CRIS Member Comments on the HB 1477 Initial Assessment Report (December 31, 2021)

Darcy Jaffe, Senior VP – Safety and Quality, Washington State Hospital Association

CRIS Member Representation: Washington State Hospital Association

Background on Washington's Crisis Delivery System

The report should acknowledge that the emergency responders (EMTs) under local jurisdictions are at the front lines of emergency/crisis management. This particularly applies to person with complex medical/behavioral situations, which are vulnerable to end up in ERs.

Law enforcement and emergency responders shouldn't be in addition to. They are part of the crisis response delivery system and always will be regardless of whether Washington creates an absolute best practice for response.

A Path Forward

Crisis service providers—this implies that hospitals or EDs were part of this request and that's not accurate. Which service providers interviewed should be more clearly described.

Additionally, the lack of input from first responders needs to be called out as a limitation of the assessment

Again, there isn't acknowledgement that EDs/hospitals still need to be interviewed; this is a significant crisis volume that isn't part of the assessment. I'm confused about why that core component of the crisis system isn't part of this assessment.

I don't know who all is included in the emergency medical service definition. It will be extremely important to include Emergency Department personnel of hospitals. They will best be able to speak to the complex medical and behavioral issues and the need for integrated emergency/crisis response.

Same comment as under point 4.

Section I: Background on Crisis Services in Washington

There isn't an agreed upon definition of Crisis which makes providing accurate background on crisis services questionable

Washington's "Patchwork" Crisis System

I object to having hospitalization and incarceration characterized together. It perpetuates stigma.

For medical emergencies, local jurisdictions work with local hospitals and created the Medic 1 system which is a national best practice standard. Now that the state has gone to integrated managed care, figuring out how to integrate and/or fund a new model will be a key task.

Delivery of Crisis Services in Washington

It would be helpful to have the numbers on those calls resulting in and integrated response with EMTs or law enforcement and the numbers of these calls that resulted in transport to an ED.

Financing of Crisis Services in Washington

If EMT response, funding is by the local jurisdiction.

Section II: A Model for the Way Forward

Accountability and Finance

Emergency medical co-morbidities need to be assessed as well as risk to individual and community

Section III: Approach to Conducting the Assessment

Methods Used for this Assessment

The lack of input from EDs/hospitals needs to be clearer

It would be helpful to document who the stakeholders were.

Were any front line clinicians included?

Same comment. That EDs/hospitals did not receive this survey needs to be called out

Areas Yet to Uncover in the Assessment

Emergency dept clinicians and social workers should be included.

Section IV: Assessment of the Current Crisis Delivery System

Important to emphasis the need for integrated services under theme 4.

Themes Related to the Accountability and Finance Strategic Area

Theme #1: Responsibility and Accountability for Crisis Services

We want to be sure that the formal community collaboration includes the hospitals (acute and psych)

Standards and policies to assure that the emergency/crisis services are integrated would be important.

Theme #2: Financing of Crisis Services

We want to have clear messaging that the disproportionate financing is because there isn't enough $ to fund the needs. The answer can't be to just move the existing funding around and provide less to the inpatient care.

#2 could include building on the current Medic 1 funding streams. This would be congruent with the plans for integration.

#5 is a long-standing issue related to community provider resentment of the cost of inpatient care. The incentive can't be to pay the hospitals/EDs less.

New funding for post crisis treatment options need to be developed. Hospitals provide the safety net but appropriate robust crisis follow-up services need to be funded as well as the capacity of hospitals maintained.

We need to be included in the survey about info on cost of care, alternatives to methods of pay and message that more equitable funding doesn't mean moving to the level of which payer is currently paying the least

I don't like the language of more restrictive. Individuals with more acute needs, require more complex services. This is congruent with the rest of health care. Again, another example of perpetuating stigma.

MORE about the payment to hospitals (because more restrictive care is, by definition, inpatient)

Theme #4: Availability of Services Across the Crisis Continuum

#1 This seems to imply people are being ITA'd who don't meet criteria. There shouldn't be a reliance. It may be that sue to lack of community services people get sicker and then need ITA care. That's not the same as reliance in my dictionary.

