MEETING SUMMARY

CRISIS RESPONSE IMPROVEMENT STRATEGY COMMITTEE MEETING SUMMARY

Tuesday, July 16, 2024; 1:00 pm to 4:00 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

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ATTENDEES

COMMITTEE MEMBERS

Adam Wasserman, State 911 Coordinator
Aleesia Morales, Tacoma Fire Department
Amber Leaders, Office of Governor Jay Inslee
Bipasha Mukherjee, Crisis Line Volunteer
Claudia D'Allegri, Sea Mar Community Health Centers
Darcy Jaffe, Washington State Hospital Association
Dillon Nishimoto, Asian Counseling and Referral Service
Kashi Arora, Community Health and Benefit, Seattle Children's
Kelly Waibel, Tulalip Health System
Kristen Wells, Valley Cities Behavioral Health Care
Larry Wright, University of Washington School of Social Work
Laura Pippin, Washington Association of Designated Crisis Responders
Levi Van Dyke, Volunteers of America Western Washington
Mark Snowden, Harborview Medical Center
Michele Roberts, Washington State Department of Health (DOH)
Michelle McDaniel, Crisis Connections
Puck Kalve Franta, Access & Inclusion Consultant
Robert Small, Premera Blue Cross
Ron Harding, City of Poulsbo
Sam Sullivan - Senator Manka Dhingra Delegate, Washington State Senate
Teesha Kirschbaum, Washington State Health Care Authority (HCA)

COMMITTEE MEMBERS ABSENT

Anna Nepomuceno, National Alliance on Mental Illness (NAMI) Washington
Connie Chapman, Washington Department of Veterans Affairs
Fennec Oak, Fennec Oak Counseling
Jane Beyer, Washington State Office of the Insurance Commissioner
Jan Tokumoto, Frontier Behavioral Health
Joan Miller, Washington Council for Behavioral Health
Justin Johnson, Spokane County Regional Behavioral Health Division

Michael Reading, Behavioral Health and Recovery Division, King County
Representative Tina Orwall, Washington State House
Representative Tom Dent, Washington State House
Senator Judy Warnick, Washington State Senate
Senator Manka Dhingra, Washington State Senate

AMERICAN SIGN LANGUAGE (ASL) INTERPRETERS

Caryl Williams Love
Heather Duval

COMMITTEE STAFF

Betsy Jones, Health Management Associates
Kristine Malana, Health Management Associates
Chloe Chipman, Health Management Associates
Jamie Strausz-Clark, Third Sector Intelligence (3Si)
Michael Anderson-Nathe (Anderson-Nathe Consulting)

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 meeting technology and expectations for committee members and public observers.

MEETING OBJECTIVES AND AGENDA

Jamie reviewed the meeting agenda and objectives for each agenda item. This meeting of the Washington Crisis Response Improvement Strategy Committee had six objectives:

1. Ground our work in the personal stories and experiences of people who encounter the crisis response system.
2. Hear updates from state agencies and subcommittees relevant to the CRIS.
3. Learn about crisis work in Indian Country and how to ensure statewide work does not create barriers for the Tribal work.
4. Discuss cross system collaborations, including the Mental Health Crisis Call Diversion Initiative pilot and 911-988 warm transfer protocol development process.
5. Confirm action items and next steps.
6. Hear public comment. (Note: Due to lower sign-up numbers, the comment period was shortened. Public comments are welcome in written form at any point throughout the process and may be submitted to HCAprogram1477@hca.wa.gov.)

PRESENTATION AND PANEL DISCUSSION: Tribal Behavioral Health Crisis Response

Vicki Lowe (Executive Director for the American Indian Health Commission, AIHC) served as moderator and opened the presentation and panel discussion of Tribal behavioral health crisis response. Vicki provided an overview of Tribal efforts in Washington to improve access to behavioral health services and crisis response for Tribal members. The behavioral health crisis response system in Washington was not developed with the inclusion of Tribes as Tribal Health Jurisdictions or Indian Health Care Providers (IHCPs). Examples of key gaps include:

- Behavioral Health Administrative Service Organizations (BH-ASOs) are not clear on how to work with FFS Medicaid patients and Indian Health Care Providers.
- Non-Tribal Providers often consider the FFS program as "not having coverage" which has a significant impact on Tribal populations given that 60% of the AI/AN population is enrolled in Medicaid FFS.
- Lack of access to voluntary in-patient treatment impacts the ability to help those in crisis.
- Tribes and Indian Health Care Providers are not directly funded to provide crisis care.

