, so they can then show up and treat users equitably.	
	Users are not turned away from receiving help based on their health insurance coverage or lack of carrier pre-authorizations.	Monitor access and outcomes to look for disparities.
	All vested parties in the system pay their share.	Examine funding streams by payer to look for parity/equity.
The crisis response system is centered on and informed by lived experience.	The system adapts to user feedback. There are systems in place to collect user feedback and clear expectations for how that feedback is used.	
	People with lived experience are involved in refining the system at all stages, including after implementation. For example, there is a continuation of a CRIS Lived Experience Subcommittee through and past implementation.	

Guiding Principle	Meaning	Measurement
	There is support throughout the system for gathering and responding to user feedback (e.g., providers distribute and collect user surveys.	
	People in crisis have access to help navigating the crisis response system and there are proactive processes in place to get feedback from people who have had negative outcomes.	
	There are people with lived experience working (i.e., employed, not just volunteering) in all parts of the system, including policymakers.	Monitor employment demographics, including % of state employees working in crisis response who report anonymously that they have lived experience. Monitor proportion of policymakers involved in making crisis response policy report having lived experience.
	Staff with lived experience have clear roles that align with their position (i.e., they aren't just "given everything").	Staff surveys that gather feedback, including on respect and support.
	There are peers interacting with system users at every stage of the crisis care continuum, and peers are being used appropriately (i.e., they are trained in the particular area of response they are addressing).	Track presence of peers at each stage of the continuum, as well as % of users who have interactions with peers.
The crisis response system is coordinated and collaborative across systems and community partners.	All aspects of the system communicate with each other in giving care to a person in crisis, and communication is timely.	
	All providers have in-depth knowledge of services and resources and are able to make informed referrals.	
	There are clear criteria for when to deploy 988 or 911.	Monitor adherence to protocols for deploying first responders vs. behavioral health.
	There is strong, consistent collaboration between 988 and 911 that supports the right response.	
	People in crisis are connected with appropriate resources without being transferred (or asked to call themselves) multiple times or falling through the cracks.	
	Someone holds responsibility for ensuring the system is coordinated and collaborative.	

Guiding Principle	Meaning	Measurement
The crisis response system is operated in a manner that honors Tribal government-to-government processes.	Culturally-driven care is recognized as evidence-based practice throughout the system.	
	There is recognition throughout the system of Tribal practices and that there are meaningful differences between tribes.	
	Staff throughout the workforce are trained in culturally-attuned care.	
	Operating agreements and procedures are in place between tribes and regional crisis partners, and a forum for discussing improvements in service provision.	
	We have identified the critical government to government processes that need to occur so the crisis response system can be successful.	Confirm this has happened.
	There is regular review and update of government-to-government processes.	Include case review of whether these processes have been appropriately implemented. Ask for Tribal feedback on whether this is happening.
The crisis response system is empowered by technology that is accessible to all.	Crisis response resources are accessible via text, chat, and other modes.	Track completed vs. incomplete/dropped contacts with the system.
	Users receive the same level of service, regardless of which mode they use to access the system.	Customer/client/consumer satisfaction surveys and other feedback modes.
	People in crisis can access help in their language, regardless of which mode they use to access the system.	Track completed vs. incomplete/dropped contacts with the system by language.
	People who communicate differently (e.g., hard of hearing, sight impaired, etc.) are able to access the system.	
	The system is easy to use, regardless of the mode of access.	Track trends over time (e.g., decreased interactions with criminal justice system, increases to referrals for social services, etc.)
	Users and providers can quickly and easily see what resources are available.	Confirm that providers have access to these resources.
	Closed-loop referrals (i.e., when a patient enters the system through a healthcare setting and ends up in a social services setting) are happening.	Track number of referrals to social services from health care, track episodes of follow up care as needed to reduce higher level of care.

Guiding Principle	Meaning	Measurement
The crisis response system is financed sustainably and equitably.	System can hire and retain workforce as needed to provide high quality services to all who need it.	Track staffing retention/hiring/turnover.
	System provides competitive salaries in line with other first responders.	Salary comparison
	System has dependable, forecasted long-term funding.	Track funding streams
	Crisis system providers are trained in how to submit claims to private carriers (understanding that when someone is in crisis, asking for insurance information is not optimal.)	Track claims to private insurers.