CRISIS RESPONSE IMPROVEMENT STRATEGY (CRIS) STEERING COMMITTEE MEETING SUMMARY

Thursday, March 24, 2022; 1:00 pm to 3:00 pm
Zoom

Meeting Agenda, Slides and Recording are available on the CRIS webpage:
https://www.hca.wa.gov/about-hca/behavioral-health-recovery/crisis-response-improvement-strategy-cris-committees

ATTENDEES

STEERING COMMITTEE MEMBERS

Amber Leaders, Office of Governor Jay Inslee
Bipasha Mukherjee, Member representing lived experience
Keri Waterland, Washington State Health Care Authority
Michele Roberts, Washington State Department of Health
Representative Tina Orwall, Washington State House
Senator Manka Dhingra, Washington State Senate

AMERICAN SIGN LANGUAGE (ASL) INTERPRETERS

Amanda Wilkes
Andrea Medlock

COMMITTEE STAFF

Betsy Jones, Health Management Associates
Brittany Thompson, Health Management Associates
Nicola Pinson, Health Management Associates
Elizabeth Tenney, Health Management Associates
Jamie Strausz-Clark, Third Sector Intelligence (3Si)
Mark Snowden, Harborview Medical Center

WELCOME, INTRODUCTIONS, AND TECHNOLOGY REVIEW

Jamie Strausz-Clark (3Si) convened the meeting and reviewed use of Zoom features to ensure understanding among meeting participants regarding use of Zoom technology for the meeting and expectations for committee members and public observers. Jamie also introduced the American Sign Language Interpreters to the meeting and reviewed how to pin their window to the screen.

Representative Tina Orwall welcomed everyone to the meeting and thanked Steering Committee members and members of the public for attending the meeting. Steering committee members introduced themselves to the public. Amber Leaders offered a land acknowledgement, recognizing that she is a guest on tribal lands and honoring tribal ancestors and leaders as stewards of these lands.

ICEMELTER

What is your go-to karaoke song?

MEETING OBJECTIVES AND AGENDA

Jamie reviewed the meeting agenda and objectives for each agenda item. This meeting of the Steering Committee had six objectives:

1. Continue to build and sustain collaborative relationships with each other.
2. Provide updates relevant to the Steering Committee.
3. Discuss action items emerging from the 3/15/22 CRIS Committee discussion on centering equity.
4. Discuss plan for recommending CRIS Committee members to sit on Governor's Blue Ribbon Commission.
5. Confirm action items and next steps.
6. Hear public comment. Jamie provided an overview of the public comment process to occur at the end of the meeting. Public comments are also welcome in written form at any point throughout the process and may be submitted to HCAprogram1477@hca.wa.gov.)

PERSONAL STORY

Jamie Strausz-Clark introduced Topher Jerome who shared his personal story and experience with the behavioral health crisis response system. Topher Jerome is a Project Director at the Behavioral Health Institute at Harborview. Topher shared his story growing up with a substance use disorder, contemplation of suicide, experience with inpatient and outpatient treatment for substance use, and the trauma experienced when accessing services in the emergency department. Now in recovery, he stressed the issues he faced navigating the crisis system and emphasized the need for safe places for people in crises to go to that are easily accessible and trauma-informed. Steering Committee members thanked Mr. Jerome for sharing his story. A recording of Mr. Jerome's story is available on the CRIS webpage as part of the March 24th Steering Committee meeting recording.

SUBCOMMITTEE UPDATES

Betsy Jones, Health Management Associates, shared the updates on recent subcommittee meetings. The Steering Committee approved the CRIS high-level work plan at their February 10th meeting, which provides an organizing framework for the work ahead to ensure the full continuum of crisis response. State agencies are responsible for implementation and the subcommittees will provide recommendations. The subcommittees started meeting this month, with the Lived Experience, Technology, Cross-System Crisis Response, and Tribal 988 subcommittees. Betsy overviewed each subcommittee briefly, including the Ad Hoc Workgroup on Vision and described the subcommittee purpose and its meeting frequency. For the Ad Hoc Workgroup on Vision, Betsy shared an update that the group has been meeting to develop a draft vision statement that will be brought back to the CRIS and Steering Committees for consideration in May. (See Subcommittee update slides available on the CRIS webpage as part of the March 24th Steering Committee meeting materials).