Vicki highlighted the impacts and poor outcomes for Tribal populations, including disproportionate suicide rates, emergency room visits, adverse childhood effects, and historical and intergenerational trauma in the AI/AN community. Vicki also provided an overview of Tribal Authority and Sovereignty and the inherent power that Tribes have to govern their people, and as well as work to develop Tribal-specific crisis response resources such as Tribal Designated Crisis Responders, Tribal Mobile Crisis Teams. Further detail regarding these efforts is available in the meeting slides and recording on the CRIS webpage. For those interested in learning more about Tribal behavioral health and crisis response efforts, email Vicki Lowe vicki.lowe.aihc@outlook.com.

Tribal Behavioral Health Crisis Response Panelists

Panelists included Councilwoman Rosalee Revey-Jacobs (Council Member at Lummi Nation), Emily Arneson (Suicide Prevention Coordinator at Port Gamble S'Klallam Tribe), and Kelly Waibel (Licensed Mental Health Counselor at Tulalip Tribe Behavioral Health). Panelist bios can be found at the end of the meeting summary.

Panel Discussion

- *What are some innovative and cultural solutions your Tribe/community are incorporating into your programs to address crisis and suicide prevention efforts?*
    - Councilwoman Revey-Jacobs highlighted Lummi Nation's crisis team, which consists of a manager and four peer supporters. They are available to go on scene and help individuals as needed. They can also bring in cultural support from elders, referred to as cultural coordinators. The whole team does everything in-house. A drug task force is also underway, with plans to hire a coordinator soon.
    - Kelly noted Tulalip's newer Designated Crisis Responder (DCR). There is also a crisis team, which consists of one mental health professional, one peer, and Kelly. Tulalip is hoping to double that number if they can find the staff. One option is to utilize behavioral health aides more in the behavioral health system, with substance use disorder (SUD), and mental health crisis to try to grow a workforce who are a part of and serve their own community. Tulalip is also working on drug task force to address opioid issues.
    - Emily shared that Port Gamble has an integrated health facility with medical, behavioral/mental health, SUD counselors, peer support, health aid, and dental all in one facility. The integrated facility supports people where they're at; they use a no wrong door approach. Port Gamble is a small community and relies heavily relies on outside crisis response systems given their population size. Port Gamble has cross-training in the facility and provides

holistic care to best support the culture and community. For example, there was an individual in crisis, and Port Gamble provided a psych nurse that also had a good rapport with their medical provider, who gave support and de-escalated the crisis. Beyond that, Port Gamble coordinates with external partners, including its BH-ASO, which contracts out mobile crisis and crisis triage services. Port Gamble has been working to outline coordination with system partners through the Tribal crisis coordination protocols.

- *What are system barriers that you are working to address crisis in your Tribe/community?*
    - Emily touched on their system, which includes someone to call, someone to come, and a place to go. Port Gamble has been partnering with the Native and Strong Lifeline, which has been helpful. While they don't have control over who is calling and who is not, it has been a great resource to continue to build that partnership and give services for referral. However, Someone to Come and a Place to Go are inconsistent and not always available. The county has one facility for crisis triage. The requirements for eligibility are lengthy and aren't necessarily "no wrong door approach," so folks are often diverted to emergency rooms. With hospitals, communication with the Tribe is lacking and inconsistent. Port Gamble has been working on different ways to address crisis coordination protocols. They're working on an approach involving individual agreements with hospital and inpatient facilities to increase communication. We know our people and what they need, so that communication is important and is a big barrier for us if we don't know where our people are.
        - Vicki noted HB 1877 recently passed, requiring all parts of crisis system to coordinate with IHCPs and Tribal governments on whether individuals are receiving care.
    - Kelly shared barriers revolve around knowing if folks are in the hospital, where they are going, where they are released to. Tulalip wants to ensure individuals in crisis have the community around them so they are successful when they come back. That coordination is getting better. As the DCR, she has been lucky to have county and BH-ASOs working well with us on training and support. However, it took time to build those relationships and figure out who does what, what is the best for the community, etc. Those are where most of the barriers are – building those relationships. Communication doesn't happen automatically like it should. Folks ask how they know whether someone is Native American – these are part of demographics that are usually gathered in the hospital setting. We are working to coordinate across systems. DCRs can go through the county system, or the Tribal court has codes for involuntary treatment. Tulalip is working with different inpatient facilities to make this work. Most of the time when someone is detained, that county system takes over the court process. That's not what Tulalip wants – they want to maintain people in their Tribal court system, which are often more restorative, with wraparound services. Tulalip is working with hospitals to make that happen, including looking at MOUs, equipment, payment, etc. The communication and relationship building takes time and persistence, which does eventually make a difference and we are grateful for that.
    - Councilwoman Revey-Jacobs noted Lummi Nation has struggled to hire on staff, which has been difficult since the COVID-19 pandemic. This has impacted Lummi Nation's most vulnerable departments, including law enforcement, behavioral health, and medical departments. Lummi Nation recently hired a behavioral health director, and she has been building their capacity, including the crisis response team and additional positions filled. They are currently letting the community know what services are available 24/7, engaging outreach, and coordinating with internal and external departments.

