HB 1477 Crisis Response Improvement Strategy Committee

April 26, 2023

Health Management Associates

Harborview Medical Center

UW Medicine | King County

Zoom Etiquette: CRIS Committee Members

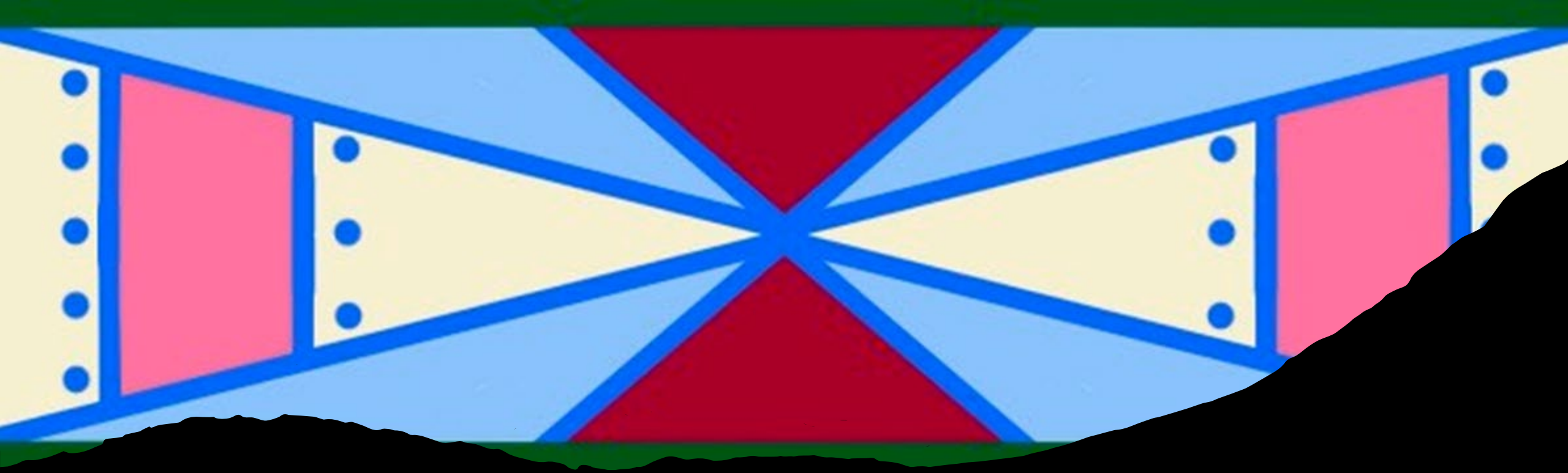
Zoom Etiquette: Members of the Public

CRIS Committee Meeting Objectives

1. Understand where we've been, where we are now, and where we are going in the CRIS process.
2. Answer questions from CRIS committee members about updates in the monthly CRIS e-newsletter.
3. Provide foundational understanding about Washington State Health Care Authority's youth-focused crisis response model, to inform CRIS discussion about youth crisis response.
4. Discuss considerations related to youth-focus crisis response, to inform future Steering Committee recommendations.
5. Confirm action items and next steps.
6. Hear public comment.

Meeting Agenda

TIME	TOPIC
2:30 pm	Technology Review
2:35 pm	Welcome, Introductions, Review Meeting Agenda
2:55 pm	Personal Story
3:15 pm	Agency Q&A
3:25 pm	Presentation: Mobile Response and Stabilization Services (MRSS) Model for Youth Crisis Response
4:00 pm	Break
4:10 pm	Discussion: Considerations for youth crisis response
5:15 pm	Action Items and Next Steps
5:18 pm	Public Comment Period
5:30 pm	Adjourn



Tribal Behavioral Health Crisis Response: Systems Updates for CRIS

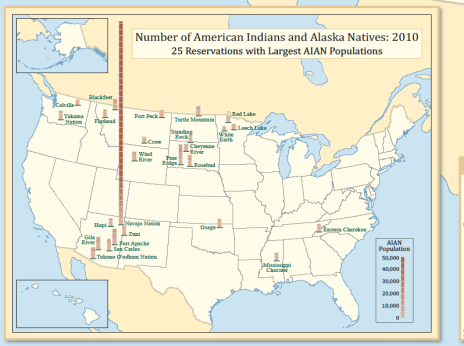
April 26, 2023

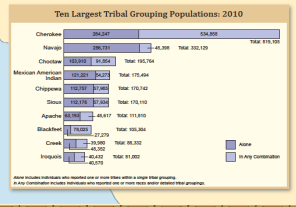
Plateau Parfleche by Jon Shellenberger Olney, Yakama

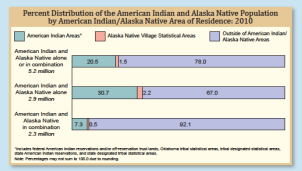

NATIVE AMERICAN NATIONS
TRADITIONAL NAMES & LOCATIONS
Syilx
Ktunaxa
Niitsitapi
Yaqan Nukiy
Aqam
Q'ilispe
Aamsskaapipikani
Nakoda
Pikuni
A'aninin
Schitsu'Umsh
Salish
Hiraacá
Anishinaabeg
Lnu'k
Wôbanakiak / Alnôbak
Wolastokwiyik
Peskotomuhkati
Agaiduka
Doyahinee
Apsáalooke
Očhéthi Šakówiŋ
Dakota
Mamaceqtaw
Odawak
Haudenosaunee/ Iroquois Nations
Newe
Numu
Lakota
Tukaduka
Tsétsêhéstâhese
Boho'inee
Kohogue
Chonnonton
Onguioaahra
Ho-Chunk
Só'taeo'o
Ponca
Umonhon
Bah-kho-je/Baxoje
Cumumba
Yoowetuh
Toompahnahwach
Yapudttka
Hinonoeino
Jiwere
Tsaiduka
Sahpeech
Pahvant
Nuwuvi
Nunt'zi
Shebedteech
Pahdteeahnooch
Chahiksichahiks
Khaze
Nutachi
Myaamiaki
Shawanwaki
Tareewach
Tawehash
Ex'celen
Weemeenooch
Kahpota
Mobach
Diné
Hopi
Tinde
Wa-zha-zhi / Niukonska
Ani'yunwi'ya
Yamparika
Quohadas
Ka'igwu
Kotsoteka
Caddo Confederacy
Chikasha
Mvskoke Etvlwv
Chahta
Chumash
Ipai
Ti'pai
Nde'h
Piipaash
Akimel O'Odham
Shis - Inday
Numunuu
Noconis
Tenawa
Tanima
Penateka
K'itsash
Ná-lzhán
Naishan Dene
Tickanwa'tic
Xumani
Tampachoa
Manso
Suma
La Junta
Tapaxcolmeh
Concho
Chiso
Auia
Yamasee
Timogua
Ohlone
Tsoyaha
Koasati
Lenni Lenape
This map is the first to document the true names and original locations of most of the documented Native American Nation in what is now the contiguous United States of America. It represents the homelands of Tribal Nations from roughly 1590 through 1850, pre-reservation period. It seeks to honor all Nations, Tribes, sub-Tribes and bands, etc by including the larger, well-known ones as well as many that did not survive the effects of European arrival. Most of the