CENTERING EQUITY IN OUR WORK: FOLLOW UP

At the last CRIS Committee meeting, CRIS members discussed ways to embed equity into the High-Level Workplan for redesigning the behavioral health crisis response and suicide prevention system. The Steering Committee members were asked to review the draft summary of CRIS member comments and provide feedback at this meeting. (See Attachment 1, Summary of March 15th CRIS Committee Breakout Group Notes and Categories of Recommendations.)

Steering Committee members appreciated the draft summary of the CRIS Committee discussion and synthesis of ideas into categories to reflect the nature of actions recommended (*i.e.,* implementation, operations, capacity building, and policy). Members agreed with next steps to send the synthesis of comments to CRIS Committee members for further feedback across all objective areas. The Project Team will then summarize input received to inform development of draft recommendations to promote equity and services for individuals in diverse circumstances. The draft recommendations will come before the Steering Committee again for review and approval.

Steering Committee members expressed support for synthesis of CRIS comments gathered at the March 15th meeting and provided the following feedback:

- Can we discuss and agree on our definition of family, with recognition that family can be biological or chosen?
- The draft workplan organizes actions by objective, but there are some actions that apply to all of the objectives. These should be summarized at the top of the workplan.
- Could there be more depth to the discussion regarding language access? Language access is not just knowing a language; it includes knowing the language of behavioral health response and the crisis system. In addition, how do we diversify the workforce to be more language accessible and inclusive?

Jamie thanked the group for their input and noted that this feedback will be incorporated into the draft summary of comments that is sent to the CRIS Committee for further review and comments.

UPDATE ON BLUE RIBBON COMMISSION

Amber Leaders, Office of Governor Jay Inslee, provided an update on the status on the Governor's Blue Ribbon Commission on the Intersection of Justice and Behavioral Health Crisis Systems. The legislation directs that two CRIS Committee members should be named to the Commission. She shared there will be an internal meeting in her office regarding the Executive Order and any changes that may be needed, which may include changes to the timeline. There will need to be a conversation in the future regarding the process for appointing CRIS members to the Blue Ribbon Commission.

PUBLIC COMMENT PERIOD

Jamie Strausz-Clark opened the public comment period: 15 people signed up for public comment, and 2 members of the public commented. Individuals were allowed two minutes to provide comment. For individuals with additional comments or time needed, Jamie highlighted the opportunity to submit public comment via email to: HCAprogram1477@hca.wa.gov.

MEETING ADJOURNED

Attachment 1. Summary of March 15th CRIS Committee Breakout Group Notes and Categories of Recommendations (For Steering Committee Review at 3.24.2022 Meeting)

