

HB 1477 SUBCOMMITTEE REPORT

July 2022

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Overview

The HB 1477 Steering Committee formed the following seven Subcommittees to inform the development of recommendations for an integrated behavioral health crisis response and suicide prevention system in Washington. (See figure A for an overview of the HB 1477 Committee Structure.)

1. *Credentialing and Training*
2. *Technology*
3. *Cross-System Crisis Response Collaboration*
4. *Confidential Information Compliance and Coordination*
5. *Tribal 988 (Tribal Centric Behavioral Health Advisory Board)*
6. *Lived Experience*
7. *Rural and Agricultural Communities*

Figure A. HB 1477 Committee Structure



* Five of the seven subcommittees are established by HB 1477. The Steering Committee established two additional subcommittees: Lived Experience, and Rural & Agricultural Communities

This *July 2022 Subcommittee Report* includes a compilation of all subcommittee meeting summaries through June 2022. The Subcommittees are charged to provide professional expertise and community perspectives on discrete topics of focus and will inform the Steering Committee recommendations for an integrated behavioral health crisis response system and suicide prevention system with elements described by HB 1477. Below is high-level overview of the charge of each Subcommittee:

1. **Credentialing and Training Subcommittee** – To inform workforce needs and requirements related to behavioral health system redesign components outlined by HB 1477.
2. **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 and suicide prevention system.
3. **Cross-System Crisis Response Subcommittee** – 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. **Confidential Information Compliance and Coordination** – To examine and advise on issues related to sharing and protection of health information needed for an effective behavioral health crisis response and suicide prevention system.
5. **988 Tribal** – To examine and make recommendations with respect to the needs of tribes related to the 988 system. (Note: The Tribal 988 Subcommittee is facilitated through the [Tribal Centric Behavioral Health Advisory Board](https://drive.google.com/drive/folders/1ug4JHf1feYoqoaKcg380oB1PKnjAK1k8) 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/1ug4JHf1feYoqoaKcg380oB1PKnjAK1k8>.)
6. **Lived Experience** – To provide diverse lived experience perspectives into the development of the Washington behavioral health crisis response and suicide prevention system.
7. **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.

HB 1477 Technology Subcommittee

HB 1477 TECHNOLOGY SUBCOMMITTEE – MARCH 21ST MEETING

Meeting Summary

Monday, March 21, 2022; 1:00 to 2:30pm

Zoom

Attendees

Committee Members

Allie Franklin, Administrator of BH Services, Harborview Medical Center- Behavioral Health Institute

Andy Leneweaver, Deputy WA State 911 Coordinator, Enterprise Systems, State 911 Coordination Office

Brittany Miles, Product Manager Leader

Jeff Bearce, Kent Police Department, Puget Sound Fire Department, Mountain View Fire and Rescue Dept.

Sriram Rajagopalan, Strategic IT Consultant

Ian Boyer, Senior Director of Information Services, Comprehensive Healthcare

Shawna Ernst, Law Enforcement Technology and Operations Manager, Spokane Police Department

Serena Chai, Data Analytics Manager, Washington State Hospital Association

Levi Van Dyke, Volunteers of America Western Washington

Mary-Sara Jones, State & Local Gov. Health & Human Services, Amazon

Michael Reading, Behavioral Health and Recovery Division, King County

Representative Tina Orwall, Washington State House

Jennifer McNamara, Chief Information Officer, Washington State Department of Health (DOH)

Kelly McPherson, State Health Information Technology Coordinator, Washington State Health Care Authority

Trinidad Medina, Chief Executive Director, Great Rivers BH-ASO

Gregg Browngoetz, Senior Director of Information Technology, Crisis Connections

Paul Arguinchona, Chief Information Officer, Frontier Behavioral Health

Facilitation Staff

Betsy Jones, Health Management Associates

Nicola Pinson, Health Management Associates

Suzanne Rabideau, Health Management Associates

State Agency Staff

Huong Nguyen, Washington State Health Care Authority (HCA)

Jennie Harvell, HCA

Jerry Britcher, HCA CIO

Christopher Chen, HCA

Lucille Mendoza, HCA (Office of Tribal Affairs)

Malia Moore, Gevity, HCA Contractor

Stalling Duenas, Gevity, HCA Contractor

Todd Mountin, Washington Department of Health (DOH)

TOPIC	DISCUSSION
Welcome, Introductions, Review Meeting Agenda	Betsy Jones (HMA) began the meeting with a welcome to the Subcommittee and review of the meeting agenda. Each meeting participant then introduced

TOPIC	DISCUSSION
	<p>themselves as subcommittee members and supporting staff. The meeting included the following objectives:</p> <ol style="list-style-type: none"> 1. Understand charge and role of the Technology Subcommittee. 2. Understand plans for the July 988 launch. 3. Understand HB 1477 Technical and Operational Plan Workplan and opportunities for input. 4. Discuss progress to date. 5. Confirm action items and next steps.
<p>Charge and Role of the Technology Subcommittee</p>	<p>Members reviewed the charge of the 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 and suicide prevention system.</p> <ul style="list-style-type: none"> • Identify issues for consideration in development of the technology and platform needed to support HB 1477 requirements. • Review and provide input into HB 1477 Section 109 Technical and Operational Plan under development by HCA and DOH. <p>The Steering Committee approved the CRIS High-Level Workplan, which will provide an organizing framework for our work ahead to ensure the full continuum of crisis response. The High-Level Workplan includes five objective areas:</p> <ul style="list-style-type: none"> • Objective 1: A place to contact – NSPL call centers • Objective 2: Someone to come – Mobile crisis rapid response teams • Objective 3: A place to go – Broad range of crisis stabilization services • Objective 4: Pre- and Post-Crisis Care – Immediately upstream and downstream of crisis events • Objective 5: Crisis system infrastructure and oversight <p>State agencies are responsible for implementation of this work, and the Steering Committee, CRIS Committee, and Subcommittees will provide recommendations. State agency partners will be providing regular and timely updates regarding implementation planning across the crisis response continuum to engage meaningful committee feedback.</p>
<p>988 NSPL July Launch</p>	<p>Todd Mountin, DOH, gave legislative background and update on the 988 NSPL July Launch.</p> <ul style="list-style-type: none"> • The federal 988 Implementation Act established the new National Suicide Prevention Line 3-digit 988 number to improve access to support for individuals in crisis.

TOPIC	DISCUSSION
	<ul style="list-style-type: none"> • Washington’s House Bill 1477 built on this federal legislation with the goal of improving access across the entire continuum of crisis care. The July 988 launch is a major step in the beginning of this larger process. • Beginning in July, people dialing 9-8-8 will be routed to one of three NSPL call centers located in Washington; text and chat will be available as well. <ul style="list-style-type: none"> ○ Note that new technology applications are not needed for July. • DOH is working with the three NSPL calls centers to ensure their capacity to answer calls. The addition of 988 will not disrupt other services, current crisis phone lines and services will remain in place. • NSPL calls are routed based on the caller’s area code (<i>i.e.</i> people with WA area codes are routed to the Washington call centers). The NSPL administrator, Vibrant, currently manages this call routing. • The Washington Indian Behavioral Health Hub will also launch a crisis line for tribal-affiliated individuals in July. <p><i>Questions/Discussion:</i></p> <ul style="list-style-type: none"> • Calls are already being routed to the centers today, so more specifically, calls dialed using the three digits 9-8-8 - will now be routed to the centers. Correct? – Yes • Will 988 calls be routed to the new tribal line or is it completely independent? – Still working on what routing for Tribal Line will look like. Routing is done by Vibrant. Ultimately, goal is to have front-end choices and messaging to enable routing. • Is the routing effort done by NSPL? – Yes, it is done by Vibrant, the administrator of NSPL.
<p>Section 109 Technical and Operational Workplan</p>	<p>Health Care Authority staff presented progress on work to develop the HB 1477 Section 109 Technical and Operational Plan.</p> <ul style="list-style-type: none"> • Stakeholder outreach updates: <ul style="list-style-type: none"> ○ Crisis provider listening sessions are in progress. Completed listening session with Designated Crisis Responders. Upcoming listening sessions will focus on Facility Based Crisis responders; Community Based Alternatives. ○ BH-ASOs Survey: Closes March 24th ○ Tribal Subcommittee Meeting: reviewed the Technical and Operational Plan and planning upcoming Tribal Roundtables. ○ Military Department: Coordinate workflow between 911 and 988, including information sharing/confidentiality • Technical solutions updates: <ul style="list-style-type: none"> ○ Plan to evaluate systems against functional requirements for Washington. ○ Note that existing bed registry systems are manual and not real time.

TOPIC	DISCUSSION
	<ul style="list-style-type: none"> • Interviews underway with other states: Colorado, Arizona, Michigan, and Georgia. Key themes to date: <ul style="list-style-type: none"> ○ States are monitoring Vibrant. ○ States have regional crisis Lines ○ Variation in terms of bed registry implementation ○ Variability on Provider /Resource directory ○ Some States considering the importance of owning/retaining access to underlying databases ○ No system-to-system integration with 911 (states have either portal view or phone) <p><i>Discussion:</i></p> <ul style="list-style-type: none"> • <i>Location tracking:</i> Question about whether geo-location creates privacy concerns for NSPL callers. Location information is essential for 1) being able to route the call to the crisis center that should be the initially answering center, and 2) for identifying the location of the caller to ensure they can be found in the worst case. At the same time, it is important that people contacting NSPLs have the ability to maintain privacy. If there is fear in communities about law enforcement responding or knowing location, this could be a barrier to calling 988. From a call center perspective, having a system built for call centers specifically would be important. <ul style="list-style-type: none"> ○ Location tracking and privacy issues should be shared with the Confidential Information Subcommittee. ○ Key questions: Does geolocation tracking/caching present a privacy concern? Do users need to opt-in? How long would systems maintain that information? • <i>Choice of technology platforms:</i> Recognition of critical decision regarding choice of technology platforms. HCA working to establish system functional requirements and will conduct vendor analysis to examine which systems meeting Washington’s need, including Vibrant system capacities. Vibrant has indicated that it will give this platform at no cost which has to be a consideration. <ul style="list-style-type: none"> ○ Next step to bring framework to subcommittee for how HCA/DOH going to make decision about Vibrant or another vendor. • <i>Rural area considerations:</i> Concern about 'one size fits all' solutions since we do have cellular reception issues in our rural communities. It is critical that we our technology can serve our urban and rural communities. • <i>Interstate collaboration in 911</i> at the state level is very active and frequent and includes 988 discussions to ensure the 911 community (at

TOPIC	DISCUSSION
	<p>the state level) is aware of what's going on with 988 in their own state as well as the other states.</p> <p><i>Comments in chat during presentation:</i></p> <ul style="list-style-type: none"> • 911 has solved all of these routing issues • The point about 25% of Coloradans having non-Colorado phone numbers is not at all unusual. This is due to the various telecommunications deregulation which allows for number portability. This means that telephone numbers are no longer specific to a particular location after purchasing service. • AZ contracted for development of a closed loop solution last year. Development continues.
<p>Next Steps & Wrap Up</p>	<ul style="list-style-type: none"> • Next step to bring framework to next subcommittee for how HCA/DOH going to make decision about Vibrant or another vendor. • Next meeting to be scheduled in April.

HB 1477 TECHNOLOGY SUBCOMMITTEE – APRIL 25TH MEETING

Meeting Summary

Monday April 25, 2022, 2:30 pm to 4:00 pm

Zoom

Attendees

Subcommittee Members

Adam Wasserman, WA State 911 Coordinator, Washington State Emergency Management Division
Andy Leneweaver, Deputy WA State 911 Coordinator, Enterprise Systems, State 911 Coordination Office
Brittany Miles, Product Manager Leader
Jennifer McNamara, Chief Information Officer, Washington State Department of Health (DOH)
Kelly McPherson, State Health Information Technology Coordinator, Washington State Healthcare Authority
Levi Van Dyke, Volunteers of America Western Washington
Michael Reading, Behavioral Health and Recovery Division, King County
Paul Arguinchona, Chief Information Officer, Frontier Behavioral Health
Rena Cummings, Project Manager II, CHPW
Rep. Tina Orwall, State Representative
Senator Manka Dhingra, Washington State Senate
Serena Chai, Data Analytics Manager, Washington State Hospital Association
Shawna Ernst, Law Enforcement Technology and Operations Manager, Spokane Police Department
Sriram Rajagopalan, Strategic IT Consultant
Trinidad Medina, Chief Executive Director, Great Rivers BH-ASO

Facilitation Staff

Betsy Jones, Health Management Associates
Nicola Pinson, Health Management Associates
Elizabeth Tenney, Health Management Associates

State Agency Staff

Huong Nguyen, Washington State Healthcare Authority (HCA)
Lucille Mendoza, HCA
Jennie Harvell, HCA
Vishal Chaudhry, HCA
Jerry Britcher, HCA
Sherry Wylie, HCA
Eliza Tharp, HCA
Matthew Gower, HCA
Luke Waggoner, HCA
Wyatt Dernbach, HCA
Ruth Leonard, HCA
Todd Mountin, Washington Department of Health (DOH)

TOPIC	DISCUSSION
Welcome, Introductions, Review Meeting Agenda	<p>Betsy Jones, Health Management Associates, welcomed everyone to the meeting and staff and subcommittee members introduced themselves. The meeting included the following objectives:</p> <ol style="list-style-type: none"> 1. Update on progress of HB 1477 Technical and Operation Plan Workplan 2. Update on HB 1477 committee activities and work to develop crisis response system process map 3. Discuss key system functional requirements and criteria to make system selection
Progress Updates	<p>Betsy overviewed the role of the Steering Committee, CRIS Committee, and subcommittees. Members reviewed the charge of the 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 and suicide prevention system, including review and input into HB 1477 Section 109 Technical and Operational Plan under development by HCA and DOH.</p> <p>Betsy provided an update on other subcommittee activities, as well as work to develop a behavioral health crisis system process map. The process map will bring together an understanding of current system interfaces, gaps, and changes needed. This will serve as a foundational tool to inform agency and subcommittee work.</p> <p>Kelly McPherson and Jennie Harvell, Washington State Health Care Authority (HCA), gave process updates on development of the Technical and Operational Plan, including:</p> <ul style="list-style-type: none"> • Crisis provider interviews (completed) • Other state interviews – Indiana, Colorado, Arizona, Michigan, Georgia, Oklahoma (in progress) • High-level functional requirements (in progress) – this topic is being brought forward to the subcommittee at today’s meeting. <p>Subcommittee members offered the following feedback and questions after these updates:</p> <ul style="list-style-type: none"> • What is the role of this subcommittee with the Technical and Operational Plan? – The subcommittee serves in an advisory role to provide review and input as HCA and DOH develops the Technical and Operation Plan. HCA and DOH will bring forward key issues for the subcommittee’s input and feedback. • Are there expectations that the Technology Subcommittee will assist with the 988 rollout in July? – There are no technology system changes occurring with the July 988 rollout. Current systems will remain in place.

TOPIC	DISCUSSION
	<ul style="list-style-type: none"> • Is there flexibility for different technologies? – Yes, states are evaluating technologies based on specific functionality needs by each state. These systems will need to be interoperable with the national Vibrant platform. • Oregon has developed an open bed platform system that allows border hospitals to triage bed availability along with a referral system. This technology should be taken into consideration here; it would be great to see what other hospital systems are adopting. • It would be helpful to have more information on other state activities and a summary of findings for each state. – Preliminary information about other state activities was shared during the March technology subcommittee meeting. Further updates on findings from other states will be brought forward to the subcommittee.
<p>Key System Functional Requirements and Process to Evaluate System Solutions</p>	<p>Huong Nguyen, HCA Data Architect, reviewed the technology system functional requirements identified by the HCA team. The HCA team reviewed HB 1477 to identify required and preferred system requirements. A list of required and preferred functional requirements have been identified in the following categories: 1) Call Center Platform (Create, Assign, and Track), 2) Responder Dispatching (Search, Dispatch, and Track), 3) Referral and Appointments (Search, Create, Assign and Track), 4) Bed Registry (Search, Schedule, and Report), 5) Reporting (Create, Customize, Share), 6) Other requirements. At the next meeting staff will recap the review of Functional Requirements and areas of input requested by the subcommittee. These requirements will inform next steps to define details for each requirement, gather information from other states, and evaluate vendor capabilities.</p> <p>Subcommittee discussion focused on the call routing system and geo-location capabilities. The current system for call routing through NSPL is based on caller phone number area code. 911 calls are routed by geolocation. Subcommittee members asked questions about the current process and provided feedback:</p> <ul style="list-style-type: none"> • Calls need to be routed to the correct place, but privacy concerns are important to address. • Washington has the opportunity to leverage some of 911’s in-state routing functions as opposed to relying on the NSPL call routing process by caller phone area code. • The call routing issues are being handled at the federal level. Does Washington need to solve this issue when there is work being done nationally and the state already has finite resources? • HB 1477’s legislative intent with GPS is to locate the crisis teams, not the callers.

