

HB 1477 Crisis Response Improvement Strategy Committee

November 16, 2021

HEALTH
MANAGEMENT
ASSOCIATES

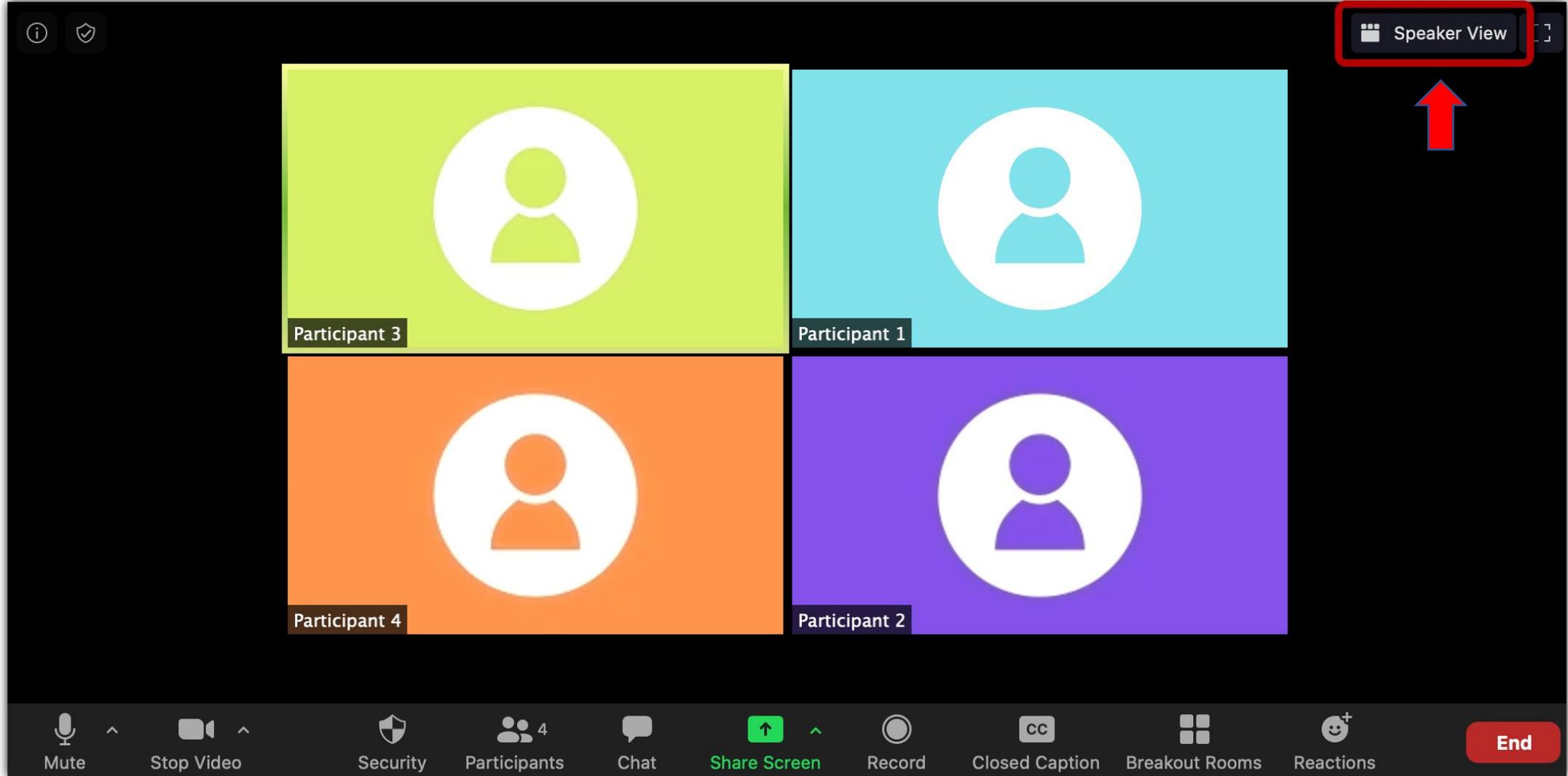
HARBORVIEW
MEDICAL CENTER

UW Medicine  King County

Zoom Etiquette: CRIS Committee Members



Zoom Etiquette: Members of the Public



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

Meeting Agenda

TIME	TOPIC
1 pm	Technology Review
1:05 pm	Welcome, Introductions, Review Meeting Agenda
1:15 pm	Personal Stories
1:35 pm	Ice Melter
1:45 pm	Presentation: Comprehensive Assessment Key Themes
2:25 pm	Break
2:30 pm	Discussion: Comprehensive Assessment Key Themes (continued)
3:35 pm	Action Items and Next Steps
3:38 pm	Public Comment
4 pm	Adjourn

PERSONAL STORIES

Jim Vollendroff
Cathy Callahan-Clem

ICE MELTER

**COMPREHENSIVE
ASSESSMENT
9 KEY THEMES**

**For Input and Discussion
with the CRIS Committee**

OVERVIEW OF KEY THEMES

- **In this section, we will review the 9 key themes identified during the discovery process.**
 - Each theme is introduced with supporting sub-themes.
 - Where applicable and available, data or graphics are shown to further explain the rationale for the theme statement.
 - It is anticipated that each theme could be further researched and expanded upon.
- **We are seeking CRIS member feedback and input on the themes identified to inform the HB 1477 January 1, 2022 report and future areas of work for the HB1477 committees.**
 - *November 16th meeting:* CRIS Committee members will have the opportunity to discuss and provide feedback during the meeting.
 - *November 16-30 written comments:* CRIS Committee members will have the opportunity to provide written feedback on themes. Please send comments to Nicola Pinson, Project Manager at: npinson@healthmanagement.com.

