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HB 1477 Lived Experience Subcommittee – February 13th Meeting

Meeting Summary

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

Zoom

TOPIC	DISCUSSION
Welcome, Introductions, Review Meeting Agenda	• HB 1477 Steering Committee member Bipasha Mukherjee welcomed everyone to the meeting and introduced the agenda. Bipasha also highlighted that the next CRIS meeting will be held on February 15th 3-6pm. This meeting agenda and Zoom link are available on the CRIS webpage - https://www.hca.wa.gov/about-hca/programs-and-initiatives/behavioral-health-and-recovery/crisis-response-improvement-strategy-cris-committees .
Discussion: Lived Experience Perspectives on Crisis System Gaps	• Puck Kalve Franta (CRIS member representing lived experience) introduced this agenda item and the importance of lived experience perspectives on crisis system gaps. • Matt Gower (Washington State Health Care Authority) presented HCA's current work to expand Mobile Crisis Response resources and develop best practices and standard team staff compositions (including clinician, peer, and supervisor). He encouraged feedback from the group, especially around current system gaps. Additional questions for feedback include: 1) Is the MCR team composition appropriate, 2) Should we consider any other models or services for MCR? 3) What should we consider a service area (regional level, county level)? 4) How should we prioritize expansion (factors to consider)? • Subcommittee discussion included: ○ **Crisis stabilization beds for individuals in jail**. Some individuals have been waiting almost a year, despite the federal requirement of a bed within seven days. This topic of conversation may need to be further addressed in future meetings. ○ **How to address the fear of police engagement when individuals call the 988 line.** How do we address concern among individual who will not call 988 due to fear that the police will show up and cause further damage? Support is needed around messaging, and clear communication and protocols for when police will be involved. ○ **Support needed for crisis response staff representing populations served.** An example was given of a call center with

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

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

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

Meeting Summary

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

Zoom

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

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	• **SB 5120-** Establishes 23-hour crisis relief facilities, that are open 24 hours, 7 days a week, to both walk-in and drop-offs. This bill passed out of the Senate and has moved to the House Health Care and Wellness committee. • **HB 1004-** Focuses on installing signs near bridges to deter jumping and give 988 information. Has passed out of the House and has been referred to the Senate Transportation Committee. • **SB 5555-** Establishes new professions of certified peer specialists, and certified peer specialist trainees to be certified by the Department of Health. Directs the Health Care Authority to develop training and examinations. This bill passed out the Senate and was referred to the House Health Care and Wellness committee. A public hearing is scheduled on March 15th. • **HB 1541 (Nothing About Us Without Us)-** Increases access and representation in policymaking for people with lived experience. Includes lived experience membership requirements for statutory entities. Requires reports of the efficacy of membership requirements and requires the creation/distribution of educational materials on best practices to support meaningful engagement. This bill passed out of the House and was referred to the Senate State Government and Elections committee. *Committee Discussion* • Highlighted importance of attention to question about focus on youth forensic diversion efforts? o Noted that there is currently legislation addressing adult forensic diversion. Appreciated this is an important point about the need for attention to this issue for the youth and juvenile system as well. • Chat: Are services going to be funded throughout the state including Central Washington? o Yes, all of the 988 work is focused on equitable funding throughout Washington. • Chat: Senate Bill 5130 relating to Assisted Outpatient Treatment passed the Senate over to the House. • Bipasha highlighted summary of potential ways to participate in the legislative session, including emailing your representatives on any issue or comments on specific bills (support, oppose, neutral), testify for a bill. Two bills discussed today (5555-peer specialists, 5120-23-hour crisis receiving centers) have public hearings this week if you are interested in testifying.
Presentation 2:	• Matt Gower (Washington Health Care Authority) introduced himself as person with lived experience as well as professional working to improve Washington's behavioral health crisis response system. Matt presented an