Crisis Response Improvement Strategy – High-Level Workplan March 15, 2022 – CRIS Discussion on Ways to Infuse Equity into the Workplan Combined Breakout Group Notes (Draft Summary for Steering Committee Review at 3.24 meeting)	Categories of Recommendations
Objective 1: Place to contact – National Suicide Prevention Lifeline crisis centers can effectively receive and respond to 988 calls, chats, and texts in a manner that is culturally responsive and tailored to meet the needs of diverse individuals and families across all ages, and deliver services according to national best practices, standards, and guidelines.	
• Need to better focus on our data so we can identify disparities (i.e., who we are serving and who we are not); maybe there needs to be a group specifically looking at this issue.	• Capacity Building (data)
Objective 1.1. Appropriate technology is in place for 988 calls to be answered by National Suicide Prevention Lifeline crisis centers. (Per Federal legislation and Washington's HB 1477)	
Objective 1.2. National technology system is in place to support text and chat services in Washington State.	
• There is an assumption that everyone has access to the same technology to call or text, but that might not be the case. How do we ensure that everyone has access to technology to access services so that no matter where someone is, how comfortable they are with technology, and what technology they have access to? • Ensure rural communities have access to devices allow to text/chat.	• Capacity Building/Policy (community investment)
Objective 1.3. Standardized process flows between 988 National Suicide Prevention Lifeline crisis call centers, regional crisis call centers, crisis services, and 911 are established and there is a plan for implementation.	
• Concern about routing and response–especially for callers in communities of color–and ensuring that calls go to the right people. Ensure law enforcement is not hijacking these calls and moments of crisis, especially given the use of area code-based system. ○ Will neighborhoods (zip codes) get a different response? (driven by bias – like sending cops to communities where more people of color reside) ○ What happens when law enforcement gets involved and how do we prevent and manage that?	• Operations (clear protocols and training)
• How do we raise awareness of how racial bias and assumptions are playing out at call centers and in our responses and how to interrupt that so the system doesn't perpetuate these inequities. This is going to require significant training and support on dismantling this (this work needs to be done across systems – so 988 and 911)	• Capacity Building (equity-focused training and procedures)
• Need to think of how we can be transparent and accountable to how this all plays out when implemented – which means good data collection, monitoring, and reporting. Need to look at the whole experience from start to finish as even if 988	• Capacity Building (data)

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does a hand off – we will still be held responsible for how it goes and if it goes poorly for communities, and that will impact who will access 988 in the future.	
Objective 1.4. Appropriate National Suicide Prevention Lifeline crisis center staffing levels are in place to respond to the volume of calls, text, and chat associated with 988.	
• Ensure there are requirements (and enforce them) about having appropriate language access infrastructure, (including use of language bank) • Text and chat should be available in different languages	• Operations (contract requirements and monitoring)
Objective 1.5. 988 National Suicide Prevention Lifeline crisis center staff have skills to provide services that are person- and family-centered, culturally responsive, and trauma-informed.	
• Training for staff on how to collect demographic data appropriately, respectfully	• Operations (clear protocols and training)
Objective 1.6. Establish standards for designation of Crisis Call Center Hubs; establish expectations for crisis call centers to provide high-quality crisis intervention services, triage, care coordination, referrals, and connections to individuals contacting the 988 crisis Lifeline. Standards will be in accordance with national requirements and best practices (SAMHSA and Vibrant Emotional Health).	
• Consider requirements regarding language access and printed materials in alternative format and other languages.	• Operations (contract requirements and monitoring)
Objective 1.7. Crisis Call Center Hubs have access to state-of-the-art Crisis Call Center Hub technology that is interoperable with 911 and Vibrant's National Unified Platform, adheres to forthcoming national requirements, complies with data privacy and security laws (including text and web-based data sharing), has a disaster preparedness plan, and is able to dispatch mobile teams, identify bed availability, schedule and conduct follow up and community service referrals, and support all system partners in navigating the crisis system.	
Objective 2: Someone to come – Mobile crisis response teams are available 24/7 and positioned to quickly travel to the locations of individuals to deliver best practice care that is culturally responsive, tailored to the needs of diverse individuals and families across all ages, and reduces the need for unnecessary ER visits and arrest.	
• Important of engaging perspectives and ensuring connections with diverse communities regarding what the system should look like.	• Implementation (build continuous community engagement during design and