- 1. Availability of the Continuum of Services**
- 2. Utilization of Services**
- 3. Accountability for the Provision of Crisis Services**
- 4. Financing of Crisis Services**
- 5. Person, Family, and Community-Centered Approaches to Delivery of Crisis Services**
- 6. Collaboration in the Delivery of Crisis Services**
- 7. Crisis Services Workforce**
- 8. Use of Technology in the Provision of Crisis Services**
- 9. Outcomes from the Delivery of Crisis Services**

THEME #1

Availability of the Continuum of Services

1. The continuum of crisis services is not consistent across regions of the state.

1.1 The manner in which funds are distributed can impact the continuum of services available for those who are Medicaid eligible and those who are not Medicaid eligible.

1.2 The number of Crisis Lines varies across regions.

1.3 Mobile Crisis Teams are present in every region, but the availability (turnaround time) can vary across the state. Crisis Stabilization Units are not available in some parts of the state and not easily accessible in many parts of the state.

1.4 Preventative services and programs such as warmlines and walk-in clinics are not consistently available across the state.

1.5 Crisis Respite programs, including Peer Respite, are not funded in all regions.

INVENTORY OF SELECTED PROVIDERS BY REGION

Each region has a 24/7 mobile crisis line under contract with the BH ASO in the region. The number of mobile crisis teams varies by region. The number of crisis stabilization beds varies widely across regions, with some regions having zero beds.

	24/7 Mobile Crisis Line Provided by	Number of Mobile Crisis Teams	Number of Crisis Stabilization Providers	Number of Crisis Stabilization Beds Across All Providers
STATEWIDE	6 providers	41	16	234

By Region

Great Rivers	Columbia Wellness	5	0	0
Greater Columbia	Protocall Services	4	3	48
King County	Crisis Connections	3	0	0
North Central	Crisis Connections	3	1	10
North Sound	Volunteers of America	5	6	90
Pierce County	Crisis Connections	3	1	16
Salish	Volunteers of America	4	2	22
Southwest	Crisis Connections	4	1	16
Spokane	Frontier Behavioral Health	8	2	32
Thurston-Mason	Olympic Health and Recovery Services	2	0	0

THEME #2

Utilization of Services

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

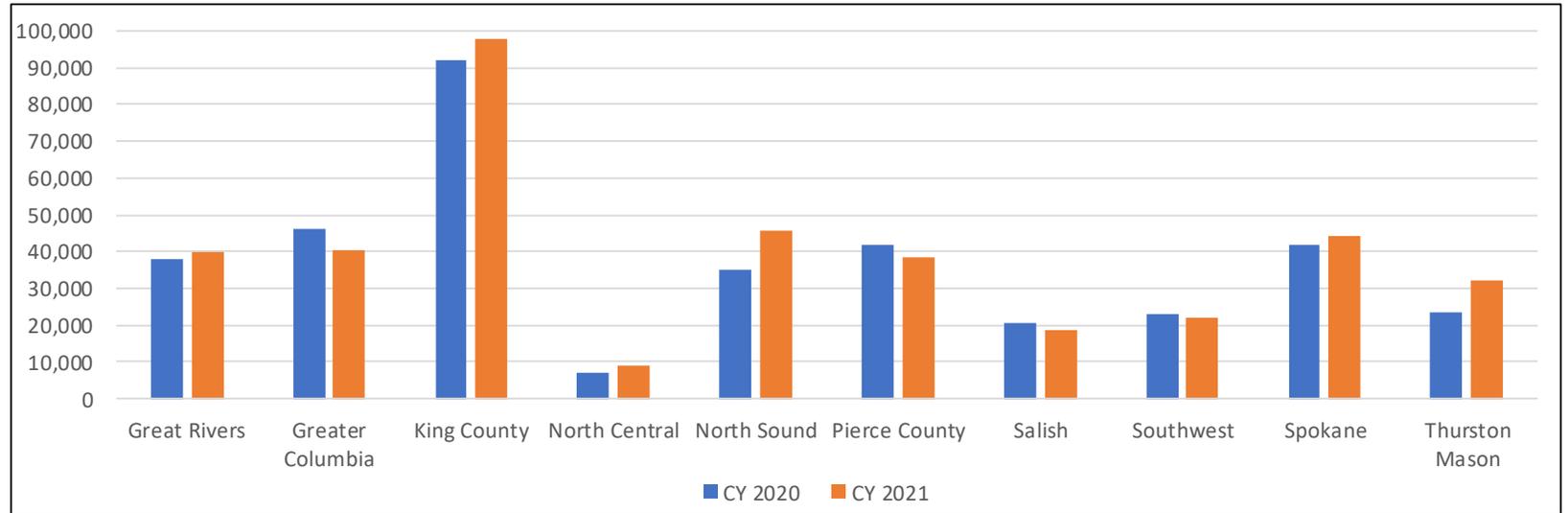
CRISIS CALL VOLUME TO BH ASO LINES VARIES BY REGION OF THE STATE

Calls to BH ASO Crisis Lines
 CY 2020: 367,765
 CY 2021*: 388,099

Percent of Calls Answered by BH ASO Crisis Lines within 30 Seconds
 CY 2020: 93.1%
 CY 2021*: 95.7%