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

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	Designated Crisis Responders. In development are Older Adult Mobile Crisis Response Teams, Tribal Mobile Crisis Response Teams, and 1477 Mobile Rapid Response Crisis Teams.
Presentation Discussion	• Subcommittee Member Discussion: request for perspectives on legislative update, the "someone to come" presentation, or any other thoughts and experiences you are comfortable sharing. ○ Shared experience as person with lived experience providing crisis support for others and feeling overwhelmed about inability to connect people to the resources they need. Looking for more resources to learn. ▪ Emphasized that the system is complex and confusing. Recognized that the goal of the 988 work is to create better system in Washington. ▪ Current regional Ombudsman are available to help navigate resources: www.obhadvocacy.org. At a future meeting, can learn more about the Ombuds resources in Washington. ○ Reiteration that police can sometimes make a crisis situation worse, and that sometimes people that really need to be in a mental health facility end up in jail. ▪ Situations where people relapse or further decompensate when Designated Crisis Response (DCR) arrives along with officers in uniforms and all of their protective gear as back up. ▪ Situations where people call in crisis and end up going to jail rather getting mental health services. This makes it extremely frustrating for the person in crisis and they lose faith in the system. Calling for help should be a connection to safety, not to jail. ▪ Shared experience as a Veteran with suicide attempt where situation led being met by officers at his home and led away in handcuffs. ○ People are not able to get services when they have reached out, leading to further mistrust and confusion in the system. ▪ Question about what is provided during the crisis response. Highlighted importance for response to co-occurring mental health and substance use disorders, as this is common. Noted the concern that not every emergency response provider carries NARCAN. ▪ Chat: https://www.npr.org/2023/02/18/1157556969/narcan-fda-over-the-counter • Matt provided overview of mobile crisis response approach to provide intervention, safety planning,

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

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	me - what is a Designated Crisis Responder report and who are Designated Crisis Responders? ▪ Chat: I agree that this is why 988 is important because first responder departments on the ground are limited in their knowledge on which services to call during a crisis. They share what they traditionally know. If anything there is a list somewhere online but no one really has time to dig during a crisis. ▪ Chat: Noted importance that Mobile Crisis to do its part in making good partnerships with stakeholders and community partners so they know how to collaborate and create access to needed resources when they are made aware of someone in crisis. ▪ Chat: What about when crisis doesn't come out because it doesn't meet their definition of crisis and then we call EMS and they tell us that it is not their job/ position. ▪ Chat: My daughter has contacted 988 twice in the past month while I was also on a video chat with her. The first time was a positive experience with my daughter and the crisis counselor developing a plan to help her move back away from the that suicide "ledge" that she had found herself. The second time she contacted 988, while I was also on video chat and the suicide thoughts had gotten much more powerful, the crisis counselor (who was a different person) responded to her in a "you got this, bruh" manner. The second experience was not helpful to my daughter at all. My daughter felt that the first time she contacted 988, she was connected with an older person and the second time she was connected with a younger person. My daughter has a SMI that she was diagnosed with at 8 years old. She is now 22 and was more knowledgeable about next steps than the second crisis counselor that she was connected with. She didn't need someone treating her like a "bruh" and telling her to think positively. Can there be better training provided to the crisis counselors that respond to people using 988? o Crisis service jobs don't pay well. ▪ Chat: Paying mental health crisis responders a good wage would help. ▪ Chat: I've been a certified peer counselor for 2 years and have not taken a job in that field due to the low wage and the confusion on what my role would even be.

