North Sound Behavioral Health Advisory Board

Agenda

February 7, 2023
1:00 p.m. – 3:00 p.m.

Call to Order and Introductions

Revisions to the Agenda

Approval of January Minutes

Announcements

- Jere LaFollette – Skagit County Appointment Recognition
- Candy Trautman – Island County Reappointment
- Chris Garden – Island County Reappointment
- Deanna Randall Secrest – Reappointment
- Jana Robinson – Snohomish County Membership Vote
- Jeannette Anderson – Skagit County Membership Vote

Brief Comments or Questions from the Public

North Sound Youth and Family Coalition Needs Assessment – Kaleb Lewis and Cam Callahan

- Link to the Assessment
  Strengths and Needs Assessment Data Presentation (nsbhaso.org)

Peer Workforce Survey – Margaret Rojas and Mandy Iverson

Diversity, Racial Equity, Inclusion – DREI Workgroup

User Experience Workplan Update – Pat Morris

Executive Committee Report

Executive Director's Report

- Link to the Crisis Dashboard Attachment
  Dashboard_20230201.pdf (nsbhaso.org)

Executive Director's Action Items

Old Business

- Legislative Discussion

New Business

- Annual Advisory Board Policies Review
  Policies for Review.pdf (nsbhaso.org)

- Advisory Board Update – County Coordinators Meeting

Report from Advisory Board Members

Reminder of Next Meeting

Adjourn

North Sound Behavioral Health Advisory Board

January 3, 2023

1:00 – 3:00

Meeting Minutes

Empowering individuals and families to improve their health and well-being

Members Present

- Island County: Candy Trautman, Rose Dennis
- San Juan:
- Skagit County: Jere LaFollete
- Snohomish County: Pat O'Maley-Lanphear, Michele Meaker, Jack Eckrem
- Whatcom County: Kara Allen, Mark McDonald, Arlene Feld, Alan Friedlob, Hannah Ordos

Members Excused:

- Island County: Chris Garden
- San Juan County:
- Skagit County: Deanna Randall-Seacrest
- Snohomish County:
- Whatcom County:

Members Absent:

- Island County:
- San Juan County:
- Skagit County:
- Snohomish County:
- Whatcom County:

North Sound BH-ASO Staff: Joe Valentine, Executive Director; Maria Arreola, Advisory Board Coordinator, Margaret Rojas; Assistant Director, Michael McAuley; Clinical Director, Kimberly Nakatani; Accountant

Managed Care Organization Representation:

- United Healthcare: Stacy Lopez
- Coordinated Care:
- Molina Healthcare: Ashley Nelson
- Community Health Plan of Washington [CHPW]:

Guests: Michael O'Brien, Snohomish County Human Services Specialist II; Joy Borkholder, The Daily Herald; Jeannette Anderson, Community Member; Mena Pebbles, Community Member; Lisa Day, Office of Behavioral Health Advocacy; Ryan Stattenfield, Director of Percival Health; Alyssa Kenney, Percival Health

Pre-Meeting Training

Non Pre-Meeting Month

Call to order and Introductions

The meeting was called to order by Chair O'Maley-Lanphear at 1:02 p.m.

Revisions to the Agenda

No revisions mentioned

Approval of November Minutes

Motion made for the approval December minutes as written. Jacked moved the motion. Kara seconded. All in favor, Motion carried.

Announcements

- Margaret introduced the newly hired staff, Kimberly Nakatani. Kimberly is an Accountant in the Fiscal Department.
- Hannah Ordos has full support from Whatcom County to proceed with her membership with the Board. Chair O'Maley-Lanphear moved a motion to accept Hannah Ordos membership to the Board. Mark seconded the motion. All in favor. Motion carried. Maria will be coordinating an official Advisory Board orientation.

