HB 1477 Crisis Response Improvement Strategy Committee

May 16, 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. Hear a wrap up of the legislative session, including the implications for 988 and crisis response improvement.
3. Identify and discuss system gaps related to crisis stabilization (a place to go), with the intent to inform HCA strategic planning as well as Steering Committee recommendations for addressing these gaps.
4. Confirm action items and next steps.
5. Hear public comment.

Meeting Agenda

TIME	TOPIC
12:00 pm	Technology Review
12:05 pm	Welcome, Introductions, Review Meeting Agenda
12:20 pm	Discussion: System Gaps – Crisis Stabilization
1:45 pm	Break
1:55 pm	Action Items and Next Steps
2:00 pm	Public Comment Period
2:15 pm	Presentation and Q&A: Legislative Wrap-Up
3:00 pm	Adjourn

HB 1477 CRIS Committee Timeline and Deliverables – 2023 Updates

- The Steering Committee – with input from the CRIS and Subcommittees – is charged to deliver to the Governor and Legislature recommendations related to funding and delivery of an integrated behavioral health crisis response and suicide prevention system in Washington, including:
  - ✓ **JANUARY 1, 2022**: Initial Assessment Washington's behavioral health crisis response and suicide prevention services.
  - ✓ **JANUARY 1, 2023**: a second progress report, including a summary of activities completed by the CRIS during CY 2022 and recommendations related to funding of crisis response services from the 988 Account created by the line tax.
  - ❑ **[UPDATE] JANUARY 1, 2024**: a third progress report, including a summary of activities completed by the CRIS during CY 2023, including recommendations related to designated 988 contact hubs.
  - ❑ **[UPDATE] JANUARY 1, 2025**: a Final Report with recommendations addressing system elements outlined by the legislation.

CRIS Committee Decision Process Map – 2023

February 2023
(Someone to Come)

Objectives:
✓ Discussion of **adult mobile crisis response** services and system gaps.

March 2023
(Someone to Come)

Objectives:
✓ Discussion of Behavioral Health Crisis Response and **Collaboration with First Responders**

April 2023
(Someone to Come)

Objectives:
✓ Discussion of **youth crisis response services** and gaps.

May 2023
(Crisis Stabilization)

Objectives:
✓ Discussion of **Crisis Stabilization Services** and Gaps.

June 2023
(Services Recommendations)

Objectives:
✓ Synthesis of **Recommendations relating to Someone to Come,** including collaboration with first responders
✓ HCA Mobile Crisis Response expansion workplan
✓ HCA Dispatch Protocols and Best Practice Guidelines

July 2023
(Services Recommendations)

o

Objectives:
✓ Synthesis of Recommendations relating to **Criss Stabilization**.
✓ Discussion of **988 Contact Hub Rulemaking**

August 2023
(Recommendations Synthesis)

Objectives:
✓ Discuss recommendations to **close gaps and enhance resources to support** Washington's crisis response system
✓ Synthesis of **policy recommendations** as foundation for January 1, 2024 Progress Report

CRIS Committee Decision Process Map – 2023

September 2023
(Draft Recommendations)

Objectives:
✓ Discuss **draft policy recommendations** as foundation for January 1, 2024 Committee Progress Report

October 2023
(Draft Report Review)

✓ No meeting this month
✓ Draft Report for CRIS Review

November 2023
(Draft Report Input)

Objectives:
✓ Review and provide input on draft January 1, 2024 Committee Progress Report.