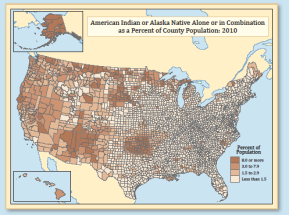
American Indians and Alaska Natives

in the United States





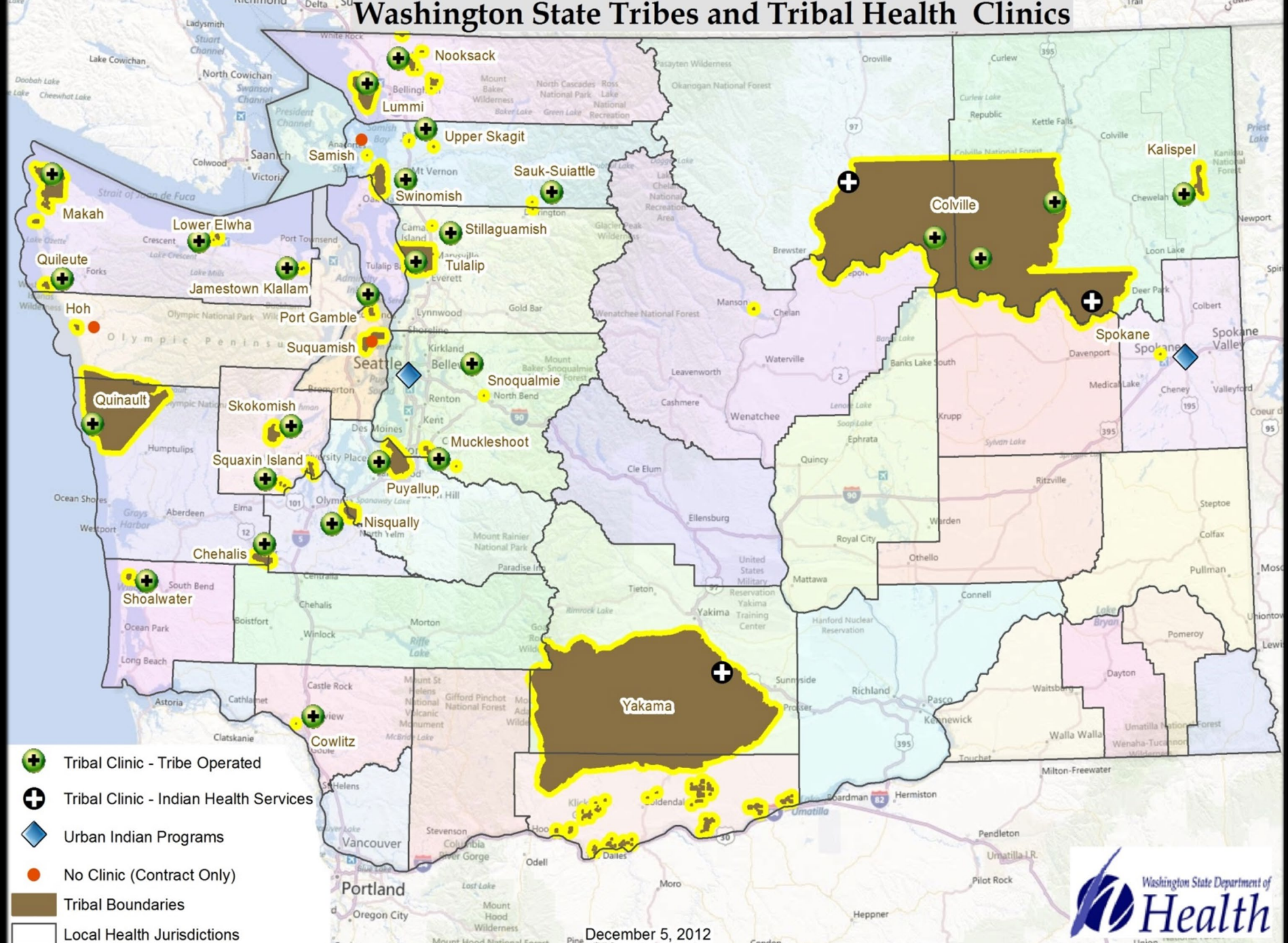




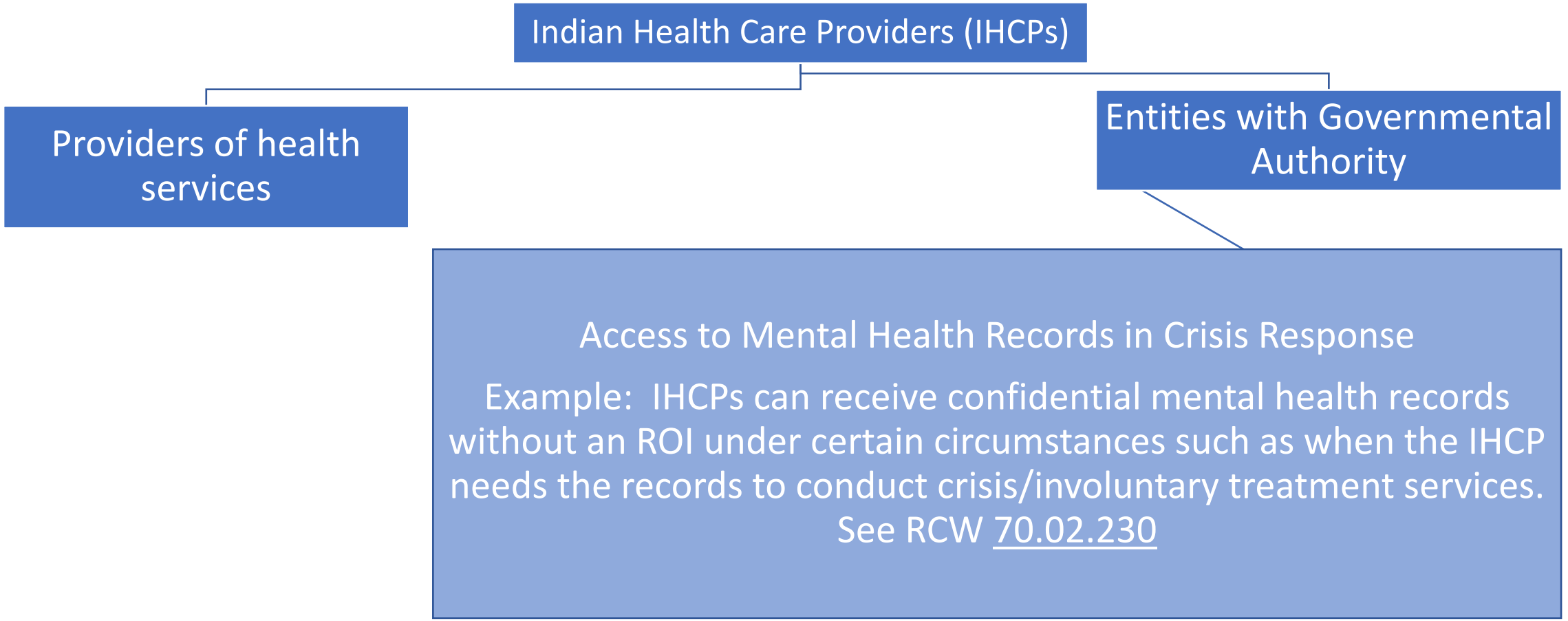
U.S. DEPARTMENT OF COMMERCE Economics and Statistics Administration U.S. Census Bureau

Prepared by Geography Division

Washington State Tribes and Tribal Health Clinics



Dual Role of Indian Health Care Providers in Behavioral Health



In 2020, the Washington Indian Health Improvement Act, SB 6259, added Indian health care providers to the list of qualified professional persons who are allowed to receive confidential mental health records under certain circumstances.

Tribal BH Crisis Response Activities

- Tribal Centric Behavioral Health Advisory Board/Tribal 988 Subcommittee: Facility, HB 1477 projects related feedback
- State legislation changes: 2020 Washington Indian BH Act and 2024 updates
- Training: MCO, ACH, DCR Academy, Forensic Navigators, BH Providers, OBHA
- Tribal BH Code template development
- Behavioral Health Hub
- Native and Strong Lifeline (Tribal 988)
- Tribal DCR Planning Meetings
- Tribal BH Crisis Response Planning
- DCR protocols and WACs
- Information gathering with Tribal BH professionals, medical directors, attorneys, judges, police, plus treatment facilities
- Sustainability planning: case rate, potential for 988 related pilot projects, billing guidance
- Upcoming: 1134 and 5120 feedback on WAC development

Thank you

American Indian Health Commission for Washington State

Kathryn Akeah

Tribal Health Consultant

kathrynakeah@gmail.com

Whale Comb by Zeke Serrano, Quinault

Personal Story

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

Hiding in Plain Sight

A Mother's Story Of Resiliency & Hope

By: Brittany Miles


The past
four years

Jaime & Me

- I am the single parent to a 15-year-old with early onset schizophrenia. Jaime is a pseudonym to honor her privacy.