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	implementation process)
• Plan continuous quality improvement to evaluate and ensure effective ways to engage diverse perspectives.	• Operations (clear protocols and training)
Objective 2.1. Mobile rapid response crisis teams are connected to the Crisis Call Center Hub technology in a manner that maximizes clinical best practice, efficiencies, and interoperability.	
• Ensure information sharing between call receivers and dispatch, including language access and other information about a person's needs so that they don't have to repeat multiple times.	• Operations (clear protocols and training) • Capacity Building (Information Technology)
Objective 2.2. Clear protocols are established to guide mobile crisis teams in a manner that maximizes clinical best practice and safety in a variety of settings, including support for voluntary processes over involuntary, reserving involuntary processes only in extreme situations. Protocols are developed on how crisis teams work with law enforcement, emergency departments, and other system partners.	
• Protocols will help to ensure consistent response across populations, rather than application of differential standards. Underscore importance of protocols to guide practice in a manner that promotes best practice and equity. • Need to clarify who will have the final authority in a crisis situation if/when law enforcement is involved. This also brings up liability questions.	• Operations (clear protocols and training)
Objective 2.3. There is equitable access to mobile response team services across the state that are accessible within designated timeframe standards established.	
• If the goal is to create a statewide system, it is important to ensure geographic equity in communities that don't currently have access. Analysis of data to identify access by subpopulations to services.	• Capacity Building (data)
Objective 2.4. Mobile crisis team staff have skills to provide services that are person- and family-centered, culturally responsive, trauma informed and non-coercive.	
• Need access and availability of professionally-trained interpreters to ensure language access. • Requirements/support to bring in professionally-trained interpreters.	• Capacity building (workforce requirements)

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	• Operations (contract requirements and monitoring)
• Training and ongoing resources to support appropriate skills on the crisis response teams. • Trauma informed and non-coercive care is critical for addressing power differentials between individuals and family members, professionals, and health care providers.	• Capacity Building (equity-focused training and procedures)
• Ensure workforce (including peers and other associate professionals) to make sure we are responding appropriately to meet people's needs.	• Capacity building (workforce requirements)
Objective 2.5. Mobile crisis teams are multidisciplinary and include peer and family support.	
• Consider using peers to provide support for people who don't feel safe with the community institutions. Ad hoc, almost a gig employment model maybe, where peers are well-vetted and then available for referral as supports as people try to navigate.	• Capacity building (workforce requirements)
Objective 3: A Place to go – A broad range of walk-in and crisis stabilization services are accessible, culturally responsive, tailored to the needs of diverse individuals and families across all ages, and provide all individuals with a no-wrong door access to mental health and substance use care and crisis stabilization services.	
Objective 3.1. Crisis stabilization providers are connected to the Crisis Call Center Hub technology in a manner that maximizes clinical best practice, efficiencies, and interoperability.	
Objective 3.2. Clear protocols are established to guide crisis stabilization providers that maximizes clinical best practice and safety in a variety of settings. Protocols are developed on how crisis facility providers work with law enforcement, emergency departments, and other system partners.	
Objective 3.3. There is equitable access to a broad range of walk-in and crisis stabilization services across the state, and individuals are connected to ongoing care. These services will include peer-run services and peer-run respite centers.	

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• Bring providers (including those who serve diverse populations) to help inform the development of crisis centers and consider utilizing them as the provider of crisis services that are a place to go.	• Implementation (engage providers throughout the design and implementation)
• *Prioritize* and utilize individuals with lived experience to help inform development and provide the services.	• Implementation (build in continuous community engagement during design and implementation process)
• Ensuring language access: which languages to have available, what about deaf and hard of hearing	• Operations (contract requirements and monitoring)
• Provide guidance and change documents (e.g. licensing) to reflect what is expected within facility pertaining to equity	• Capacity Building (equity-focused training and procedures)
Objective 3.4. Crisis stabilization provider staff have skills to provide services that are person- and family-centered, culturally responsive, trauma informed and non-coercive.	
• Assess what the staffing needs are to ensure that the staff make up reflect the needs of individuals served • Assess that the staff have the necessary skills to address the diverse needs of individuals who seek services	• Capacity Building (workforce requirements)
• Develop action plan for training about equity and culturally responsive.	• Capacity Building (equity-focused training and procedures)
Objective 3.5. Standardized process flows are developed for coordination with law enforcement and there is a plan for implementation.	