ED's should be included in the list of priority customers

Need to add crisis follow-up services and ensure access to therapeutic follow-up and medications, regardless of ability to pay

There needs to be acknowledgement that the SBC system is not a best practice but rather a band-aid when no appropriate treatment bed is available. Individuals hospitalized involuntarily under SBC are generally not appropriate for diversion. It is dismissive of the urgent acuity of the patient who requires an emergency detention to propose that they could be diverted.

This hasn't been resolved at all—other than getting the State out of the unconstitutionality of it

Who is being relieved of pressure?

This has nice potential as outlining an integrated response among the front line clinicians.

This model focuses more on the diversion from criminal justice unlike models that include the integrated medical response.

Theme #6: Use of Technology in Delivering Crisis Services

The technology needs to support a multidisciplinary and integrated response.

It would be helpful to know what the pilots are that they reference.

This needs to be fully funded including access to medications, if needed.

The 24/7 scheduling and bed tracking are technologies that probably promise more than they can deliver. We want to be clear that tracking beds doesn't isn't the same as creating more of them.

Theme #8: Collaboration in the Delivery of Crisis Services

It will be important that the systems are integrated and much thought given on preventing creating a new siloed respond system.

This would be important data to collect as WA moves to a more integrated crisis response system.

Section V: Funding Crisis Response Services

Development of the Model to Forecast Crisis Service Delivery Costs

We want to be sure that new and expanded services don't calculate to less funding for existing services

This needs to be explored in depth. Although there is an assumption that cost savings will occur by diversion to less acute non-ED services. The 988 system may provide services to a whole new set of individuals who are less clinically acute than those in EDs and inpatient beds.

If only claims for ED visits were used it will be vastly underreported

This is a classic and, historically, flawed assumption. The new 988 system has potential to provided broader services but is at risk of expanding the reach of services, rather than developing alternatives to treat those in acute need.

Intended Model Refinement in Calendar Year 2022

How were the estimates calculated?

Jennifer Stuber, Professor, UW School of Social Work & Co-Founder Forefront Suicide Prevention

CRIS Member Representation: University based suicide prevention center of excellence

Introduction

What is the national standard that is mentioned that Washington is working towards? It isn't until page 36 that we really get a sense of what this might be. Having this national standard front and center seems critical to organizing the work, and assessing how far off, as a state, are we from the national standard. The fact that we have no vision or national standard anchoring the Steering & CRIS committees and subcommittees has hampered these efforts. Who are the subject matter experts on crisis delivery systems in general and for Washington State?

Background

Seems to miss the mark. Crisis services need to be available to all Washingtonians and be person-centered and trauma-informed for people in crisis and their families/ supports. In theory, this is supposed to be happening through the BH-ASOs. However, there are several fundamental flaws in our current system. The critical points below are not covered in terms of the so-called patchwork of service that is described in the current report.

1) I believe, commercial insurers pay nothing for crisis services for covered lives (they bear no risk), which means there are no incentives to keep people insured by them from going into crisis.

2) The BH-ASOs don't seem to have accountability to HCA to deliver the continuum of crisis services. There are limited data about the most basic things including, how many mobile crisis teams are there in the state currently and, what are their response times?; How do existing mobile crisis teams coordinate with the DCRs around involuntary treatment, and coordinate with other emergency responders?; What's the current status or outcomes for a single individual in crisis in terms of their ability to access any follow-up service? What outcomes are we tracking currently?

3) Related, the BH-ASOs don't appear to have purview or authority to provide coordination/ collaboration-- over the crisis system in its region. There are exceptions to this, but no consistency

4) This background provides almost no mention of current first responders (911/ EMS/ firefighters), community health providers, and EDs who are drowning in crisis work currently. I am worried how it might feel for them to not be acknowledged or praised for doing this work in dire circumstances currently, and then, not seeming to acknowledge their role explicitly in visioning Washington's future crisis system. Ouch.

