Summary of CRIS Committee discussion and input on system performance metrics aligned with Washington's Vision and Guiding Principles (DRAFT - February 27, 2024)

Guiding Principle	Meaning	Measurement
People in crisis experience timely access to high-quality, coordinated care without barriers.	We determine what "timely" means, depending on the service, and people in crisis receive services in a timely manner.	Identify targets for providing 1) initial, live response and 2) trained behavioral health response for each type of service and measure whether system is meeting these targets.
	Responders know the system, know what services a person in crisis has already received, and are able to provide informed referrals.	Track how many transitions a person makes before they get the service they need.
		Gather client/customer/consumer satisfaction surveys to ask whether people who accessed the system received a "high-quality service" (i.e., they felt the service was helpful, met their needs, and met their expectations for timeliness).
	Youth have access to evidence-based intervention (e.g., Mobile Response and Stabilization Services - MRSS)	Percent or number of youth who accessed the system who were connected to MRSS.
	Translation services are available to anyone who needs them.	Track how often people ask for help in a language other than English, which language, and whether or not they are able to receive that language support.
People in crisis experience a welcoming response that is healing, trauma-informed, provides hope, and ensures people are safe.	People who accessed the system feel like it was valuable for them to use the services and that they benefited from the services.	Gather qualitative feedback from users about how they experienced the system, e.g., whether it felt trauma-informed, healing, and hopeful; whether they would use it again if they had another crisis.
	People who accessed the system see themselves reflected in the people providing services, meaning the providers may have shared identities with the people they are serving and/or lived experience.	Monitor demographics of workforce--including whether they have lived experience (recognizing that there are privacy limits to what we can ask)
	Responses are appropriately matched to the need, e.g., use of first responders is avoided when a behavioral health response is sufficient.	Monitor first responder vs. behavioral health deployments for appropriateness.
	Users know what they are consenting to when they ask for help.	
	The physical environment (i.e., the facility) is well kept and demonstrates care for individuals in crisis.	Physical space assessments

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People in crisis experience person- and family-centered care.	The caller (person in crisis and/or family, when appropriate) defines the crisis, resolution, and whether the crisis has been adequately addressed.	Gather qualitative feedback from users about whether they felt centered (e.g., they felt listened to, they agreed with the documentation of resolution, they offered options for resolution, they did not have to repeat their story multiple times, etc.)
	The caller does not need to tell their story multiple times.	
	The caller is able to explore various options for referrals/resolution and determine which is the right fit.	
	People in crisis are listened to when they have a complaint or grievance about the care they received; they are not dismissed.	
	Responders are trained in motivational interviewing.	
	Mental health advanced directives are followed (e.g., providers have access to mental health advanced directives).	Monitor how often individuals/families are asked about advanced directives, whether they were followed, and why.
	Individuals are asked who they want involved in their care.	
	Families are offered support resources, including respite care.	Quotes from families are included in documentation of resolution.
	Support exists for people who need extra help.	
People in crisis experience care that is responsive to age, culture, gender, sexual orientation, presence of disabilities, geographic location, language, and other needs.	The workforce is trained in provide culturally-responsive, welcoming, trauma-informed, and healing care.	
	Call takers are trained to be responsive to age, gender, sexuality, language needs, and/or presence of an intellectual or developmental disability, including neurodivergence.	Number of trainings provided to call takers on needs related to different identities (e.g., sexuality and gender expression, age, neurodivergence etc.)
	The system is flexible and adapts to the needs of the user. For example, people in crisis with intellectual or developmental disabilities are able to access the services they need, even if they need support with communication and/or activities of daily living.	Demographic information about people who received crisis services crossed with outcomes data about whether or not the services met their needs.
	People in crisis receive the level of support that meets the needs/acuity of their crisis.	Measure whether individuals in crisis have a clear treatment plan focused on what is effective/appropriate rather than just what NOT to do.
	People in crisis feel heard and supported after their experience with calling 988.	Client/customer/consumer feedback loop, including but not only a survey.

