HB 1477 Crisis Response Improvement Strategy Committee

July 12, 2022

Health Management Associates

Harborview Medical Center

UW Medicine | King County

Zoom Etiquette: CRIS Committee Members

Zoom Etiquette: Members of the Public

CRIS Committee Meeting Objectives

1. Understand where we've been, where we are now, and where we are going in the CRIS process
2. Hear updates on state agency activities relevant to CRIS Committee
3. Based on understanding of current state and best practices, discuss the missing pieces we need to address to achieve the vision for a crisis response system
4. Confirm action items and next steps.
5. Hear public comment.

Meeting Agenda

TIME	TOPIC
3:00 pm	Technology Review
3:05 pm	Welcome, Introductions, Review Meeting Agenda
3:20 pm	Personal Story
3:40 pm	Updates
3:55 pm	Setting the Table: Current State
4:50 pm	Break
4:55 pm	Discussion: Missing Pieces
5:35 pm	Action Items and Next Steps
5:38 pm	Public Comment Period
6:00 pm	Adjourn

CRIS Committee Decision Process Map – 2022

February 2022 (Workplan and Roles)

Objectives:
- ✓ Feedback on Initial Assessment.
- ✓ Development of High Level Workplan to frame overall objectives for work ahead.
- ✓ Understanding of committee and state agencies roles.

March 2022 (Centering Equity)

Objectives:
- ✓ Identify tangible actions to center equity in the High Level Workplan.

May 2022 (Vision & Guiding Principles)

Objectives:
- ✓ Adopt vision and guiding principles for Washington's behavioral health crisis response system.

July 2022 (Crisis Service Gaps & Goals)

Objectives:
- ✓ Recommend expanded and/or new crisis system services to achieve Washington's vision based on understanding of current services in Washington and crisis system best practices.

September 2022 (Roadmap and Budget)

Objectives:
- ✓ Articulate roadmap to achieve the vision for Washington's crisis response system.
- ✓ Inform process to develop budget recommendations.
- ✓ Review Section 109 Technical and Operational Plan (Tech/Op Plan).

November 2022 (Draft Progress Report)

Objectives:
- ✓ Review and provide input on draft January 2023 Progress Report – 1) Vision, 2) Equity, 3) Services, 4) System Interfaces, 5) Staffing/Workforce, 6) Funding, 7) Technology (Tech/Op plan).

December 2022 (Final Progress Report)

Objectives:
- ✓ Review final January 2023 Progress Report.

Personal Story

Objective: *Set the context for why we are engaged in this work.*

Javi Barria

CRIS Updates

Objective: *Share updates relevant to CRIS Committee*

Washington State Department of Health

DEPARTMENT OF HEALTH UPDATE
JULY 12, 2022

988 Goes Live on July 16

What changes:

- Call, text, chat 988 via cell phone, land line, voice-over internet device

What doesn't change:

- Current NSPL number
- Crisis call center capacity building
- Dispatch for DCRs/MCR teams or local/regional crisis services
- Connections with 911 and regional crisis services

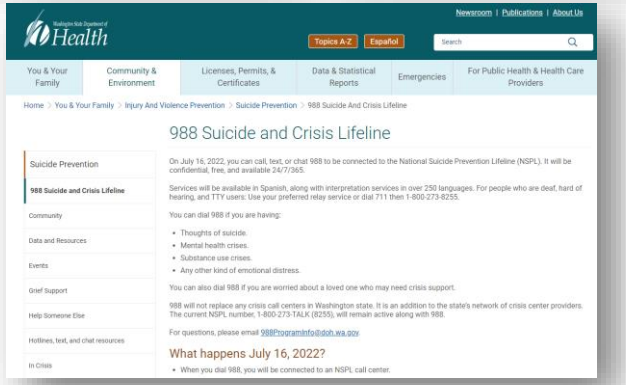
Next steps

- Assess call volume and staffing needs

988 Communications

DOH communications activities:

- 988 webpage
- One-pagers for key audiences
- Social media/communications toolkit for partners
- Social media posts
- Press release
- NSPL crisis center site visit and media availability
- Participation in cross-agency communications team



https://doh.wa.gov/chk/node/14398

Native and Strong Lifeline

- Native and Strong Lifeline dialpad option available after July 16
- Still need to sort out backup routing processes
- Interest in using Native and Strong Lifeline as model for other states
- National interest by Vibrant in indigenous sub-network

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

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

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

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Setting the Table: Current State

Objective: In preparation to provide feedback on what we need to do to achieve the vision for a crisis response system, understand the current state, including:

- Current utilization of crisis services in WA.
- What state agency teams are doing for mobile crisis teams and crisis stabilization services.
- Best practices in other states for mobile crisis teams and crisis stabilization.

Examination of Crisis Services Used in Washington from July 2020 – June 2021

Health Management Associates

July 12, 2022

WHAT CRISIS-RELATED SERVICES ARE AVAILABLE FOR REVIEW?

For all clients

- Calls to regional crisis lines in Washington (not the NSPL)
- Mobile Team Dispatches
- Designated Crisis Responder Dispatches for Involuntary Treatment Investigations

Source: Behavioral Health Administrative Service Organizations, reported in summary format to the Health Care Authority on a quarterly basis from 10 different sources

For Medicaid eligible clients specifically

- Calls to regional crisis lines in Washington (not the NSPL)
- Mobile Team Dispatches
- Designated Crisis Responder Dispatches for Involuntary Treatment Investigations
- Crisis Stabilization after Mobile Team dispatched

Source: Health Care Authority claims data warehouse

PROS AND CONS OF EACH DATA SOURCE

	PRO	CON
Source: BH-ASO regional data sources	Able to report on all that live in Washington, not just Medicaid	Information about individual clients by age group, by race, and by ethnicity are stored at each BH ASO. There is not one data source for this information.
Source: Health Care Authority claims data warehouse	Information of crisis service usage by region, by age group, by race, and by ethnicity is available.	But the granular detail on crisis use is only available for individuals enrolled in Apple Health (Medicaid)

HOW WILL CRISIS SERVICE DATA BE USED?