5) The BH-ASOs do not operate the National Suicide Prevention Lifeline and thus, offer a duplicative service in some respects through the county crisis line, creating a dizzying array of phone numbers that are not well known or remembered by individuals in behavioral health crisis or their families. The point of 988 is to keep it simple for people in crisis and their families; to streamline services and make them more effective and available for individuals in crisis. The new crisis system ultimately, needs to be efficient for the taxpayer and maximize limited state contributions. How will this be achieved without any discussion of possibly integrating county crisis lines and the national suicide prevention lifeline?

A Path Forward

Themes don't make sense to me since they are not anchored in the national standard. As a result, the subcommittees don't have clear charges. An alternative might be to organize around the three service delivery areas: 1)call centers/ county crisis lines; 2) mobile crisis/ DCRs/ 911/ EMS/ fire; 3) crisis stabilization/landing zones/ EDs. Then, look at cross cutting issues such as accountability, technology, financing, practice guidelines, coordination/ collaboration and what is needed in terms of future policy work for each. I don't know if it's feasible or if this is the best way to reorganize at this stage, but I am worried we don't have a clear way to get much needed information to legislators in time for the 2022 and 2023 legislative sessions. The ability to provide input without clear direction is problematic.

I also want to acknowledge that as a CRIS member, being asked to provide feedback on this report after it has been submitted, as opposed to before it was submitted, feels invalidating (like our role as advisors, isn't really valued). I personally would appreciate a report out at the next CRIS meeting about what the comments from the CRIS committee related to this report, and what, if any, course corrections are planned as a result.

Joan Miller, Senior Policy Analyst, Washington Council for Behavioral Health

CRIS Member Representation: Washington Council for Behavioral Health

Thank you for the opportunity to provide feedback on the Steering Committee's initial assessment of our state's behavioral health crisis response and suicide prevention services. I found the report to be comprehensive despite the years-long work we have ahead of us. I'm excited for our shared goal of ensuring the success of the new 988 hotline so that residents of Washington State have better access to behavioral health services and supports, before, during, and after a crisis.

Overarching Context and Comments

Before I dive into the different sections of the Initial Assessment, I'd like to offer some general comments about the present state of the community behavioral health system, which is the system largely responsible for our current crisis response services, including 24/7 crisis call lines, mobile crisis outreach, ITA evaluations by designated crisis responders (DCRs), and crisis triage and stabilization.

For maybe the first time ever, these providers have started to limit or stop new outpatient admissions because they do not have an adequate workforce. Clinicians are leaving community behavioral health because they can make 27–47% more at a hospital or in private practice. A safety-net system that was once creatively finding a way to provide walk-in hours or next-day appointments for patients is now instituting waitlists. When behavioral health agencies are unable to get a person into outpatient care,

the situation often gets worse. Eventually, the person ends up in crisis needing more intensive and expensive services. *If we want to ensure that when people call 988 there is an adequate response, we first need to stabilize the community behavioral health system by increasing Medicaid reimbursement rates high enough to pay competitive wages.*

Comments on the Initial Assessment

Introduction

The introduction mentions working toward a national standard but then never articulates what that standard looks like. The report and the CRIS itself should be guided by a vision statement grounded in established national best practices.

Section I: Background on Crisis Services in Washington

The background covers the name changes well; the RSNs did indeed go from that term to BHOs to BHASOs, and MCOs came on the scene with integrated managed care. It also addresses how local 2 revenues have allowed some communities fund services that other regions lack. However, the background does not acknowledge at all how the public behavioral health crisis system is subsidizing individuals with private insurance. I don't see how we can ensure crisis services are equitably available to all who need them, if we don't begin to address commercial insurance plans not covering crisis services for their enrollees. In an ideal crisis system, individuals with private insurance would not be considered underinsured.

Delivery of Crisis Services in Washington

This section provides data related to the volume of calls made to the NSPL and the BHASO regional crisis lines. *The number of calls to the regional lines far exceed those to the NSPL, so much so that it's quite concerning that the Initial Assessment does not address how the regional crisis lines will continue to operate in this changing landscape*, particularly with the go-live July 2022 date for 988 approaching so soon.