- *What recommendations do you have for the CRIS committee to ensure the state addresses crisis system barriers?*
    - Kelly recommended encouraging communication; don't be afraid to ask. As a non-Native American, she is here to support the community. Tribes are resilient. Sometimes they just need support in what they want and need to do. Important to support the direction the Tribes would like to follow.
    - Emily echoed Kelly's thoughts, adding that training is important. We need to have training across ask sectors about Tribal sovereignty and crisis response processes. People need to be informed at all levels, including folks on the ground to understand what the Tribes are looking for and be familiar with the process. Prioritizing a no wrong door approach is important as well. Right now people are more familiar with and comfortable with 911, but there is a need to integrate our services to work together in tandem and ensure people receive what they need, no matter where they call or who they ask for help from.
    - Councilwoman Revey-Jacobs also recommended improving care coordination between local, state, and tribal resources, as well as government to government agreements, to ensure alignment and expectations.
- *Share experiences from your community on partnerships with hospitals and inpatient behavioral health facilities.*
    - Kelly noted that historically, relationships have been challenging. Police will take people into the emergency room, they are released after evaluation, and sent back out in two hours, while no one from Tulalip is notified. This is part of the reason the DCR and the crisis team was a priority for this community. Partnerships are getting better, but there are still times where someone is in a hospital and gets listed as a missing person because no one knows where they are. HIPAA regulations also prevent families from calling and asking if an individual is at the hospital or facility. Sometimes detectives will call Kelly about a missing person with a mental health history and ask if she knows where they are. Working with hospitals, Tulalip's DCRs have also started to get calls from the ER and inpatient social workers and about patients they believe are Tribal members. It's a work in progress, specifically coordinating with Tribal court orders to keep Tribal members within the Tribal court system instead of going through the county system.
        - Vicki added that since HB 1877 passed, that coordination between hospitals should be happening. She encouraged the group to think about what is keeping people and organizations from following the law in these circumstances.
    - Emily noted Port Gamble has been working on partnerships and relationships with their BH-ASO, and now coordinating with the hospitals. Port Gamble will need to have agreements in place with the hospitals moving forward. They are beginning to work more on those relationships, and Emily believes their success may vary from facility to facility. One struggle has been medical clearance; Hospitals are asking them to go to the ER before someone can go inpatient, for example. People are being sent home when they should not have been sent home or kept when they should not have been kept. The hospital also gets to decide when the DCR comes in or not, even if Port Gamble calls for a DCR in the county to come into the hospital. Staff turnover can also make relationship building difficult. An overall culture change is needed regarding the importance of communicating with Tribes. While the care coordination agreements will be challenging, that's the avenue that Port Gamble must take right now, because the communication and coordination are not happening for them.

- Councilwoman Revey-Jacobs echoed Emily's points on culture change and mental health. Lummi Nation does not have a good partnership with the hospitals at this time. She emphasized that it feels there is no follow through with them, and that their people are slipping through the cracks. Inpatient behavioral health facilities have no availability. However, the Councilwoman is hopeful they are heading in a good direction. Lummi Nation has a new Tribal liaison in the hospital to help build that bridge so they can coordinate better.
- Vicki highlighted these challenges as institutional barriers and institutionalized racism. The Tribal leaders have been working on these for decades, including relationship building. She noted upcoming legislation from AIHC that will focus on addressing the hospital and ER challenges.

CRIS Committee Q&A:

- Kristen Wells asked to hear about "practice-based evidence" in crisis response since that is unique to the way Tribes think about evidence for interventions.
  - Vicki noted that evidence-based practices are created based on evidence that is not typically representative of Tribes. Tribes therefore have practices from their ancestors that have been handed down and have worked for thousands of years.
  - Councilwoman Revey-Jacobs shared that Lummi Nation has brought on two Tribal elders to provide cultural support as cultural coordinators. They are important to the community members and add value to the crisis system.
  - Emily noted their culture is their prevention. Talking about mental health and suicide is becoming easier within the community; there is less stigma, but it's still a challenge. Emily has begun facilitating groups to come together. Events that bring the community together are on the front end of prevention, and do not necessarily target a specific issue. Within the system, Port Gamble's integrated care also looks at the whole person to support treatment.
  - Kelly highlighted services at Tulalip's health clinic, including reiki, massage, and acupuncture. Tulalip also encourages community events, connection, and community. They look at the energy individuals are feeling and consider cultural treatments such as going to the water. This involves looking at what is most helpful to the individual rather than what might be considered a best practice or evidence-based. Evidence-based practices don't always work on a community that it wasn't based on, so adapting to the community is key.
  - Vicki emphasized that treatments may be different in each community. She highlighted efforts to implement behavioral health aides and ensure they are Medicaid billable. These are "grow your own" providers; they have a longer pathway to certification, and fit better with how Tribal people work. There are also projects to support billing for traditional Indian medicine—the Seattle Indian Health Board has developed billing codes. The AIHC is working on a credentialing process through a State Plan Amendment (SPA) with HCA. A few other states have amended their Medicaid State plan to include billing for traditional Indian medicine.
- What is something you wish the CRIS Committee and all state policymakers and lawmakers understood about Tribal sovereignty and how it affects your behavioral health crisis response work?
  - Councilwoman Revey-Jacobs emphasized that Lummi Nation knows how to take care of their people. She recommended more trust in the Tribes and better coordination.
  - Emily echoed the Councilwoman's thoughts and emphasized that relationships are fundamental to the behavioral health crisis system. Should be a part of the process from start to finish.

    - Kelly noted they aren't trying to build a whole new system, but rather developing a community-based system instead of a state-based system.
    - Vicki added that Tribal sovereignty means that the Tribe has the right to govern their own people and manage their own resources. There's a federal trust and responsibility for the federal government to respect that. When a Tribe does something differently, that doesn't mean they are doing something wrong. It's not anyone else's right to tell Tribes they are wrong when they make decisions. Harm can result for Tribes when Tribal sovereignty is not understood.
- What do you think needs to happen on the state side to improve implementation of the intent of this bill?
    - AIHC is working on implementation plan that includes educating all relevant partners. The Commission will partner with HCA, DOH, and others to get information out statewide to help people understand changes and what they are responsible for.
- Michele Roberts asked if the panelists had any suggestions for the 988 Native and Strong Lifeline.
    - Councilwoman Revey-Jacobs emphasized the importance of coordinating care.
    - Kelly echoed the importance of continuing to coordinate.
    - Emily added communicating services to callers. Callers can also be referred directly to Port Gamble to provide or identify services. Having coordinated many times with 988, Emily is grateful for the relationship. It takes time to see the community trust the line; it will continue to take time. However, she has started to hear success stories, which is exciting.
- Vicki Lowe noted Councilwoman Revey-Jacobs mentioned difficulty in filling positions. She asked if there is anything the state can do to support addressing Tribal workforce needs.
    - Councilwoman Revey-Jacobs noted that Lummi Nation will need to ensure their salaries are adequate and ensure staff are happy to come to work.
    - Kelly noted overall, hiring providers is a challenge nationwide. This is a universal struggle.
    - Emily echoed the idea that workforce is a struggle everywhere. Port Gamble is interacting with county and state systems; any way they can support retention is important. Staff turnover causes issues and prevents progress in the system. If there is turnover, that transition could be smoother to ensure progress isn't completely lost.
    - Vicki noted that AIHC has created a behavioral health attestation process for Tribal behavioral health agencies. In the last legislative session, the Commission passed the bill to have an attestation process Tribally operated. Working on trying to get through backlogs and issues with behavioral health providers; this isn't specific to Tribes. There are a lot of people wanting to become providers, but the process has been difficult. The legislature has worked on this too. There are federal rules about IHCPs that DOH and HCA follow— leadership may follow but education throughout the system is needed and important.

CRIS Committee Member Discussion:

- Dillon Nishimoto, ACRS, emphasized the need to cultivate the habit of communication, not just when it's a crisis, but also normalize reaching out/coordinating even for routine things.
- Bipasha Mukherjee, CRIS and Steering Committee member representing Lived Experience, echoed Dillon's comment and expressed her frustration regarding the issues around coordination and communication. She added hospital ERs consistently seem to be a place where many groups are not getting the right care in a crisis. She hopes there are broader bills that change that.