TOPIC	DISCUSSION
	<ul style="list-style-type: none"> For tracking the location of responders, it would be helpful for responders to be able to see the location of other responders for safety and situational awareness.
Next Steps & Wrap Up	<p>At the next meeting the group will review a recap of system functional requirements, an update on the ongoing GPS and geolocation conversations, and plans for future subcommittee input into the Technical and Operational Plan. The next subcommittee meeting will be May 23rd from 1pm – 2:30pm. Monthly calendar invites will be sent to attendees going forward.</p>

HB 1477 TECHNOLOGY SUBCOMMITTEE – MAY 23, 2022 MEETING

Meeting Summary

Monday, May 23, 2022; 1:00 pm to 2:30pm

Zoom

Attendees

Subcommittee Members

Brittany Miles, Product Manager Leader
Ian Boyer, Senior Director of Information Services, Comprehensive Healthcare
Jennifer McNamara, Chief Information Officer, DOH
Kelly McPherson, State Health Information Technology Coordinator, HCA
Kevin Bromer, Executive Director, Health of Technology and Data Strategy, Ballmer Group
Levi Van Dyke, Volunteers of America Western Washington
Mary-Sara Jones, State & Local Gov. Health & Human Services, Amazon
Paul Arguinchona, Chief Information Officer, Frontier Behavioral Health
Rena Cummings, Project Manager II, CHPW
Representative Tina Orwall, State Representative
Senator Manka Dhingra, Washington State Senate
Shawna Ernst, Law Enforcement Technology and Operations Manager, Spokane Police Department
Sriram Rajagopalan, Strategic IT Consultant
Trinidad Medina, Chief Executive Director, Great Rivers BH-ASO

Committee Staff

Betsy Jones, Health Management Associates
Nicola Pinson, Health Management Associates
Elizabeth Tenney, Health Management Associates

Agency Staff

Huong Nguyen, HCA
Jennie Harvell, HCA
Jerry Britcher, HCA
Debbie Spaulding, HCA
Eliza Tharp, HCA
Jack Kent, HCA
Lonnie Peterson, HCA
Matthew Gower, HCA
Lucilla Mendoza, HCA
Michelle Izumizaki, DOH
Todd Mountin, DOH

Additional Participants

Senator Joe Nguyen, Washington State Senate

TOPIC	DISCUSSION
<p>Welcome, Introductions, Review Meeting Agenda</p>	<p>Betsy Jones, Health Management Associates (HMA), welcomed everyone to the meeting and shared the following meeting objectives:</p> <ol style="list-style-type: none"> 1. Update on HB 1477 committee activities and work to develop crisis response system process map 2. Update on work to schedule Vendor demonstrations 3. Request for Subcommittee Input: key system functional requirements, including GPS and In-state call routing 4. Request for Subcommittee Input: Review technical options and considerations for storing and making Mental Health Advance Directives available during times of crisis. 5. Overview of Final Technical and Operational Plan development and future Technology Subcommittee agenda topics
<p>Committee Updates</p>	<p>Betsy updated the subcommittee on recent activity from other committees and workgroups.</p> <ul style="list-style-type: none"> • The Ad Hoc Workgroup on Vision finalized the draft vision statement and guiding principles, with input from the CRIS Committee and several subcommittees, and presented them to the Steering Committee on May 19th. Steering Committee members are currently voting on finalizing the statement and guiding principles via email. The draft vision and guiding principles are included in meeting materials. • Work sessions were held in March and April with 911, 988 call centers and regional crisis line representatives to develop a crisis system process map. The purpose of this work is to bring together an understanding of the current system, interfaces, gaps and changes needed. <p>Kelly McPherson, Washington State Healthcare Authority (HCA), updated the subcommittee on discussions regarding request to schedule vendor demonstrations for the subcommittee. Jack Kent, HCA attorney, joined to address questions relating to the procurement process and the committee’s neutrality in engaging in demonstrations. The purpose of the demonstrations would be to give committee examples of what crisis system technology systems can look like.</p> <p>What would be the subcommittee’s preference on vendor demonstrations and logistics? The group stated they would like demonstrations and discussed options going forward:</p> <ul style="list-style-type: none"> • There could be a RFI process so that all vendors would receive information and be able to respond. More time would be needed in this case for the subcommittee to listen to the vendors. • Another option is different states could show what technology they are using.

TOPIC	DISCUSSION
	<ul style="list-style-type: none"> • Key decision criteria could be listed in the RFP and subcommittee members could use that for evaluation. This could help distinguish vendors from one another and help members understand what meets certain criteria and what does not. • Jennie Harvell, HCA, asked if members of the subcommittee can participate in an evaluation panel for the RFP if they are engaging in vendor demonstrations now on their own. Jack answered that those who participate in the evaluation would be asked to sign a confidentiality and conflict of interest document that says they are not aware of a conflict of interest but will notify the procurement coordinator if this situation changes and take the appropriate action. • Subcommittee members shared they would be open to scheduling additional subcommittee meetings for these demonstrations. <p>Next steps are for the HMA project team to review potential options for scheduling technology vendor demonstrations and send a follow up email to the committee.</p>
<p>Request for Subcommittee Input: Key System Functional Requirements</p>	<p>Jennie Harvell and Huong Nguyen, HCA, updated the subcommittee on GPS, in-state call routing, and other the key system functional requirements.</p> <p>HCA prepared a briefing paper on GPS and in-state call routing and HB 1477 requirements that was shared with the Steering Committee last week. Staff will send this briefing paper to subcommittee members.</p> <ul style="list-style-type: none"> • GPS vs. Geo-location: The paper explains the difference between GPS and geo-location. For purposes of the Final Technical and Operational Plan, HCA and DOH are interpreting the phrase GPS to mean geo-location technology. HCA anticipates that the plan will contain technology recommendations that use geo-location to map and track locations of the caller, responders, and firefighters. The plan is anticipated to recommend technology solutions that also work with geo-location tools. • For in-state call routing, HCA and DOH will explore 911 capabilities and whether this can be utilized with 988 to ensure in-state call routing. <p>Representative Orwall noted concern with in-state call routing not going through the NSPL system and having Washington create a new system within the state. The lines are designed to be part of a national system, and it would be costly to create a whole new system at the state level when the system already exists at the national level. Subcommittee members discussed in-state call routing options and the current system. NSPL and Vibrant currently have the capacity to route calls to an in-state backup center as opposed to a national back-up center, which could be established.</p> <p>Huong Nguyen, HCA’s Data Architect, recapped April’s meeting and the key functional requirements discussion. She overviewed functional requirements not found in HB 1477 statutory requirements that were identified through stakeholder processes, and</p>

TOPIC	DISCUSSION
	<p>she discussed the requirement, the recommended functionality, and how it might operate. Subcommittee members discussed the bed registry system and how it could operate.</p> <p>Follow up: Share GPS and in-state call routing briefing paper with subcommittee members for comment by Friday, June 3rd.</p>
<p>Request for Subcommittee Input: Mental Health Advance Directives</p>	<p>Jennie Harvell provided a background on mental health advance directives, which allow individuals to document in advance what they would want to happen when their health problems become severe enough to need assistance from others. She shared links outlining information regarding these directives, and an example template (see meeting materials).</p> <p>HCA presented several questions for the subcommittee’s input:</p> <ul style="list-style-type: none"> • What technology platforms and tools would be effective for creating, storing, sharing, and accessing these directives? • How can interoperable exchange of and access to these directives be supported during times of crisis? • What data governance policies and procedures should be considered for the platform? • What method could be used for privacy and security? <p>Follow up: HCA requested feedback from subcommittee members by Friday, June 3, 2022.</p>
<p>Overview of Final Technical and Operational Plan</p>	<p>Kelly McPherson, HCA, reviewed the process for developing the Final Technical and Operational Plan.</p> <ul style="list-style-type: none"> • A draft Technical and Operational Plan was submitted to the legislature in January, and is available on the HCA website (https://www.hca.wa.gov/assets/program/draft-leg-report-988-operational-plan.pdf). The draft Technical and Operational Plan was shared with the Technology Subcommittee for comment in January. • The Final Technical and Operational Plan will be a plan for how to procure technology solutions to enable the implementation of HB 1477. HCA is engaging the following activities in the development of the Final Plan: <ul style="list-style-type: none"> ○ Information gathering from several sources (Crisis Call Lines, Providers/Responders, States, Technology Vendor, and other groups). ○ Identifying functional requirements for needed platforms/technology systems ○ Gathering information from vendors based on HCA criteria to identify vendors for interviews. ○ Participation in CRIS Committee/Subcommittee meetings

TOPIC	DISCUSSION
	<ul style="list-style-type: none"> • Potential future agenda topics for the Technology Subcommittee include: <ul style="list-style-type: none"> ○ Presentation of state crosswalk (June) ○ Crisis provider interview summary (July) ○ BH-ASO/RCLs crosswalk (July) ○ Final Plan (August) <p>Subcommittee members noted that it would be helpful to see a high level version of the state crosswalk at the next meeting.</p>
<p>Next Steps and Wrap Up</p>	<p>Betsy asked if subcommittee members would rather take up their remaining meetings with demonstrations and receive written updates from HCA, or if they would like to schedule demonstrations outside of subcommittee meetings and continue conversations with HCA during regular subcommittee meeting times. Subcommittee members agreed to have additional meetings for vendor demonstrations. HMA will work on scheduling these, as well as follow up on other agenda items noted throughout this meeting.</p> <p>Additional follow up: Share GPS and in-state call routing briefing paper with subcommittee members for comment by Friday, June 3rd; Request for additional subcommittee feedback on MHADs by Friday, June 3, 2022.</p> <p>The next meeting will be on June 20th from 1:00 – 2:30pm. (New meeting date identified for June 22, 1:00-2:30pm due to conflict with Juneteenth holiday)</p>

HB 1477 TECHNOLOGY SUBCOMMITTEE – JUNE 22, 2022 MEETING

Meeting Summary

Wednesday June 22, 2022, 1:00 pm to 2:30 pm

Zoom

Attendees

Subcommittee Members

Kelly McPherson, State Health Information Technology Coordinator, Washington State Healthcare Authority
Levi Van Dyke, Volunteers of America Western Washington
Mary-Sara Jones, State & Local Gov. Health & Human Services, Amazon
Paul Arguinchona, Chief Information Officer, Frontier Behavioral Health
Rena Cummings, Project Manager II, CHPW
Rep. Tina Orwall, State Representative
Serena Chai, Data Analytics Manager, Washington State Hospital Association
Shawna Ernst, Law Enforcement Technology and Operations Manager, Spokane Police Department
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Matthew Gower, HCA
Luke Waggoner, HCA
Wyatt Dernbach, HCA
Ruth Leonard, HCA
Todd Mountin, Washington Department of Health (DOH)
Jenn Combes, DOH

TOPIC	DISCUSSION
Welcome, Introductions, Review Meeting Agenda	<p>Betsy Jones, Health Management Associates (HMA), welcomed everyone to the meeting and shared the following meeting objectives:</p> <ol style="list-style-type: none">1. Update on work to schedule Vendor demonstrations.2. Update on GPS/Geo-location, In-State Call Routing, and Mental Health Advanced Directives.3. Overview of state crisis system technologies and functionalities.4. Request for input on other state crisis system technology RFPs.

TOPIC	DISCUSSION
	<p>5. Provide overview of process for gathering input to embed equity into the CRIS High Level Workplan and request for Subcommittee to submit input by email.</p>
<p>Committee Updates</p>	<p>HMA is in the process of scheduling vendor demonstrations for subcommittee members. Four vendor demonstrations have been scheduled and two are in progress. HMA is requesting that demonstrations will be recorded for subcommittee members who are not able to join at the scheduled times.</p> <p>Kelly McPherson and Jennie Harvell with Washington State Health Care Authority (HCA) shared the following updates:</p> <ul style="list-style-type: none"> • Provided an update on development of the Section 109 Technical and Operational Plan. Discussed HCA’s information gathering progress and expectations for the Final Plan to include recommendations to pursue RFIs and/or RFPs for systems to support the crisis call center platform and enhanced behavioral health client referral system. HCA and DOH have requested an extension on the delivery of the final plan to October 31, 2022, to allow time for committee comments. • Updated the subcommittee on GPS, geolocation, and in-state call routing. The FCC and SAMHSA met in late May to discuss 988/911. There was widespread agreement that using 911 infrastructure to support 988 routing for call, text and chat for crisis response and timely provision of services is important. The FCC and SAMHSA will develop a phased approach for implementing this for 988 calls/response. • Discussed potential new mental health advance directives technology. HCA is exploring the feasibility of using WA-Notify technology for mental health advance directives. At the July technology subcommittee meeting, two experts who led development for this technology will discuss its potential use for mental health advance directives.
<p>Other State Crisis System Technology Overview and Crosswalk</p>	<p>Kelly McPherson and Jennie Harvell with Washington State Health Care Authority (HCA) shared information about technology systems that has been gathered based on interviews with other states. She and Jennie provided a summary of Arizona, Colorado, Oklahoma, Indiana, Georgia, Maryland, Michigan, and Oregon’s Crisis Technology System, which included detailing the following:</p> <ul style="list-style-type: none"> • State structure for their crisis system • Current behavioral health process and technology • Future technology and integrations • Reporting (for Georgia) • Referrals and registries (for Maryland and Oregon) <p>The Subcommittee discussed the following topics:</p>

TOPIC	DISCUSSION
	<ul style="list-style-type: none"> • Arizona’s vendor, Solari, plans to align with the Vibrant platform. Solari has a robust system and they will not move to the Vibrant platform but they will make sure it is interoperable with the platform. Solari will not be doing text and chat for the state or Arizona. • Why were these states chosen? These states were identified as aligning or aligning closely with HB 1477 requirements or they were brought up in meetings as a state of interest. • Does Colorado have a system for referrals? No, right now referrals are handled by phone and warm hand-offs. They have a resource directory developed by the call centers that is updated regularly. It is not clear if the resource directory was part of the call center platform, Zoho. • Colorado and Arizona both use Contexture for their health information exchange. • Indiana appears to be more at the planning stage for their crisis system and reviewing technology systems they might need. • Does Georgia’s crisis technology system meet all the requirements that HB 1477 has called out? The intent of Georgia’s system mirrors most of the requirements called out by HB 1477, but the actual capabilities of their system do not meet those expectations. • Michigan’s system also closely mirrors the functional requirements identified in HB 1477. • Does Michigan have geolocation capabilities or not? HCA will need to follow up on this question. • How well does Oregon’s transition for dispatching work? HCA will need to follow up on this question. <p>HCA summarized several findings from other state activities, noting that:</p> <ul style="list-style-type: none"> • Five out of the seven states are using NSPLs for responder dispatching and are exploring 911/988 relationships. • Four out of seven of the states currently have or are in the process of implementing a bed registry and are not moving forward with Vibrant UP. • One state of the seven is using a regional dispatch system (Oregon) • One state of the seven is in the procurement phase for call centers (Indiana) <p>HCA invited subcommittee members to review and provide feedback regarding other state crisis technology contracts and RFPs (Arizona, Oklahoma, Oregon, Indiana, Ohio). HMA will follow up to provide the documents and/or links to the documents after the meeting.</p>

TOPIC	DISCUSSION
Request for Subcommittee Input: Embedding Equity into the CRIS High Level Workplan	<p>HMA provided background regarding HB 1477 charge to committees to develop recommendations to promote equity in services for an integrated behavioral health crisis response and suicide prevention system. HMA requested feedback from this subcommittee on ways to embed equity into the CRIS High-Level Workplan with a focus on technology systems. HMA reviewed the High Level Workplan and provided examples of feedback that was gathered from the CRIS Committee. HMA will send a word version of the workplan to the subcommittee after the meeting; feedback is requested by July 15th.</p>
Next Steps and Wrap Up	<ul style="list-style-type: none"> • HMA is following up with Vendor demonstration scheduling information. • HMA will send the following to members: <ul style="list-style-type: none"> ○ The spreadsheet of key functional requirements from HCA; ○ The other state RFP documents and links that HCA requested the subcommittee review; and ○ The CRIS High Level Workplan, with a request for subcommittee feedback on activities to embed and promote equity by July 15th. <p>The next meeting will be on July 18th from 1:00pm – 2:30pm.</p>

HB 1477 Lived Experience Subcommittee

HB 1477 LIVED EXPERIENCE SUBCOMMITTEE – MARCH 21ST MEETING

Meeting Summary

Monday, March 21, 2022, 3:00 pm to 5:00 pm

Zoom

TOPIC	DISCUSSION
<p>Welcome, Introductions, Review Meeting Agenda</p>	<ul style="list-style-type: none"> • HB 1477 Steering Committee member Bipasha Mukherjee welcomed everyone to the meeting and introduced the project team the Lived Experience Subcommittee. Bipasha is the Steering Committee member representing lived experience. <ul style="list-style-type: none"> ○ CRIS Committee members representing lived experience (Puck Kalve Franta, Michael Robertson, Cathy Callahan-Clem) and Health Management Associates staff (Betsy Jones, Nicola Pinson, Elizabeth Tenney) will be supporting the subcommittee’s meetings and its moderation • The Lived Experience Subcommittee was created to bring people with lived experience into a central role in the crisis response system redesign process, recognizing that lived experience perspectives are critical to help the CRIS and Steering Committees develop recommendations for a more robust, stable, and equitable system across the state.
<p>Charge for Lived Experience Subcommittee & Future Meeting Plans</p>	<ul style="list-style-type: none"> • Jim Vollendroff provided context on the formation of the Lived Experience Subcommittee, and the overall HB 1477 CRIS, Steering Committee and Subcommittee structure. • Under HB 1477, the Steering Committee, with input from the CRIS and subcommittees, is charged to make recommendations for an integrated behavioral health crisis response and suicide prevention system. • There are currently seven subcommittees (Tribal 988, Credentialing & Training, Technology, Cross-System Collaboration, Confidential Information, Rural & Agricultural, and Lived Experience). The role of the subcommittees is to provide professional expertise and community perspectives on a variety of topics. • The voices of lived experience are crucial, valuable, and essential to this work. Input from the Lived Experience Subcommittee meetings will help the CRIS and Steering Committees better understand the perspective of those who have experience with the system, positive or negative, and will inform their recommendations to improve the system. • Jim discussed the plan for future meetings to focus on specific crisis system related topics areas. Feedback on the structure is welcome. He also discussed privacy and noted the information shared at these meetings will be de-identified when shared with the CRIS and Steering Committee, unless permission is otherwise given.