- For the report that will be delivered by the Steering Committee to the Governor and Legislature on January 1, 2023, some of these provisions include:
  - Build cost estimates for each of the components of the integrated behavioral health crisis response and suicide prevention system.
  - Develop a plan for the statewide equitable distribution of crisis stabilization and other services.
  - Recommend allocation of crisis system funding responsibilities among Medicaid MCOs, commercial insurers, and behavioral health administrative service organizations.
- In the September CRIS meeting, an outline of the cost estimating process will be shared in order to receive feedback from CRIS members.
- The data shared today is to
  - Offer information on what is known today related to crisis service use
  - Convey where there are known data limitations
  - Propose ideas of how these results can be used for the cost forecasting model

Results using the Data Sources Directly from Behavioral Health Administrative Service Organizations

KEY FINDINGS FOR CRISIS SERVICE UTILIZATION USING THE BH-ASO DATA SOURCES, TOTAL POPULATION

For the 12-month period July 1, 2020 to June 30, 2021:

- There were 381,800 calls to the Regional Crisis Lines
  - 93% of the calls were answered live within 30 seconds
  - 2% of the calls were abandoned by the caller after 30 seconds

- 55,434 mobile teams were dispatched statewide
  - This is 7.1 dispatches per 1,000 residents in Washington

- 30,596 Designated Crisis Responders were dispatched for Involuntary Treatment Act investigations
  - This is 3.9 investigations per 1,000 residents in Washington
  - 49% of ITA investigations resulted in a detention

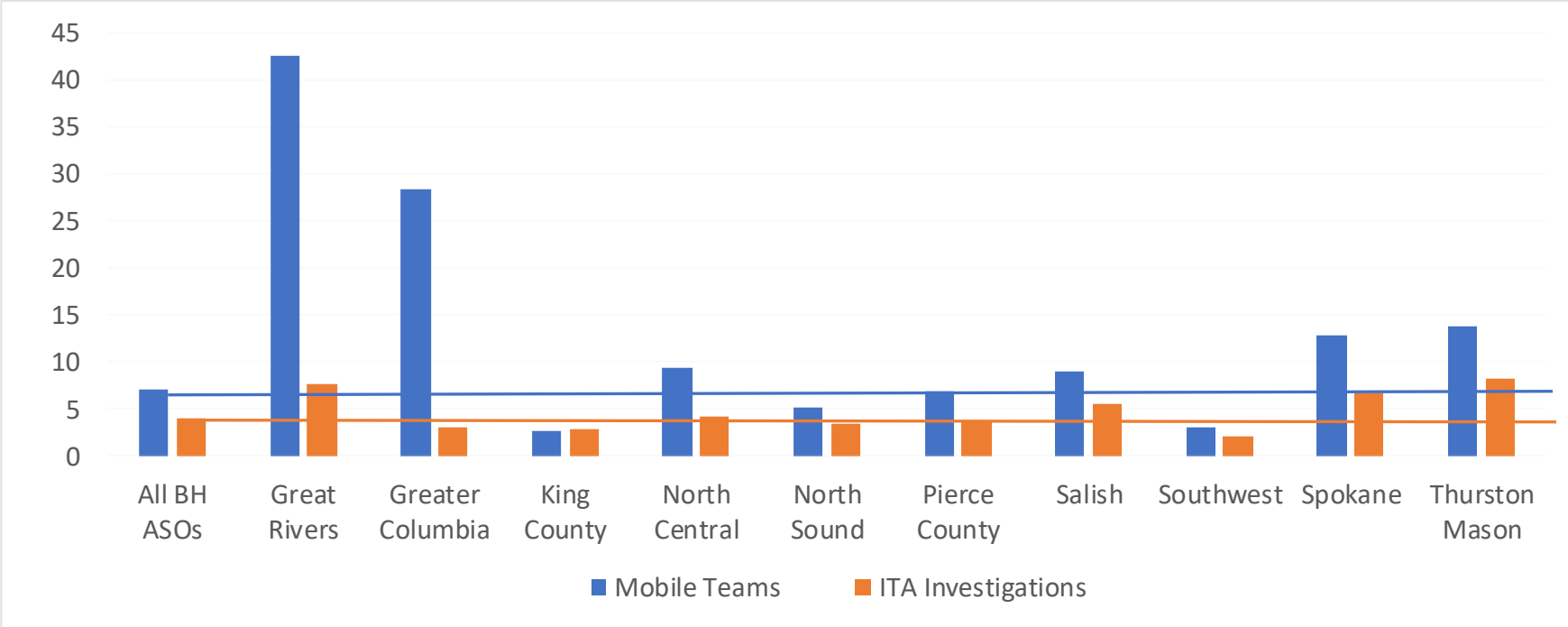
KEY FINDINGS FOR CRISIS SERVICE UTILIZATION USING THE BH-ASO DATA SOURCE, TOTAL POPULATION

For mobile teams:
The statewide use is 7.1 dispatches per 1,000 residents (blue line across).
For ITA Investigations:
The statewide use is 3.9 investigations per 1,000 residents (orange line).

The Great Rivers and Greater Columbia Regions far outpace other regions on the number of mobile crisis teams dispatched. Spokane and Thurston-Mason are also above statewide average.

Great Rivers, Spokane, and Thurston-Mason have more ITA investigations than statewide average.

Mobile Crisis Outreach and ITA Investigations Per 1,000 Residents BH ASO Region, July 2020 - June 2021



How should this data be interpreted?