- Bipasha added that another example of Practice Based Medicine (PBM) vs Evidence Based practice (EBP) is Acupuncture which for a long time was not considered EBP and covered as a treatment. Now it is but a lot of things known to help are not researched in part due to lack of financial gain, so they never make it into EBP. From India – Neem is known to be highly medicinal and but very little money is put into research because it can't be patented to make money as it's a tree that's been grown for 1000s of years and used as medicine. This is deeply frustrating for people coming from other systems that have used practices for way longer than the term EBP existed. EBP is wonderful and needed but what do we do if there is not enough funding to bring them into the world of EBP because there isn't financial gain to be made.
- Lucy Mendoza, OTA, noted that OTA HCA is hiring for its 1877 position.
- Claudia D'Allegri, SeaMar, noted her facilities receive Tribal members seeking care. In some cases, Tribal members prefer services away from their community to avoid judgement. How do you recommend we provide those services while being culturally appropriate?
    - Kelly noted she experiences similar challenges. Tulalip recommends connecting individuals to services in different areas, so they are still within a Tribal community but it's not their community. Additionally, offering virtual appointments, other services where they don't have to go somewhere where people will see them, can be helpful. In a close-knit community, people talk. Tulalip tries to be conscientious of that.
    - Vicki added there is a Native Resources Hub that anyone can call and connect to the Indian healthcare delivery system with more appropriate services.
    - Councilwoman Revey-Jacobs highlighted Lummi Nation's new Tribal health center, noting it has a discreet entrance. At their care offices, the substance use disorder services are tucked away in their own section so people can discreetly use the services.
- Jane Byer, OIC, noted the care model at Port Gamble is probably the care model that everyone should have access to; the ability to effectively work with people before they get into a crisis is impressive. Jane plans to connect with DOH and talk to the hospital licensing folks about not letting the DCR into ER to do an evaluation as that should not be happening.
- Michele, DOH, touched on helping to connect people to services, especially coming out of treatment. What are ways to explore identifying if someone is a Tribal member?
    - Vicki shared that a question would be "Do you receive services from an Indian Health Care Provider?" which is noninvasive. Would need to support the people asking the questions to be comfortable with asking about race and ethnicity.
    - Kelly liked that idea, noting you typically ask someone about their primary care provider, so it's not more invasive. Just getting information that is needed without making people feel they are being discriminated against.
    - Jamie asked if an individual said yes, what would be the next step to connect them to their particular Tribe of citizenship? We have heard it's important for the Tribe to be able to keep track of and serve individuals.
        - Vicki noted the hospitals know how to bill Tribes for people, meaning they should know that the individuals are Tribal. Language in HB1877 says if they have reason to believe someone is a Tribal member or is connected to an IHCP, they should be connecting with that IHCP. Other tips could be if the individual has an address on a Tribal reservation, certain last names, etc.

- Dillon noted an advantage of having co-located services in a community center, health center, behavioral health center, it helps normalize coming together without the fear of getting asked, "What are you doing here?"
- Kristen Wells reflected on the personal story from the last CRIS meeting. Leah shared her story about her son; after he was in a detox facility, he got sent to an unlicensed facility where his hair was cut. Thinking about how that trauma could have been avoided if the detox center had identified this is a Native person and connected him to support from Tribes in the area. This came up when panelists emphasized the importance of communication and coordination with the Tribes, and how that is missed.
- Beyond cultural competency, Emily highlighted the importance of cultural humility. This is what will change our system. Cultural humility involves knowing that you don't have the answer necessarily, and that you should ask, listen, and be present, as well as create empathy and understanding with the community you are working with.

Jamie thanked Vicki for moderating and the panelists for their preparation and discussion. Vicki expressed appreciation for the CRIS Committee and State government, particularly in honoring how to appropriately work with the Tribes in Washington State and the Urban Indian health programs. She highlighted the work of the Tribal Centric Behavioral Health Advisory Board, which hosts the 988 Tribal Subcommittee, has been incorporated into CRIS reports and broader crisis response improvement efforts.

DISCUSSION: Legislative Session and State Agency Updates

Teesha Kirschbaum, HCA and Bob Beymer, HCA, provided an update on the 988 Technology Platform timeline. Teesha overviewed the purpose of the technology platform, including connecting all background systems to improve coordination statewide. Bob outlined the updated timeline for implementing the platform, which is expected to roll out in its initial phase in approximately April 2027. The updated timeline includes changes from the legislative session, specifically additional requirements and an extension on the timeline associated with SB 6308. Between now and December of 2024, HCA will be completing a holistic feasibility study by leveraging previous research and potential solutions, including software and services provided by Vibrant. The feasibility study will also look at other emergency networks, infrastructure, and technology that may be applicable, as well as an assessment of current approaches used by other states with their 988 systems. Efforts in the first half of 2025 will include conducting a request for proposal (RFP), including developing and communicating requirements to the vendor base for the system. The vendor base will then take from June – December 2025 to develop proposals. HCA is seeking to select an apparently successful bidder (ASB) in December 2025 to spearhead the development and implementation of the technology platform. January – April 2026 will involve contract negotiation and onboarding with the vendor, after which the technology platform will begin to be built. HCA anticipates a phased rollout for the initial solution in April 2027. (See meeting slides for a visual overview of the technology platform timeline.)

Michele Roberts, DOH, celebrated the two-year anniversary of the 988 3-digit dialing code going live and the accomplishments of the past two years. She highlighted the significant increase in call volume and the success of the crisis system in Washington State.