- The past four years have been filled with anxiety and dread. We've consistently been failed by the system. Our family has endured trauma on the journey to a diagnosis – I've been falsely reported to CPS by a licensed DCYF resource when seeking help for Jaime.
- There is no support at the local & state level due to income. Private insurance covers little, especially medication. Most costs are out of pocket.
- Jaime wasn't well enough for school whether in-person or virtual. I left a lucrative tech career to be her full-time caretaker.


How we're doing today

Be fearless, there's hope

- I've found my voice. I'm a member of the HB1477 Technology Subcommittee, a board member for the Regional Crisis Response Program, and a member of other mental health organizations.
- I've written two well received opinion articles published in The Seattle Times & PubliCola in support of the Crisis Care Centers Levy. Both illuminated the struggles for those who are missed by the system.
- Through writing and advocacy, I've found my passion. Mental health matters and I'm going to fight for kids like Jaime.
- No one should experience the stigma and trauma we have.


The system needs to…

Find the middle way

- The prospect of losing everything to get a modicum of what you need isn't the way.
- Most social services are out of reach and I'm dependent on private organizations which can only help so much.
- Like middle housing, we need legislative support to help families which struggle to meet the needs of a seriously mentally ill child.

What will you do?

- Ignoring the mental health gap is kicking the can down the road. Putting pressure on the middle class causes a domino effect of economic and housing instability. Our story attests to this ugly truth.

- What representative or senator will commission studies to examine the depth of the problem from the middle-class perspective? Jaime and I are not alone.

- What bills can be written and sponsored in the next legislative session? Who among you will have the courage to stand, fight, and legislate for kids and families like mine?