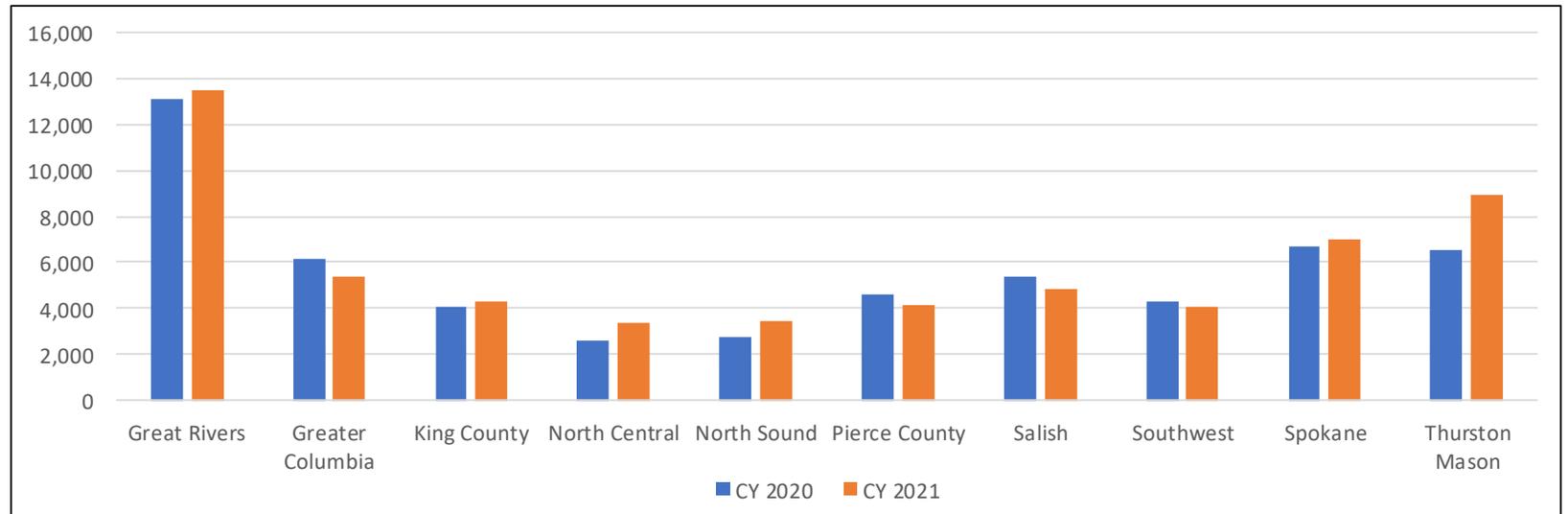
*Note that CY 2021 data is estimated annualized figures based on calls reported by BH ASOs to date.

Call Volume to BH ASO Crisis Hotlines (2021 data is annualized)



Call Volume to BH ASO Crisis Hotlines Per 100,000 Residents for each BH ASO Region (2021 data is annualized)