- In July 2022, the first month that we have a full data set after 988 launched, Washington received 5998 calls, 357 chats, and 339 texts.
- In June of 2024, Washington state received 9113 calls, 1205 chats, and 3467 texts.

- The Native and Strong Lifeline has also seen significant increases in volumes. In December 2022, the month after it launched, Washington state received 232 calls. In May of this year, Washington state received 535 calls.

Michele added the volumes are expected to increase as more people become aware of 988 through increased communications and marketing.

Presentation and Group Discussion: 988 and 911 Cross-System Collaboration

Elaina Perry, DOH, provided an overview of DOH 988-911 cross-system initiatives, including the Mental Health Crisis Call Diversion Initiative (MHCCDI) and Transformation Transfer Initiative. The MHCCDI, funded by HB 1134, involves partnerships between each of Washington's three 988 Lifeline crisis centers and 911 Public Safety Answering Points (PSAPs) in their region to embed specially trained 988 crisis counselors in the PSAP. This pilot will run between January and December 2024 and will help to gather data, lessons learned, and best practices for transferring behavioral health crisis calls from 911 to 988. WA DOH will release a formal evaluation of the pilot phase in June 2025.

Building on the MHCCDI, WA DOH is working with Health Management Associates (HMA) to support the 911-988 Warm Transfer Protocols project. This work will develop clear and regionally adaptable warm transfer protocols that provide workflows between 911 and 988, as well as a train-the-trainer program to support implementation of these protocols. This work will include an environmental scan for protocols and resources in Washington and nationally, community listening sessions (Summer 2024), cross-system partner workshops (Fall 2024), and development of a training to implement protocols that can be regionally adapted statewide (Spring 2025).

Elaina reviewed the MHCCDI mid-point data, including trends in numbers of calls transferred, call-taker survey data (baseline and mid-point), and successes and challenges identified to date. Key successes include reduced strain on 911, perceived increase of frequent 911 callers now opting to call 988, and increased confidence of 911 and 988 call-takers for supporting 911 callers with behavioral health crises. The project is also learning from and working to address challenges that have arisen, including stigma felt by 911 callers being referred to 988, difficulty engaging individuals experiencing hallucinations or delusions, issues with resource limitations (not available 24/7) and technology. Efforts to address these challenges include increasing training for staff around motivational interviewing and supporting people with higher levels of acuity crises, increasing funding, continued work on the statewide technology platform, and developing in 988 remote and embedded staffing models with PSAPs. For further detail, please see DOH MHCCDI mid-point data meeting slides.

911 and 988 Diversion Initiative Panelists

Elaina facilitated a discussion with each of the 988 call centers and 911 representatives to share their experiences with the MHCCDI. Panelists included: Sara Schumacher (Director RCL/988 at Frontier Behavioral Health), Diane Mayes (Clinical Director of 988 Crisis Services at Crisis Connections), Levi Van Dyke (Chief Behavioral Health Officer, Volunteers of America Western Washington), Adam Wasserman (State 911 Coordinator at Washington State Emergency Management Division), and Katy Gilbert (State 911 Coordinator at Washington State Emergency Management Division).

Panel Discussion

- *Considering the midpoint data and your own experiences, what is your biggest takeaway?*

- Diane shared Crisis Connection's experiences and improvements, emphasizing the importance of collaboration and addressing limitations. Recognizing 988 is a newer program, coming into their existing facility has been a learning experience, and there are going to be nuances along the way to address. They continue to meet monthly and talk regularly with the leadership team, as well as ongoing meetings to discuss challenges for process improvement including training and collaboration across teams. Limitations surround the technology and disposition codes and what qualifies as a mental health call. Crisis Connections is currently addressing many of these concerns and establishing best practices from learnings across the state and national platforms. She emphasized the enthusiasm from the call takers, noting they understand the value of the work, which enhances the relationship. She added their program has 211 specialists embedded in the program as well, which allows for a holistic no wrong door approach.
- Sara echoed Diane's thoughts, noting the data wasn't surprising on their end and aligns with their experience, particularly comments around training and helping callers transferred from 911 to 988. She shared FBH quickly learned callers feel calling 911 is appropriate to receive urgent help. FBH found success working with PSAPs to forecast needs. In trying to understand limitations and strengths of services, FBH became more aware of opportunities to support. Trust was established with PSAPs through in-person meetings and interactions. Sara also noted that FBH's pilot isn't operating 24/7, and there are opportunities for expansion.
- Levi pointed out the need for better training and support for staff and highlighted the importance of data consistency. Staff consistency and workforce have been challenging for Volunteers of America's (VOA) pilot, specifically having a specialized, co-located staff with a different level of training and knowledge than the broader group of crisis counselors. He added VOA has learned a lot and continues to focus on work between systems on common language around system, intervention, and data pieces.
- Adam emphasized the embedding of 211 from the Valley Communications Center in Crisis Connections is key. 211 is a critical aspect used by 911 to get people to resources and should be more a part of these efforts. Adam emphasizes the importance of interoperability between 911 and 988 systems, as some callers would be better served by transferring to 988. For a lot of PSAPs, need to be able to transfer those calls. As noted, trust is key. He highlights the challenge of telecommunicators trusting 988 counselors and letting go of calls. Need to get telecommunicators to meet with crisis counselors to build that trust.