• Ground accountability in community:
  ○ Determine what and how we report back to communities, for accountability
  ○ Consider regional crisis forum
  ○ Provide consistent messaging on what to expect in equity and inclusion
	• Operations (contract requirements and monitoring)
	• Capacity Building (data capacity)

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	• Implementation (build continuous community engagement during design and implementation process)
• Measures to ensure not using law enforcement when not needed	• Operations (contract requirements and monitoring) • Capacity Building (data)
Objective 4: Pre- and Post-Crisis Care – Services immediately upstream and downstream of crisis events are culturally responsive, tailored to diverse individuals and families across all ages, and accessible to all and support individuals and families to avoid cycling in and out of the crisis system.	
• Emphasize pre-crisis; also the family members who are not in the actual crisis (adult experiencing Vicarious Trauma)	• Implementation (build out sub-objectives that are prevention focused and more inclusive.)
Objective 4.1. Pre- and Post-Crisis Care providers are connected with Crisis Call Center Hub technology in a manner that maximizes clinical (ADD and CULTURAL) best practices, efficiencies and information sharing to support next steps for the person's transition to follow-up non-crisis care.	Suggested language in yellow highlight.
• Children and their families need a warm hand-off to someone who understands child/adolescent development and can better engage. • Other populations who may hesitate to engage need a warm hand-off to someone with a trauma-informed approach.	• Capacity Building (equity-focused training and procedures) • Operations (clear protocols and training)
Objective 4.2. Services such as next day appointments, post-hospitalization and post-crisis services, warmlines, peer and family supports, and navigation supports are culturally responsive and developed to address the needs of diverse individuals and families across all ages to avoid whenever possible situations from escalating and to not cycle in and out of the crisis system.	

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• Next-day appointments need providers that have that cultural awareness for all callers (e.g., education/training in cultural awareness, stigma, and trauma-informed care). • Pre- and post-crisis care for people in the agricultural sector need workforce who understand this sector, can meet language and cultural needs.	• Capacity Building (equity-focused training and procedures) • Capacity Building (workforce requirements)
Objective 4.3. Expanded use of community education programs or campaigns are used to educate the community about where and how to access services.	
• Those involved with ed campaigns represent the diversity of the community	• Implementation (build continuous community engagement during design and implementation process)
• Educational campaigns should be culturally responsive; address stigma reduction; age/development of individuals need to be represented (e.g., Intellectual disabilities) and tailored for specific communities.	• Implementation (marketing and communications with an equity focus)
Objective 5: A statewide crisis system is designed, administered, and monitored with oversight that ensures equitable, efficient, and person-centered behavioral health crisis system that demonstrates quality outcomes and performance.	
Objective 5.1. A vision and principles for the crisis system is developed and drives administrative oversight and local operational and clinical practices across the state.	
Objective 5.2. Sovereign tribal authorities – crisis system is designed in a manner that respects the existing processes and governing bodies of tribal governments to address tribal behavioral health and crisis system needs and gaps.	

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Objective 5.3. System partners – including individuals and family members with lived experience, first responders, emergency, crisis and community providers, government, and managed care plans – collaborate to design, implement, and oversee an effective and equitable behavioral health crisis system.	
• Ensure that the veterans' populations are included in this objective as a system partner.	• Implementation (engage partners throughout design and implementation)
Objective 5.4. Cross-system metrics are developed in collaboration with system partners that allow for crisis system transparency and oversight through report disseminated and improvement strategies implemented. Metrics include satisfaction ratings by individuals, family members, and system stakeholders.	
• Metrics need to reflect and be appropriate to the populations that are being served. This could include metrics specific to ensuring diversity and also metrics that are more global in nature should show metrics at the sub-population level as well.	• Capacity Building (data) • Operations (contract requirements and monitoring)
• Clearly define who the sub-populations are that will be measured.	• Operations (contract requirements and monitoring)
Objective 5.5. Shared data is developed to evaluate overall crisis system performance and support performance improvement across the system.	
Objective 5.6. Appropriate levels of braided funding (including Medicaid, Medicare, commercial, local and other dollars) are available to support a high functioning system, include sufficient access to crisis lines, mobile teams, and walk-in and crisis stabilization services as well as and prevention and post crisis services.	
• Address disparity of services based on funding (e.g. between Medicaid fee-for-service, Medicaid Managed Care, commercial insurance, uninsured.	• Policy (funding models and parity)