TOPIC	DISCUSSION
	<ul style="list-style-type: none"> If members are interested in sharing their personal stories at the CRIS or Steering Committee meetings, they should contact Nicola Pinson (npinson@healthmanagement.com)
<p>Shared Understanding of Lived Experience</p>	<ul style="list-style-type: none"> The Subcommittee was divided into four breakout rooms for introductions and to discuss perspectives on the definition of lived experience. The Lived Experience Subcommittee is operating under an inclusive definition of lived experience: If you have been in the mental, substance use, or behavioral health system, have received any crisis services, or have any experience with the crisis system at all, and you feel that you have lived experience – then you are someone with lived experience. <ul style="list-style-type: none"> Family members and peers are an important part of the lived experience population. Recognition that different groups bring different perspectives. Recognition that there may be people in crisis who do not identify with a diagnosis of mental health conditions or substance use disorders. Anyone who has used services in the behavioral health system is a person with lived experience. If you have been on the receiving side of crisis services, then you are an individual with lived experience. May be a person who did or did not get their needs met. If there is a person in crisis, gather as much as input as many people as possible who know that person. Important to gather information from the person’s counselors; strong emphasis on using peer counselors. Don’t criminalize mental health and substance use disorders. Importance of taking in the voices of youth directly. Noted perspectives from students and the experience of stigma in schools. Providers who are part of the behavioral health and crisis system are part of the lived experience – these perspectives are important to have at the table, but are also distinct from individuals and family members with lived experience. Noted that the Lived Experience Subcommittee is for individuals and family members with lived experience and that there are other tables for engaging provider perspectives. Professional may also have personal lived experience that would be appropriate for participation in the Lived Experience Subcommittee. Ensure that both negative and positive lived experience are shared. Companions that walk with people in the journey are part of the lived experience. Supported expansive definition of peer. Recognition of the unique experience of immigrant populations. Need to consider a person’s immediate communities and how they provide support.
<p>Update from CRIS Committee and Subcommittees</p>	<ul style="list-style-type: none"> Betsy Jones provided updates from the CRIS Committee and the other subcommittee meetings. She shared the CRIS High-Level Workplan framework, developed based on the national best practices established by the Substance Abuse and Mental Health Services Administration (SAMHSA), that will be used to organize

TOPIC	DISCUSSION
	<p>the work ahead to ensure the full continuum of crisis response. State agencies will be responsible for implementation of this work, and the Steering Committee, CRIS and Subcommittees will provide recommendations. The workplan uses the following framework:</p> <ul style="list-style-type: none"> ○ A place to contact – crisis call centers ○ Someone to come – mobile crisis rapid response teams ○ A place to go – Broad range of crisis stabilization services ○ Pre- and post-crisis care immediately before and after crisis events ○ Crisis system infrastructure and oversight <ul style="list-style-type: none"> ● Beth Mizushima, Director of the Office of Healthy and Safe Communities within the Washington Department of Health (DOH), provided an update on the launch of the 988 line in July. <ul style="list-style-type: none"> ○ Beginning in July, people dialing 9-8-8 will be routed to one of three NSPL call centers located in Washington; text and chat will be available as well. ○ DOH is working with the three NSPL calls centers to ensure their capacity to answer calls. The addition of 988 will not disrupt other services, current crisis phone lines and services will remain in place. ○ NSPL calls are routed based on the caller’s area code (<i>i.e.</i> people with WA area codes are routed to the Washington call centers). The NSPL administrator, Vibrant, currently manages this call routing. ○ The Washington Indian Behavioral Health Hub will also launch a crisis line for tribal-affiliated individuals in July. <p><i>Discussion/Comments:</i></p> <ul style="list-style-type: none"> ● Will there be access to peer providers? – There are ongoing conversations on expanding access to peer providers and peer programming; this is a conversation that is happening at the CRIS and Steering Committees, as well. <ul style="list-style-type: none"> ○ Peer services were highlighted as a priority. ● We know crisis often occurs in isolation. That "someplace to go" could help so many. Sometimes when someone is in crisis they need someone to come to them in the community, but there are also times when someone could be in crisis (or near crisis) and just need another human to connect with; someone to hear and listen to them, validate them, and perhaps share some insights or ideas about what could help right them now. What if someone could walk into any mental health agency or clinic and say "Is there a Certified Peer Counselor (CPC) I can speak with?" without having to wait? I know there are currently 1,300+ people on the CPC training waiting list. I think the expansion and advancement of Peer Support Services is key to this effort." ● We need more peers in schools as well. My daughters school has no access to resources and she spends most of her week there. ● "Agree on peers and expanding that definition to keep in mind rural areas and minority groups of all kinds who turn to their immediate community for support." ● "Ambulances and law enforcement can be so intimidating for someone experiencing a mental health crisis so it's awesome that a dedicated team is being formed."

TOPIC	DISCUSSION
	<ul style="list-style-type: none"> • All people living with mental challenges will get the help they need when they want it. The moment, I have found, is brief when my loved one said, "OK I will take help now." We need to respond "now" with help. • Build the workforce out of the communities we serve, rather than trying to train people how to serve "others". • How can 988 help communities build support systems within communities? No "othering" • Re-education programs for first responders. Training to help recognize where they are needed and where a crisis team could maybe intervene instead. • I hope when it comes to the reality of staffing a crisis 988 services, we remember that the person who is at risk to take their life that we have to help their families be helpful too. • Highlighted example in Indiana where crisis line notifies school districts if receives a call from a student in the district. This gives school awareness to provide additional support. This would be helpful as part of crisis line follow up. • Important to address mental health issues in schools. Kids receive counseling in school but don't have that same support at home. Working to create a parent-student liaison position to help provide parents with support and resources.
<p>Interactive Exercise: Inform A Vision Statement For Washington's Behavioral Health Crisis Response And Suicide Prevention System</p>	<ul style="list-style-type: none"> • Jim Vollendroff provided background on the work that is underway to develop a vision statement for Washington's behavioral health crisis response and suicide prevention system. The Steering Committee formed an Ad Hoc Workgroup Vision with the charge to develop a <i>draft</i> vision statement for consideration by the CRIS Committee and approval by the Steering Committee in May. The CRIS and Steering Committee would like to engage input and perspectives from the Lived Experience Subcommittee to inform this vision statement. • <i>What would the Lived Experience Subcommittee want to say in a vision statement?</i> The group offered ideas for potential vision statements and provided feedback on what a good statement would look like and what it would include. Many agreed the statement should encompass a holistic, person-centered, trauma-informed, and culturally conscious approach while emphasizing: <ul style="list-style-type: none"> ○ Education ○ Community support ○ Healing ○ Equity ○ Inclusivity ○ Confidentiality ○ Peer Counseling ○ Recovery, support to create a life worth living. [Note to be careful about use of the term "recovery" because links to mental health and substance use disorder conditions; for someone with a LGBTQ crisis, for example, don't need recovery, just need your needs met.] ○ De-stigmatization ○ Important to be family focused, including community and natural supports. ○ Encouraged review of messaging in the SAMHSA 988 website

TOPIC	DISCUSSION
	<p>Suggestions for vision statements are listed below:</p> <ul style="list-style-type: none"> ○ A crisis call shifts the outcome for a family or individual toward solutions and real-time support for unmet needs. ○ People in crisis are able to get support without further trauma. ○ Equitable rapid access to culturally appropriate responders in each county. ○ Person-centered, trauma-informed, culturally sensitive crisis response that supports consumers, families, and providers, and meets the needed level of care. ○ Live support for those in crisis and their supporters that includes access to in-person Certified Peer Counselors for both intervention and ongoing post-crisis care to promote recovery and ongoing wellness. ○ A system that supports easy access of equitable resources, interventions, and recovery for all. ○ Crisis care for Washington state residents will be accessible, trauma-informed, supportive, and culturally conscious, and will acknowledge that crisis care is an involved process that does not end with the termination of a phone call or an initial appointment ○ For a Crisis response system that answers with a desire to first listen respectfully and seeks to understand ALL people who call out for help. That their response is holistic and inclusive as well as gives hope; or at least offers them the possibility that there are others who can hold their hope until they can hold it for themselves. ○ Responding to people as individuals and not disorders based on desired outcome and not protocol. ○ Sustainable pay for care providers, that incentivizes them to stay engaged and reduces burnout. Accountability for providers. ○ "A place where ALL (individual or family) can find help when in crisis and leads to ongoing support" ○ Holistic support for moving from crisis, through to surviving, to thriving. ○ For Peers to be recognized as a pivotal and equal team member to assist a person(s) experiencing a crisis; for a peer to connect on a level that lends a level of nonjudgmental understanding and help. ○ A cry for help elicits real help, doesn't harm, and creates a pathway for ongoing support to meet essential needs. <ul style="list-style-type: none"> ● Recognition of the lack of representation from communities that are most impacted are not represented in the planning process. Need to be intentional about reaching out to engage perspectives from people of color. Will bring back this back to the Lived Experience Subcommittee at a future meeting to further discuss strategies to engage these populations.

TOPIC	DISCUSSION
	<ul style="list-style-type: none"> Staff will take this input back to the Ad Hoc Work Group on Vision, the group that is focused on creating a draft vision statement for consideration by the CRIS Committee. At the next Lived Experience Subcommittee, staff will plan time for further feedback on a draft vision statement that is being developed by the Ad Hoc Work Group on Vision.
Next Steps & Wrap Up	<ol style="list-style-type: none"> Contact Nicola Pinson (npinson@healthmanagement.com) if you are interested in sharing your personal story at an upcoming committee meeting. The next Lived Experience Subcommittee meeting will occur in April. An email will go out with the April date. Plan for future meeting agenda to include discussion of strategies to engage perspectives of people of color and other marginalized populations in the planning process. The Project Team will share the Lived Experience Subcommittee’s initial input the vision for Washington’s crisis response and suicide prevention system with the Ad Hoc Workgroup on Vision. The Lived Experience Subcommittee will further consider and provide input on Washington’s vision during the Subcommittee’s April meeting.

HB 1477 LIVED EXPERIENCE SUBCOMMITTEE – APRIL 18TH MEETING

Meeting Summary

Monday, April 18, 2022, 5:00-6:30pm

Zoom

TOPIC	DISCUSSION
<p>Welcome, Introductions, Review Meeting Agenda</p>	<ul style="list-style-type: none"> • Bipasha Mukherjee, HB 1477 Steering Committee member representing lived experience, welcomed everyone to the meeting and introduced the planning team for the Lived Experience Subcommittee. <ul style="list-style-type: none"> ○ CRIS Committee members representing lived experience (Bipasha Mukherjee, Puck Kalve Franta, Cathy Callahan-Clem, Michael Robertson) and Health Management Associates staff (Betsy Jones, Nicola Pinson, Elizabeth Tenney) and Melanie Estes (legislative intern to Representative Orwall) are part of the planning group to support the subcommittee’s meetings. • The Lived Experience Subcommittee was created to bring people with lived experience into a central role in the crisis response system redesign process, recognizing that lived experience perspectives are critical to help the CRIS and Steering Committees develop recommendations for a more robust, stable, and equitable system across the state.
<p>Recap of the Last Meeting: Charge for Lived Experience Subcommittee and Shared Understanding of Lived Experience</p>	<ul style="list-style-type: none"> • Bipasha provided the group with a recap of the last Lived Experience Subcommittee meeting, which took place in March. At that meeting, subcommittee members recognized the following shared understanding of lived experience: <i>If you have been in the mental, substance use, or behavioral health system, have received any crisis services, or have any experience with the crisis system at all, and you feel that you have lived experience – then you are someone with lived experience.</i> <ul style="list-style-type: none"> ○ Family members and peers are an important part of the lived experience population. Family may include a person’s support network not limited to biological or legally-defined family. ○ Recognition of the diverse lived experience of different groups. ○ Recognition that there may be people in crisis who do not identify with a diagnosis of mental health conditions or substance use disorders, such as LGBTQ+ populations. ○ Providers who are part of the behavioral health and crisis system bring important direct perspectives but are also distinct from individuals and family members with lived experience. Providers may bring their own personal lived experience.

TOPIC	DISCUSSION
Update from CRIS Committee and Subcommittees	<ul style="list-style-type: none"> • Betsy Jones (HMA) provided an overview of the HB 1477 committee structure and roles, and an update of recent committee meetings and topics (see meeting slides). Several subcommittees have focused on providing input into the draft vision statement, which is the focus of today’s Lived Experience subcommittee meeting.
Interactive Exercise: Inform A Vision Statement For Washington’s Behavioral Health Crisis Response And Suicide Prevention System	<ul style="list-style-type: none"> • Betsy Jones provided an overview of the Ad Hoc Workgroup on Vision and the process to develop a draft vision statement. A number of individuals with lived experience participated on the Ad Hoc Workgroup on Vision, including Laura Van Tosh, Michael Robertson, and Melanie Estes. <ul style="list-style-type: none"> ○ A vision statement, in general terms, is an aspirational statement of an organization or system that states what they would like to achieve. • Laura Van Tosh participated in Ad Hoc Workgroup on Vision as a person with lived experience. Members of the workgroup brought different perspectives to the table. Laura discussed aspects and rationale for the different guiding principles. • Topher moderated and facilitated the discussion gather subcommittee member input. Members were asked to provide the following input: Do the vision statement and principles work from the perspective of people with lived experience? If not, what would you like to see changed? What do you like about the vision statement and principles? <ul style="list-style-type: none"> ○ Vision statement is clear cut and hopeful – suggest ‘a connection to anyone who is struggling’ is not inclusive of family members, suggested change: “to anyone affected by crisis” ○ Phrase ‘offering hope and recovery’ is overused and doesn’t mean much – people want something more actionable/accountable ○ Instead of equitably financed suggested change: “sustainably and equitably providing care”. Financed is just the money and not the actual delivery of care. ○ Instead of enhancing the system that responds to crises, there was encouragement to develop a robust infrastructure focused on prevention. ○ Recognize the need to provide individuals with the right level of care. ○ The vision is missing trauma informed care which is critical in envisioning new system. ○ It would be better to say ‘people in crisis will experience’ for guiding principles – convey more action/agency. ○ ‘988 offers a connection’ is too passive, Suggested “builds” which is more active. ○ Offering hope and recovery is a buzzword that people don’t connect with or like. ○ Include some action component in the statement – offering a path to recovery – something more concrete at the end.