Statewide Values are 4,803 for CY 2020 and 4,997 for CY 2021



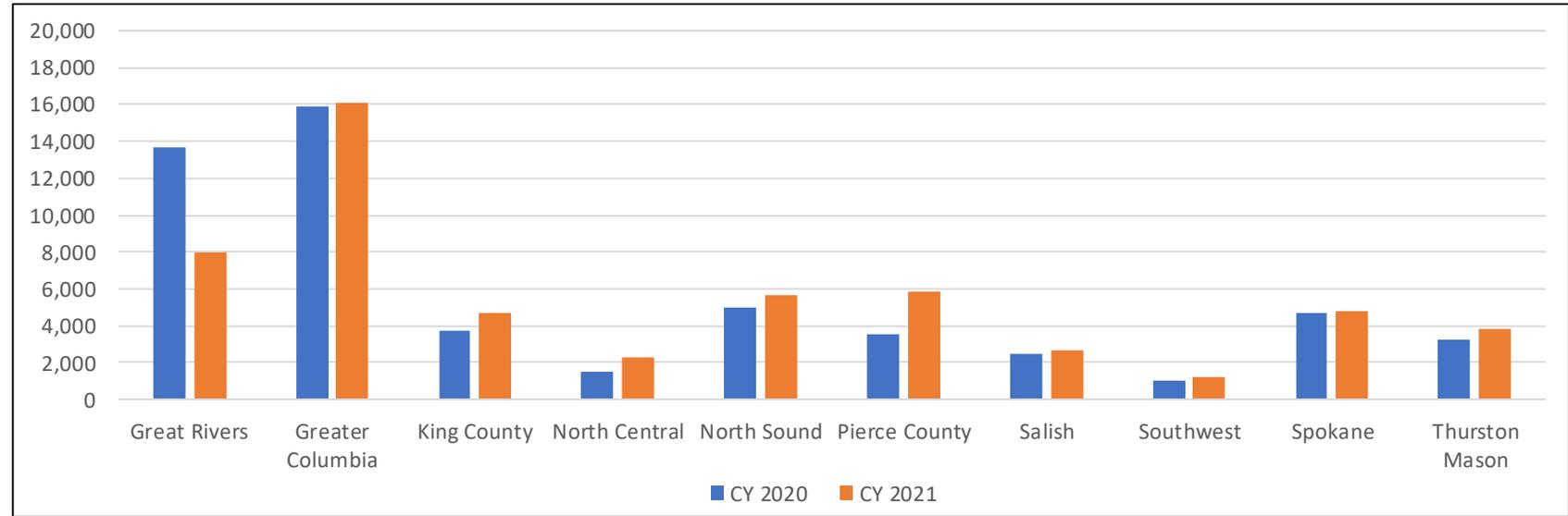
VARIATION IN MOBILE CRISIS OUTREACH IS SIGNIFICANT ACROSS REGIONS

Statewide Mobile Team Volume

CY 2020: 10,831
 CY 2021: 9,674*

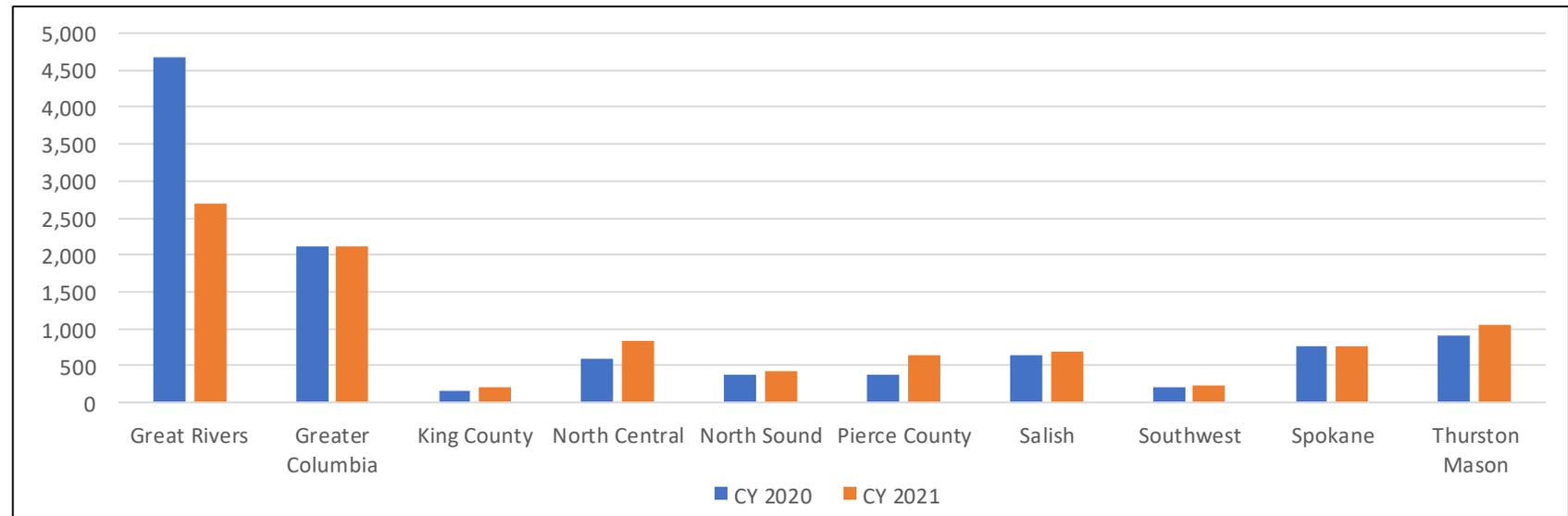
*estimated annualized number

Volume of Mobile Crisis Outreach for each BH ASO Region (2021 data is annualized)



Mobile Crisis Outreach Per 100,000 Residents for each BH ASO Region (2021 data is annualized)