More information is needed to determine if:

1. Certain regions have higher mobile team/ITA use based on staffing configuration OR
2. Certain regions have lower use because there may be need but no capacity to serve OR
3. Certain regions have alternative services/modalities in place to prevent the need for mobile teams and ITA investigations OR
4. Most likely, some combination of all 3

NEW DATA BEING TRACKED BY THE HCA FROM BH-ASOs STARTING JULY 1, 2021

- **Among all mobile teams requested,**
  - **The percentage of the total responded to within 2 hours (defined as Emergent)**
  - **The percentage of the total responded to within 24 hours (defined as Urgent)**

- **Among the ITA Investigations being conducted,**
  - **The percentage that are being conducted via telehealth**

- **Among the ITA Investigations conducted that result in detention,**
  - **The percentage with a primary diagnosis related to mental health**
  - **The percentage with a primary diagnosis related to substance use disorder**

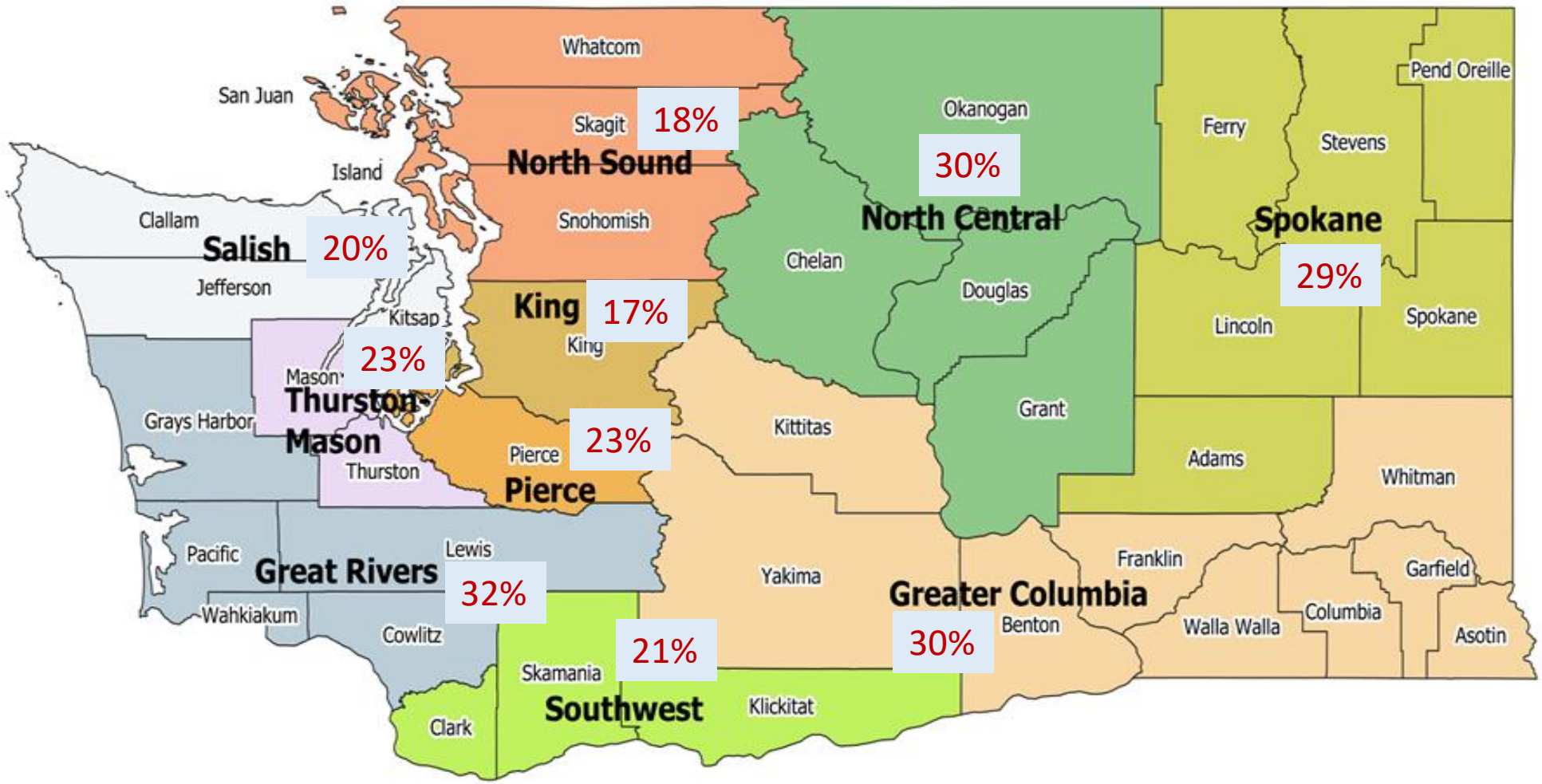
How will this data be useful for future planning?

1. Response time information can help inform the total number of mobile teams needed.
2. Results from these new data elements can help identify what additional data needs to be collected to add precision to forecast future need.

Results using the Health Care Authority's Data Warehouse for Medicaid Data Only

WHO IS ENROLLED IN MEDICAID?

As of April 1, 2021, almost one in four individuals that live in Washington (22.3%), are enrolled in Apple Health, the state Medicaid program. The percent of individuals enrolled in Apple Health does vary by region.