TOPIC	DISCUSSION
	<ul style="list-style-type: none"> ○ Support for the Venn diagram but feel it needs something like ‘a system structure that is visible, understandable, and immediately usable by those in need’. ○ Important to include that people experiencing crisis have options that bypass the emergency room – idea of giving people more choices that are less traumatizing should be included in Venn diagram. ○ Caregivers don’t necessarily see themselves in this vision. Most parents do not know what to do when leaving inpatient care – they are terrified – caregivers must have support/be supported too. ○ Note anti-racism wording - What does it actually mean to be anti-racist? What are the actual actions being taken to be anti-racist? In these committee meetings and going forward? ● <i>Additional Comments from the Chat</i> <ul style="list-style-type: none"> ○ “Love how all of this is written but we have a long way to go and I'm speaking about crisis response to adults and how individuals are treated in the emergency room/hospital.” ○ “The vision is great. I am in a rural area working with people with developmental and physical disabilities and our services really lack for dual diagnosis mental health services. Most people have to travel at least an hour to get the services needed. It would be great if the rural areas can get specialized mental health support for those with a dual diagnosis.” ○ “I think we also need to keep the DRW report on DCR's and that process and DRW's recommendations” ○ “I think "offering hope and recovery" lacks action. I would prefer to see something such as "offering a path forward so the individual's needs will be met.”” ○ “Agree completely as a caregiver who often interacts with the system for adolescent child!” ○ “Love the PATHWAY language - not just immediate crisis response” ○ “Agreed. Because “financing” is not always sufficient to meet rural areas’ needs, sometimes structural variations are needed as well to meet rural counties’ needs” ○ “On the left side the last bullet ‘Care that is responsive to developmental, cultural, and linguistic needs’ It needs to include gender too. Gender diversity matters and is often discriminated against” ○ “Yes, I believe we need to think about harm and benefit and increasing benefit.” ○ “Agree with adding gender and sexual orientation/“LGBTQ identity” to be shorter”

TOPIC	DISCUSSION
	<ul style="list-style-type: none"> ○ “988 needs to be implemented within the current BH Ombudsman services” ○ “Also given we are a diverse state with Tribes and Rural communities, not to mention gender variance, various immigrant communities, it would be nice to have something that says - Meeting people where they are (in their respective communities)” ○ “department of health is important because of crisis calls that lead to many hours in emergency rooms/boarding -in our area their phone is taken away and all possessions and others without mental health needs are not treated this way” ○ “I think what I heard of the vision statement sounds really great and fairly comprehensive. However, I am blind so I can't reread the slides. I would love to see something specific to people with disabilities addressed. The goal should be to develop a system that is flexible to meet all of the unique needs of those struggling with a disability as well as trying to navigate what can be a complicated system.” ○ “First bullet under "The Crisis System is intentionally" could be edited to say: "Grounded in equity, trauma-informed, and anti-discriminatory”” ○ “We have DRW on the big CRIS and I’m here also from a disability justice angle, but disability competence is definitely still an issue.”
Personal Stories	<ul style="list-style-type: none"> ● Bipasha highlighted the importance of people’s stories to share how do we can make the system responsive to our needs. ● Individuals interested in sharing their story are invited to reach out to learn more about sharing their story at an upcoming committee meeting.
Outreach Strategies to Engage Diverse Voices	<ul style="list-style-type: none"> ● Puck Franta introduced the agenda topic and the importance of reaching diverse communities that don’t feel included in the current system. ● How would you invite those to the community? Many people do not trust the system. What can we do to get people who do not trust the system to come to these meetings? ● How do we connect with people outside the normal structures? <ul style="list-style-type: none"> ○ Puck shared a link to the Linktree in the chat as another way to have conversations – may submit an anonymous form or attributed form ● Noted potential options to structure meetings in a variety of ways to support engagement, e.g. breakout groups, casual parts of the meeting, different time length of meetings. ● Further discussion of strategies to engage diverse perspectives and embed equity in our work will be brought to the next meeting.

TOPIC	DISCUSSION
<p>Next Steps & Wrap Up</p>	<ul style="list-style-type: none"> • Contact Nicola Pinson (npinson@healthmanagement.com) if you are interested in sharing your personal story at an upcoming committee meeting. • The next Lived Experience Subcommittee meeting will occur in May, but it has not been scheduled yet. An email will go out in early May. • Next meeting agenda to include discussion of strategies to engage perspectives of people of color and other marginalized populations in the planning process. • The Project Team will share the Lived Experience Subcommittee’s input on the vision for Washington’s crisis response and suicide prevention system with the CRIS Committee at their May meeting.

HB 1477 LIVED EXPERIENCE SUBCOMMITTEE – JUNE 8, 2022 MEETING

Meeting Summary

Monday, June 8, 2022 6:00 pm to 8:00 pm

Zoom

TOPIC	DISCUSSION
<p>Welcome, Introductions, Review Meeting Agenda</p>	<p>HB 1477 Steering Committee member Bipasha Mukherjee welcomed everyone to the meeting and reviewed the meeting agenda. Bipasha is a CRIS Committee and Steering Committee member representing lived experience. Betsy Jones and Jim Vollandroff are part of the Health Management Associates/Harborview Behavioral Health Institute (HMA/BHI) team providing facilitation support to meetings.</p> <p>The Lived Experience Subcommittee was created to bring people with lived experience into a central role in the crisis response system redesign process, recognizing that lived experience perspectives are critical to help the CRIS and Steering Committees develop recommendations for a more robust, stable, and equitable system across the state.</p> <p>Objectives for this meeting included:</p> <ol style="list-style-type: none"> 1. Provide Committee update 2. Gather input to center equity into the CRIS High Level Workplan and discuss strategies to promote equity <p>Brittany Thompson, HMA, reviewed the Zoom technology to ensure subcommittee member understanding of how to use Zoom to engage in the meeting.</p>
<p>CRIS Committee Status Updates – Including Vision Statement Update</p>	<p>Michael Robertson, a CRIS member representing lived experience, introduced himself and reviewed the final Vision and Guiding Principles developed by the Ad Hoc Workgroup on Vision and approved by the Steering Committee. The vision and guiding principles were developed by the Ad Hoc Workgroup on Vision through meetings held March-May 2022 with input from the Rural & Agricultural, Lived Experience, and Tribal subcommittees, as well as the Children and Youth Behavioral Health Workgroup. The Ad Hoc Workgroup on Vision also included several members with lived experience.</p> <p>The final vision statement focused on centering the language around people in crisis, removal of jargon, and use of action-oriented language. Members reviewed Washington’s vision and guiding principles for the crisis response and suicide prevention system:</p> <ul style="list-style-type: none"> • <i>Vision: 988, Washington's Crisis Response: building understanding, hope, and a path forward for those in need, where and when they need it.</i> <ul style="list-style-type: none"> ○ Guiding Principles – People in Crisis experience:

TOPIC	DISCUSSION
	<ul style="list-style-type: none"> ▪ 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 ○ Guiding Principles – the crisis system is intentionally: <ul style="list-style-type: none"> ▪ Grounded in equity and anti-racism ▪ Centered in and informed by lived experience ▪ Coordinated and collaborative across system and community partners ▪ Empowered by technology that is accessible by all ▪ Financed sustainably and equitably ▪ Operated in a manner that honors tribal government-to-government processes <p>Subcommittee members discussed the following:</p> <ul style="list-style-type: none"> • Noted concerns for inclusion regarding having a voice to advocate for those with intellectual disabilities, autism spectrum disorder, and other mental illness and crisis response. Highlighted opportunity to raise this issue during the discussion of ways to center equity in the CRIS High Level Workplan to ensure these voices are heard. • Question regarding the establishment of the infrastructure to make this vision happen. HMA/BHI is working with state agencies to bring forward the work they are currently doing to support the crisis response system and gathering input from the committees to provide feedback on changes and actions needed to achieve Washington’s vision. • The following suggestions were made by members: Contact Arc of King County, investigate Cahoots model of Mobile Crisis Response that originated in Oregon. • Highlighted concern that Lived Experience member of the Steering Committee does not have voting rights. Members were encouraged to raise this concern with legislators and state agencies to address this concern and make changes need to allow voting rights. This is an issue that has been raised previously as well and is being brought forward to the Steering Committee. • Questions about methods to share information about these meetings. Subcommittee members encouraged to share information with their networks and spread the word about these Subcommittee meetings.

TOPIC	DISCUSSION
	<p>HMA/BHI provided an overview of the HB1477 committee structure and roles. Member reviewed the Lived Experience Subcommittee charge to provide diverse lived experience perspectives into the development of the Washington behavioral health crisis response and suicide prevention system. This includes but is not limited to: Identify issues for consideration with perspectives of lived experience; Review and provide input to inform development of Committee recommendations; Inform state agency implementation planning.</p> <p>Subcommittee members received an overview of other Subcommittee meetings occurring parallel to the work of the Lived Experience Subcommittee. The May 2022 Subcommittee Report includes a compilation of all subcommittee meeting summaries and is available on the HCA website: https://www.hca.wa.gov/assets/program/cris-subcommittee-Report-20220501.pdf.</p>
<p>Centering Equity in the CRIS High Level Workplan & State of the Lived Experience Subcommittee</p>	<p>The CRIS Committee and Subcommittees are charged with advising the Steering Committee in developing recommendations for an integrated behavioral health crisis response and suicide prevention system, including recommendations to promote equity in services for individuals in diverse circumstances.</p> <p>Jim Vollendroff introduced the request for the Lived Experience Subcommittee’s input on ways to center equity in the CRIS High Level Workplan. The High Level Workplan provides an organizing framework to ensure the full continuum of crisis response:</p> <ul style="list-style-type: none"> ○ Objective 1: A place to contact – NSPL call centers ○ Objective 2: Someone to come – Mobile crisis rapid response teams ○ Objective 3: A place to go – Broad range of crisis stabilization services ○ Objective 4: Pre- and Post-Crisis Care – Immediately upstream and downstream of crisis events ○ Objective 5: Crisis system infrastructure and oversight <p>Jim highlighted examples of population groups that experience behavioral health disparities and the goals for input on how to ensure equity is centered in all aspects of 988 and Washington’s behavioral health crisis response system.</p> <p>Puck Kalve Franta, CRIS member representing lived experience, supported facilitation of Subcommittee discussion to gather input on how equity can be centered moving forward.</p> <ul style="list-style-type: none"> ● Relevant services for neurodiverse communities: For individuals with intellectual disabilities, autism spectrum disorder, individuals with dementia and traumatic brain injury, crisis response often escalates and exacerbates the crisis. They are taken to the emergency department and the crisis is made worse. It is critical for workforce training to enable proper response to these populations, as well as appropriate facilities to go to.

TOPIC	DISCUSSION
	<ul style="list-style-type: none"> • Families at Washington Autism Alliance with Intellectual and Developmental Disabilities/Autism/Mental Health challenges are those you are seeing in the "Stuck in Hospital" boarding trend because there is no place for them to go in the existing systems. • Inclusion of Pierce County - many folks are moving there from Seattle displacement • Establish ways for people who are using the crisis response system to give real-time input. Give feedback on what is happening and how to address improvements as we go. 988 needs to be a high tech model and must adapt to real time change. • Goals to find ways to reach out to hear stories from people who aren't able to join the LE Subcommittee meetings. How can we support this outreach? • Discussed outreach to communities to hear their voices rather than asking them to come to the Lived Experience Subcommittee. • Recommend that 988 has a Diversity Equity and Inclusion Director. • Recommend support opportunities for remote jobs expand the work force and the engagement of peers with lived experience. • Priority to have a broad variety of people share their stories to inform change to the system. Noted current work with the National Alliance on Mental Illness (NAMI) to identify resources to support people to share their stories. • Concern with asking people most negatively impacted to do this work for free. • PR materials to share peer-to-peer. • Get the word out with advertising about 988. • Do not ask people most negatively impacted to do this work for free. • It's important to address what happens in the response and how choices can be narrowed especially with Designated Crisis Responders (DCRs) response and there needs to be an emphasis on choices/options. • Recommend creating a system that connects people in crisis with families and peers who have experience and understand how to navigate the complex and intersecting disability systems at the local level. This support needs to be immediate to support people in crisis. • Facilities are very traumatizing - one member's son can't even drive by one of the hospitals in Olympia because he was so traumatized there. • Another place could be a behavioral health urgent care that is low sensory. "there is a low-sensory behavioral health urgent care facility up north and there is one in Missouri - in the Ozarks • "Parents & caregivers see "unintended consequences" because of no space to give input • Highlighted concern that the Steering Committee member representing lived experience does not have voting rights, and that persons with lived experience do not have a voice at the highest level of the process.

TOPIC	DISCUSSION
	<ul style="list-style-type: none"> Getting everyone to these meetings isn't possible (folks without tech) and even if some folks come they would have trouble participating (non-verbal/hard of hearing folks). We need the system to serve those folks too but they aren't here so we need to find a way to involve them. A lot of Gen Z want to TEXT or VIDEO chat. A lot of them have PTSD from Covid. <p>Resources that were provided include:</p> <ul style="list-style-type: none"> CRIS Meetings: https://www.hca.wa.gov/about-hca/behavioral-health-recovery/crisis-response-improvement-strategy-cris-committees#meeting-schedule 988 Crisis Jam Learning Community: https://talk.crisisnow.com/learningcommunity/ Email Address for Public Comments in the CRIS Committee Meetings: HCAprogram1477@hca.wa.gov Lived Experience LinkTree: https://linktr.ee/livedexperience <ul style="list-style-type: none"> Anonymous forms to submit input, among other resources and links. National survey collecting input from people with Lived Experience. <p>Please also see visual below shared on screen to capture Lived Experience Subcommittee member input.</p> <p>Objective 1: A place to contact – NSPL call centers</p> <p>Objective 2: Someone to come – Mobile crisis rapid response teams</p> <p>Objective 3: A place to go – Broad range of crisis stabilization services</p> <p>Objective 4: Pre- and Post-Crisis Care – Immediately upstream and downstream of crisis events</p> <p>Objective 5: Crisis system infrastructure and oversight</p> <p>Real-time response feedback</p> <p>Parents & caregivers - "unintended consequences" because of no space to give input - establish a way people can give real-time input</p> <p>988 needs a DEI Director</p> <p>988 needs to be a high tech model and must adapt to real time change.</p> <p>outreach options - Facebook etc</p> <p>Dakota Steel or Mat Gower @HCA</p> <p>Get the word out with advertising about 988</p> <p>there should be remote jobs - a lot of Gen Z went to TEXT or VIDEO chat. A lot of them have PTSD from Covid</p> <p>Inclusion of Pierce County means many folks are moving there from Seattle displacement</p> <p>Preference for calling stories 'success stories'</p> <p>another place could be a behavioral health urgent care that is low sensory</p> <p>how do we do outreach at the LE group?</p> <p>there is a low-sensory behavioral health urgent care facility up north and there is one in Missouri - (member is in the Ozarks)</p> <p>another place could be a behavioral health urgent care that is low sensory</p> <p>Facilities are very traumatizing - one member's son can't even drive to one of the hospitals in Olympia because he was so traumatized there</p> <p>Relevant services for neurodiverse communities</p> <p>Consulting with communities rather than asking them to come to us</p> <p>Not ask people most negatively impacted to do this work for free</p> <p>Hear people's voices without them being at the LE meetings</p> <p>Katie Omt - partnerships@washingtonautismadvocacy.org and keom@comcast.net - lived experience in mental health (25+ years including 3 months inpatient), daughter bipolar and BPD, son high-needs autistic/IDD/trauma and anxiety. I serve as the Civic Engagement & Advocacy Officer for Washington Autism Alliance. Our families at WAA with IDD/Autistic/Mental Health challenges are those you are seeing in the "Stuck in Hospital" boarding trend because there is no place for them to go in the existing systems.</p>
Open Space	Provided 30 minutes for members to share thoughts on topics of their choice and is a less formal structure than the rest of the meeting.

TOPIC	DISCUSSION
<p>Closing Remarks</p>	<p>Bipasha remarked that 988 is federally rolling out on July 16; this does not mean that all systems and implementations are in place. This is the beginning of a long road to produce positive change for crisis response.</p> <p>Other closing remarks included:</p> <ul style="list-style-type: none"> • LinkTree account should be widely shared and includes (https://linktr.ee/livedexperience). This provides an anonymous way to share stories. • Please continue to join the Lived Experience Subcommittee meetings. Information regarding the July meeting date will be shared with the Subcommittee as soon as possible.