Financing of Crisis Services in Washington

Not until page 14 is there explicit acknowledgment that privately insured policy holders are considered underinsured for the purposes of crisis services. The Initial Assessment should have gone further to explain which services private insurers are required to cover and which they are under no obligation to pay for (e.g., mobile crisis outreach). *It is imperative that the Steering Committee make recommendations for how to fund the crisis response system more fairly and equitably, and to ensure commercial insurers pay their share.* The CRIS Committee must also be deeply involved in helping to develop those recommendations.

Section II: A Model for the Way Forward

We think it's great the Steering Committee is using the National Council's Roadmap to Ideal Crisis System as its framework. This section also mentions that the Steering Committee does intend on developing a Vision Document with the CRIS Committee; it feels important to get our work grounded in that document as soon as possible.

Section III: Approach to Conducting the Assessment

As I've already commented before, there was not enough outreach to crisis providers in the community behavioral health system, including behavioral health agencies that run PACT teams or WISe programs

that require 24/7 access, including crisis services. We appreciate that one of the priority items for 2022 will be to obtain more feedback from the providers. *The Washington Council would like to work with the Steering Committee to determine which approaches and formats would yield the greatest number of responses from providers.*

Section IV: Assessment of the Current Crisis Delivery System

Theme 1: Will the vision described in the first option for moving forward include the regional BHASO crisis lines with both short- and long-term solutions?

Theme 2: *The Washington Council would like to help draft the questions for the provider survey described in the second option for moving forward.* It's crucial that providers have a mechanism to 3 explain the costs to deliver services that may not show up in claims data. However, providers are being inundated with surveys and requests for information, so we'd like to help make it as easy for them as possible to respond.

Theme 4: I appreciate the acknowledgement that we need to balance the continuum of care to include more crisis prevention and post-crisis stabilization. *I suggest also emphasizing the importance of increased access/capacity for ongoing outpatient treatment and recovery supports.* These are foundational to preventing crises and ensuring ongoing stability.

Theme 5: This section has a lot of suggestions related to training. However, we're not going to solve our workforce crisis with more training. We need the system to be adequately funded so we can pay staff enough for them to stay. I'm also not sure how the options for moving forward in this section will get us to the recognized practices and National Council's Key Takeaways.

Section V: Funding Crisis Response Services

Again, I wish the Initial Assessment was clear on which services most commercial insurance pays for and which services it does not. *The Group 2 section of Exhibit V.1 seems very misleading and gives the impression that commercial insurers and self-funded private insurance plans pay for existing crisis lines, DCR investigations, mobile crisis teams, and crisis stabilization.* My understanding is that they pay for inpatient stays and ED visits only.

This section also makes an assumption that BHASO crisis lines will transfer callers to a 988 crisis line, but I'm not sure I understand why a regional crisis line would transfer rather than assisting the caller themselves. Regarding Exhibit V.6—why aren't SUD ED Visits and SUD Inpatient Hospital Stays included in the lists? Also, by residential treatment centers, do you mean Evaluation & Treatment facilities and Secure Withdrawal Management & Stabilization facilities?

Section VI: Recommendations for Activities for the CRIS

It would have been nice to offer these comments before the Initial Assessment was submitted to the Governor and Legislature, so I appreciate that in the future the CRIS Committee will be able to provide feedback on these reports before submission. We also hope that you will make an effort to have strong provider representation on the three new proposed subcommittees. *As a provider association, the Washington Council should have a seat on the Service Delivery Costs Subcommittee. I'd recommend our CEO Ann Christian.*

Activities for Each CRIS Subcommittee

Finally, I wanted to make a brief comment about the proposed activities for the Credentialing and Training Subcommittee. When conducting an inventory of the licensure of staff delivering crisis services, it is important to keep in mind that licensing and educational requirements will depend on the setting in which the staff are providing services.

For example, many clinicians providing crisis response as employees of a licensed community behavioral health agency (including DCRs and mobile crisis outreach teams) may not hold an individual 4 license or advanced degree, but they do operate in a supervised, supported structure with established protocols and quality standards. On the other hand, out-stationed behavioral health crisis response staff who are the sole behavioral health expert embedded in a co-responder team may need to meet licensing and educational standards for independent practice. *It is essential that there is robust provider participation on the Credentialing and Training Subcommittee to help inform the recommendations about whether licensing requirements should be adjusted.* We must ensure that the regulatory framework does not become even more burdensome on providers.