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	▪ Chat: I have seen multiple job listings on Indeed for Peers that have wages from $18 to $24 and hour. I understand it is much more expensive to live on the West Side. But, I do see multiple jobs on that sight for CPC's Just an FYI. ▪ Chat: Just my experience, but I have applied for multiple peer jobs and crisis response teams, and the process was horrendous. I didn't take the jobs due to a lack of info or lack of knowledge on their part to even answer my questions… ▪ Chat: Peers are concerned if DOH gets involved with peer certification the certificate will be priced out of reach . The price of certified counselor has gone from 305 to 800 a year. o Question of who 988 is helping. Shared perspective that their crisis doesn't fit int the "buckets" mentioned in the 80 page National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit. The report says: 1) anyone, anytime, … and 2) substance abuse/use disorder and mental health / mental illness. It seems like WA is gearing to only those with mental health issues or suicide prevention. o Chat: I suggest 1) that families should have a support person who can calm them down. After the family is supported and calmer coach them as to what to say to the 988 call center next time e.g. tell the call center that the person has a mental illness diagnosis (if they do), tell the call center if the ill person is afraid of police or if the family anticipates that the ill person will be submissive (or confrontational if that is true). Etc, etc. - give as much info as possible to inform the responders who/what they are going into. The current system alienates the family especially with HIPAA laws. Yet how can the state do this without the help of the family? 2) All police/firemen should be required to take crisis intervention training ("CIT"). Police do so much better if they have been trained in CIT. For example, the last time the police came the lead introduced himself "Hi, I'm Mike". This was so helpful to decelerate the situation vs. one time years ago when the mentally ill person was tazered and criminalized. o Chat: I am here as the mother of an adopted 33 year old daughter with fetal alcohol spectrum disorder and schizoaffective disorder. She is a frequent user of the 988 number and ultimately ends up going to the ER and being hospitalized if there is a bed. (She has had over 50 ER visits since 2004). There are undiagnosed folks on our streets, jails and prisons so fetal alcohol spectrum disorder is a public health issue.. as it is estimated that one in 20 individuals are prenatally exposed so please support HB 1168 which would provide prevention, diagnostic, treatment and support services for persons who experience prenatal substance exposure.

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	○ Overall appreciation for creating space to for people to share their lived experience. ○ Emphasis on taking action and pursuing policy change
Open Discussion and Closing Statements	• This section of the agenda blended with discussion above. • Lived Experience members may also contact CRIS project manager, Nicola Pinson, for follow up questions or requests for resources (Nicola Pinson, npinson@healthmanagement.com).

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

Meeting Summary

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

Zoom

TOPIC	DISCUSSION

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

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

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

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

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

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

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

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

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

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

Meeting Summary

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

Zoom

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

TOPIC	DISCUSSION

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

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

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

TOPIC	DISCUSSION

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

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

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

Meeting Summary

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

Zoom

TOPIC	DISCUSSION
Welcome, Introductions, Review Meeting Agenda	• HB 1477 Steering Committee member Bipasha Mukherjee welcomed everyone to the meeting and introduced the agenda. Bipasha also highlighted that the next Lived Experience Subcommittee meeting will be held on July 10th, from 1-3pm. Meeting agendas and Zoom links are available on the CRIS webpage - https://www.hca.wa.gov/about-hca/programs-and-initiatives/behavioral-health-and-recovery/crisis-response-improvement-strategy-cris-committees. • Kristen Wells shared Washington Speaks information as a resource providing support to individuals to share their lived experience. Please reach out to Brittany Thompson at Health Management Associates (CRIS project coordinator, bthompson@healthmanagement.com) if you would like to be part of a Live Experience group training to give each other support and feedback for sharing personal stories at a CRIS or Steering Committee meeting. • Sherry Wylie (HCA) shared slides highlighting opportunities for people with lived experience to get involved, including some opportunities that come with stipends. This information, including links and contact information, has been posted to the CRIS webpage as part of the meeting slides. ○ Children and Youth Behavioral Health Workgroup ▪ Youth and Young Adult Continuum of Care (YYACC) subgroup ▪ Prenatal – 25 Behavioral Health Strategic plan subcommittees ○ Center of Parent Excellence (COPE) ○ Washington State Community Connectors (WSCC) ○ A Common Voice COPE Project ○ SPARK – Students Providing and Receiving Knowledge ○ The Mockingbird Society ○ Youth Move National
Legislative Update	• Megan Celedonia (988 Coordinator, Governor's Office) provided a legislative update and overview of her role. ○ Megan's position at the 988 Hotline & Behavioral Health Crisis System Coordinator in the Governor's Office was created in HB 1477 (2021) and extended in HB 1134. Megan oversees statewide implementation of 988 and cross-agency collaboration between DOH and HCA. Megan's position is specific to 988, while Amber Leaders focuses on Washington behavioral health services overall. ○ Bills reviewed: (slides are available on the CRIS webpage) ▪ HB 1134 – 988 ▪ SB 5120 – Crisis Relief Centers