Statewide Values are 665 for CY 2020 and 669 for CY 2021



THEME 2: DCR INVESTIGATIONS GROWING OR STEADY IN MOST REGIONS IN CY 2021, BUT RATE VARIES BY REGION

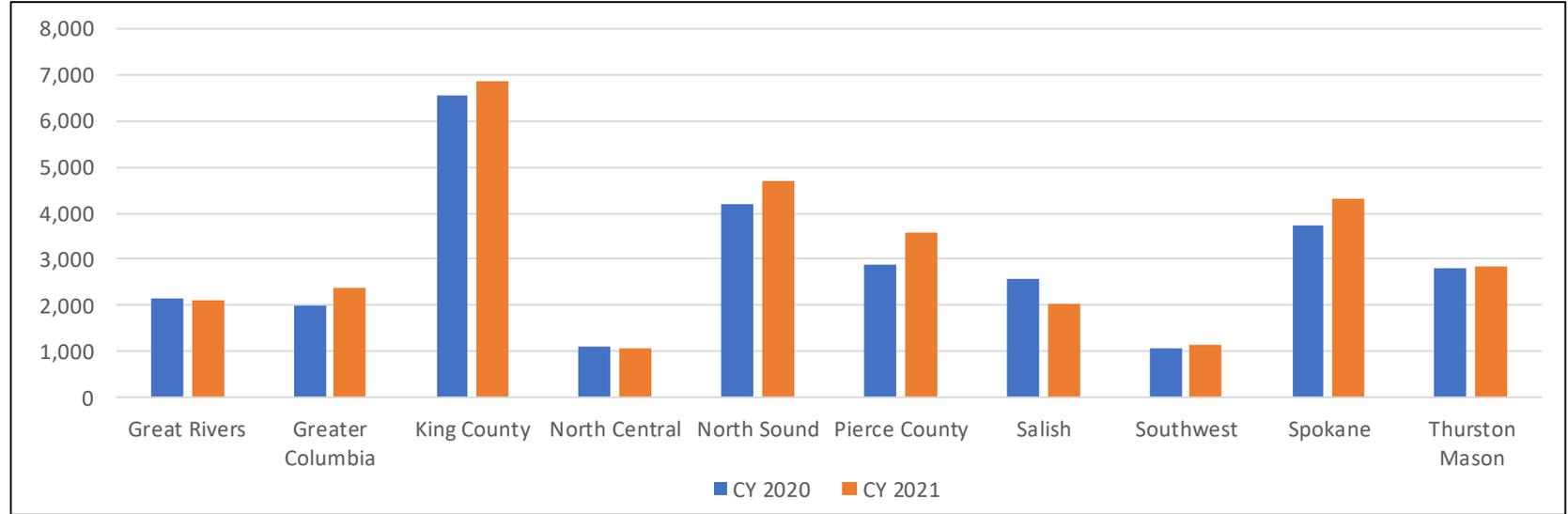
Statewide DCR Investigations

CY 2020: 29,043

CY 2021: 31,030*

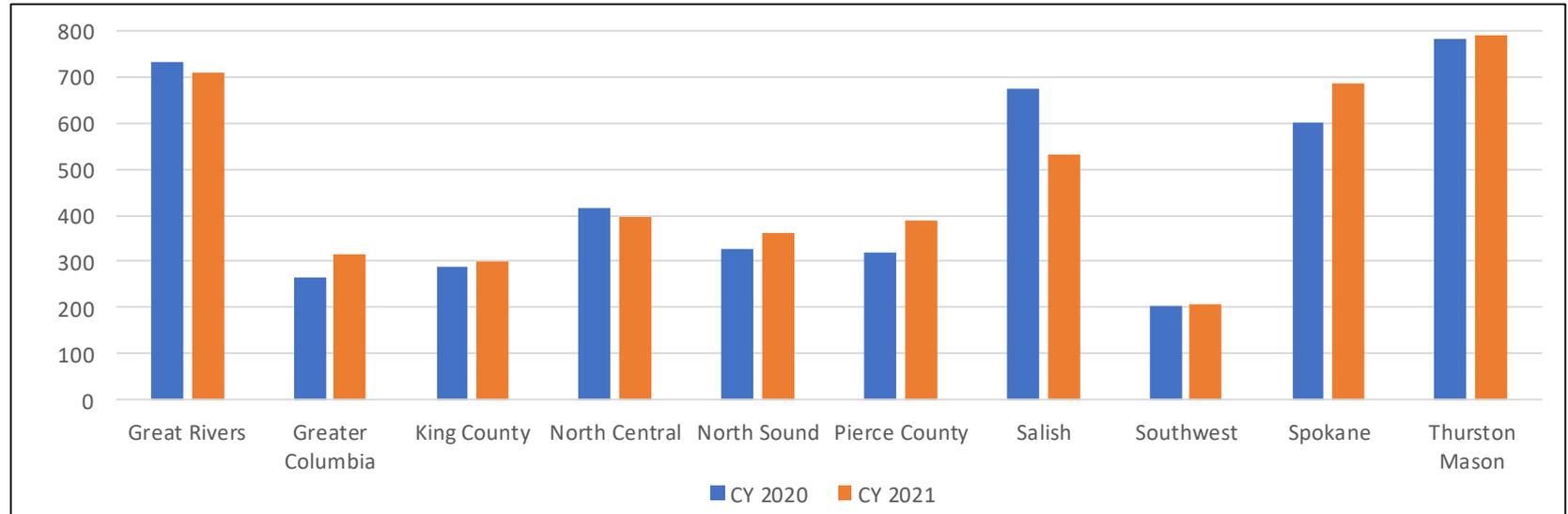
*estimated annualized number

Volume of Designated Crisis Responder Investigations for each BH ASO Region (2021 data is annualized)