HB 1477 Cross System Collaboration Subcommittee

HB 1477 CROSS SYSTEM COLLABORATION SUBCOMMITTEE – MARCH 17TH MEETING

Meeting Summary

Thursday, March 17, 2022, 3:00 pm to 5:00 pm

Zoom

Attendees

Committee Members

Adam Wasserman, Washington State Emergency Management Division

Annabelle Payne, Pend Oreille County

Cody Maine, Community Paramedic, Walla Walla Fire Department

Dan Crawford, Associate Professor, UW Psychiatry Department

Dianne Boyd, Clinical Director, YMCA

Jan Tokumoto, Chief Operating Officer, Frontier Behavioral Health

Jane Beyer, Senior Health Policy Advisor, Washington State Office of the Insurance Commissioner

Jessica Shook, Crisis Services Manager, Olympic Health and Recovery Services

Jim Theofelis, Founder & Executive Director, NorthStar Advocates

Joan Miller, Senior Policy Analyst, Washington Council for Behavioral Health

Joe Avalos, Thurston-Mason BH-ASO

Joe Valentine, North Sound BH-ASO

John Nowels, Undersheriff, Spokane County Sheriff's Office

Johnny Hawley, Neighborhood Safety Team Lead, Catholic Charities, Eastern Washington

Julie Rickard, CEO, Moment by Moment Suicide Prevention & Suicide Prevention Coalition of N. Central WA

Kashi Arora, Program Manager, Mental and BH, Community Health and Benefit, Seattle Children's

Kim Hendrickson, Housing, Health and Human Services Director, City of Poulsbo, Poulsbo Fire CARES Program

Kim Lettrick, Communications Manager, 911 Center for Benton and Franklin Counties

Laura Morris, Director, Tacoma's Fire Department CARES Program

Levi van Dyke, Deputy Director Behavioral Health, Volunteers of America

Linda Grant, Chief Executive Officer, Evergreen Recovery Centers

Neil Olson, Senior Director of Clinical Operations, Crisis Connections

Paul Borghesani, Associate Professor, UW School of Medicine

Rena Fitzgerald, Administrative Operations Manager, Volunteers of America

Rep. Tina Orwall, State Representative

Richard Kirton, Executive Director, Kitsap 911

Stacey Okihara, Frontier Behavioral Health

Facilitation Staff

Betsy Jones, Health Management Associates

Liz Arjun, Health Management Associates

Elizabeth Tenney, Health Management Associates

Suzanne Rabideau, Health Management Associates

Darren Xanthos, Health Management Associates

State Agency Staff

Camille Goldy, Tipline Manager, State Attorney General
 Tim Candela, Washington State Department of Health (DOH)
 Beth Mizushima, DOH
 Eliza Tharp, Washington State Health Care Authority (HCA)

TOPIC	DISCUSSION
<p>Welcome, Introductions, Review Meeting Agenda</p>	<p>Betsy reviewed the meeting agenda and objectives for each agenda item. This meeting of the Washington Crisis Response Improvement Strategy Steering Committee had four objectives:</p> <ol style="list-style-type: none"> 1. Understand charge and role of the Cross System Collaboration Subcommittee. 2. Understand agencies plans for the July 988 launch. 3. Discuss development of crisis response system Process Map. 4. Confirm action items and next steps.
<p>Charge and Role of the Cross System Collaboration Subcommittee</p>	<p>Members reviewed the charge of the Cross System Collaboration subcommittee to examine and define complementary roles and interactions among crisis system stakeholders across the continuum of response.</p> <p>The Steering Committee approved the CRIS High-Level Workplan, which will provide an organizing framework for our work ahead to ensure the full continuum of crisis response. The High-Level Workplan includes five objective areas:</p> <ul style="list-style-type: none"> • Objective 1: A place to contact – NSPL call centers • Objective 2: Someone to come – Mobile crisis rapid response teams • Objective 3: A place to go – Broad range of crisis stabilization services • Objective 4: Pre- and Post-Crisis Care – Immediately upstream and downstream of crisis events • Objective 5: Crisis system infrastructure and oversight <p>State agencies are responsible for implementation of this work, and the Steering Committee, CRIS Committee, and Subcommittees will provide recommendations. State agency partners will be providing regular and timely updates regarding implementation planning across the crisis response continuum to engage meaningful committee feedback.</p>
<p>988 NSPL July Launch</p>	<p>Beth Mizushima, DOH, gave legislative background and update on the 988 NSPL July Launch.</p> <ul style="list-style-type: none"> • The federal 988 Implementation Act established the new National Suicide Prevention Line 3-digit 988 number to improve access to support for individuals in behavioral health crisis. • Washington’s House Bill 1477 built on this federal legislation with the goal to improve access across the entire continuum of crisis care. The July 988 launch is a major step in the beginning of this larger process.

TOPIC	DISCUSSION
	<ul style="list-style-type: none"> • Beginning in July, people dialing 9-8-8 will be routed to one of three NSPL call centers located in Washington; text and chat will be available as well. • DOH is working with the three NSPL calls centers to ensure their capacity to answer calls. The addition of 988 will not disrupt other services, current crisis phone lines and services will remain in place. • NSPL calls are routed based on the caller’s area code, (<i>i.e.</i> people with WA area codes are routed to the Washington call centers). The NSPL administrator, Vibrant, currently manages this call routing. • The Washington Indian Behavioral Health Hub will also launch a crisis line for tribal-affiliated individuals in July.
<p>Process Map Development</p>	<p>The HMA project team is working to support the development of a process map to visualize the system and bring together an understanding of current system interfaces, gaps, and changes needed. This map will provide a foundational tool to inform subcommittee work, providing an understanding of the current system and future state needs. Two process map sessions are scheduled in March with 988, 911 and regional crisis line representatives to begin this work.</p> <p><i>Discussion:</i></p> <ul style="list-style-type: none"> • Noted the need to include firefighters in this work given 911 and behavioral health calls may go to fire departments, especially in cities struggling with 911 call volume. • What is the status of the Vibrant platform? - There is a technology subcommittee meeting next week that will discuss Vibrant and further examine its platform and viability. • The process map should be tailored to address the needs of young people or parents of young people. There could be a different map for these populations, but the burden of understanding how they system works should not fall on the user. The guiding principle must be that the design does not create any new burden for those in crisis. <ul style="list-style-type: none"> ○ System needs to be framed as no wrong door. ○ Keep in mind trauma associated with the crisis process. ○ How would a youth interact if calling system on behalf of themselves as well as a parent calling on behalf of a youth? ○ How will the system address intellectual disabilities for both youth and adults? ○ Consider roles of peers involved for youth and family. ○ Consider how dispatch would work with youth; currently youth are often directed to go to the emergency rooms.

TOPIC	DISCUSSION
	<ul style="list-style-type: none"> • Noted the need for coordination between 988, 911 and the regional crisis lines. What is the role of 911 dispatch teams? What about regional crisis teams? What are criteria for 911 to transfer calls to 988? <ul style="list-style-type: none"> ○ Question as to whether or not there is capacity for 988 to answer all calls that the regional lines get now because inevitably some will go to the 988 lines depending on the messaging that is put out there. ○ Where do the regional crisis teams and regional crisis lines fit into the communication between 911 and 988? As they are going to be going out to the calls. How does this process account for the non-linear process and the current co-response teams. ○ Noted concerns that 988 is not able to identify the location of callers. ○ Discussion of the 911/988 systems and interoperability generally. ○ Important to recognize the role of law enforcement in the system, while respecting the tension and fear of law enforcement experienced by some communities. ○ Noted that engagement with the crisis system is not a linear process, and that there are diverse needs of callers. Frequent callers must also be a consideration. ○ Need to have public facing guidance that spells out when to call 911 vs. 988 vs. regional crisis lines- the overall hope is that whomever receives the call that there will be enough coordination and interoperability that the caller will get the services they need no matter who they call. • How do we ensure access for communities with limited resources? <ul style="list-style-type: none"> ○ It will be important to ensure that the new system does not contribute to systemic biases or stigmatize mental illness. ○ Consideration of language access is important. ○ There should be a resource hub for all resources in the state that could help case managers and the public navigate the system. • Request for the process mapping work to address next-day appointments. • Often, alcohol and drug use disorders are disconnected from the mental health system. How do we ensure that is not the case in the future? • There needs to be a process for a physical person to meet someone who is in crisis, like a dispatch service for someone in crisis as opposed to advising them to go to the hospital. Consider how to ensure warm handoffs rather than giving callers more numbers to call.

TOPIC	DISCUSSION
	<ul style="list-style-type: none"> • How can we make sure the workforce will be able to respond to an anticipated increase in demand for services?
Next Steps & Wrap Up	The process mapping exercise will occur next week, and the group will reconvene on March 29 th .

HB 1477 CROSS SYSTEM COLLABORATION SUBCOMMITTEE – JUNE 21, 2022 MEETING

Meeting Summary

Tuesday June 21, 2022, 9:00 am to 10:30 am

Zoom

Attendees

Committee Members

Beth Mizushima, Washington Department of Health (DOH)
Cody Maine, Community Paramedic, Walla Walla Fire Department
Dan Crawford, Associate Professor, UW Psychiatry Department
David Makin, Associate Professor, Director of the Complex Social Interactions Lab, WA State University
Dianne Boyd, Clinical Director, YMCA
Eliza Tharp, Washington State Health Care Authority (HCA)
Jan Tokumoto, Chief Operating Officer, Frontier Behavioral Health
Jim Theofelis, Founder & Executive Director, NorthStar Advocates
Joe Avalos, Thurston-Mason BH-ASO
Johnny Hawley, Neighborhood Safety Team Lead, Catholic Charities, Eastern Washington
Julia O'Connor, Washington Council for Behavioral Health
Kashi Arora, Program Manager, Mental and BH, Community Health and Benefit, Seattle Children's
Kim Lettrick, Communications Manager, 911 Center for Benton and Franklin Counties
Levi van Dyke, Deputy Director Behavioral Health, Volunteers of America
Linda Grant, Chief Executive Officer, Evergreen Recovery Centers
Neil Olson, Senior Director of Clinical Operations, Crisis Connections
Rena Fitzgerald, Administrative Operations Manager, Volunteers of America
Rep. Tina Orwall, State Representative
Richard Kirton, Executive Director, Kitsap 911
Stacey Okihara, Frontier Behavioral Health

Facilitation Staff

Betsy Jones, Health Management Associates
Darren Xanthos, Health Management Associates
Nicola Pinson, Health Management Associates
Laura Collins, Health Management Associates

State Agency Staff

Camille Goldy, Tipline Manager, State Attorney General
Megan Celedonia, 988 Coordinator, Governor's Office
Amira Caluya, DOH
Jenn Combes, DOH
Tim Candela, DOH
Todd Mountain, DOH
Debbie Spaulding, DOH
Huong Nguyen, HCA
Jennie Harvell, HCA

Kelly McPherson, HCA
 Mathew Gower, HCA
 Sherry Wylie, HCA
 Wyatt Dernbach, HCA

TOPIC	DISCUSSION
<p>Welcome, Introductions, Review Meeting Agenda</p>	<p>Betsy reviewed the meeting agenda and objectives for each agenda item. This meeting had six objectives:</p> <ol style="list-style-type: none"> 1. Provide HB 1477 Committee updates. 2. Review process map goals and principles. 3. Review and discuss current state crisis system process maps and areas to improve in the future state. 4. Discuss next steps for addressing process map intersections with system partners. 5. Provide overview of process for gathering input to embed equity into the CRIS High Level Workplan and request for Subcommittee to submit input by email. 6. Confirm action items and next steps.
<p>Committee Updates</p>	<p>Members reviewed the charge of the Cross System Collaboration subcommittee to examine and define complementary roles and interactions among crisis system stakeholders across the continuum of response.</p> <p>Members reviewed overview of key activities and timeline to support HB 1477 Committee recommendations (see meeting slides). These include but are not limited to:</p> <ul style="list-style-type: none"> - Analysis of Medicaid claims and encounter data to inform understanding of Washington current service utilization and gaps. - Identification of other state best or promising practices and national benchmarks to inform recommendations for system goals. - Development of service cost estimates to inform funding recommendations. - Develop of Crisis System Process Map to bring together understanding of current system interfaces and gaps (which is the focus of this subcommittee, Cross System Collaboration and Coordination). <p>Members reviewed Washington’s vision and guiding principles for the crisis response and suicide prevention system, approved by the Steering Committee. The vision and guiding principles were developed by the Ad Hoc Workgroup on Vision through meetings held March-May 2022 with input from the Rural & Agricultural, Lived Experience, and Tribal subcommittees, as well as the Children and Youth Behavioral Health Workgroup.</p>

TOPIC	DISCUSSION
	<p>Members received an overview of other Subcommittee meetings occurring parallel to the work of the Cross System Collaboration Subcommittee. The May 2022 Subcommittee Report includes a compilation of all subcommittee meeting summaries and is available on the HCA website: https://www.hca.wa.gov/assets/program/cris-subcommittee-Report-20220501.pdf)</p>
<p>Crisis System Process Mapping – Update and Review</p>	<p>Members received update on work to develop a crisis system process maps that brings together an understanding of current system interfaces, gaps, and changes needed. The process map is a foundational tool for the Cross System Collaboration Subcommittee to inform changes needed.</p> <ul style="list-style-type: none"> • To date, have held two 2-day work session with 988 call centers, 911, and Regional Crisis Line (RCL) representatives participating. Work is underway to address system intersections specific to tribal populations, children and youth, and incorporation of additional system partners. <p>Members reviewed crisis system process map goals identified by participants during the work sessions:</p> <ol style="list-style-type: none"> 1. Establish a standard process to identify where calls belong and transfer calls for between 911, 988 and RCLs 2. When possible, develop reliability in processes across the regions 3. Establish reliability between 988, 911 and the Regional Crisis Line 4. Begin to develop an understanding of each other’s objectives and differences 5. Establish a process that increases automation and reduces manual decisions 6. Establish back-end processes that provide “no wrong door” for callers 7. Develop a process that results in the least restrictive response for callers 8. Improve Consumer experience 9. Short term goals for July – important so that we don’t lose callers. 10. Until new policies are established 911 will continue to do their work the same way. Need immediate practices/workflows in place so the calls get to 988 and vice versa 11. Keep in place what’s working <p>Members reviewed table of Regional Crisis Line and 988 entities (Volunteers of America, Crisis Connections, and Frontier Behavioral Health) that manage crisis calls in each of Washington’s 10 regions. In five of the 10 regions, the same entity manages 988 and Regional Crisis Line calls; in the remaining five regions, two different entitles manage these calls.</p>

TOPIC	DISCUSSION
	<ul style="list-style-type: none"> • Noted that process map work is currently paused pending guidance/decision on the scope and role of the 988 NSPL call centers and the RCLs. Need this direction in order to operationalize a process map toward this vision. <p><i>Discussion</i></p> <ul style="list-style-type: none"> • Highlighted importance of embedding data collection within the process map, including data to track system outcome metrics; noted intersection with the Technology Subcommittee. <ul style="list-style-type: none"> ○ Recognized that data is currently being collected, e.g. BH-ASOs report on a quarterly basis on quantitative and qualitative data. ○ 988 NSPL calls centers currently required to collect data regarding caller satisfaction. Current model used is recommended by the International Council for Helplines. ○ Important to identify where in the process to collect this data. Intersects with the Technology Subcommittee. ○ Washington State University is proposing to build a data system for police contacts with the public (SB 5259) that may parallel nicely with a data system on 988. The infrastructure proposed in an open-source solution that could integrate disparate data systems. ○ Highlighted importance of including qualitative information in the data collection. • Discussed relationship between Regional Crisis Lines and the NSPL 988 calls centers across Washington regions. <ul style="list-style-type: none"> ○ During the 988 roll out, there will be parallel systems receiving calls (988 call centers and the RCLs). ○ Provided overview of RCLs – provide 27/7 crisis lines as well as dispatching mobile crisis teams and designated crisis responders. RCLs are funded by the Health Care Authority through contracts with BH-ASOs in each of Washington’s 10 regions (mix of state general funds and Medicaid dollars). The NSPL call centers are funded through the Department of Health. ○ Anticipate that 988 call centers will start receiving calls that had historically going to RCL. Important to create a transition for this shift to ensure that people in crisis are able to access care. For example, in the Thurston-Mason region, the RCL currently receives the majority of crisis calls (approximately 3,000 calls/month), while the NSPL call center receives approximately 300 calls/month.

TOPIC	DISCUSSION
	<ul style="list-style-type: none"> ○ Orwall highlighted goal to lean into 988 and support this transition. ○ Orwall emphasized the goal to respond within 15 to 20 minutes. <ul style="list-style-type: none"> ▪ With current funding and capacity, reality is that RCLs are currently not able to dispatch rapidly. Investment will be critical to support the goal for rapid response. ○ As 988 becomes the hub, what is the role for the RCLs? This is a good topic for further exploration. Most calls that RCLs currently receive are not crisis calls, but rather operational in nature (hospitals, referrals for DCRs). ○ Also need to consider role crisis receiving centers that we are building. ○ Highlighted opportunities to consider how Fire/EMS fits into the system (including CARES teams), particularly with workforce challenges. <ul style="list-style-type: none"> ▪ Partnerships on these co-responder teams will be essential. Having persons with lived experience. Also, having some of the mental health clinicians from behavioral health agencies to be members of these teams would allow more linkages to behavioral health services, access to historic behavioral health services and help flow Medicaid funding into these teams. ● Reviewed potential areas to improve Cross System Transfers <ul style="list-style-type: none"> ○ Common definition of “Imminent Risk” for transfers to 911 across all entities – 911, 988, and RCLs. Imminent Risk is a term defined by NSPL that all 988 call centers use. ○ Common criteria for 988 referrals to RCLs for dispatch of mobile crisis response and designated crisis responders. ○ Alignment on minimum datasets for knowledge transfers across all entities. ○ Development of standards for RCL dispatch decisions and transfer processes. ○ Development of common tools – job aides and screening guides. ○ Common standards for when handoffs are complete ● Highlighted importance of intentionally building standards to ensure equity for people receiving services, including but not limited to considerations of age of callers. Need to ensure that all callers feel safe and building policies that support this including hand-offs. <ul style="list-style-type: none"> ○ Equity should also be added to goals.