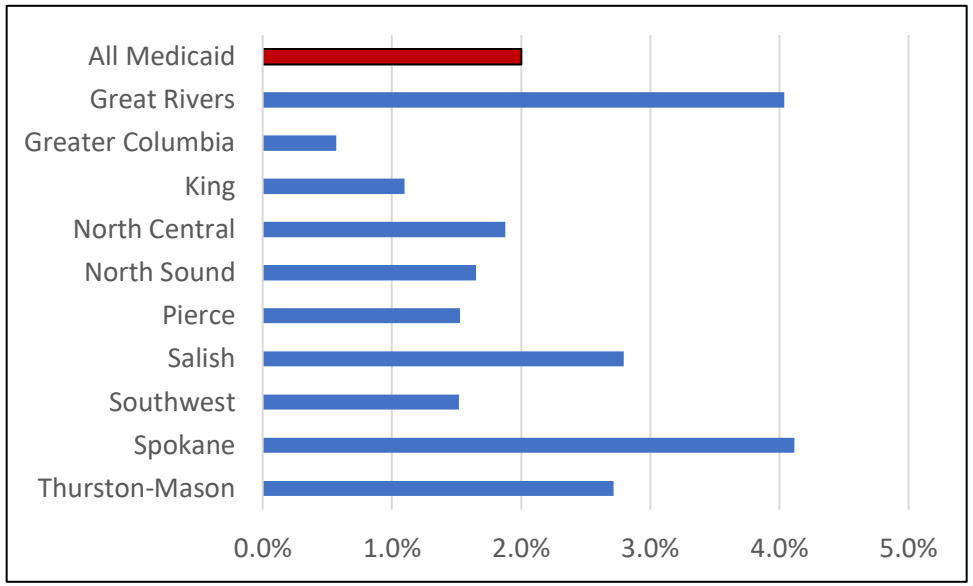
HOW WAS THE MEDICAID UTILIZATION OF EACH CRISIS SERVICE EXAMINED?

By Diagnosis	Individuals presenting with a Mental Health Primary Diagnosis	Individuals presenting with a Substance Use Disorder Primary Diagnosis		
By Region	Great Rivers	North Central	Salish	Thurston-Mason
	Greater Columbia	North Sound	Southwest	
	King	Pierce	Spokane	
By Age Group	Age 0 to 10	Age 19 to 29	Age 40 to 64	
	Age 11 to 18	Age 30 to 39	Age 65 and over	
By Race or Ethnicity	Hispanic	American Indian or Alaska Native	Asian	Other Race or Unknown
	Non-Hispanic	African-American	Pacific Islander or Hawaiian	

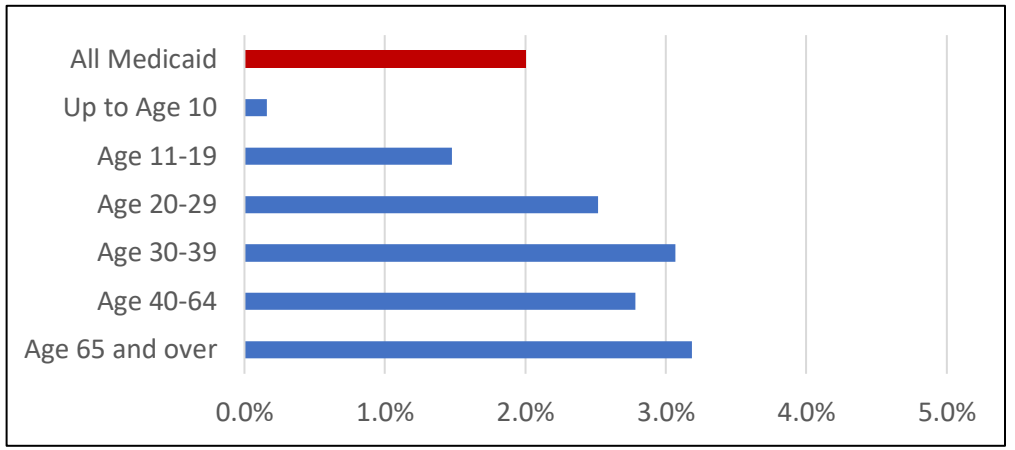
USE OF MOBILE CRISIS TEAMS, JULY 2020 – JUNE 2021, MEDICAID

2.0% of the total Medicaid enrollment (34,118 individuals) received either a mobile crisis team service or ITA investigation.

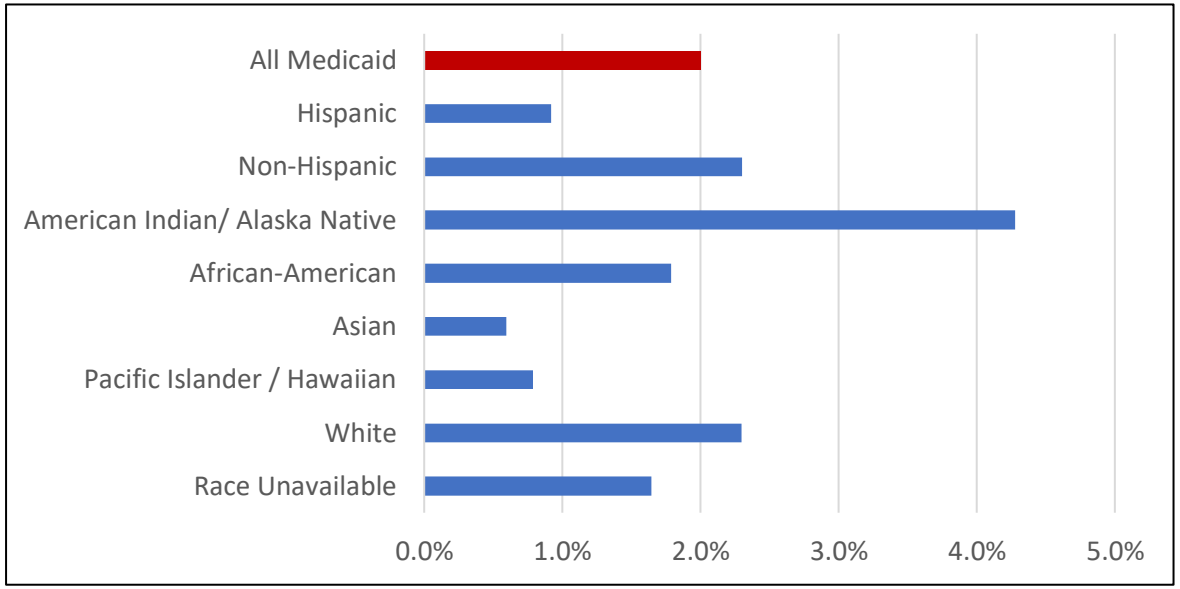
Although the statewide average is 2.0%, the proportion of Medicaid users by region varies as seen below.