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Objective 5.7. Recommendations related to behavioral health workforce needs by each region across the state are developed. These recommendations include minimum licensure, education, and training requirements for staff delivering crisis services, as well as strategies to support the existing workforce and recruit new staff.	
• No support from Medicaid or the state to fund peer-supported work that is happening now. There is a lot of "red tape" often "cuts us off at the knees." Often default by necessity to a less diverse team than desired and needed. • Many individuals want to contribute and have necessary cultural affiliations, but can only serve as volunteers due to their immigration status and time availability (e.g., only available part time). This limits us on the richness of the potential workforce available.	• Capacity Building (workforce requirements) • Policy (funding models and parity)
Objective 5.8. Reimbursement approaches incentivize a highly-coordinated system of care across system partners that results in quality outcomes and supports provider viability and sustainability.	
• There needs to be incorporation of paid volunteers into reimbursement. • Also needs to have payment parity at the service level across payers and across disciplines, where appropriate.	• Capacity Building (workforce requirements) • Policy (funding models and parity)
Objective 5.9. Statewide minimum standards of operational and clinical practices are developed that foster use of best and promising practices while also allowing for tailored implementation at the local level.	

Main Room Discussion Notes

To be further integrated/synthesized into potential recommendations for consideration:

Objective 1 – Place to Contact

1. Be intentional about collecting information to ensure we are sending the person in crisis to the correct respondent
    a. Explore AI response options to collect this information
2. Consider disability status to ensure we are building in accessibility (on websites, apps, etc.)
    a. Have materials, resources tested by people with accessibility test them to make sure they work from the user standpoint
3. Ensure that there are multiple ways for folks to reach out that take into account digital literacy issue and lack of broadband access.
    a. Need to work with Department of Commerce/Office of Broadband to expand access to internet service across the state.
    b. With all intersecting systems, ensure no wrong door for people in crisis

Objective 2 – Someone to Come

1. Faster response (less than 24 hours)
    a. If the mobile team can't get out within a timely manner, provide continued contact with the individual from the crisis response team
    b. Conduct survey of current workforce to determine reasonable response time
    c. Consider other televentions with specified response times
    d. Reconsider using FaceTime for crisis response (WACs currently may prevent)
2. Be intentional about workforce to support these mobile teams:
    a. Need people who look like and can relate and speak to the person in crisis
    b. With workforce constraints, need to be creative in finding people who can serve in this role, e.g., placing endorsements on professional certifications such as paramedic certifications. An example of an endorsement would be a Mental Health Responder who could function in the role similar to a designated crisis responder.
    c. More behavioral health response embedded with police
3. Consider language access (spoken language, sign language), access to interpreters
4. Address the inequities in how Medicaid clients receive response (e.g., some Medicaid clients have to go to the ER rather than getting home response)
5. Return to a system where the mobile crisis team is an objective observer to address the need for hospitalization, allow for diversion whenever possible
    a. Consider allowing physicians to deem someone "gravely disabled" or overrule a designated crisis responder, in case designated crisis responders have a subjective view of detainment (**Note there is some disagreement on this point—some people had concerns about the motives of physicians and wondered if they could be objective in their assessment).
6. People have been failed many times, so we need to ensure mobile response fulfills its promises and does not let people down
7. Implicit bias training for responders so response is more equitable, especially for BIPOC
8. Training for mobile crisis teams about the special needs of the child welfare population and how work with DCYF caseworkers/guardians/caregivers

For further clarification:

- Provide spaces to help people have a space to reflect on their life challenges to get clear on the issues for themselves