CRIS Committee Member Discussion:

- Dillon asked about the development of warm handoff protocol from 988 to 911, and what joint training exercises will look like to avoid professional conflict.
  - Elaina noted the national average is 2% of all calls to 988 need transfer to 911 for imminent risk of life.
  - Adam noted challenges for 988 counselors in being able to locate the caller through their discussion with them, especially if they need emergency services. The 988 counselors and suicide hotline call counselors are excellent and well trained. However, there are times when they are unable to gather caller location in situations that require an emergency response. This is where the protocols from 988 to 911 come in. Even though it's only 2% of calls, these are the imminent life and death, making it a challenge.
  - Diane noted their diversion data is looking consistent with their general call team – 98% of their calls are deescalated and navigated on the phone with 988 team and even in house with

the diversion team. Some get transitioned back to 911, but the process is to stay on the phone with the caller until someone arrives.
    - Sara noted FBH call centers follow similar practices to the other 988 centers. The need for active rescue or imminent response is incredibly low, particularly with the diversion program. There aren't often calls transferred to FBH that then escalate to the point of needing emergency response and transfer back to 911.
    - Levi confirmed VOA's data is consistent, around 2-3%. There is slight variation between modalities.
- Puck Franta, CRIS Committee member, noted they understand from the cross-systems meeting that the embedded calls are not actually going to 988. Someone previously explained that was so the hand-off was sure to have access to local resources. That seems like part of what we were hoping 988 could do, and it makes the pilot less about what I thought it was going to be.
- Elaina noted the current tech platform that is run by Vibrant, the national administrator, has no way to develop a backdoor number or a way for 911 staff to call their local 988 center and skip the recording upfront that allows you to pick from those top four options. HCA felt that would be inappropriate for a 911 response to have them sit through a recording, and then be put on hold, be put into the statewide queue, and then be picked up either by the 988 provider in their jurisdiction that they're hoping to reach or outside of it. So those concerns made us lean towards having basically backdoor lines or conference lines that would allow 911 to directly reach these 988 centers that they're intending to. We actually are exploring a technological solution to that. Vibrant is exploring a way to create those internally. But that doesn't mean they're not going to 988; these are 988 staff. They're operated by our 988 centers, and they're funded through our 988-line fund. This is being sorted through 988, but yes, the numbers and the routing are what's missing. It's not going to appear on our broad State metrics, but we're really hoping to fix that hopefully with the help of Vibrant.
- Dillon asked about the training to help identify where someone's located. Are there any current trainings that other providers could also take? It is a challenge to identify if someone doesn't just voluntarily tell you where they're at.
    - Adam noted he was referring to the training 988 crisis counselors go through. He has observed the crisis counselors are good at leveraging directed questioning to try to get a location from callers when they're in need of help, or they don't know where they are. If they're hallucinating and they've driven off, they may not know where they are. And unfortunately, the way the system is set up now, there's no location on that. Adam will go back and talk to some of our telecommunicator training staff and see if they have resources. There's also directed questioning training on some issues like this. He encouraged combined training between the two systems.
    - Diane noted Crisis Connection's clinicians are very well versed in coaching call staff to get that information. For example, while supervising and providing support to the clinical team during an out of state call in Colorado, the caller was not very responsive on the phone, and was slurring and was having a difficult time. The team had the caller find a piece of mail in their home and read the address, and responders were able to show up at that door and find that person. She emphasized asking about physical queues that can help to location, and then taking every ounce of information until we ideally get better identification resources available to us.
- Bipasha shared her experience answering calls at a regional crisis line. Hearing how these 988 centers are working together to align embodies the no wrong door policy for the community. Regardless of

who answers, you will get very consistent and high-quality care which is huge for the lived experience community. Hopeful 911 and 988 will both become just a doorway to enter the system and get the help. She congratulated DOH, Crisis Connections, VOA, and FBH.
    - Adam noted beyond 988, 911, and 211, he added regional crisis lines are also important.
    - Sara thanked Bipasha and the Lived Experience Subcommittee for providing input and feedback that can be leveraged by the crisis centers.