The percent of users was found to be similar across different age bands of adults near the overall 2.0% average.



Crisis services are disproportionately used by American Indian / Alaska Native Medicaid enrollees compared to the overall average. Other races/ethnicities were lower than the statewide average.



How should this data be interpreted?

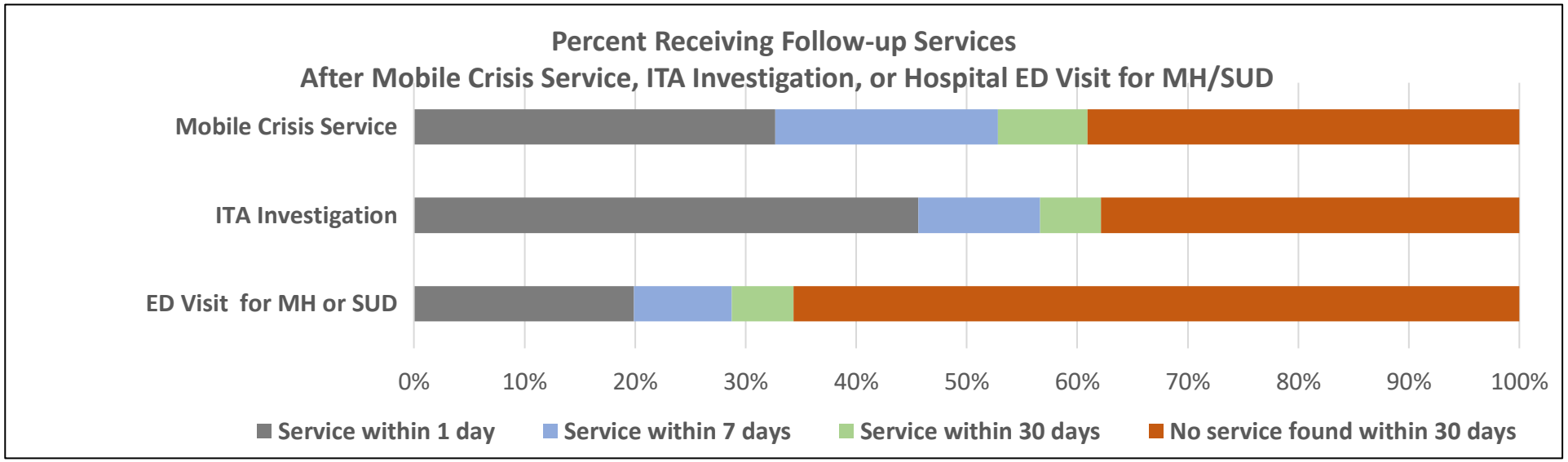
Further investigation is warranted to determine if there is under-reporting for certain population groups.

WHO RECEIVED FOLLOW-UP SERVICES AFTER A CRISIS SERVICE WAS DELIVERED TO A MEDICAID ENROLLEE? Study Period July 2020 – June 2021

33% of enrollees who had a mobile crisis service received a mental health service within **1 day** (gray portion of bar), 53% within **7 days** (gray and blue combined), and 61% within **30 days** (gray, blue and green combined). But for 39% of these enrollees, no evidence of follow-up was found within 30 days (red portion).

A higher percentage of enrollees who had an ITA investigation received a mental health service within **1 day** (46%). Like those that had a mobile team service, for 38% there was no evidence of follow-up within 30 days.

Only 20% of enrollees who had a hospital emergency department visit related to mental health or substance abuse received a mental health service within **1 day**. 66% had no follow-up was found within 30 days.



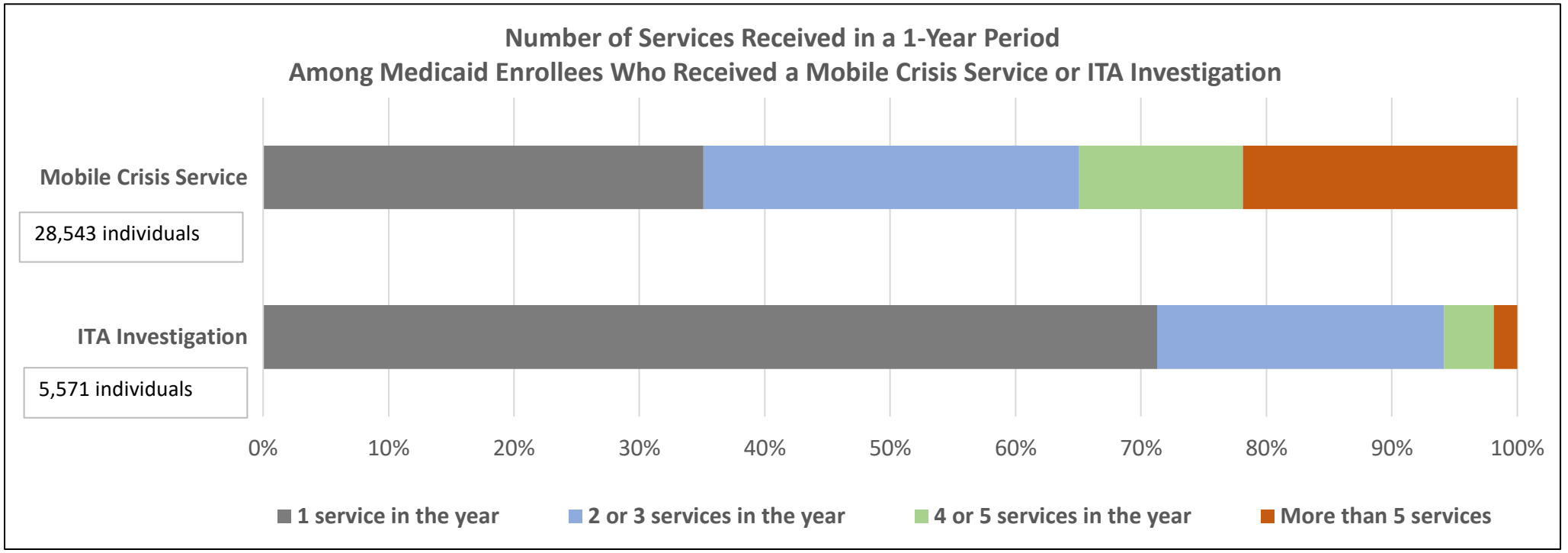
How should this data be interpreted?