Your silence is deafening

Thank you

AGENCY Q&A

Objective: *Answer questions from CRIS Committee about updates in the monthly e-newsletter*

Presentation: Mobile Response and Stabilization Services (MRSS) model for youth crisis response

Objectives:

- *Understand HCA's model and delivery system approach to support youth crisis response, based on SAMHSA best practice guidelines.*
- *Inform discussion (later in this meeting) about considerations related to youth crisis response.*

Youth Mobile Response & Stabilization Services (MRSS)

Implementing Best Practices for Youth and Families

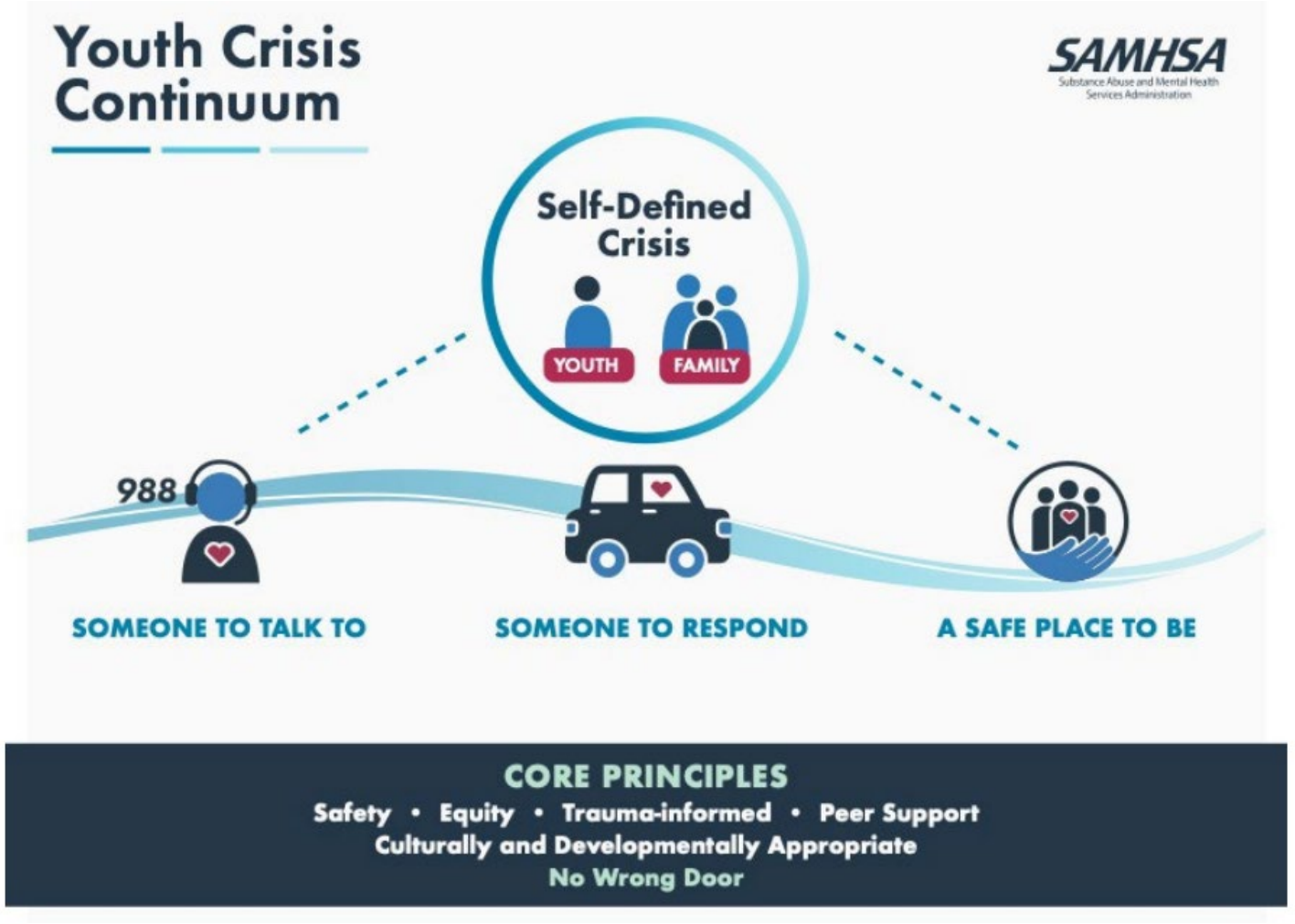
Washington State Health Care Authority

How Do Families Access Crisis Services?

- Schools/providers/doctors/parents identify needs early - youth to the Emergency Dept. (ED)
- 911 activation - Law Enforcement/Ambulance/Fire response - youth to Emergency Dept. or risk Juvenile Justice or child welfare involvement
- Once in the Emergency Dept. - Families wait for medical clearance, often 10-18 hours
- A few will go to adolescent inpatient, then get discharged
- Often discharged home without supports in place
- In a few regions, people call the regional or provider crisis line – get in person response

Mobile Response and Stabilization Services (MRSS)

- Safety
- Equity
- Trauma-Informed
- Peer Support
- Culturally Appropriate
- Developmentally Appropriate
- No Wrong Door



MRSS and SAMHSA Crisis Best Practices

Youth Mobile Response and Stabilization Svc.	SAMHSA Crisis care best practice toolkit
Single point of access, not 911	Single point of access, not 911
Crisis defined by parent/youth	Crisis defined by caller
Comprehensive youth assessment	Risk assessment for danger to self & others
Respond without Law Enforcement	Respond without law enforcement
Teams trained in developmentally appropriate interventions	Crisis responders trained in safety
Designed to interrupt care pathway	Designed to address the needs of adults
Stabilization in-home - 8 weeks	Teams may provide transportation
Warm handoffs to natural and clinical supports is core component	Facility based stabilization
	Referrals

Goals of Mobile Response and Stabilization

Support and Maintain	Outreach and Engagement	Promote	Reduce	Assist
Support and maintain youth in current living environment	Engage youth and families by providing access to care	Promote safe behavior in home, school and community	Reduce use of ED's, Inpatient units and detention centers	Assist families in linking with community and clinical services

Youth Mobile Response & Stabilization

- 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) *MCO
  - 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
  - Care coordination and warm handoffs to existing systems of care and clinical supports when clinically appropriate