Thank you for the opportunity to provide feedback on the Steering Committee's Initial Assessment. Please feel free to reach out with any questions. I look forward to the work we have ahead!

Justin Johnson, Assistant Director, Community Services, Housing, & Community Development Department, Spokane County Regional Behavioral Health Division

CRIS Member Representation: Behavioral Health Administrative Service Organization (rural region)

Section I: Background on Crisis Services in Washington

Delivery of Crisis Services in Washington

Shouldn't this qualifier include NSPL lines as well? Are all calls received by NSPL screened to only receive suicide/crisis issues or are they subject to the same constraints as the BH-ASO crisis lines depending on the Individual accessing the call line?

Section IV: Assessment of the Current Crisis Delivery System

Theme #1: Responsibility and Accountability for Crisis Services

Clarity should be provided as to why - Workforce crisis, funding challenges, impact of HB 1310, and COVID restrictions .

Request further clarity on language regarding this section. Perhaps - ...how the crisis delivery system is performing statewide.

The current language appears to indicate no such dashboard exists anywhere. However, the Spokane BH-ASO manages a Crisis System Dashboard that provides crisis service delivery data for our region since becoming a BH-ASO (2019).

This is true - however, not complete. The varied level of tracking and reporting is subject to various MCO's determination of collected data. MCO's remain split a reporting framework, causing disparate reporting methodologies due to varied levels of tracking and reporting by the BH-ASOs

Kashi Arora, Program Manager – Mental and Behavioral Health, Community Health and Benefit, Seattle Children's

CRIS Member Representation: Children and Youth Behavioral Health Work Group

- ☐ On page 16 is a paragraph beginning Once a call is received… which outlines the number of calls to mobile teams and the proportion of calls to mobile teams vs crisis calls overall. I think this is something we should look at for children and adolescents too. I've heard anecdotal reports that calls to crisis lines involving minors (outside of King/Pierce/Snohomish counties) get directed to law enforcement as opposed to mobile crisis because there are not yet youth-specific mobile crisis teams.
- ☐ On page 20 and in the sections of that style, the headline Key Takeaways from [strategic area] for CRIS to consider was confusing to me as it seems to indicate these were key learnings rather than key identified needs. The bulleted list that follows the heading on page 20 reflects what is *necessary*, not what is current state – at least from my perspective. I also have this feedback for the list on page 21 under the headline of the same style.
- ☐ On page 22, the second bullet point has a typo. I believe the sentence should read: Crisis response begins as early as possible, well before a person *contacts* 911 (or 988) and continues until stability is regained.
- ☐ On page 22, I wonder if more specificity would be valuable in the 4th bullet point about a service continuum for all ages and people of all cultural backgrounds. Clearly delineating the ages is an important visual reminder of the population we're serving. Suggested rephrase: There is a service continuum tailored to the needs of people of all ages (including families in the perinatal phase, children, youth, adults, and seniors) as well as responsive to all cultural backgrounds.
- ☐ On page 35, for Theme 4 about availability of services in the blue box for where we are today I think it's important to note that 4.2 and 4.3 are reflective of the adult crisis response system but not of the child/adolescent crisis response system. Mobile crisis teams for youth are not yet in every region; the legislature provided funding for 6 youth-specific mobile crisis teams in 2021 and required that every region have one for youth (by a specified deadline), but not all regions actually have one yet. Additionally, I believe crisis stabilization units are only available to adults, so there are extremely limited crisis stabilization options for children and adolescents. It is important to note that as we consider where we are today. I appreciate that meeting with key informants about the gaps in services for children and adolescents is listed as one of the options for moving forward I anticipate there will be interesting learnings and gaps identified.
- ☐ On page 42, for Theme 5 about crisis services workforce – in the orange box for what we have heard, I was surprised to not see either bias reduction or anti-racism training as a part of #2 and wonder if that could be added to reflect/capture the feedback that workforce need to be trained in ways that do not perpetuate racial inequity and disparity.
- ☐ Starting on page 75, I appreciate the delineation of the activities for the various CRIS subcommittees. Some of the things I was expecting to be within the scope of the Cross-System Crisis Response Subcommittee are now in the Regional Crisis Response Subcommittee. I want to flag that some way of consistent collaboration or transparency between the two subcommittees seems critical as the work seems to be quite related or even overlapping.