If the Medicaid results are a guide, then more attention is warranted for follow-up care for next-day appointments and within 7 days of a crisis-related event. HB 1477 requires strategies be put in place to ensure next-day appointments.

HOW CAN WE MEASURE THE UNMET NEED FOR CRISIS SERVICES?

35% of clients received only one mobile team service during the year, **30%** received two or 3 services, **13%** received 4 or 5 services, and **22%** more than 5 services.

71% of clients received only one ITA investigation during the year. **23%** received 2 or 3, and **6%** received more than 3.



For Medicaid, over 34,000 enrollees received crisis services, but over 106,000 Medicaid enrollees had a primary diagnosis for mental health or substance use disorder.

How should this data be interpreted? More data points and analysis is required to determine how many more between 34,000 and 106,000 are in need or could be in need of services.

HOW OFTEN IS CRISIS STABILIZATION USED AS A SERVICE IN MEDICAID, July 2020 – June 2021

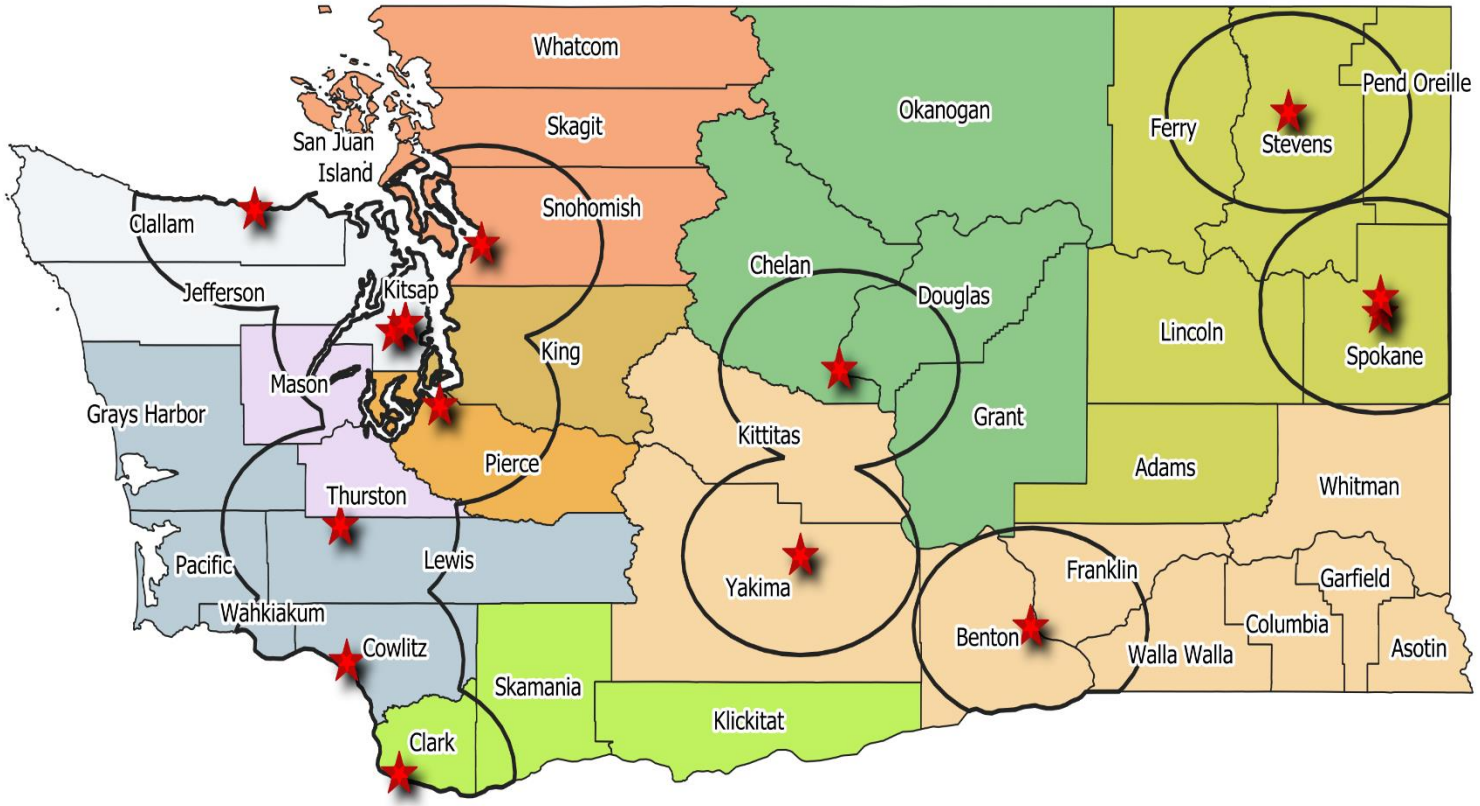
Crisis stabilization services were in limited use by individuals that received a crisis service.