System Partners Who Can Refer Youth to MRSS

Primary care

Schools

Police

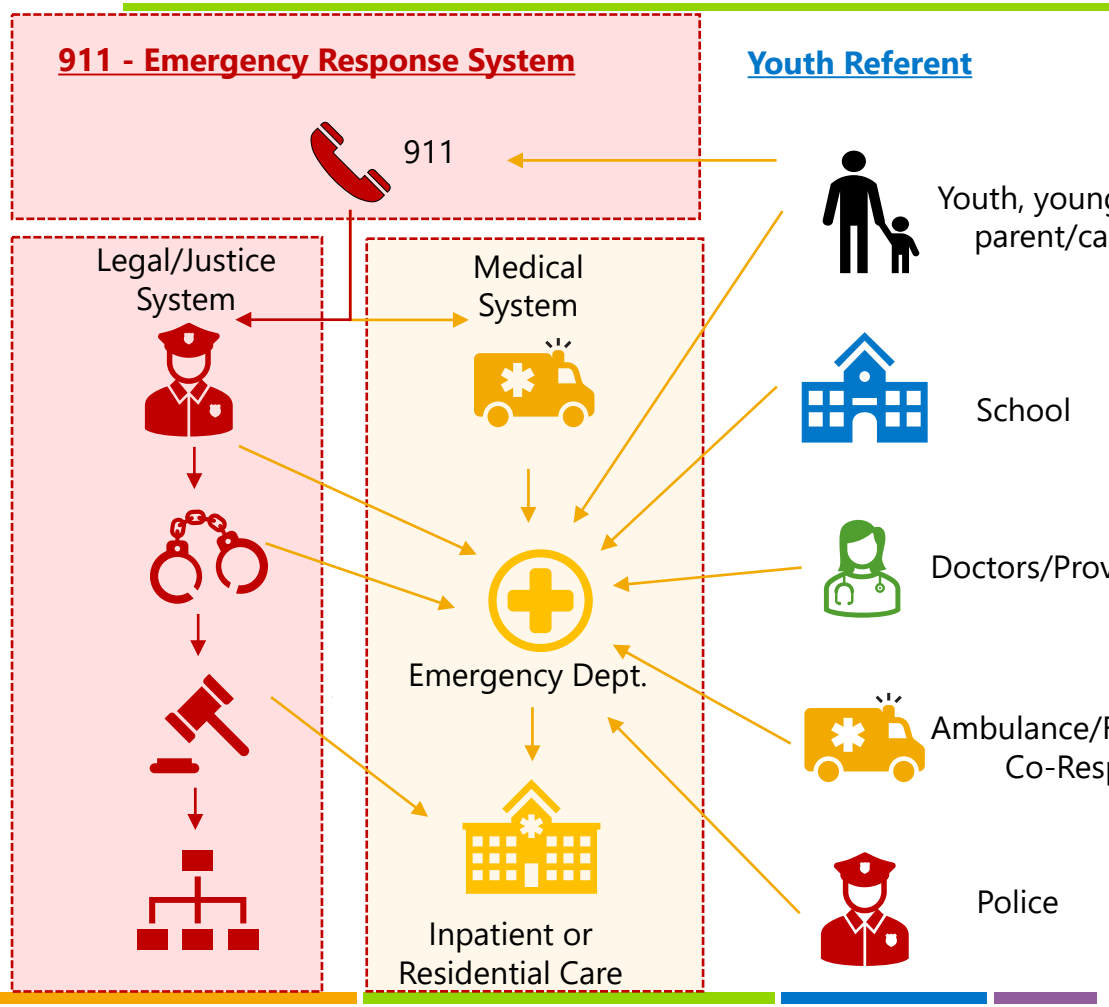
ED's

Inpatient Units, BH Providers

Juvenile **Justice or DCYF**

Who Are Partners In Youth Crisis?

Care Pathway via 9-1-1 & the Medical Model



Youth Referent

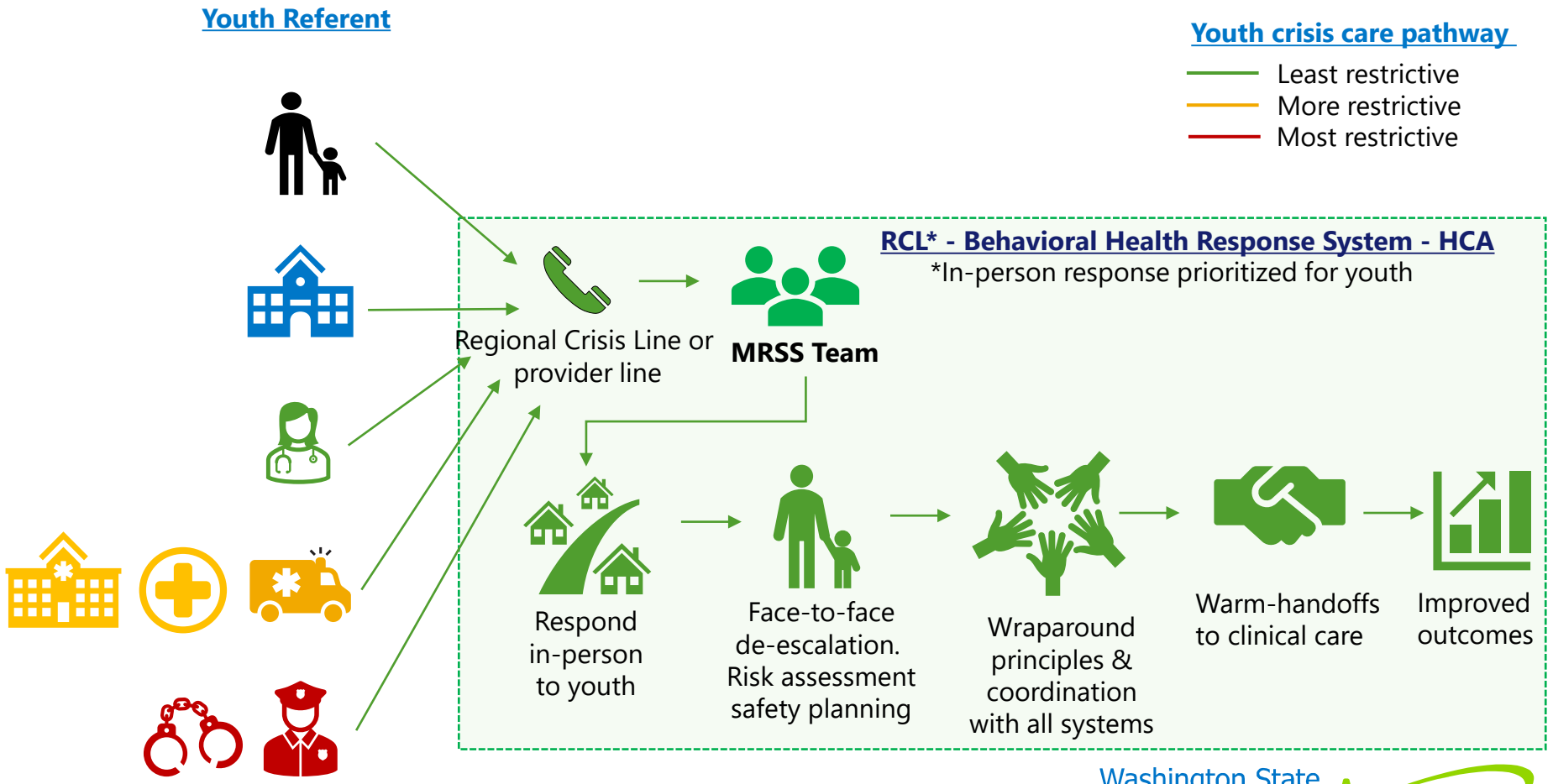
- Youth, young adult or parent/caregiver
- School
- Doctors/Providers
- Ambulance/Fire or Co-Response
- Police