December 2023
(Approve Progress Report)

Objectives:
✓ Steering Committee approval of draft January 1, 2024 Committee Progress Report

2024

Priority Areas of Focus
✓System goals, metrics, and oversight
✓System Infrastructure (technology, workforce, cross-system coordination)

Personal Story

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

Discussion: System Gaps – Crisis Stabilization

Objectives

- *Understand what crisis stabilization services in Washington include and the current distribution of crisis stabilization services.*
- *Discuss and surface barriers to getting from acute crisis to crisis stabilization, to inform HCA strategic planning and future discussions on how to address those gaps.*

Somewhere to go and Safe place to be

Support after the crisis

Washington State Health Care Authority

Crisis Systems Team

Matthew Gower

Wyatt Dernbach

Stabilization and Triage Administrator

Luke Waggoner

MCT Administrator - Adults

Sherry Wylie

MCT Administrator – Youth and Families

Washington State Health Care Authority

Crisis Stabilization for Adults

How to support and keep people out of crisis

Washington State Health Care Authority

Ideal Continuum: From Acute Crisis to Stabilization (Adult)

Crisis De-escalation

- Mobile Rapid Response
- Crisis Relief Center (SB 5120)
- Program of Assertive Community Treatment (PACT) team

Stabilization

- In-home stabilization
- Next Day Appointments
- Facility based stabilization
  - Crisis Stabilization Unit
  - Peer Respite
  - Withdrawal Management (for Substance Use Disorder)
  - Inpatient Evaluation and Treatment

Post-Crisis

- Outpatient Services
  - Primary Care Provider
  - Behavioral health treatment
- Long-term social supports
  - Supportive housing/employment
  - Social services
- Crisis planning
  - Wellness Recovery Action Plan
  - Mental Health Advance Directive
- Community supports
  - NAMI
  - Peer-run support groups

Crisis Stabilization Services

- Personal supports
  - Developing new skills
  - Crisis planning
  - Building on existing supports
- Resource connections
  - Community resources
  - Short or long-term assistance programs
- Connection to treatment
  - Outpatient intakes
  - Next day appointments

In-home vs. Facility Stabilization

In home

- Problem-solves with person and chosen supports in their own environment
- Provides stabilization services with minimal disruption to life
- Up to 14 days
  - Often by mobile crisis team

Facility

- Safe environment to stabilize
- Can provide more services like medication management
- Often short stays of a week

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Crisis Facilities

- Crisis Stabilization Units
  - Short stays often between 3-5 days
  - Voluntary services and involuntary holds
- Peer Respites
  - Home-like setting to receive onsite peer support
  - Stays up to 7-days
- Withdrawal Management
  - For people in a substance abuse crisis
  - Stays range from less than a day to two weeks

Inpatient

- Evaluation and Treatment
  - Can be stand alone or located in a hospital
  - Longer stays ~1 to 2 weeks on average
  - Can be involuntary
- Secure Withdrawal Management
  - Involuntary for Substance Use Disorder
  - Stays equivalent to Evaluation and Treatment Services
- Long-term beds
  - 90/180 Evaluation and Treatment based beds
  - State hospital

Youth Stabilization

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Ideal Continuum: From Acute Crisis to Stabilization (Youth)

Crisis De-escalation

- Mobile Response and Stabilization Services (MRSS) Teams
- Warm handoff to existing provider, physician, or Wraparound with Intensive Services (WISe) team
- 23 hour stabilization unit
- Referrals