This is an incredibly thorough report and it is exciting to see the National Promising Practices.

Kimberly Hendrickson, Housing, Health and Human Services Director, City of Poulsbo / Project Manager - Poulsbo Fire CARES program

CRIS Member Representation: Emergency medical services department with a CARES program representative

Despite some mention of 911 call centers, first responders, co-responders, and emergency departments in this report, the attention is insufficient. These are the touchpoints where people with the highest need for crisis response intersect with the crisis system and the quality of crisis response can have life or death consequences. I'd like to see future reports and recommendations include:

- ☐ A focus on 911/988 integration and the role of 911 call takers and dispatchers in crisis response.
- ☐ Minimum standards/best practices for first responder-led crisis response, including the use of co-response teams and training standards for these teams.
- ☐ Specific discussion of the role of fire/EMS in the crisis system, particularly innovative programs, in Washington state, such as Health One and Fire CARES.
- ☐ Minimum standards/best practices when emergency rooms handle individuals in crisis situations—and discharge individuals to care.
- ☐ Specific consideration of how emergency responders can communicate more effectively with community mental health agencies and behavioral health professionals before, during, and after crisis situations.

Perhaps the newly proposed Regional Crisis Response Subcommittee will take up some of these topics. It would be helpful if this subcommittee was made up of a meaningful number of representatives from the 911/first responder/co-responder community.

Finally, the few references to police response/co-response are dismissive and negative. I think it's important to note that, for the last 6 months, the state of Washington has experimented with what happens when police are disincentivized to respond to crisis situations—and the results have been highly unfortunate (see, for example, https://crosscut.com/news/2021/09/seattle-police-intervening-fewer-mental-health-calls-data-show). I hope we can get to a place where we acknowledge police as a critical part of the crisis system, both for the behavioral health professionals who go out into the field and for many individuals in crisis. Our task, I believe, is to improve this part of the crisis system instead of minimizing it or wishing it away while developing other alternatives.

Michael Reading, Chief of Crisis Systems and Services, Behavioral Health and Recovery Division, King County

CRIS Member Representation: Behavioral Health Administrative Service Organization (urban region)

Background on Washington's Crisis Delivery System

The RSNs were a region-based system as well - not county by county

The RSNs were already regionalized. The regions changed very little in the move to BHOs. The change to BHO was primarily to integrate SUD into the RSN system which is why the name was changed to "behavioral health."

All regions transitioned to BH-ASOs. 3 regions are administered by a private vendor, 3 are county-based administration. Report makes it sound like some BHOs didn't become BH-ASOs.

Might also want to add something like "BH-ASOs hold contracts with a network of providers around the state, including the Crisis Call Centers."

Section I: Background on Crisis Services in Washington

Recommend making a distinction here - "a network of providers managed by the RSNs."

The RSNs were not county by county entities. They were largely the same regions as the BHOs. They were managed by counties which came together in interlocal agreements to administer BH services on behalf of multiple counties in a region.

Delivery of Crisis Services in Washington

NSPL does not accredit call centers, rather, they require participating call centers to be accredited. Crisis Line accreditation may be by organizations like CARF, American Association of Suicidology, International Council of Helplines.

Although this is a good picture of % of calls that result in DCR referral/dispatch, the DCRs are dispatched in other ways as well.

Robert Small, Behavioral Health Medical Director and Psychiatrist, Premera Blue Cross

CRIS Member Representation: Commercial health insurance

I think that this is a comprehensive and well-written document for the purpose of the initial report to the Governor and the legislature, especially considering that the work of the CRIS Committee and the Steering Committee is in what I would categorize as an early stage. I do not have anything substantive to add.