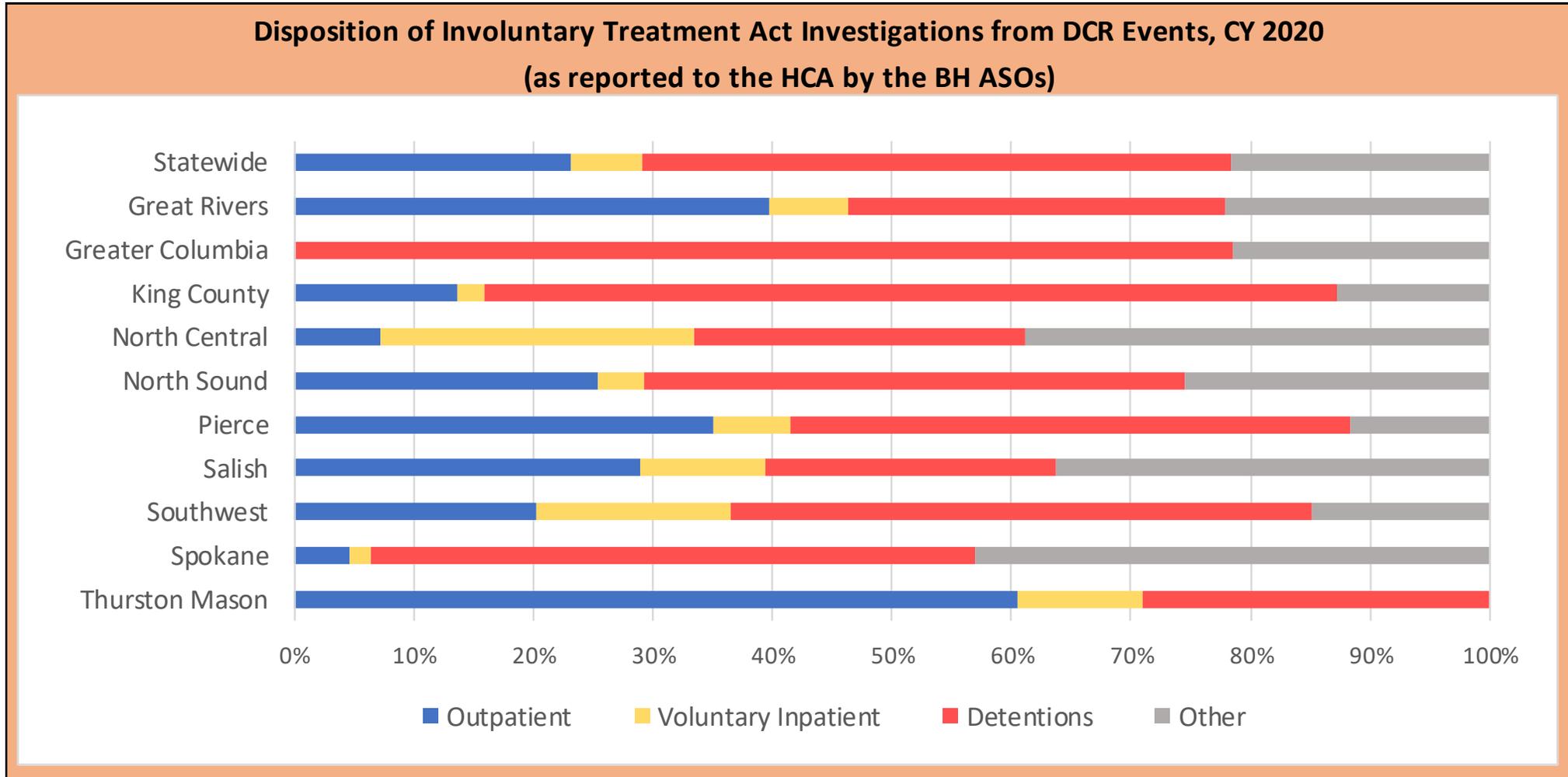


Designated Crisis Responder Investigations Per 100,000 Residents for each BH ASO Region (2021 data is annualized)