Stabilization

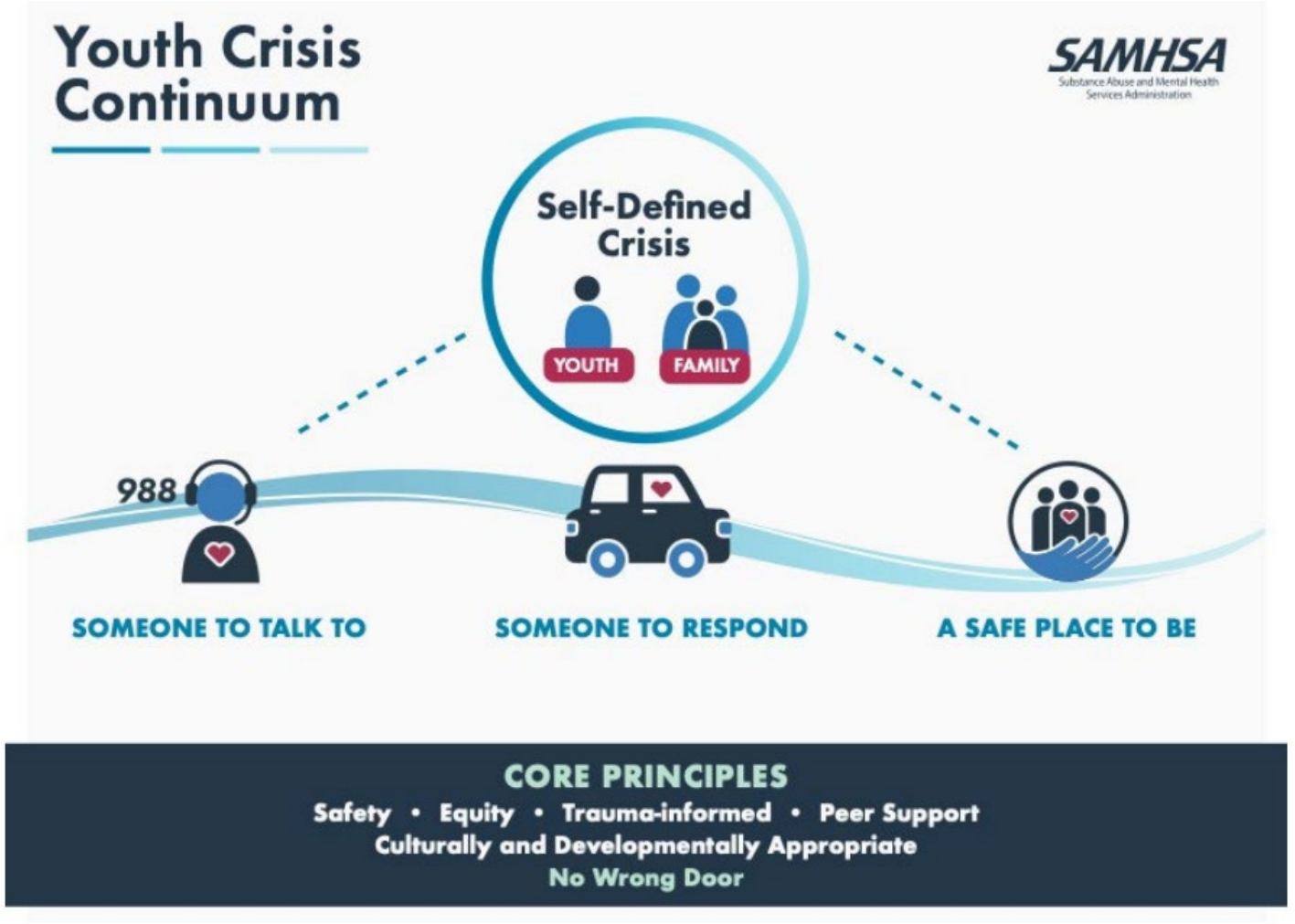
- MRSS In-home stabilization
- Wraparound Principles
- Next Day Appointments
- Referrals
- Warm-handoffs to clinical supports
- Facility based stabilization
  - Crisis Stabilization Unit
  - Withdrawal Management
  - Adolescent Inpatient Evaluation and Treatment
  - Residential
  - Residential Crisis Stabilization Program (RSCP)
  - Children's Long Term Inpatient Program (CLIP)

Post-Crisis

- Natural supports
  - Wraparound principles
  - Crisis plan
- Resource connections
  - Community resources
  - Short and long-term assistance programs for families
  - Parenting community supports
- Outpatient Services
- School Mental Health Professional
- Intensive Outpatient
- WISe services

Mobile Response and Stabilization Services (MRSS)

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



What is not working for stabilization

- Coordination
  - EDs
  - First Responders
  - Facility discharges
- Funding stability
  - Firehouse model for Crisis Stabilization Units
  - Stabilization service funding for Mobile Rapid Response Crisis Teams
- Capacity
  - Staffing

Questions?