TOPIC	DISCUSSION
	<ul style="list-style-type: none"> ○ Equity is also called out explicitly in the DOH contracts. There are specific training requirements for high-risk populations. ● Reviewed Crisis System Process Maps <ul style="list-style-type: none"> ○ Reviewed 988 to 911 Process Map (DRAFT) – map focuses on handoffs from 988 call centers to 911. NSPL call centers agreed that the process map reflects a high-level overview of current processes. Previous discussion highlighted the key takeaways from the process map work. ○ Question about where on the map there is an intersection with dispatch of Fire/EMS (e.g. CARES teams, co-responder teams). Fire/EMS teams can help with current limited capacity of mobile crisis teams. This would be part of the RCL map to address dispatch of mobile crisis teams and other services; this work could identify availability of secondary resources (such as first responders) when mobile crisis teams are not available. Important to recognize that Fire and EMS have experience already with transporting people to crisis centers. ○ Next steps are to consider process map interfaces with the tribal systems, as well as children and youth.
<p>Request for Subcommittee Input on Ways to Embed Equity into the CRIS High Level Workplan</p>	<ul style="list-style-type: none"> ● HB 1477 calls for recommendations to promote equity in services to individuals in diverse circumstances of culture, race, ethnicity, gender, socioeconomic status, sexual orientation, and for individuals in tribal, urban, and rural communities. ● Provided overview of process to gather input from the CRIS Committee and Subcommittees to inform these recommendations. Request for subcommittee input on activities to embed equity into the CRIS High-Level Workplan. The Workplan was approved by the Steering Committee and provides an organizing framework to ensure the full continuum of crisis response. <ul style="list-style-type: none"> ○ Objective 1: A place to contact – NSPL call centers ○ Objective 2: Someone to come – Mobile crisis rapid response teams ○ Objective 3: A place to go – Broad range of crisis stabilization services ○ Objective 4: Pre- and Post-Crisis Care – Immediately upstream and downstream of crisis events ○ Objective 5: Crisis system infrastructure and oversight ● Request for input on activities to embed equity into the High Level Workplan to be submitted to Nicola Pinson (npinson@healthmanagement.com) by July 15. Subcommittee members will receive a follow up summary of request and copy of the High Level Workplan to enter recommendations.
<p>Next Steps & Wrap Up</p>	<ul style="list-style-type: none"> - Follow up by email with request for subcommittee input on embedding equity.

HB 1477 Credentialing and Training Subcommittee

HB 1477 CREDENTIALING AND TRAINING SUBCOMMITTEE – APRIL 21ST MEETING

Meeting Summary

Thursday April 21, 2022, 3:00 pm to 4:30 pm

Zoom

Attendees

Subcommittee Members

Aubrey Newton, Northwest Laborers’ – Employers Corporation and Education Team
Brandy Grant, Community Police Commission
Catie Holstein, Washington State Department of Health (DOH)
Courtney Colwell, Volunteers of America (VOA)
Jan Tokumoto, Frontier Behavioral Health
Stacey Okihara, Frontier Behavioral Health
Jessica Shook, Olympic Health and Recovery Services
Karl Hatton, Port Angeles Police Department, Pencom 9-1-1
Laurie Lippold, Partners for Our Children
Melody Youker, Martin Hall Juvenile Detention
Michael Delay, Columbia River Mental Health Services
Neil Olson, Crisis Connections
Shannon Simmons, Seattle Children’s Hospital
Stephanie Thelen, Catholic Community Services

Facilitation Staff

Betsy Jones, Health Management Associates
Nicola Pinson, Health Management Associates
Elizabeth Tenney, Health Management Associates

State Agency Staff

Michelle Izumizaki, DOH
Beth Mizushima, DOH
Matthew Gower, Washington State Healthcare Authority (HCA)
Sherry Wylie, HCA
Luke Waggoner, HCA
Kelly McPherson, HCA
Eliza Tharp, HCA
Huong Nguyen, HCA
Wyatt Dernbach, HCA
Ruth Leonard, HCA
Todd Mountin, DOH

TOPIC	DISCUSSION
Welcome, Introductions, Review Meeting Agenda	<p>Betsy Jones, Health Management Associates, welcomed everyone to the meeting and staff and subcommittee members introduced themselves.</p> <p>This meeting included the following objectives:</p> <ol style="list-style-type: none"> 1. Understand charge and role of the Credentialing & Training Subcommittee. 2. Understand agencies plans for the July 988 launch. 3. Understand staffing and training standards for National Suicide Prevention Line call centers. 4. Gather input on future topics for discussion.
Charge and Role for the Credentialing and Training Subcommittee	<p>Betsy overviewed the charge and role of the credentialing and training subcommittee and how it works with and relates to the Steering committee, the CRIS committee, and the other subcommittees.</p> <p>The charge of the Credentialing and Training Subcommittee is to inform workforce needs and requirements related to behavioral health system redesign components outlined by HB 1477. Specific areas of recommendations identified in HB 1477 include:</p> <ul style="list-style-type: none"> • Minimum education requirements such as whether appropriate for call center hubs to employ clinical staff without a bachelor’s or a master’s degree based on the person skill and life experience. • Inform plans to establish capacity of call center hubs to integrate Spanish language interpreters and Spanish-speaking call center staff into their operations.
988 NSPL July Launch	<p>HCA (Matthew Gower) and DOH (Beth Mizushima) staff provided legislative background and update on the 988 NSPL July Launch.</p> <ul style="list-style-type: none"> • The federal 988 Implementation Act established the new National Suicide Prevention Line 3-digit 988 number to improve access to support for individuals in crisis. • Washington’s House Bill 1477 built on this federal legislation with the goal of improving access across the entire continuum of crisis care. The July 988 launch is a major step in the beginning of this larger process. • Beginning in July, people dialing 9-8-8 will be routed to one of three NSPL call centers located in Washington; text and chat will be available as well. • DOH is working with the three NSPL calls centers to ensure their capacity to answer calls. The addition of 988 will not disrupt other services, current crisis phone lines and services will remain in place. • NSPL calls are routed based on the caller’s area code (<i>i.e.</i> people with WA area codes are routed to the Washington call centers). The NSPL administrator, Vibrant, currently manages this call routing. • The Washington Indian Behavioral Health Hub will also launch a crisis line for tribal-affiliated individuals in July.

TOPIC	DISCUSSION
	<p><i>Discussion/Questions:</i></p> <ul style="list-style-type: none"> • Will there be enough people to answer calls? Is Washington ready for that capacity increase? – DOH is working with Call Centers to increase capacity based on an estimated increased call volumes using Vibrant modeling figures. DOH will be monitoring call volumes as 988 is implemented and will take action as appropriate. • Currently most NSPL calls are resolved over the phone, but there are instances where call centers work with law enforcement on dispatch or have a need to deploy mobile crisis units. Recognized that when the marketing for 988 changes to a behavioral health crisis line, there may be many more dispatch situations than anticipated. • Once 988 launches and becomes the behavioral health crisis line, more people will call that line. 988 needs to be thoughtful in its messaging so that it is not overwhelmed with calls that are not intended for the line. • How will coordination and hand offs across the regional crisis lines, 911, and 988, the NSPL be managed? -- This is work that is currently underway to develop a process map to address these system interfaces. • The intersection between 988 and 911 will be an important consideration going forward. When should you call 988? When should you call 911? Messaging is so important.
<p>NSPL 988 Call Centers – Current Standards</p>	<p>Betsy introduced this agenda item and turned it over the NSPL call center representatives joining the call to provide an understanding of current call center staffing and training requirements.</p> <p>Neil Olson (Crisis Connections), Stacey Okihara (Frontier Behavioral Health), and Courtney Colwell (Volunteers of America) shared information about the NSPL accreditation process and call center staffing and training requirements. NSPL centers must be accredited by one of several recognized accreditation bodies. These bodies require that call centers have staffing and training policies in place, but do not require a single set of standards that all call centers must follow. Each call center may therefore establish its own staffing and training policies. There are no minimum education requirements outlined by NSPL that call center staff must meet. A reason for this is that many call centers are staffed by volunteers. With the new 1477 bill, call centers are moving into a paid staff model, and various paid positions may require certain education requirements. More recently, NSPL is beginning to engage more directly in call center staffing and training activities.</p> <p><i>Discussion/Questions:</i></p> <ul style="list-style-type: none"> • Which positions are hardest to recruit and retain? – Master’s level supervisors are difficult to hire. It is also hard to hire for weekend and overnight shifts.

TOPIC	DISCUSSION
	<ul style="list-style-type: none"> • Call centers have some flexibility in establishing staff training and education requirements. Accreditation provides a framework for policy, procedures, and expectations about how services should be managed, but is not prescriptive. • HCA (Matthew Gower) shared they are currently working on mobile crisis team staffing requirements and will bring to this subcommittee for input at a future meeting. • Noted the need to gather data on all current call center staffing and training requirements. This will provide baseline information about what is happening currently and where we need to go. What level of training or certification does the person answering a phone call need? What should the core level of basic training be across the state? • Subcommittee members shared the following perspectives: <ul style="list-style-type: none"> ○ A robust training program makes more sense for this work than higher education requirements. There could be a professional certification tailored to this field of work, but it should not be an academic certification. ○ Experiential experience is just as important as academic experience. ○ Criminal history requirements should be reassessed to consider where appropriate to allow individuals with a criminal history to work in these settings. ○ Ideally a staffing and training model would allow flexibility to meet the needs of varied situations. Every situation is different and there should be a model or procedure to assess risk levels to understand who would be the best fit for response.
Next Steps & Wrap Up	<p>Betsy shared that staff would take the feedback from this meeting and consider it in creating the next agenda, and further development of current NSPL call center staffing and training standards to inform the subcommittee’s discussion of future-state standards under HB 1477.</p>

HB 1477 CREDENTIALING AND TRAINING SUBCOMMITTEE – JUNE 22, 2022 MEETING

Meeting Summary

June 22, 2022, 3:00 pm to 4:30 pm

Zoom

Attendees

Subcommittee Members

Courtney Colwell, Volunteers of America (VOA)
Jan Tokumoto, Frontier Behavioral Health
Jessica Shook, Olympic Health and Recovery Services
Karl Hatton, Port Angeles Police Department, Pencom 9-1-1
Laurie Lippold, Partners for Our Children
Melody Youker, Martin Hall Juvenile Detention
Michael Delay, Columbia River Mental Health Services
Neil Olson, Crisis Connections
Stephanie Thelen, Catholic Community Services
Lora Ueland, Valley Com 911
Jolene Kron, Salish BH-ASO

Facilitation Staff

Betsy Jones, Health Management Associates
Nicola Pinson, Health Management Associates
Elizabeth Tenney, Health Management Associates

State Agency Staff

Allison Wedin, HCA
Amira Caluya, DOH
Beth Mizushima, DOH
Deb Spaulding, HCA
Matthew Gower, Washington State Healthcare Authority (HCA)
Sherry Wylie, HCA
Kelly McPherson, HCA
Luke Waggoner, HCA
Lucilla Mendoza, HCA
Jenn Combes, DOH
Jennie Harvell, HCA
Kelly McPherson, HCA
Eliza Tharp, HCA
Wyatt Dernbach, HCA
Todd Mountin, DOH
Megan Celedonia, Governor's Office

TOPIC	DISCUSSION
Welcome, Introductions, Review Meeting Agenda	<p>Betsy Jones, Health Management Associates, welcomed everyone to the meeting and staff and subcommittee members introduced themselves. This meeting included the following objectives:</p> <ol style="list-style-type: none"> 1. Provide HB 1477 Committee updates 2. Provide follow up summary of NSPL Call Center current staffing and training expectations 3. Request for Subcommittee input on opportunities to center equity in NSPL Call Center staffing and training 4. Understand HCA current activities relating to Mobile Crisis Teams 5. Request for Subcommittee input on Mobile Crisis Team Guide 6. Confirm action items and next steps.
Committee Updates	<p>Members reviewed the charge of the Credentialing and Training subcommittee to inform workforce needs and requirements related to behavioral health system redesign components outlined by HB 1477.</p> <p>Members reviewed Washington’s vision and guiding principles for the crisis response and suicide prevention system, approved by the Steering Committee. The vision and guiding principles were developed by the Ad Hoc Workgroup on Vision through meetings held March-May 2022 with input from the Rural & Agricultural, Lived Experience, and Tribal subcommittees, as well as the Children and Youth Behavioral Health Workgroup.</p> <p>Members reviewed overview of key activities and timeline to support HB 1477 Committee recommendations (see meeting slides). These include but are not limited to:</p> <ul style="list-style-type: none"> - Analysis of Medicaid claims and encounter data to inform understanding of Washington current service utilization and gaps. - Identification of other state best or promising practices and national benchmarks to inform recommendations for system goals. - Development of service cost estimates to inform funding recommendations. - Develop of Crisis System Process Map to bring together understanding of current system interfaces and gaps (which is the focus of this subcommittee, Cross System Collaboration and Coordination). <p>Members received an overview of other Subcommittee meetings occurring parallel to the work of the Cross System Collaboration Subcommittee. The May 2022 Subcommittee Report includes a compilation of all subcommittee meeting summaries and is available on the HCA website: https://www.hca.wa.gov/assets/program/cris-subcommittee-Report-20220501.pdf</p>

TOPIC	DISCUSSION
<p>Embedding Equity into NSPL Call Center Staffing & Training</p>	<p>Beth Mizushima, DOH, provided an overview summary of NSPL call center training and staffing requirements. At the previous Subcommittee meeting in April, members engaged in an initial discussion of current NSPL call center training and staffing requirements. DOH staff prepared a summary of this information for the Subcommittee’s review at today’s meeting. This understanding of baseline requirements will inform the subcommittee’s consideration of recommendations for additional training and credentialing needed to support HB1477 goals.</p> <p>At the federal level, Vibrant Emotional Health (the NSPL administrator) requires NSPL calls centers to provide for basic training of call center staff (both new and active staff members), but there are otherwise limited federal staffing and training requirements for call centers. NSPL accreditation bodies otherwise establish only general expectations that NSPL call centers maintain staffing and training policies, and it is up to each call center to create their own staffing and training requirements. More recently, in April 2022, Vibrant also announced the development of three core self-paced online trainings for crisis counselors available in fall 2022, which will be required for all crisis counselors under the new network agreements.</p> <p>In Washington, each of the NSPL call centers have established a range of staff trainings. DOH compiled an initial list of call center trainings across a number of areas (e.g. confidentiality, customer services, crisis intervention, diversity and cultural humility). The list is based on NSPL, DOH, and other state training requirements applicable to various organizations (e.g., behavioral health agencies). This list is a starting point for discussion of NSPL trainings but does not necessarily capture all call center training activities.</p> <p><i>Discussion:</i></p> <ul style="list-style-type: none"> • Members noted that the scope and depth of training in each subject area may vary across call centers. There are currently no standards regarding the content and depth of trainings. How can we standardize so that there is baseline expectations for what these trainings address. • Noted that the table reflects trainings required by multiple sources, including NSPL, DOH and Washington Administrative Code (WAC). • Noted that some check boxes in some topic areas are not checked for the call centers because they may be embedded in other training topic areas. • With respect to promoting and embedding equity, noted the need to improve call center diversity, equity and inclusion trainings. • To promote equity in services across the state, subcommittee members noted the need the ensure a common level of training across staff. • Noted need for the committee to identify baseline training requirements to ensure a common level of competency across the state. No matter where

TOPIC	DISCUSSION
	<p>someone is across the state, they should have access to people with the same basic training.</p> <ul style="list-style-type: none"> • Noted opportunity to build a core set of trainings in a shared platform (e.g. Relias) that everyone could access. <p>HMA provided background regarding HB 1477 charge to committees to develop recommendations to promote equity in services for an integrated behavioral health crisis response and suicide prevention system. HMA requested feedback from this subcommittee on ways to embed equity into the CRIS High-Level Workplan with a focus on staffing and training requirements. HMA reviewed the High Level Workplan and provided examples of feedback that was gathered from the CRIS Committee. HMA will send a word version of the workplan to the subcommittee after the meeting for Subcommittee members to submit feedback by email.</p>
<p>Mobile Crisis Teams</p>	<p>HCA provided background about mobile crisis response teams and HCA goals to support implementation of models in Washington based on SAMHSA best practices. Provided overview of mobile crisis team models for youth and adults, including current practices and future-state goals. Review current training requirements to teams. HCA is starting to move towards standardizations for mobile crisis teams, with trainings launching in the fall aligned with SAMHSA’s best practices requirements along with other new trainings. HCA has also been looking at creating a more standardized approach to training, and they are exploring options that would help build the workforce. HCA noted that it has been shown that experience is generally more important than education for mobile crisis responders.</p> <p>HCA is requesting Subcommittee feedback on Mobile Crisis Team training and workforce development efforts. Potential ideas for discussion include:</p> <ul style="list-style-type: none"> • MCR Academy <ul style="list-style-type: none"> • 40-hour training • Provide core crisis intervention competencies for those with BA/BS degrees in psychology, social work or related fields • Develop BH Crisis Responder vocational type degree program <ul style="list-style-type: none"> • Develop a 24-month degree program to train BH Crisis Responders and prepare them to work on MCR teams and co-responder teams. • Working with DOH on allowing peers to respond to initial crisis with bachelor level clinician, currently must be MHP <p>HMA will follow up to share the HCA draft Mobile Crisis Team guide with the Subcommittee for further discussion of training and staffing requirements at the next Subcommittee meeting.</p>

TOPIC	DISCUSSION
Next Steps & Wrap Up	HMA to follow up with the following materials: <ol style="list-style-type: none"> 1. HCA Draft Mobile Crisis Team guide 2. High Level Workplan with notes compiling ideas to embed equity in the workplan.