Statewide Values are 378 for CY 2020 and 402 for CY 2021

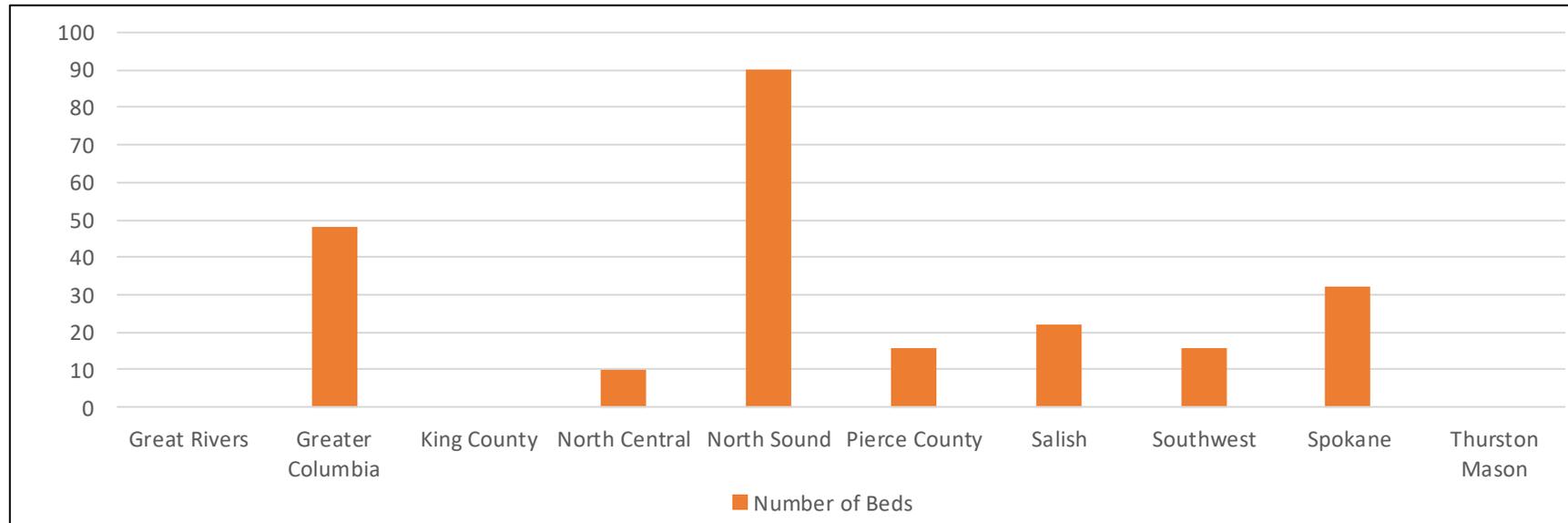


THEME 2: HALF OF DCR OUTREACH INVESTIGATIONS IN CY 2020 RESULTED IN DETENTION



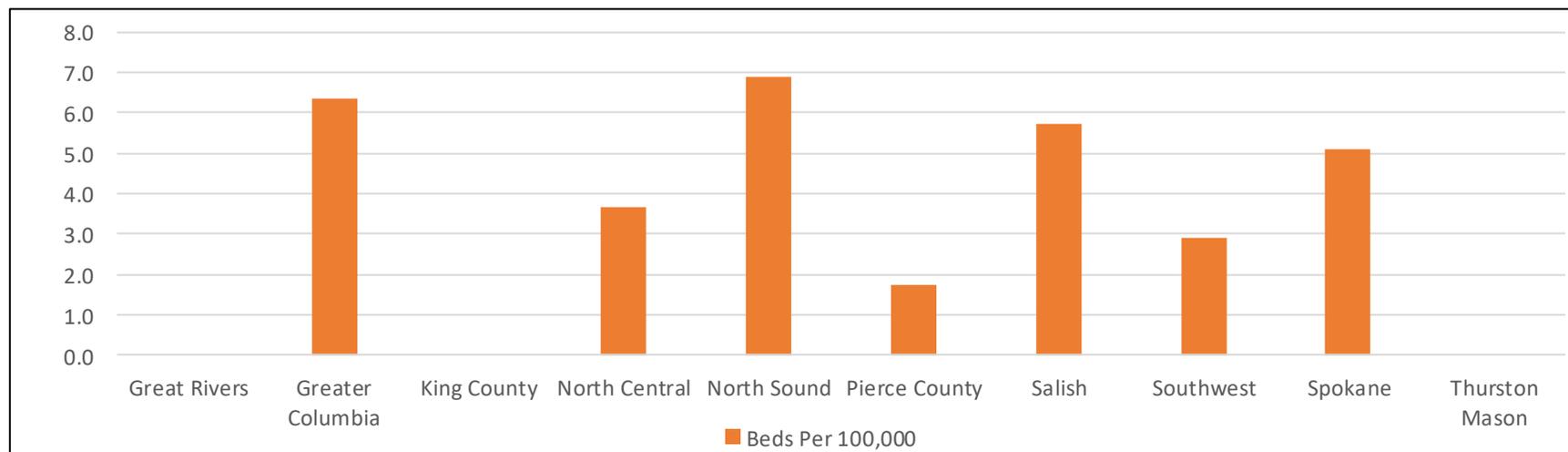
THEME 2: SOME REGIONS HAVE NO CRISIS STABILIZATION BEDS

Crisis Stabilization Beds Available in each BH ASO Region as of November 2021 (no bar means zero beds)



Crisis Stabilization Beds Per 100,000 Residents Available as of November 2021

Statewide Value is 3.0



THEME #3

Accountability for the Provision of Crisis Services

3. With the implementation of integrated managed care, the accountability and monitoring of the delivery of crisis services changed and is now bifurcated.

3.1 For Medicaid clients, the scope of what the BH ASOs deliver under crisis services narrowed. The Medicaid MCOs took over responsibility for more of the crisis services.

3.2 For non-Medicaid clients, however, the scope of what the BH ASOs deliver under crisis services did not narrow. In other words, the BH ASOs offer some crisis services to non-Medicaid clients but not to Medicaid clients.

3.3 There appears to be different interpretations across the state as to where responsibility of crisis services to Medicaid clients begins and ends between the BH ASOs and the MCOs.

3.4 The BH ASOs no longer have real-time data on crisis encounters for Medicaid members for all crisis services in the continuum.

3.5 Alternatively, the MCOs do not have all information on their Medicaid clients related to crisis services due to varied levels of tracking and reporting by the BH ASOs to the MCOs.

THEME #4

Financing of Crisis Services

4. Total financing appears to be disproportionately balanced to more restrictive care than less restrictive care, and to acute crisis events and less toward the prevention of crisis events.

4.1 Payments to BH ASOs from the HCA for non-Medicaid clients are based on historical payments and not necessarily on preferred outcomes such as diversion to lower levels of care, when appropriate.

4.2 Payments to MCOs from the HCA for Medicaid clients are made on a per member per month (PMPM) basis. There is variation of this PMPM at the regional level, usually because of differences in historical utilization. That is, higher-cost services in the past will drive a higher PMPM.

4.3 Payments to BH ASOs from the MCOs for Medicaid clients and the services under BH ASO responsibility are often paid out in advance but later reconciled on a per service basis. Therefore, in order to maximize the initial revenue received, there is an inherent bias to deliver more costly services.

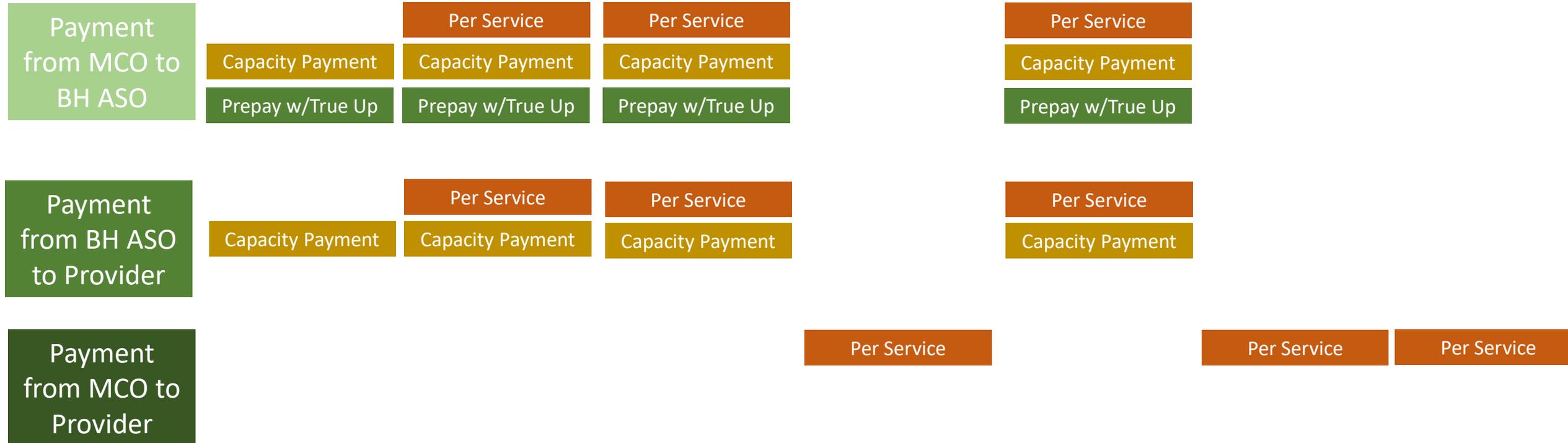
4.4 The BH-ASOs often pay their local crisis providers based on capacity for 24/7 availability (“the firehouse model”). Other providers are usually paid directly by the MCO on a per service or per day basis. Providers that may deliver services across the continuum can be reimbursed differently by MCOs and BH ASOs.