Youth crisis care pathway

- Least restrictive
- More restrictive
- Most restrictive

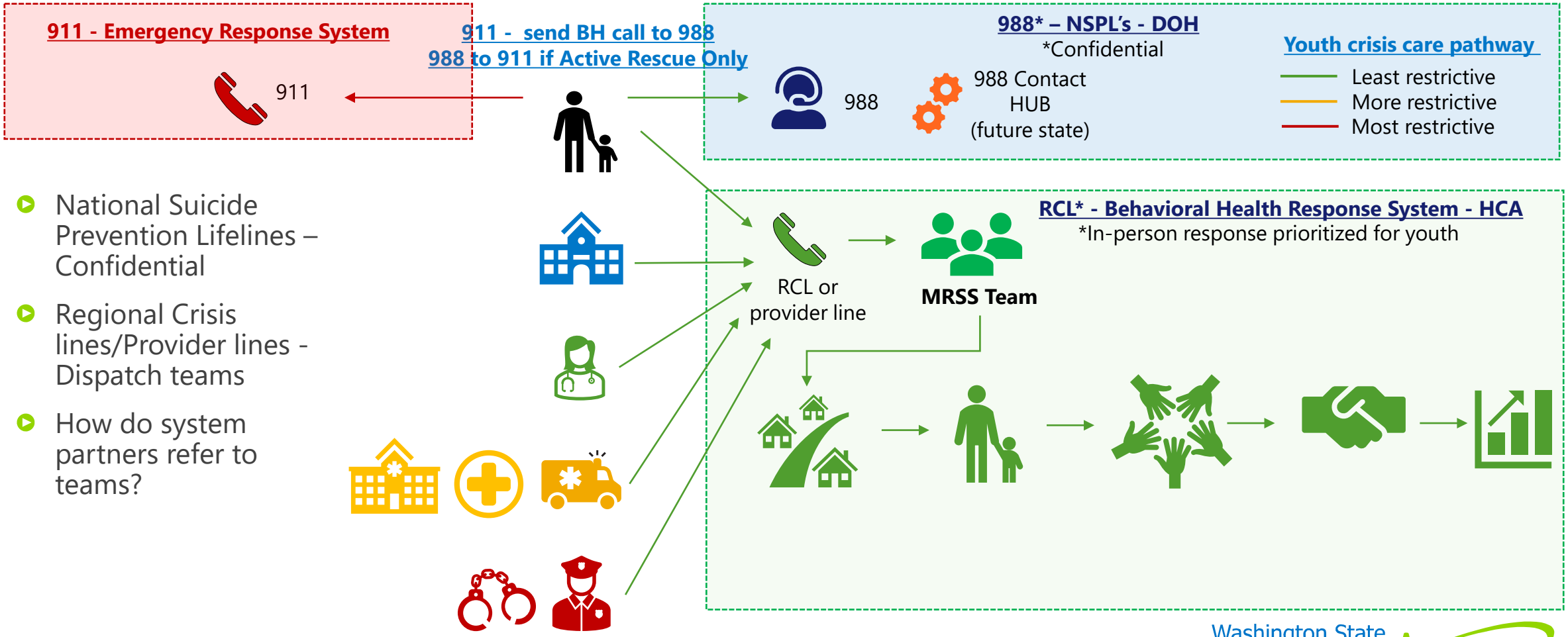
Washington State Health Care Authority

MRSS - Recovery Oriented & Delivered at Home



Washington State Health Care Authority

MRSS is Designed to Interrupt Care Pathways



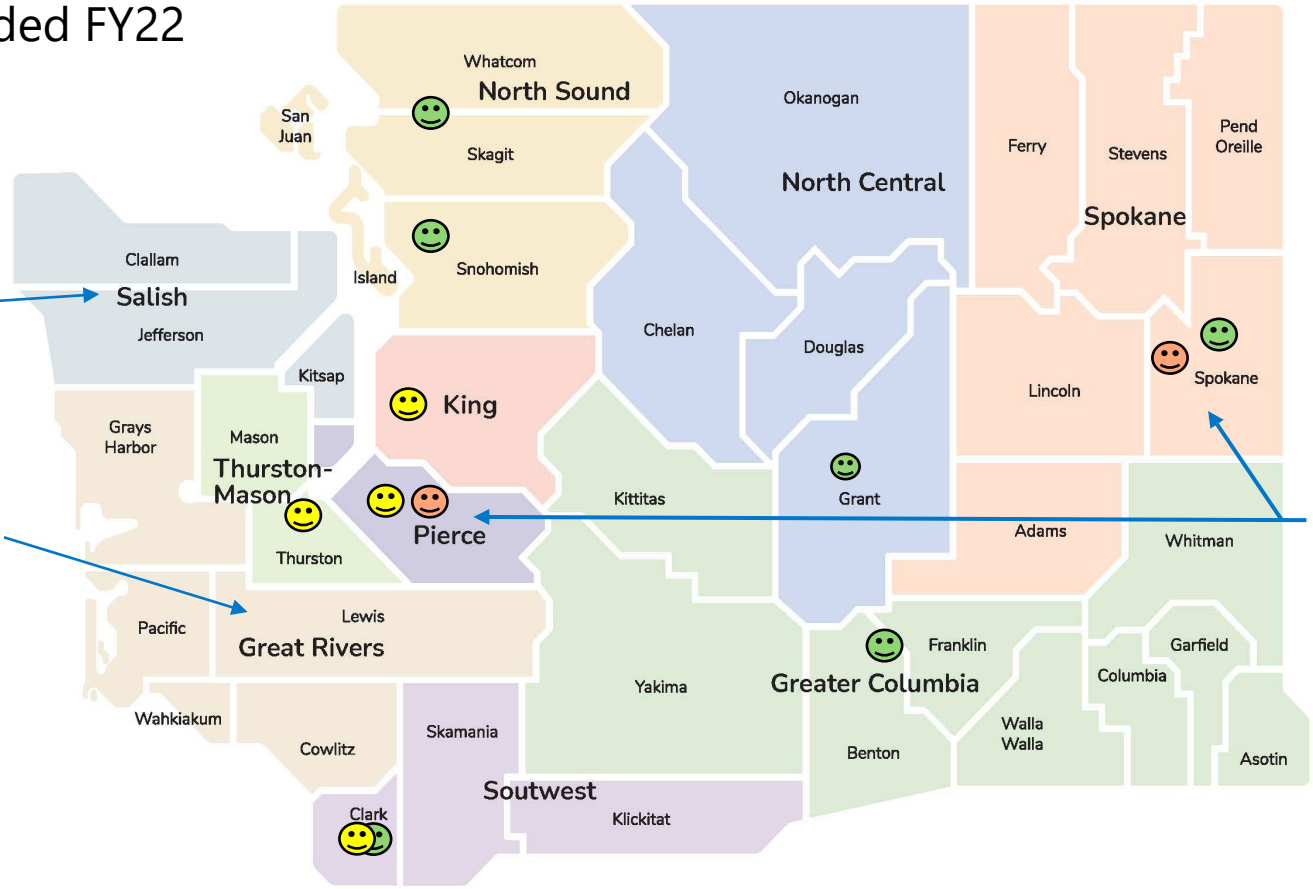
- National Suicide Prevention Lifelines – Confidential
- Regional Crisis lines/Provider lines - Dispatch teams
- How do system partners refer to teams?

Washington State Health Care Authority

10 Behavioral Health Administrative Service Organizations (BH-ASO)'s in WA

- Existing youth teams before 988 went live
- Proviso teams added FY22
- SOC Grant