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	Staff at call centers are representative of the people they serve.	Demographic information about call takers compared to the populations they serve.
	Callers have access to language supports.	Data on calls that included use of an interpreter, including completed calls, dropped or incomplete calls, and calls where the requested language supports were not available.
	People are able to access support through texting (because not everyone is able to make phone calls)	Measure use of text/chat
The crisis response system is grounded in equity and anti-racism	The system is aware of where institutional racism exists and how to mitigate.	Conduct organizational audits to identify and address systemic racism.
	There are embedded and ongoing systems to assess and affect equity and racism.	
	People working in the system routinely and consistently receive training in equity and anti-racism, there are clear expectations about participating, and they are compensated to participate.	Track participation in trainings.
	The system values and treats workers equitably, so they can then show up and treat users equitably.	
	Users are not turned away from receiving help based on their health insurance coverage or lack of carrier pre-authorizations.	Monitor access and outcomes to look for disparities.
	All vested parties in the system pay their share.	Examine funding streams by payer to look for parity/equity.
The crisis response system is centered on and informed by lived experience.	The system adapts to user feedback. There are systems in place to collect user feedback and clear expectations for how that feedback is used.	
	People with lived experience are involved in refining the system at all stages, including after implementation. For example, there is a continuation of a CRIS Lived Experience Subcommittee through and past implementation.	
	There is support throughout the system for gathering and responding to user feedback (e.g., providers distribute and collect user surveys.	

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	People in crisis have access to help navigating the crisis response system and there are proactive processes in place to get feedback from people who have had negative outcomes.	
	There are people with lived experience working (i.e., employed, not just volunteering) in all parts of the system, including policymakers.	Monitor employment demographics, including % of state employees working in crisis response who report anonymously that they have lived experience. Monitor proportion of policymakers involved in making crisis response policy report having lived experience.
	Staff with lived experience have clear roles that align with their position (i.e., they aren't just "given everything").	Staff surveys that gather feedback, including on respect and support.
	There are peers interacting with system users at every stage of the crisis care continuum, and peers are being used appropriately (i.e., they are trained in the particular area of response they are addressing).	Track presence of peers at each stage of the continuum, as well as % of users who have interactions with peers.
The crisis response system is coordinated and collaborative across systems and community partners.	All aspects of the system communicate with each other in giving care to a person in crisis, and communication is timely.	
	All providers have in-depth knowledge of services and resources and are able to make informed referrals.	
	There are clear criteria for when to deploy 988 or 911.	Monitor adherence to protocols for deploying first responders vs. behavioral health.
	There is strong, consistent collaboration between 988 and 911 that supports the right response.	
	People in crisis are connected with appropriate resources without being transferred (or asked to call themselves) multiple times or falling through the cracks.	
	Someone holds responsibility for ensuring the system is coordinated and collaborative.	
The crisis response system is operated in a manner that honors Tribal	Culturally-driven care is recognized as evidence-based practice throughout the system.	
	There is recognition throughout the system of Tribal practices and that there are meaningful differences between tribes.	

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government-to-government processes.	Staff throughout the workforce are trained in culturally-attuned care.	
	Operating agreements and procedures are in place between tribes and regional crisis partners, and a forum for discussing improvements in service provision.	
	We have identified the critical government to government processes that need to occur so the crisis response system can be successful.	Confirm this has happened.
	There is regular review and update of government-to-government processes.	Include case review of whether these processes have been appropriately implemented. Ask for Tribal feedback on whether this is happening.
The crisis response system is empowered by technology that is accessible to all.	Crisis response resources are accessible via text, chat, and other modes.	Track completed vs. incomplete/dropped contacts with the system.
	Users receive the same level of service, regardless of which mode they use to access the system.	Customer/client/consumer satisfaction surveys and other feedback modes.
	People in crisis can access help in their language, regardless of which mode they use to access the system.	Track completed vs. incomplete/dropped contacts with the system by language.
	People who communicate differently (e.g., hard of hearing, sight impaired, etc.) are able to access the system.	
	The system is easy to use, regardless of the mode of access.	Track trends over time (e.g., decreased interactions with criminal justice system, increases to referrals for social services, etc.)
	Users and providers can quickly and easily see what resources are available.	Confirm that providers have access to these resources.
	Closed-loop referrals (i.e., when a patient enters the system through a healthcare setting and ends up in a social services setting) are happening.	Track number of referrals to social services from health care, track episodes of follow up care as needed to reduce higher level of care.
The crisis response system is financed sustainably and equitably.	System can hire and retain workforce as needed to provide high quality services to all who need it.	Track staffing retention/hiring/turnover.
	System provides competitive salaries in line with other first responders.	Salary comparison
	System has dependable, forecasted long-term funding.	Track funding streams

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	Crisis system providers are trained in how to submit claims to private carriers (understanding that when someone is in crisis, asking for insurance information is not optimal.)	Track claims to private insurers.