Thank you for listening

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Contact information

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- Information about the CRIS Committee
- More information about 988
- SAMHSA best practice toolkit
- Tribal Hub

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23-hour facilities

Current Landscape

- <24 hours
- Not standardized
  - Services, entry requirements, and referrals vary
- Voluntary
- Youth and adults

Crisis Relief Center

- <24 hours, with exceptions
- Standardized
  - MH & SUD crises, care for minor medical needs
  - Must allow 988, first responder, walk-in, and self-referrals
- Voluntary or holds to assess for involuntary treatment
- Adults only

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Group Discussion Exercise

Objectives

- *Engage in root cause analysis exercise to identify barriers to getting from acute crisis to crisis stabilization (i.e., access to the full crisis stabilization service continuum including crisis de-escalation, a place to go, and post crisis stabilization)*

Problem Statement: Crisis stabilization services offer the community no-wrong-door access to mental health and substance use care. The goal of these services is to quickly stabilize the person in crisis, avoid hospitalization or incarceration, and help the person transition back into the community. The problem is that in Washington State, not everyone who is experiencing a crisis gets stabilized. In this exercise, please consider a range of crisis stabilization services, including crisis de-escalation, a 'place to go' crisis stabilization units, and post crisis stabilization.

HB 1477 CRIS Committee – Root Cause Analysis

Why? Some people—particularly those who live outside the I-5 corridor—do not have crisis stabilization services in their local area.	Why? Potential providers outside of the I-5 corridor have had difficulty accessing adequate funding.	Why? **Funding is typically available for capital investments but does not cover operating costs.**	Why?
			Why?
		Why? **Funding sources are complex and can be unpredictable.**	Why?
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			Why?

Developing Tribal Evaluation and Treatment or Secure Withdrawal Management Facilities

In Washington State

History of Tribal Efforts to Improve Access

When it come to mental health crisis services, Washington State and the behavioral health system have treated Tribes as providers instead of governments. The managed care system often conflicts with federal laws on tribal sovereignty and the federal trust responsibility. Failure to recognize Tribes as governments and to comply with state and federal laws results in delay in or lack of AI/AN access to behavioral health services.

The 2013 Tribal Centric Behavioral Health report to the legislator addressed the failures of managed care in Indian country and identified key strategies to improve the coordination between Tribes and the (then) Mental Health Crisis system in our state. However, by 2016, these strategies had yet to be implemented. Instead, the State was applying for a Medicaid Waiver to incorporate substance use disorder services into a system that Tribal Leaders said was not working for the AI/AN population in Washington State. Tribes fought to ensure that AI/AN would be exempt from the Medicaid managed care system.

View the 2013 Tribal Centric Behavioral Health Report here: GetPDF (wa.gov)

Tribal Evaluation and Treatment Facility Workgroup

- Funded by legislature in July 2017
- Workgroup did not start until Nov. 2017
- Five subcommittees:
  - Clinical and Cultural Models
  - Facilities and Siting
  - Operations
  - Legislative
  - Governance

Why Culturally Appropriate Practices?

"There needs to be an explicit acknowledgement that each Tribe knows what works best in a tribal community and that a pilot project or study that works in one tribal community may not necessarily be easily replicated in another. Each Tribe in Washington has its own rich and unique history, culture and traditions. It is essential that the development of culturally appropriate and responsive providers for behavioral health services includes interaction with the Tribes directly. *Quotation from Report to the Legislature: Tribal Centric Behavioral Health, 2SSB 5732, Section 7 Chapter 388 Laws of 2013 (November 30, 2013), page 21.*

Facilities Funding Options:

- Department of Commerce funds
- Legislative request for set aside funds
- USDA Rural Grants
- Bank loan options
- Reinvestment Account
- Department of Enterprise Services (for land)
- General Services Administration (for land)
- Single Tribe invest in facility
- Multiple Tribes (consortium) invest in facility