THEME 4: MODELS OF PAYMENT FOR SERVICES DELIVERED IN MEDICAID CAN VARY BY REGION

Crisis Services to be Paid



Potential Methods of Payment



THEME #5

Person, Family and Community-Centered Approaches to Delivery of Crisis Services

5. There are no systematic standard practices to support the person and family-centered approach within the current crisis system. This impacts both access and best practices for interventions.

5.1 In some regions, services are often rendered in a more, not less, restrictive setting due to lack of alternative options for less-restrictive settings for those in crisis.

5.2 Further, the options for individual and family empowerment (e.g., respite, warm line, drop-in) are limited in many regions. This can limit the ability to proactively prevent a crisis and results in a higher reliance on the crisis system itself.

5.3 Significant variations in the crisis service continuum and resource restrictions exist in rural communities.

5.4 Person-centered, culturally responsive, and trauma-informed approaches are inconsistently applied across the state.

5.5 Although peers are used in many settings in many parts of the state, there appears to be consensus that peers can be leveraged even more.

THEME #6

Collaboration in the Delivery of Crisis Services

6. Although there are a variety of collaborative efforts underway to create a system of care for crisis services, collaboration is fragmented and not always consistent.

6.1 Since the implementation of integrated managed care, there is not a coordinated effort between the HCA, the MCOs and the BH ASOs to track the follow-up of clients after a crisis-related event.

6.2 The lack of real-time information to providers across the continuum of services can impede more cohesive collaboration.

6.3 There are some promising collaborative efforts underway today that should be explored further to leverage across the crisis system.

6.4 There is variation across MCOs and BH ASOs in the levels of collaboration and support of community initiatives.

THEME #7

Crisis Services Workforce

7. Workforce among behavioral health practitioners in many parts of the state is severely challenged and impedes expansion of the continuum of crisis service delivery.

7.1 Recruitment and retention of behavioral health practitioners impacts the access to and availability of crisis services in Washington.

7.2 Peer support specialists are under-utilized in many portions of the crisis service continuum.

7.3 Regulations and licensure requirements can serve as an additional impediment to crisis service delivery.

7.4 Behavioral health workforce training and standards are varied across regions.

THEME #8

Use of Technology in the Provision of Crisis Services

8. There is limited technology used in the delivery of crisis services across the continuum. This results in the lack of real-time data to initiate coordination and to monitor client outcomes.

8.1 Call centers are using state-of-the-art call management systems to route crisis calls.

8.2 Call centers have the ability to report call metrics.

8.3 The BH ASO region-based crisis lines are not connected electronically to the three Lifeline call centers.

8.4 Health information technology platforms are not being utilized (e.g., bed registry, available outpatient appointments, client-specific ED use or other history) by the call centers or by providers to assist in coordinating and delivering services.

8.5. The information flow of services used by Medicaid clients before, during, and after a crisis event between BH ASOs, MCOs, and individual providers is fragmented and inconsistent. Where it occurs, the information is not in real-time.

THEME #9

Outcomes from the Delivery of Crisis Services

9. To date, there has been limited focus on the outcomes from the delivery of crisis services in Washington. There are opportunities to develop, monitor, and report out to the public the outcomes from recent and future investments in the crisis delivery system.

9.1 There is little data collected today at the system level to assess the effectiveness of crisis service delivery (e.g., mobile team response time, diversion to less restrictive care, measures to assess prevention of crisis services).

9.2 There is limited fidelity monitoring to determine if Washington's crisis delivery system aligns with national best practices.

9.3 Information to assess individuals' or families' experiences with care is limited.

9.4 Service utilization data is not being aggregated and analyzed at the statewide level to drive improvement.

NEXT STEPS

- **We are seeking CRIS member feedback and input on the themes identified to inform the HB 1477 January 1, 2022 report and future areas of work for the HB1477 committees.**
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HB 1477 Report/ Comprehensive Assessment Timeline

Date	Milestone
11/16	CRIS Committee Meeting and Feedback on Assessment Key Themes
11/30	Deadline for CRIS Committee feedback on themes
12/20	Draft Report for Steering Committee approval
12/20 – 1/13	CRIS Member Comment Period (Comments to be posted publicly as a companion to the report)
12/27	Steering Committee approval for submission
12/30	Final Report

**COMPREHENSIVE
ASSESSMENT KEY
THEMES –
BREAKOUT GROUP
DISCUSSION**

ACTION ITEMS AND NEXT STEPS

	First Name	Last Name	Registration Time
1.	Donette	Boyett	11/10/2021 17:54
2.	Lisa	Striedinger	11/10/2021 19:39
3.	Christina	Suarez	11/10/2021 21:05
4.	Gina	Casillas	11/11/2021 7:01
5.	Patty	Horne-Brine	11/11/2021 7:51
6.	Phyllis	Cavens	11/11/2021 11:23
7.	Roxanne	Slayton	11/13/2021 11:35
8.	Daniel	Montana	11/15/2021 9:32
9.	Susan	Baird-Joshi	11/15/2021 10:06
10.	Jacob	Towle	11/15/2021 10:48