- Funded, building
- Funded, building

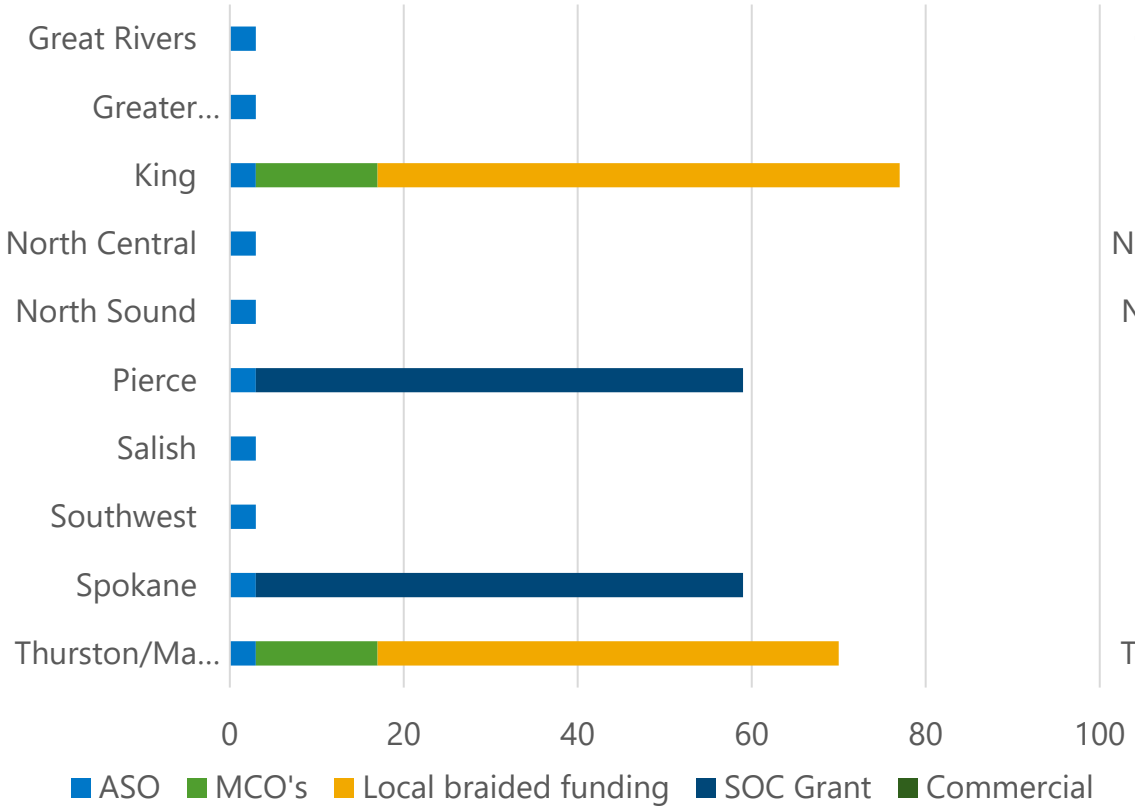


SAMHSA
System of Care Grant
To implement MRSS

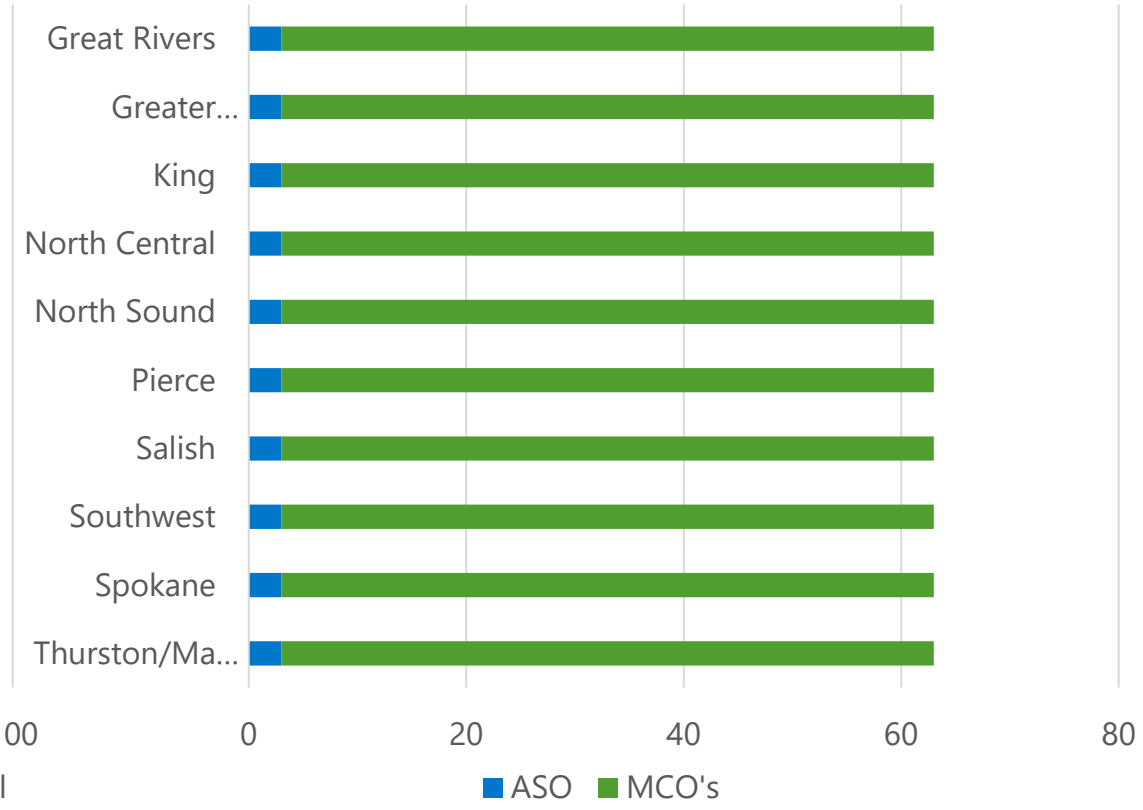
SB 5092 Sec. 215 (65)

Youth Mobile Crisis Team Service Delivery

Current State – Days of Service by Region



Future State – Days of Service by Region



Youth Crisis Continuum: Key Limitations

- Emergency Dept. - remains the primary access point for youth and caregivers, goal to bring care to them instead
- There are a handful of adolescent inpatient units in the state
- Currently only 13 of 39 Counties with youth teams
- Notice of funding opportunity – For 2-90-day Residential Crisis Stabilization Programs (RSCP) – Dept. of Commerce
- 23-hour youth crisis relief centers would offer Emergency Dept. and Justice System diversion- can discharge directly to Youth teams.
- Stabilization phase currently only 14 days in WA State Plan

Ongoing Work for Youth MRSS Delivery

- Mobile Response and Stabilization Services Quality Learning Collaborative – System level participation
- Technical Assistance from Quality Learning Collaborative – data collection in select regions
- System of Care (SOC) Grant from SAMHSA 4 years – Working with Spokane and Pierce to implement MRSS fully
- State Plan Amendment – January 1, 2024 – to Remove limiting 14-day language
- Contracts with Managed Care Organizations

Questions?

Matt Gower - Crisis Systems Team Lead matthew.gower2@hca.wa.gov

Sherry Wylie – Youth MCT Program Administrator sherry.wylie@hca.wa.gov

Luke Waggoner – Adult MCT Program Administrator luke.waggoner@hca.wa.gov

Wyatt Dernbach – Stabilization and Triage Administrator wyatt.dernbach@hca.wa.gov

LIVED EXPERIENCE SUB COMMITTEE MTG THEMES

- **Caveat**

We rarely have youth attend our meetings. Mostly it is parents, caregivers, people who have (had) their own mental health and/or SUD challenges. Some are now providers trying to help families get the help.

SYSTEM IS SILOED, OPAQUE, VERY HARD TO NAVIGATE

- Even people who know the system have a hard time navigating it
- Caregivers are asked to become case managers
- Central system where records are kept could be helpful

INADEQUATE RESOURCES - GAPS IN THE SYSTEM

- Rural areas never see enough investment
- Urban areas seeing long waits