* Combination of funding source likely needed

Facility Design – E&T and Secure Detox

Up to an ASAM 3.7 Level

- Medically monitored intensive inpatient services
- Physician available to access in person within 24 hrs of admission
- Nursing assessment on admission
- Medication prescription and monitoring
- Coordination of necessary services and discharge planning
- Planned regimen of professionally directed evaluation and treatment services
- Availability of seclusion of restraint

E&T Level of Care

- Examination of medical evaluation within 24 hrs by a licensed physician, advanced registered nurse practitioner, or physician assistant certified
- Nursing assessment on admission
- Psychosocial evaluation by a mental health professional
- Development of an initial treatment plan
- Consideration of Less Restrictive Alternative (LRA) treatment
- Availability of seclusion and restraint

Staffing Models E&T and Secure Detox

Evaluation and Treatment Staffing Model	Secure Detox Staffing Model
40 Staff • (2) FTE Psychiatrist/Medical ARNP • (.25) FTE Program Director • (.1) FTE Medical Director • (1) FTE Lead Nurse • (2) FTE Tech • (2) FTE Relief Staff • (5) FTE RN • (5) FTE LPN • (1) FTE Social Worker (Discharge) • (2) FTE Peer Support Specialist • (5) FTE MH Professional • (1) FTE Program Secretary • (3) FTE Certified Nursing Assistant	• (1) FTE Physician 8hrs/40hrs/ On call hourly rate * reduced rate $50.00 * Required per WAC • Or (2) .5 FTE licensed physician, physician assistant, or advanced registered nurse practitioner (ARNP) • (4) FTE RN 24/7 • (2) FTE CDP Required per WAC • (5) FTE Unit Clerk (LPN) • (8) FTE Unit staffing • (4) Security (2) .5 FTE • (1) MHP ? To address co-occurring issues • (1) CDP/MHP Dual credentialed ? for ITA discharge and Continuum of Care Placement/ Discharge Assistance required per WAC Chemical Dependency Professionals

Contracting Beds from Current Providers

Option to contract for beds from current providers

- Great Rivers and Cascade are open to contracting options with Tribes.
- Fairfax Hospital is also interested (approximately $1,200 per day). Invested in providing culturally competent services with training and hiring proficient staff.
- NS Region E&T (16 beds) & Secure Detox (16 beds)
- Yakama Nation Astria Hospital

Moving forward:

Understanding What we accomplished

Outstanding questions

What needs updated

What was accomplished:

Passage of the Indian Behavioral Health Act in 2020

- Established a process to appoint Tribal Designated Crisis Responders
  - funding beginning 7/1/2022
- Requires non-Tribal Designated Crisis Responders to notify Indian Health Care Providers of Involuntary Treatment Assessment
  - Whether or not detained

Other Accomplishments:

- Implementation of coordination hub
  - includes access to available beds reporting
  - Native and Strong crisis line
- Training of non-Tribal Designated Crisis Responders on working with AI/AN patients and Tribal Governments
- Review and updates to Washington State's Designated Crisis Responder Protocols to include coordination with Tribes/IHCPs.
- Tribal Government able to petition for involuntary treatment under Joel's Law

Outstanding question:

- What is the best way to stand up a statewide governing board?
- How do crisis stabilization facilities fit into the plan?
- Is the need more for statewide facilities or individual Tribes/regional facilities?
- What about contracting with hospitals for beds to increase current access?

What is still needed:

- Update possible funding sources
- Clearly laid out licensing/approval process
- Updated building/remodel costs
- Updated operations cost - establishing cost- based Medicaid rates
- Understanding court costs and reimbursements

Thank you

American Indian Health Commission for Washington State

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Executive Director

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Whale Comb by Zeke Serrano, Quinault

Break

Action Items & Next Steps

Public Comments

Public Comment

	Name
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2.	
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Presentation and Q&A: Legislative Wrap-Up

Objectives:

- *Learn about legislation that passed in the 2023 session that affect behavioral health, especially crisis response, and the implications for the work we are doing now.*
- *Discuss the potential implications for the work that we are doing now.*