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

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

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

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

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

TOPIC	DISCUSSION
	open committee, as opposed to the other subcommittees, which are closed. ○ Several CRIS positions open right now (LGBTQ+, University center of excellence, and first responder co-responder programs). ○ **Chat:** The meetings are one thing, but the work that needs to be done between meetings is a lot! • **Chat:** FYI: Medicaid Managed Care Organizations are subject to the following requirement: 7.17. Required Reporting for Admission, Discharge, and Transfer (ADT) Notifications. The Contractor will require the use of interoperable Health Information. Technology (HIT) to create and send admission/discharge/transfer notifications. (ADTs) to providers, facilities, or practitioners on behalf of Enrollees admitted to. Inpatient Psychiatric Hospitals and Units that have access to HIT/EHRs. ○ See the complete Medicaid managed care requirement here: https://www.hca.wa.gov/assets/billers-and-providers/ahimc-medicaid.pdf • **Chat:** When I mention it to people or leadership, the common response is "There's a lot pieces." • **Chat:** It's very challenging to follow. I'm just glad at least peers at the decision table are brought to the table more than I have seen before at this level. • **Chat:** We worked hard to get a lived experience vote on the Steering Committee, and I agree that it would be great to have this opportunity in more places beyond the CRIS! • **Comment:** When we talk about evaluating involuntary treatment facilities for efficacy, it's a bizarre experience. It's like evaluating a parachute as people are falling out of airplanes. This work is about repairing parachutes. • **Comment:** Surveys/requests for input should be distributed before the meeting to get more stakeholder engagement.
Closing Statements	• Bipasha provided a recap of the meeting. • Next meeting is July 10th, from 1-3pm. • Lived Experience members may also contact Brittany Thompson, for follow up questions or requests for resources (bthompson@healthmanagement.com).

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

Meeting Summary

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

Zoom

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

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

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

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

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

TOPIC	DISCUSSION

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

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

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

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

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

Meeting Summary

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

Attendees

Subcommittee Members

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

Facilitation Staff

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

State Agency Staff

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

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

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

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

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	• Ferry County: 0 – 2.3% of callers • Adams County: normally less than 1% of callers The crisis centers have also filled almost all vacant positions; currently looking for a Diversity Equity and Inclusion (DEI) coordinator still. Several staff have taken the AgriSafe training—one of the staff made a farmworker resource list to share with other crisis center staff to use for calls. There are two staff members that grew up in agricultural farming communities, including the crisis call center trainer, two staff members grew up in rural Washington, and one staff member grew up on a cattle ranch. *Subcommittee Discussion* • Has there been any movement toward a dial pad option for the agricultural population? ○ There are currently several conversations occurring between state representatives and stakeholders. There is also attention to providing specific training to crisis center staff to ensure a culturally-appropriate response to people in rural and agricultural areas. Conversations have included the AgriSafe network and help line. A few states use the help line for people in the agriculture industry and specific training around that. VOA has had some staff go through training from the AgriSafe network, and they are considering expanding to additional staff. Additional dial pad option is a conversation at the state level, which also brings SAMHSA and Vibrant in—requires a lot of stakeholders at the table. • Don McMoran added he has access to AgriSafe Rescue Courses that he can share with the group if anyone is interested.
Discussion: Recommendations to Ensure Access to 988 Lifeline for Rural & Agricultural Communities	Don McMoran, WSU Skagit County Extension, shared current resources to build upon. When WSU Skagit County Extension received its $7.18M Farmer Ranch Stress Assistance Network Grant, it became responsible for setting a call line up. Developing its own would cost around $4M to start and $2M to maintain, so the team looked to existing call centers, particularly the Farm Aid resource line, to partner. The line functions out of the east coast (MA)—they have a call center connecting callers to someone that understands farm culture and connections within community (e.g., USDA, attorney, CPA, etc.).