- Urgent need to develop well trained and supported work force
- Resources In Between: Youth that is not in acute crisis but not doing well

BUILDING TRUST WITH DISENFRANCHISED COMMUNITIES

- Houseless persons, People of Color – Especially Black and Hispanic persons; LGBTQ+; People on the spectrum, neurodivergent, other developmental issues.
- Deep distrust of law enforcement and government
- Bad experience as youth results in not seeking help as adults, deepening behavioral health issues.

WHO OFFERS HELP MATTERS

- People turn to communities they are familiar with
- Youth needs support. But so do adult caregivers and siblings
- Peers/People with Lived Experience **must** be part of who responds.
- Peers help address deep sense of shame, guilt, and stigma. Vital to bridging divides
- Skill set of responders makes a big difference. Adequate training is a must

YOUTH VOICE AND CAREGIVER VOICE

- A tender and delicate issue
- Caregivers feel they are not trusted by the system and crucial information is not shared with them
- Youth seeking help on their own without caregiver/parental knowledge
- When families think youth needs help, but youth doesn't agree

Break

Discussion: Considerations for Youth Crisis Response System

Objectives

- *Share perspectives of CRIS members—based on personal and professional knowledge and experiences—about considerations related to youth crisis response.*
- *Identify issues or considerations that we still need to work through to inform future Steering Committee policy recommendations.*

Discussion Questions

1. Based on what you have heard about the MRSS model, the LE Subcommittee feedback, and your own personal and/or professional experiences, how can we better ensure that youth calls to 988 result in the outcomes we aspire to (i.e., MRSS engagement)?

2. What are the current barriers to these outcomes?

3. What are some ideas for how we can address these barriers?

Questions:

1. Based on what you heard in the previous discussion, what sounds like a potential emerging recommendation?

2. What barriers or considerations do you think still need further discussion?

Action Items & Next Steps

Public Comments

Public Comment

	Name
1.	Karen Kelly
2.	Laura Van Tosh
3.	
4.	
5.	
6.	
7.	
8.	
9.	