HB 1477 Rural & Agricultural Communities Subcommittee

HB 1477 RURAL & AGRICULTURAL COMMUNITIES SUBCOMMITTEE – APRIL 14TH MEETING

Meeting Summary

Thursday, April 14, 2022, 3:00 pm to 5:00 pm

Zoom

Attendees

Subcommittee Members

Don McMoran, WSU Skagit County Extension
Elizabeth Weybright, WA State University
Diana Porter, Consumer Voices are Born
Jenelle Strine, Disorder Counselor, Makah Tribe
Jovanna Centre, Comprehensive Healthcare
Judy Nelson, PayDirt Farm News
Laura Prater, UW School of Medicine
Lexa Donnelly, Great Rivers BH-ASO
Lindsey Shankle, Lewis County Public Health and Social Services
Mike Worden, Okanogan County Sheriff's Office
Pam Lewison, JP Ranch/Washington Policy Center
Peggy Needham, Reach Out Walla Walla Suicide Prevention
Representative Tom Dent, WA State House of Representatives
Sindi Saunders, Greater Columbia BH-ASO
Susan Gregory, Volunteers of America
Tonya Stern, Frontier Behavioral Health

Facilitation Staff

Betsy Jones, Health Management Associates
Nicola Pinson, Health Management Associates
Suzanne Rabideau, Health Management Associates
Elizabeth Tenney, Health Management Associates
Michael Anderson-Nathe, Michael Anderson-Nathe Consulting

State Agency Staff

Beth Mizushima, Washington State Department of Health (DOH)
Eliza Tharp, Washington State Healthcare Authority (HCA)
Luke Waggoner, HCA
Matthew Gower, HCA
Sherry Wylie, HCA
Wyatt Dernbach, HCA
Theresa Tamura, HCA

TOPIC	DISCUSSION
<p>Welcome, Introductions, Review Meeting Agenda</p>	<p>Staff, agency, and subcommittee members introduced themselves to the group and Betsy Jones, Health Management Associates, reviewed the meeting agenda. Meeting objectives included:</p> <ol style="list-style-type: none"> 1. Understand charge and role of the Rural & Agricultural Communities Subcommittee. 2. Understand agencies plans for the July 988 launch. 3. Begin discussion of opportunities to center equity from the perspective of rural and agricultural communities. 4. Review and provide input into Washington’s vision for a behavioral health crisis response and suicide prevention system. 5. Confirm action items and next steps.
<p>Charge and Role of the Rural & Agricultural Communities Subcommittee</p>	<p>Members reviewed the charge and role of the Rural and Agricultural Communities Subcommittee: To provide rural and agricultural community perspectives into the development of the Washington behavioral health crisis response and suicide prevention system. This charge includes, but not limited to, informing the following recommendations outlined by HB 1477:</p> <ul style="list-style-type: none"> • Recommendations to promote equity in services for individuals of diverse circumstances of culture, race, ethnicity, gender, socioeconomic status, sexual orientation, and for individuals in tribal, urban, and rural communities. • Recommendations ensure the availability of resources to meet the unique needs of persons in the agricultural community who are experiencing mental health stresses, which explicitly addresses concerns regarding confidentiality. <p>The Steering Committee approved the CRIS High-Level Workplan, which will provide an organizing framework for our work ahead to ensure the full continuum of crisis response. The High-Level Workplan includes five objective areas:</p> <ul style="list-style-type: none"> • Objective 1: A place to contact – NSPL call centers • Objective 2: Someone to come – Mobile crisis rapid response teams • Objective 3: A place to go – Broad range of crisis stabilization services • Objective 4: Pre- and Post-Crisis Care – Immediately upstream and downstream of crisis events • Objective 5: Crisis system infrastructure and oversight <p>State agencies are responsible for implementation of this work, and the Steering Committee, CRIS and Subcommittees will provide</p>

TOPIC	DISCUSSION
	<p>recommendations. The Subcommittee role is to provide professional and community perspectives that inform the recommendations that are developed by the Steering Committee.</p>
<p>988 NSPL July Launch</p>	<p>DOH (Beth Mizushima) and HCA (Matthew Gower) provided legislative background and update on the 988 NSPL July Launch.</p> <ul style="list-style-type: none"> • The federal 988 Implementation Act established the new National Suicide Prevention Line 3-digit 988 number to improve access to support for individuals in crisis. • Washington’s House Bill 1477 built on this federal legislation with the goal of improving access across the entire continuum of crisis care. The July 988 launch is a major step in the beginning of this larger process. • Beginning in July, people dialing 9-8-8 will be routed to one of three NSPL call centers located in Washington; text and chat will be available as well. • DOH is working with the three NSPL calls centers to ensure their capacity to answer calls. The addition of 988 will not disrupt other services, current crisis phone lines and services will remain in place. • NSPL calls are routed based on the caller’s area code (<i>i.e.</i> people with WA area codes are routed to the Washington call centers). The NSPL administrator, Vibrant, currently manages this call routing. • The Washington Indian Behavioral Health Hub will also launch a crisis line for tribal-affiliated individuals in July. <p><i>Discussion/Questions:</i></p> <ul style="list-style-type: none"> • Connectivity of the line has been tested and the expectation is that all carriers are prepared and ready for the July launch. • Calls are currently routed by area codes and the three NSPL call centers will answer Washington calls. Subcommittee members emphasized that calls need to be routed based on physical location in order to meet the needs of rural and agricultural communities.
<p>Initial Discussion: Providing Rural & Agricultural Community Perspectives on Centering Equity</p>	<p>Michael Anderson Nathe, an independent consultant working with the HMA facilitation team, provided an overview of committee work to develop recommendations for centering equity in the crisis system redesign work. Michael shared the High-Level Workplan and requested the group’s input on tangible ways to embed equity. As an example, the group discussed Objective 1 (A place to call), identifying the following input:</p>

TOPIC	DISCUSSION
	<ul style="list-style-type: none"> • Farmers have a fundamental lack of trust in the government. If the call lines are not working perfectly from the start, the agricultural community will not buy into it. • Calls must be routed to the correct location to meet the needs of rural and agricultural communities. • Trust is a critical issue. It will be critical to understand who these communities trust. It needs to be someone who understands their situation. Farm life is incredibly difficult and has unique stressors. • Protection of personal rights and freedoms is imperative. This community needs someone to save their life, not take their rights away. If they think they are going to lose something like a freedom or right they will not call. • In border communities, tribes may want to receive services from a separate state, which is closer. • Training individuals answering calls on the issues unique to rural and agricultural communities is important. There is currently a pilot program providing education and tools for people taking these calls focused on recognizing the unique challenges and perspectives of American farmers. • Anonymity is important. It is important to manage anonymity give rural and agricultural communities can be small and personal information can spread quickly. People are generally okay with sharing information with the person who answers the call but would have concern about information shared beyond that person. <p>As a next steps, workgroup members were asked to provide feedback by April 29th to the HMA project team (contact: Nicola Pinson, npinson@healthmanagement.com) on tangible actions to center equity across all five objectives in the High-Level Workplan.</p>
<p>Interactive Exercise: Inform a Vision Statement for Washington’s behavioral health crisis response and suicide prevention system</p>	<p>Suzanne Rabideau, Health Management Associates, provided context on the work to date to develop a draft vision statement, and request at this meeting for input and feedback from the Rural & Agricultural Communities Subcommittee.</p> <p>Subcommittee members reviewed the draft vision statement and guiding principles:</p> <ul style="list-style-type: none"> • Vision statement: “988 offers a connection to anyone who is struggling, meeting them with acceptance and empathy, offering hope and recovery.”

TOPIC	DISCUSSION
	<ul style="list-style-type: none"> • Guiding Principles: <ul style="list-style-type: none"> ○ People in Crisis Experience: A seamless system without barriers; A welcoming response that is healing and provides hope; Person and family centered care; Care that is responsive to developmental, cultural, and linguistic needs. ○ The Crisis System is Intentionally: Grounded in equity and anti-racism; Centered in and informed by lived experience; Coordinated, collaborative across system partners; Empowered by technology; Sustainably and equitably financed. <p>Members were asked whether the vision statement and principles work for rural and agricultural communities. If not, what would they like to see changed? What do they like about the vision statement and principles?</p> <ul style="list-style-type: none"> • Overall felt rural interests reflected in the vision statement, although the language felt “pastel” and needs to be more direct and plain language to speak to a rural and agricultural audience. Many farmers will not respond to words like ‘acceptance’, ‘empathy’, ‘hope’, and ‘recovery’, especially older ones. • Appreciated its focus on lived experience and family. • Consider including the concept of anonymity in the vision • Suggestion to shorten the vision and principles. Nine bullet points of principles plus a vision statement is a lot. • Many in rural and agricultural communities do not have access to crisis care resources. This community is in crisis mode all the time because they do not have the resources to meet their needs. Connecting them to 988 is great, but then what? How do we support them moving forward? • How are you going to get the word out about the 988 number? Distinguished vision statement from communications campaign and messaging to reach rural and agricultural communities. • When a farmworker is in crisis, there is a 15-minute period that is crucial for care. Something related to the need for rapid response could be added. <p>Suzanne thanked the group for their feedback and asked them to share any additional feedback with the HMA Project Team (Nicola Pinson – npinson@healthmanagement.com) by April 29th. This input will be brought</p>

TOPIC	DISCUSSION
	forward into the process to finalize the vision statement, including review by the CRIS Committee at their May meeting.
Next Steps & Wrap Up	<p>Next steps:</p> <ol style="list-style-type: none"> 1. Staff will summarize the subcommittee’s input on the draft vision statement which will be shared at the May CRIS Committee meeting. Subcommittee members are invited to share additional feedback due by April 29th. 2. Equity conversations will continue going forward, and initial feedback on tangible action to embed equity into the High Level Workplan are request by April 29th.

HB 1477 RURAL & AGRICULTURAL COMMUNITIES SUBCOMMITTEE – JUNE 23, 2022 MEETING

Meeting Summary

Thursday, June 23, 2022, 3:00 pm to 4:00 pm

Zoom

Attendees

Subcommittee Members

Allison Browne, WA Department of Health (DOH)
Bob Small, Premera Blue Cross
Brittany Campbell, Northeast WA Education Service District 101
Don McMoran, WSU Skagit County Extension
Elizabeth Weybright, WA State University
Diana Porter, Consumer Voices are Born
Jenelle Strine, Disorder Counselor, Makah Tribe
Jean Marie Dreyer, Washington State Health Care Authority (HCA)
Jodie Hartman, Lakewood VA Outpatient Mental Health
Jovanna Centre, Comprehensive Healthcare
Judy Nelson, PayDirt Farm News
Laura Prater, UW School of Medicine
Lexa Donnelly, Great Rivers BH-ASO
Lindsey Shankle, Lewis County Public Health and Social Services
Mike Worden, Okanogan County Sheriff's Office
Nicole Davis, Crisis Connections,
Pam Lewison, JP Ranch/Washington Policy Center
Peggy Needham, Reach Out Walla Walla Suicide Prevention
Representative Tom Dent, WA State House of Representatives
Sindi Saunders, Greater Columbia BH-ASO
Skylar Newkirk, Klickitat Valley Health
Susan Gregory, Volunteers of America
Todd Kimball, Walla Walla County
Tonya Stern, Frontier Behavioral Health
Tori Bernier, Summit Pacific Medical Center

Facilitation Team

Betsy Jones, Health Management Associates
Nicola Pinson, Health Management Associates
Elizabeth Tenney, Health Management Associates
Mark Podrazik, Health Management Associates

State Agency Staff

Beth Mizushima, Washington State Department of Health (DOH)
Eliza Tharp, Washington State Healthcare Authority (HCA)
Luke Waggoner, HCA
Matthew Gower, HCA
Sherry Wylie, HCA
Wyatt Dernbach, HCA
Theresa Tamura, HCA

TOPIC	DISCUSSION
<p>Welcome, Introductions, Review Meeting Agenda</p>	<p>Staff, agency, and subcommittee members introduced themselves to the group and Betsy Jones, Health Management Associates, reviewed the meeting agenda. Meeting objectives included:</p> <ol style="list-style-type: none"> 1. Provide HB 1477 Committee updates 2. Provide overview of approach to Medicaid claims and & encounter data analysis 3. Provide input on potential mapping approach for determining gaps in services in rural areas 4. Understand HCA current activities relating to Mobile Crisis Teams 5. Request for Subcommittee input on Mobile Crisis Team Guide 6. Confirm action items and next steps
<p>Committee Updates</p>	<p>Members reviewed the charge of the Rural & Agricultural Subcommittee to provide rural and agricultural community perspectives into the development of the Washington behavioral health crisis response and suicide prevention system.</p> <p>Members reviewed Washington’s vision and guiding principles for the crisis response and suicide prevention system, approved by the Steering Committee. The vision and guiding principles were developed by the Ad Hoc Workgroup on Vision through meetings held March-May 2022 with input from the Rural & Agricultural, Lived Experience, and Tribal subcommittees, as well as the Children and Youth Behavioral Health Workgroup.</p> <p>Members reviewed overview of key activities and timeline to support HB 1477 Committee recommendations (see meeting slides). These include but are not limited to:</p> <ul style="list-style-type: none"> - Analysis of Medicaid claims and encounter data to inform understanding of Washington current service utilization and gaps. - Identification of other state best or promising practices and national benchmarks to inform recommendations for system goals. - Development of service cost estimates to inform funding recommendations. - Develop of Crisis System Process Map to bring together understanding of current system interfaces and gaps <p>Members received an overview of other Subcommittee meetings occurring parallel to the work of the Rural & Agricultural Subcommittee. The May 2022 Subcommittee Report includes a compilation of all subcommittee meeting summaries and is available on the HCA website:</p>

TOPIC	DISCUSSION
	https://www.hca.wa.gov/assets/program/cris-subcommittee-Report-20220501.pdf
Approach to Determining Gaps in Services in Rural Areas	<p>Mark Podrazik, Health Management Associates (HMA), shared that HMA is working with data provided by the Health Care Authority to analyze crisis service utilization in the Medicaid program to present at the July 12th CRIS committee meeting. He explained the major components of the analysis, how the populations and service categories were defined, and what populations and subpopulations are included.</p> <p>HMA requested feedback from the subcommittee on their research methods.</p> <ul style="list-style-type: none"> • Members were appreciative that teenage and elderly populations were being examined as subpopulations. • What about those who don't qualify for support through Medicaid? HMA is still working to receive other types of data. • Are evaluation and treatment facilities included within the nine service categories that were displayed? These would likely be placed in the crisis services category, as the categorization is based on the type of claim. • Does the medication assisted treatment services category include medications for treatment of alcohol use disorders? HMA will follow up on adding this to the service category. <p>HMA requested subcommittee feedback on definition of rural and urban areas. members had other ideas for how to look at regional variation in the state. He showed two maps of the state that characterized rural and urban areas differently and asked subcommittee members for their feedback or method preference. Subcommittee members offered input:</p> <ul style="list-style-type: none"> • Suggestion that rural or urban areas should be categorized by county. • Suggestion to simplify approach. We need to be able to define rural and agricultural areas clearly before choosing the level of categorization. <ul style="list-style-type: none"> ○ Population concentration per square mile is one way to define rural or agricultural areas. • Recommend that rural and agricultural groups are not separated; generally speaking if you work in agriculture you live in a rural environment.