Within 1 day after the crisis service was received, the percentage that received crisis stabilization was:

- 7.0% of enrollees who had a mobile crisis service,
- 5.0% who had an ITA investigation, and
- 2.9% who had who had a hospital ED visit related to mental health or substance abuse.

Usage of crisis stabilization services is low because there are few providers offering it in the state.

The stars on the map to the right show where the crisis stabilization centers are located. The circles around each star show a 30-mile service coverage area.



ASSESSMENT OF CRISIS DATA AND RECOMMENDATIONS ON DATA

Based on what has been observed related to the crisis service data, the following items are recommended:

1. **Develop consistency in coding for mobile teams, ITA investigations, and crisis stabilization services among BH ASOs, Medicaid MCOs, and commercial MCOs.**
2. **Build a reporting mechanism to track mobile team and ITA investigations across all payers (and the uninsured) that is stored in one central location for external reporting and monitoring. Elements that would be tracked include, but are not limited to, the following:**
    - **Location where client received the service at the county level**
    - **Response time for mobile teams and ITA investigations**
    - **Availability of crisis stabilization beds**
    - **Type of follow-up delivered immediately after mobile team/ITA was dispatched**
    - **Documentation if a next-day appointment was scheduled**
    - **Documentation if a next-day appointment was scheduled and followed through by the client**

RECOMMENDATION FOR MOVING FORWARD ON ESTIMATING NEED AND COSTS

Assign workgroup of members of the CRIS to meet with state agency representatives to develop benchmarks for outcome thresholds. Then use these thresholds as the basis for budgeting. Continue to track and trend data to refine estimates of need over time. An example of a process flow is shown at left. An example of a staged budgeting estimate is shown at right.

July – Nov 2022

Workgroup meets to define outcome measures and targets to meet capacity for mobile teams, crisis stabilization and follow-up services. Related to this is decisions on the method for tracking the data needed to measure targets over time.

Sept 2022	Nov 2022
Construct of crisis system cost estimates given to CRIS, with assumptions.	2nd version of cost estimates given to CRIS, with refinements.

Example of How Targets Can Be Established to Build Cost Estimate

	Funding is Done in Phases Based on Specific Targets		
	Phase 1	Phase 2	Phase 3
Mobile Teams	Funding enables **4%** of individuals in state with MH/SUD to receive mobile team service.	Funding enables **7%** of individuals in state with MH/SUD to receive mobile team service.	Funding enables **10%** of individuals in state with MH/SUD to receive mobile team service.
Crisis Stabilization	Funding enables 20% of individuals with mobile team service to receive crisis stabilization service.	Funding enables 25% of individuals with mobile team service to receive crisis stabilization service.	Funding enables 30% of individuals with mobile team service to receive crisis stabilization service.
Follow-up	Funding enables follow-up for 50% of individuals after mobile team service.	Funding enables follow-up for 70% of individuals after mobile team service.	Funding enables follow-up for 90% of individuals after mobile team service.

Key takeaways for crisis services

Someone to respond and somewhere to go

Washington State Health Care Authority

Adult services

- Working to align current mobile crisis to SAMHSA's best practices which includes
  - Responding with mobile crisis first to minimize the use of LEOs, 1st responders, and DCRs
  - Integrating peers into teams
- Establishing new models for a "place to go"
  - Establishing 23-hour models statewide as an alternative to Eds
  - Peer Respites
  - Expanding stabilization facilities to reduce E&T stays
- Work still to be done to ensure statewide availability of crisis resources and ensure they are affective.

Youth Services

- Working to expand youth mobile crisis teams statewide and align them to the MRSS model
  - Adding 6 teams to make at least 1 youth team in each region.
  - Implementing 8 weeks of in-home stabilization going forward
  - Working to expand number of youth teams further to ensure adequate access across the state
- Working to incorporate youth-based crisis services as the first response when parents or caregivers or youth 13+ call and:
  - Schools
  - LEOs
  - Call centers
- Developing alternatives to EDs and youth specific places to go
- Youth crisis is complex - lots of considerations unique to this population

Biggest challenges and recommendations

- How do we ensure there is adequate funding for stability and parity for our crisis system?
  - Fund resources as a "fire house model" or at capacity
  - Fund crisis service providers better then outpatient to retain workers
- Equity
  - Recruit from communities to provide services to their community
  - Train service providers in cultural practices relevant to them and ensure there are experts to consult.
- Workforce
  - Look to alternative programs to train staff
  - Integrate more peers
- Geographic diversity
  - Ensure services are available across the state by using remote services
  - Provide transportation to local resources or telehealth hubs

Arizona Learning Adventure – May 2022

- CRIS committee members traveled to Maricopa County in May 2022
- Maricopa County has over 50% of the state's population
- Hosted by RI International
- Visited RI HQ for learning sessions
  - Crisis Now model
  - Funding Model
- Learned about RHBA's
- Visited a call center
- Visited Mobile Crisis Outreach Dispatch Ctr.
- Facility tours – 3 levels of care

Features Comparison

	WASHINGTON STATE	MARICOPA CO.
Medicaid Program	Apple Health	Arizona Cost Containment
Service Delivery	Integrated Managed Care. HCA contracts with MCOs and BHASOs to coordinate regional services.	Integrated Managed Care AND Regional BH Authorities (RBHAs) to coordinate care for clients with a SMI.
Care Delivery	1477 implementation to support move towards no wrong door.	No wrong door policy. Three levels of care: 1) 23 hour; 2) short term beds; 3) respite center
Billing	1688 (new) protects consumers against out of network charges for emergency BH crisis services. 1477 Next day appt availability. Self funded plans excluded	Insurers required to pay for mental health services equally with physical care. Bill insurers for as much crisis services as possible.
Call Center Structure	3 NSPL Centers.	Single statewide vendor starting Oct. 2022.
Liability	No liability protections for crisis providers.	Invol. Tx law provides protection to staff – cannot be liable for patient harm upon release if reasonable precautions were taken.
Peers	Professional requirements limit use of sparse workforce.	Making good use of available work force.