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	• First the team asked Farm Aid to increase the volume they serve. Call center originally inaccessible for the West—available 8 hours a day, M – F on east coast time. Next asked about putting Farm Aid operators in WSU Skagit County Extension and they agreed. Now there are 2 operators in Burlington, WA, taking calls from 11 am – 7 pm. • Farm Aid does not want to move to a 24/7 hotline, regardless of available funding options. Would potentially partner with another organization to get there. • AgriSafe helpline, WSU Skagit County Extension's partner, has put together the AgriStress helpline specifically for agriculture. Various states have signed on. Cost-wise, it's the best option for 988 moving forward—$200k to add Washington to the helpline. However, not all operators have a farm background, which is problematic if goal is to have operators who have a deep understanding of agriculture. • Another option is for Washington to start its own call center specifically for farmers and farm workers. The call lines would be ancillary to 988 call lines, but there would be a potential to bring them into the 988 call structure. That will be up to leadership; some legislators are interested in going down that road. *Subcommittee Discussion:* • There is a lot of excitement and momentum around these conversations. Looking forward to getting more information and weighing the options to see how we can produce something that will work well. Our representatives are looking to collaborate and want to move the needle quickly. • The dial number is a good approach; it would be helpful to explore that more. Hoping to balance what we want with what is actually available and possible. • The 988 number is picking up steam. First cautioned about it, and continued to use the 10-digit national number. Have since heard 988 is here and working well now. • There is a new state voucher program that provides vouchers for farmers and farm workers to see a certified counselor or therapist. The program uses the WSU psych clinic and telehealth—only has the capacity for 4 people per month, and only one individual is using the voucher currently. This group can share information

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

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

Meeting Summary

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

Zoom

Attendees

Subcommittee Members

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

Agency Staff

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

Committee Staff

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

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

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

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

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

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

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

HB 1477 Technology Subcommittee – February 23rd Meeting

Meeting Summary

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

Zoom

Attendees

Subcommittee Members

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

Committee Staff

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

State Agency Staff

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

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

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

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

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

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

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

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	• Are we asking for a list of integrations as part of the RFI? It might be nice to know what other systems the vendors already partner with.
	• Is the RFI directed to specific vendors? Or is it open to all vendors to respond?
	  ○ Combination of both. All RFIs and RFPs get posted to our web system where various vendors will routinely check. The big vendors that we have talked to are looking for it, and we plan to let vendors know that it's there and how to find it. We can't specifically send this out to vendors, but we can let them know that it's there
	
	Mathew Gower, HCA, discussed the team's efforts regarding business process mapping. The purpose is to get more insight into how we can better fill gaps with technology solutions and best practices, dispatch protocols, etc. The team is also going to each crisis center site to see how the work is done and observe existing technology. The team has met with VOA and ORHS. The work is important to understanding how to support and build off of existing capabilities. The team is also working to streamline and standardize data reporting to better track mobile crisis teams, services provided by adult and youth teams, and follow-up services.
	
	Subcommittee Discussion:
	• Once finished, will the work be shared with the subcommittee?
	  ○ Yes. We are in the process of evaluating the timeline and process for bring this work through subcommittees for input.
	• Is there future journey state mapping as part of next steps? What happens once you get the business processes mapped?
	  ○ These efforts were focused on the current state. We will do future-state process mapping as well to determine technology tools needs.
	• Can you share more about the timing and timeline for business processes mapping and when you expect to be done?
	  ○ We are finalizing dates with partners. Our goal is to do at least one onsite visit with each of the NSPLs, and potentially RCLs as well; hoping to finish by end of April. This will inform the technology platform.
	• Could we get a process map from one of the exemplary state systems (e.g., Arizona or Georgia)? This could inform us and get us to what the future state should be, especially as we get to the RFP stage.
	  ○ This may be a matter of what other states can share. Might also be useful to re-present the information shared previously on other states.
	  ○ HCA noted that the teams working with the NSPL and RCLs are learning a lot. Those key takeaways could be really useful.
	  ○ This could be a simple matter of outreach to see what they have available to help us learn and develop some ideas.

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

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