ACTION ITEMS AND NEXT STEPS

Next steps and action items for the meeting:

- DOH to share 988 call volume data with the CRIS Committee.
- CRIS Committee members to attend smaller meetings in August to discuss lived experience stories.
- DOH to conduct community and tribal listening sessions on 911 and 988 warm transfer protocols (see schedule shared in meeting slides.)

PUBLIC COMMENT PERIOD

Jamie reviewed the public comment process and opened the public comment period; no one signed up. 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

Panelist Bios: Tribal Behavioral Health Crisis Response

CRIS Meeting – July 16, 2024

Panelists:

Moderator: Vicki Lowe, American Indian Health Commission for Washington State (AIHC)

Vicki Lowe, Executive Director of the American Indian Health Commission for Washington State (AIHC) since July 2015, is a Jamestown S'Klallam descendant. She has also worked in the Health Department of the Jamestown S'Klallam Tribe since December of 1996. Through their Purchased and Referred Care (PRC) Program, the Jamestown S'Klallam Tribe purchased insurance for their Tribal Members without access to any other coverage since 1995. Ms. Lowe has seen this program through many changes in the private insurance world as well as Medicare and Medicaid. She participated on the Basic Health Sponsorship Workgroup, negotiated a Tribal Member only plan with a commercial carrier, initiated contracting with commercial carriers at the Jamestown Family Health Clinic, participated in the creation and implementation of the Jamestown S'Klallam Tribe Employee Plan, a self-funded plan, worked with Jamestown S'Klallam Tribe's newly created Human Resources Department to review and update benefits for the employee's plans - benefits including Life, AD&D and LTD, Long Term Care Coverage, Self-Funded Worker's Compensation and Wellness benefits. She also worked on implementation of the Indian provisions of the Affordable Care Act into the Employee Benefits and PRC programs.

Beginning in 2012 she began working with the AIHC and WAHBE to implement the Tribal Assister program for the Washington Health Benefits Exchange. This project has been expanded to include Medicare, Medicaid and I.H.S. benefits training.

Ms. Lowe is also very involved in the Jamestown S'Klallam Tribal Community. She has been part of the Jamestown Canoe Family since 2009, pulling in the Tribe's canoe since 2012. She supports singing and drumming, language, weaving classes and other culture programs. In 2012, she was honored as the Jamestown S'Klallam Tribe's Volunteer of the Year. Most of all she enjoys spending time with her family, husband Jim, five children and four grandchildren.

Councilwoman Rosalee Revey-Jacobs, Lummi Tribe

Rosalee Revey-Jacobs is a Council Member for Lummi Nation. She is a lifelong resident of Whatcom County and shares 4 grown children and 3 grandchildren with her husband of 30 years. Her passion is advocating for children in the ICW system, MMIW(P) as well supporting positive change in mental health/behavioral health for her people. Rosa is committed to supporting the Lummi community overcome the significant harms and loss due to the fentanyl crisis that is ravaging the Nation and do all she can so as to help bring the community to a better place. Part of her work in this regard has included oversight of the Lummi Foundational Public Health Services initiative and the Lummi Drugs Task Force, developing policies and projects to support health, safety and prevention in the homeland. In addition, as one of the Lummi government Health Representatives, she advocates at the federal and State legislature levels in support of policies and legislation that strengthens Lummi families, promotes health equity, community health, healing and social justice. Her personal interests are crafting, floral designing, and spending time with her loved ones.

Emily Arneson, Port Gamble S'Klallam Tribe

Emily Arnesen currently works for the Port Gamble S'Klallam Tribe as the Suicide Prevention Coordinator within the Community Health Center which provides integrated care through medical, behavioral health, and dental services. She has a bachelor's degree in human services from the University of Minnesota and a

background in working with youth. Additionally, she uses her own lived experience as a certified peer counselor to inform her work. Her role consists of community engagement, external partnership collaboration, and behavioral health crisis coordination planning.

Kelly Waibel, Tulalip Tribe Behavioral Health

Kelly Waibel is a Licensed Mental Health Counselor with a MS in Clinical Psychology, dual specialization in Clinical Counseling and Forensic Psychology from Capella University. She has worked in crisis services for almost four years now, including being imbedded with law enforcement, mobile crisis services and her current role.

Kelly is currently working as the Crisis Department Manager/Designated Crisis Responder (DCR) for Tulalip Tribes. She is working on building a full crisis team, starting with two teams consisting of a Certified Peer Counselor and a Therapist. She works with any person on the reservation, or any Tulalip Tribal Members within Snohomish County, and coordinates closely with other departments including Police, Tribal Court, Behavioral health, Community Health, Tulalip Health Clinic and many more.