TOPIC	DISCUSSION
	<p>HMA offered example of mapping approach used in project in Indiana where HMA analyzed whether a population had access to substance use disorder treatment. In this example, a 20-mile radius was drawn around each substance use provider to show a coverage area, with counties indicated. Subcommittee members appreciated the map of Indiana shown and agreed this type of mapping approach to demonstrate access gaps would be helpful in Washington.</p>
<p>Mobile Crisis Response Teams</p>	<p>HCA provided background about mobile crisis response teams and HCA goals to support implementation of models in Washington based on SAMHSA best practices.</p> <p>Provided overview of mobile crisis team models for youth and adults, including current practices and future-state goals. Review current training requirements to teams. HCA is starting to move towards standardizations for mobile crisis teams, with trainings launching in the fall aligned with SAMHSA’s best practices requirements along with other new trainings. HCA has also been looking at creating a more standardized approach to training, and they are exploring options that would help build the workforce. HCA noted that it has been shown that experience is generally more important than education for mobile crisis responders.</p> <p>HCA is requesting subcommittee feedback on how to adapt the mobile crisis response team models to rural areas, as HCA recognizes it will be important to adapt team systems to the needs of rural areas. What are the non-traditional partnerships that might be beneficial?</p> <ul style="list-style-type: none"> • Suggestion that it would be helpful to consider partnering with groups familiar to those in agriculture but not traditional mental health responders. Building trust is critical for creating a quick and effective behavioral health response model. <p>Representative Dent emphasized the need for the Subcommittee to focus on the initial call and response for agricultural and rural individuals. Betsy noted that the next meeting can be entirely dedicated to the initial crisis call. Today’s discussion focused on the “Someone to Come” aspects of the crisis response system.</p>
<p>Next Steps & Wrap Up</p>	<p>The HMA team will follow up with the next meeting date and materials for the subcommittee to review.</p>

HB 1477 Confidential Information Compliance & Coordination Subcommittee

HB 1477 CONFIDENTIAL INFORMATION COMPLIANCE & COORDINATION – APRIL 20TH MEETING

Meeting Summary

Wednesday April 20, 2022, 2:30 pm to 4:00 pm

Zoom

Attendees

Subcommittee Members

Cara Helmer, Washington State Hospital Association
Carolina Brown, Department of Corrections
Jeff Kimball, Family Behavioral Health
Jennifer Kreidler, Peninsula Community Health Services
Jesse Hayes, Washington State Department of Health (DOH)
Levi Van Dyke, Volunteers of America
Martyrna Timmerman, Volunteers of America
Mike McIntosh, Catholic Community Services of Western Washington
Nicole Sharp, Walla Walla County Department of Community Health
Sam Méndez, Washington State Health Care Authority (HCA)
Tonya Stern, Frontier Behavioral Health

Facilitation Staff

Betsy Jones, Health Management Associates
Nicola Pinson, Health Management Associates
Elizabeth Tenney, Health Management Associates

State Agency Staff

Todd Mountin, Washington Department of Health (DOH)
Matthew Gower, Washington Health Care Authority (HCA)
Caitlin Stugelmeyer, HCA
Jennifer Brown, DOH
Wyatt Dernbach, HCA
Jennie Harvell, HCA
Luke Waggoner, HCA
Samuel Morones

Additional Participants

Jerome Johnson

TOPIC	DISCUSSION
Welcome, Introductions, Review Meeting Agenda	<p>Betsy Jones, Health Management Associates, welcomed everyone to the meeting and staff and subcommittee members introduced themselves. Betsy reviewed the meeting agenda. This meeting included the following objectives:</p> <ol style="list-style-type: none"> 1. Understand charge and role of the Confidential Information & Coordination Subcommittee. 2. Understand agencies plans for the July 988 launch. 3. Understand National Suicide Prevention Line (NSPL) 988 Call Center privacy standards. 4. Understand privacy law impacts (i.e., HIPAA and 42 CFR Part 2) on various scenarios for information sharing.
Charge for the Confidential Information Compliance & Coordination Subcommittee	<p>Betsy overviewed the charge and role of the confidential information compliance and coordination subcommittee and how it works with and relates to the Steering committee, the CRIS committee, and the other subcommittees.</p> <p>The charge of the Confidential Information Compliance and Coordination Subcommittee is to examine and advise on issues related to sharing and protection of health information needed for an effective behavioral health crisis response and suicide prevention system. This includes the following elements identified by HB 1477:</p> <ul style="list-style-type: none"> ➤ Inform information-sharing guidelines to enable crisis call center hubs to actively collaborate with system partners to establish a safety plan for individuals in crisis in accordance with best practices and provide next steps for the person’s transition to follow-up noncrisis care. ➤ Ensure the availability of resources to meet the unique needs of persons in the agricultural community who are experiencing mental health stresses, which explicitly addresses concerns regarding confidentiality.
988 NSPL July Launch	<p>Todd Mountin, DOH, gave legislative background and update on the 988 NSPL July Launch.</p> <ul style="list-style-type: none"> • The federal 988 Implementation Act established the new National Suicide Prevention Line 3-digit 988 number to improve access to support for individuals in crisis. • Washington’s House Bill 1477 built on this federal legislation with the goal of improving access across the entire continuum of crisis care. The July 988 launch is a major step in the beginning of this larger process. • Beginning in July, people dialing 9-8-8 will be routed to one of three NSPL call centers located in Washington; text and chat will be available as well. • DOH is working with the three NSPL calls centers to ensure their capacity to answer calls. The addition of 988 will not disrupt other services, current crisis phone lines and services will remain in place.

TOPIC	DISCUSSION
	<ul style="list-style-type: none"> • NSPL calls are routed based on the caller’s area code (<i>i.e.</i> people with WA area codes are routed to the Washington call centers). The NSPL administrator, Vibrant, currently manages this call routing. • The Washington Indian Behavioral Health Hub will also launch a crisis line for tribal-affiliated individuals in July. <p><i>Discussion/Questions:</i></p> <ul style="list-style-type: none"> • Subcommittee members raised concerned about call routing conducted based on the caller’s area code. Many people living in the state have out of state area codes. How do we make sure that people are connected to someone locally? -- Currently, the system is dependent on the Vibrant platform for routing. Washington has recognized this concern and is looking into potential options, including 911 tools and standards. The Federal Communications Commission is holding a hearing on 988 and geolocation in late May where this issue will be discussed along with potential solutions. Currently, call centers engage in a warm transfer between states to make a local connection and ensure the individual on the phone feels supported. Call centers operate in accordance with NSPL standards and are committed to making a local connection.
<p>988 NSPL Call Center Privacy Standards</p>	<p>Levi Van Dyke, Volunteers of America, provided an overview of 988 NSPL call center privacy standards currently in place (Levi shared the following link with a summary of current privacy expectations for callers: https://suicidepreventionlifeline.org/chat-terms-of-service/). Currently, NSPL call centers gather limited personal health information, they house their data in their own electronic records systems, and each call center establishes policies to cover data privacy and security. Chat and text are somewhat different, as the Lifeline receives more data and information through that function. Caller anonymity is a key aspect of NSPL services.</p> <p><i>Discussion:</i></p> <ul style="list-style-type: none"> • Members recognized the importance of considering the impacts to privacy as Washington development plans to implement HB 1477 goals for increased information sharing. • Members recognized the significant difference between 911 and 988 expectations for caller privacy, where 911 gathers significantly more information about a caller and their location in order to initiate a response. • Recognition of intersection between this subcommittee and the technology subcommittee with respect to work on information sharing. • NSPL call centers are not HIPAA-covered entities; important to understand the point at which in the transfer of information that it becomes protected by HIPAA or 42 CFR Part 2.

TOPIC	DISCUSSION
Information Sharing & Federal and State Privacy Laws	<p>Sam Mendez, HCA, provided an overview of federal and state privacy laws and key considerations for crisis system information sharing. This included a review of the Health Insurance Portability and Accountability Act (HIPAA) and 42 CFR Part 2. HIPAA and Part 2 generally require consent to disclose protected health information with exceptions for specific circumstances. One of the HIPAA exceptions allows disclosures if “necessary to prevent or lessen a serious and imminent threat to the health or safety of the patient...” 42 CFR Part 2 allows information to be disclosed to medical personnel to the extent necessary for “a bona fide medical emergency” in which the patient’s consent cannot be obtained.</p> <p><i>Discussion:</i></p> <ul style="list-style-type: none"> • Noted that NSPL call centers focus on maintaining caller anonymity and operate based on the NSPL privacy standards (they are not HIPAA-covered or Part 2 entities). They may work with 911/first responder to initiate an active rescue and identify a person’s location only if there is “imminent risk” to the caller’s life. This occurs after they have exhausted options to de-escalate the crisis with the caller. • Noted that it would be helpful to develop scenarios to illustrate these exceptions. • Noted the importance of understanding when HIPAA and Part 2 requirements are activated in the course of information sharing across the continuum of crisis response. At what point would consent be required? Can you ask for consent to disclose protected health information to providers in advance of an emergency? The group agreed these were important conversations that they will continue to have going forward, including consideration of privacy concerns for specific populations.
Next Steps & Wrap Up	<p>Staff will follow up with the Subcommittee to schedule the next meeting. Staff noted they will be bringing an equity conversation at an upcoming meeting, as well further discussion of information sharing across the continuum of crisis response and key considerations for privacy.</p>

HB 1477 CONFIDENTIAL INFORMATION COMPLIANCE & COORDINATION – JUNE 28, 2022 MEETING

Meeting Summary

Tuesday, June 28, 2022, 11:30 am to 1:00 pm

Zoom

Attendees

Subcommittee Members

Cara Helmer, Washington State Hospital Association
Diane Mayes, Crisis Connections
Jeff Kimball, Family Behavioral Health
Martyna Timmerman, Volunteers of America
Mike McIntosh, Catholic Community Services of Western Washington
Sam Méndez, Washington State Health Care Authority (HCA)
Sindi Saunders, Greater Columbia BH-ASO

Facilitation Staff

Betsy Jones, Health Management Associates
Nicola Pinson, Health Management Associates
Elizabeth Tenney, Health Management Associates
Michael Anderson-Nathe, Anderson-Nathe Consulting

State Agency Staff

Allison Wedin, HCA
Amira Caluya, DOH
Beth Mizushima, DOH
Codie Marie Garza, Washington Department of Veterans Affairs
Deb Spaulding, DOH
Eliza Tharp, HCA
Jenn Combes, DOH
Jennie Harvell, HCA
Lonnie Peterson, DOH
Luke Waggoner, HCA
Matthew Gower, HCA
Megan Celedonia, Washington Governor's Office
Todd Mountin, DOH
Wyatt Dernbach, HCA

Additional Participants

Jerome Johnson

TOPIC	DISCUSSION
<p>Welcome, Introductions, Review Meeting Agenda</p>	<p>Betsy Jones, Health Management Associates, welcomed everyone to the meeting and staff and subcommittee members introduced themselves. Betsy reviewed the meeting agenda. This meeting included the following objectives:</p> <ol style="list-style-type: none"> 1. Provide HB 1477 Committee updates 2. Update on work to develop HB 1477 Technical and Operational Plan and discussion of intersection with Confidential Information Subcommittee 3. Update on Tribal Data Sovereignty considerations, GPS/Geo-location and In-State Call Routing, and Mental Health Advanced Directives 4. Discuss opportunities to embed equity into the CRIS High Level Workplan with respect to information sharing and confidentiality
<p>Committee Updates</p>	<p>Members reviewed the charge of the Confidential Information Compliance and Coordination Subcommittee and their role in the development of the Washington behavioral health crisis response and suicide prevention system.</p> <p>Members reviewed Washington’s vision and guiding principles for the crisis response and suicide prevention system, approved by the Steering Committee. The vision and guiding principles were developed by the Ad Hoc Workgroup on Vision through meetings held March-May 2022 with input from the Rural & Agricultural, Lived Experience, and Tribal subcommittees, as well as the Children and Youth Behavioral Health Workgroup.</p> <p>Members reviewed overview of key activities and timeline to support HB 1477 Committee recommendations (see meeting slides). These include but are not limited to:</p> <ul style="list-style-type: none"> - Analysis of Medicaid claims and encounter data to inform understanding of Washington current service utilization and gaps. - Identification of other state best or promising practices and national benchmarks to inform recommendations for system goals. - Development of service cost estimates to inform funding recommendations. - Develop of Crisis System Process Map to bring together understanding of current system interfaces and gaps (which is the focus of this subcommittee, Cross System Collaboration and Coordination). <p>Members received an overview of other Subcommittee meetings occurring parallel to the work of the Confidential Information Compliance and Coordination Subcommittee. The May 2022 Subcommittee Report includes a compilation of all subcommittee meeting summaries and is available on the HCA website: https://www.hca.wa.gov/assets/program/cris-subcommittee-Report-20220501.pdf</p>

TOPIC	DISCUSSION
<p>HB 1477 Technical and Operational Plan</p>	<p>Jennie Harvell, HCA, updated the subcommittee on the progress with the Technical and Operational Plan currently in development. The DOH and HCA are required to create this plan to develop and implement the required technology and platforms to support HB 1477 program activities. The updated draft plan is due at the end of August, and the final plan by October 31, 2022. Jennie discussed the technology requirements for the plan, the process for developing the plan, current progress, and the vision; HCA asked for feedback on this work from the subcommittee to help identify considerations relating to confidentiality, data privacy, information, and security concerns.</p> <p>Subcommittee members provided feedback on concerns related to geolocation and GPS:</p> <ul style="list-style-type: none"> • Discussion regarding the purpose of geolocation for 988, and the difference between GPS and geolocation. • Law enforcement has raised concerns about GPS and geolocation usage, as this could jeopardize law enforcement’s ability to respond to a crisis event. The work has shifted away from tracking law enforcement for this reason. • Geolocation may reduce veteran engagement with the system, as they would likely be concerned upon finding out their location was being tracked. The Rural & Agricultural Subcommittee has also raised this concern. HCA noted that SAMHSA and FCC are considering these issues. <p>HCA provided an update on tribal data sovereignty principles, which has been raised by tribes. This applies to information sharing between governments and include information sharing on behalf of tribal members in crisis. These principles extend to contractors engaged by a state agency. Data sharing agreements, then, are needed with each tribal government and state agencies and contractors. The data sharing template is in development. HCA and DOH are currently working with Vibrant to determine routing of 988 calls to the Native and Strong Line.</p> <p>HCA shared an update on technology that is being explored for mental health advance directives. In July, the Technology Subcommittee will hear from experts who developed the technology system and consider its operability for mental health advance directives. Subcommittee provided input on confidentiality concerns or considerations over the mental health advance directives or use of a repository to store these types of documents:</p> <ul style="list-style-type: none"> • A shared understanding of privacy and the nature of these documents critical. • There are technical challenges with securing data and information that are stored online and in repositories. <p>After the meeting, HMA will send out a request to subcommittee members asking for written feedback on HCA’s Technical and Operational Plan.</p>

TOPIC	DISCUSSION
<p>Request for Subcommittee Input: Embedding Equity into the CRIS High Level Workplan</p>	<p>Michael Anderson-Nathe, part of HMA’s team and expert in equity work, provided background regarding HB 1477 charge to committees to develop recommendations to promote equity in services in an integrated behavioral health crisis response and suicide prevention system. HMA is requesting feedback from this subcommittee on ways to embed equity into the CRIS High-Level Workplan with respect to information sharing and confidentiality.</p> <p>Michael overviewed the High-Level Workplan and to provide examples of the types of feedback requested.</p> <ul style="list-style-type: none"> • How do we share information between different centers and maintain confidentiality while also being useful or helpful to the caller? There is a balance to strike here. • What other work is happening that might contribute to trying to standardize process flows between 988 and 911? This activity of providing feedback on the workplan and embedding equity may help to identify current activities in this area. • Discussed Objective 1.3 and the need to consider how to streamline or standardize information gathered to avoid requesting that callers share their information several times. • Recognized the need to ensure confidentiality across the system and recognition of critical information sharing where needed. <p>HMA explained the feedback process and requested Subcommittee feedback by July 15th. HMA will follow up to share the High-Level Workplan and highlight workplan objectives where confidentiality and information may be especially relevant for the subcommittee to focus on; Subcommittee members are invited to provide feedback across all of the objectives.</p>
<p>Next Steps & Wrap Up</p>	<p>HMA is finalizing the dates for the next subcommittee meeting and will send out an email update.</p> <p>HMA will send out a request for subcommittee input on activities to embed equity in the CRIS High Level Workplan.</p> <p>HMA will send out the draft Section 109 Technical and Operational plan, following HCA’s presentation.</p>