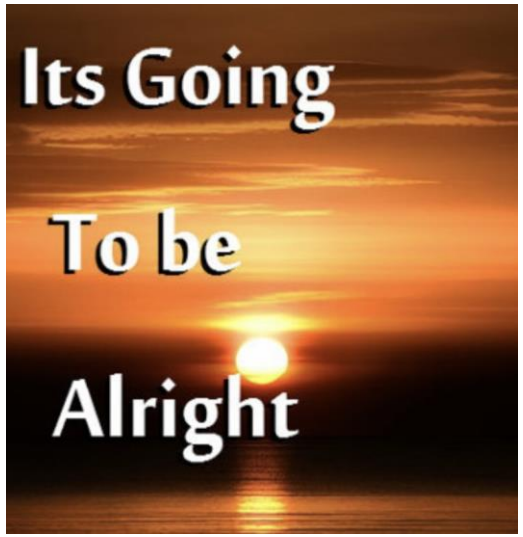
Arizona Learning Adventure

Many take-aways, here are some of our biggest items to embrace

- Peer First
- No Wrong Door
- Medical Clearance
- Coverage for the first 23 hours

Arizona Add-ons!

- Timely responses is needed to be a true alternative to 911
- Clinically driven and community based
- Lived experience on the teams
- Transportation alternatives to police



Crisis Services Best Practices – Someone to Come

Someone to Come – SAMHSA Recommended Best Practices (beyond minimum expectations)

- Incorporate peers into team
- Respond without law enforcement accompaniment unless there are special circumstances that support diversion
- Implement real-time GPS technology in partnership with the region's crisis call center hub to support efficient connections
- Schedule outpatient follow-up appointments in a manner synonymous with a warm handoff

State	Model	Approach
Arizona	Mobile Crisis	No wrong door/no wrong insurance; braided funding model; credentialed peers; technology that directly links crisis lines with mobile teams, dispatches teams, has GPS capabilities; 60-90 minute response times (target is 30 minutes)
Ohio	Mobile Response Stabilization Services (MRSS)	Wraparound approach for persons under 21 and their families; includes peers; MRSS Tool Kit offers protocols and tools for the core services/levels of response
Colorado	Community Response Team (CRT); Support Team Assisted Response (STAR)	CRT operates through fire department under the Community Assistance Referral and Education Services program (CARES) and offers resources and health care access to individuals with high ED or 911 utilization; STAR deploys EMTs and BH clinicians to individuals in BH or social crisis

Crisis Services Best Practices – A Place to Go

A Place to Go – SAMHSA Recommended Best Practices (beyond minimum expectations)

- Function as a 24-hour or less crisis receiving and stabilization facility
- Offer a dedicated first responder drop-off area
- Incorporate some form of intensive support beds into a partner program to support flow for additional support
- Include beds within the regional bed registry system operated by the crisis call center hub to support efficient connection
- Coordinate connection to ongoing care

State	Model	Approach
Arizona	Crisis Urgent Walk-In, Crisis Observation, Crisis Stabilization, Crisis Residential	Common attributes are: serves adults and youth, "peers first" contact, no wrong door, police drop off, screen for involuntary, serve Medicaid and non-Medicaid individuals
California	"Alameda model" Crisis Stabilization Unit (CSU)	CSU contiguous with a dedicated psychiatric hospital designed to reduce wait times, decrease psychiatric boarding and prevent admissions
Michigan & Wisconsin	Peer-Run Respite Programs	Voluntary, non-medical, overnight programs in a home like environment for persons experiencing behavioral health crisis or emotionally distressing challenges

Break

Discussion: Missing Pieces

Objective: Based on understanding of current state and best practices, discuss the missing pieces we need to address to achieve the vision for a crisis response system.

Focus Areas:

- Someone to Come
- A Place to Go

Discussion Questions

Based on your understanding of current state and best practices, what are the missing pieces we need to address to achieve Washington's vision for a crisis response system? [Today's focus areas: 'Someone to Come' and 'A Place to Go']

- *What existing services need to be expanded?*
- *What are new services that need to be developed?*

CRIS Member Breakout Groups

Room 1	Room 2	Room 3	Room 4
Suzanne Rabideau	**Laura Collins**	**Mark Podrazik**	**Michael Anderson-Nathe**
Adam Wasserman	Amber Leaders	Bipasha Mukherjee	Caitlin Safford
Heather Sanchez	Robert Small	Ron Harding	Rep. Tina Orwall
Puck Kalve Franta	Darya Farivar	Judy Warnick	Dillon Nishimoto
Joan Miller	Jan Tokumoto	Levi Van Dyke	Jennifer Stuber
Michele Roberts	Senator Manka Dhingra	Linda Grant	Kimberly Hendrickson
Rep. Tom Dent	Michael Robertson	Michael Reading	Summer Hammons
Anna Nepumoceno	Jessica Shook	Kashika Arora	Michelle McDaniel
Justin Johnson	Claudia D'Allegri	Keri Waterland	

Action Items & Next Steps

Public Comments