Brief Comments from the Public

None

Behavioral Health Needs Assessment – Percival

- Ryan and Alyssa from Percival Health provided an in-depth presentation of the Behavioral Health Needs Assessment. Members were encouraged to provide feedback.
- The full Behavioral Health Needs Assessment can be found here PowerPoint Presentation (nsbhaso.org)
- Joe highlighted an invitation for members to attend a discussion with the County Coordinators regarding the needs assessment. Maria will be coordinating attendance with those interested in participating.

Executive Directors Report

Joe reported on the following.

- Governor Inslee's 2023-2025 Recommended Budget – Behavioral Health
- Workforce Training and Education Board: Behavioral Health Workforce 2022 Report

- Update on Homeless Outreach Stabilization Team [HOST]
- Crisis Services Update
- New North Sound BH-ASO Staff Person: Assisted Outpatient Treatment Coordinator
- End of State COVID Emergency Order

Executive Director's Action Items

Joe introduced the Action Items.

Motion to move Pathfinder Snohomish County forward to the Board of Directors for approval. Motion seconded. All in favor. Motion Carried.

Motion to move Pathfinder Skagit and Whatcom forward to the Board of Directors for approval. Motion seconded. All in favor. Motion Carried.

Executive/Finance Committee Report

The December Expenditures were reviewed and discussed. Motion to move the Expenditures to the Board of Directors for approval. Motion seconded. All in favor. Motion Carried.

Old Business

History of Advisory Board Site Visits – Margaret Rojas

Margaret provided context of the site visits. Site visits were created to educate members firsthand of the community resources available. Members can have one on one discussion with front line staff providing services to individuals.

Due to COVID in person restrictions at facilities, site visits have been put on hold. Chair O'Maley-Lanphear requested to continue the relevance of site visits while on COVID restrictions to the April meeting.

Legislative Discussion

A survey will be sent to members to provide highlights on each of the legislative priorities. The legislative Ad Hoc Committee will meet to review the survey results and begin drafting the legislative supporting document. The committee will report back during the February meeting.

New Business

None

Report from Advisory Board Members

None

Reminder of Next Meeting

Tuesday, February 7, 2023

This will be a hybrid meeting. Those who are interested in attending in person, please notify Maria.

Adjourn

Chair O'Maley-Lanphear adjourned the meeting at 2:54 p.m.

Certified Peer Counselor Support Survey (CPC Version)

The North Sound Behavioral Health Administrative Services Organization (North Sound BH-ASO) would like to learn what kinds of support is currently needed by Certified Peer Counselors (CPCs) in our area. We are hoping to gain insights directly from those providing CPC services, like yourself. This survey is intended for Certified Peer Counselors CPCs currently living in or providing services in the North Sound area of Washington State. This includes Whatcom County, Skagit County, Snohomish County, San Juan County, and Island County. A separate survey will be sent to providers.

All questions are optional, and you may complete the survey anonymously if you prefer, however, if you provide your email we will send you a $10.00 Starbucks gift card.

1. **Please provide your contact information, you may skip this question if you prefer to complete the survey anonymously.**
    - *Name*
    - *Address*
    - *City/Town*
    - *State/Province*
    - *ZIP/Postal Code*
    - *Email Address*

2. **Are you currently working as a CPC?**
    - *Yes*
    - *No*

3. **How long have you been working as a CPC?**
    - *Less than a year*
    - *1 year*
    - *2 years*
    - *3+ years*

4. **In what North Sound county(s) do you provide CPC services?**
    - *Island County*
    - *San Juan County*
    - *Skagit County*
    - *Snohomish County*
    - *Whatcom County*
    - *None of the above*

5. **What type of CPC services do you provide?**
    - *Crisis*
    - *Outpatient*
    - *Triage*

- *WISe*
- *Other (please specify)*

6. **If you are currently employed as a CPC, do you experience challenges in your supervision?**
    - *Yes*
    - *No*

7. **What suggestions do you have for making improvements to the supervision process?**

8. **Do you find that a lack of understanding of your role (from leadership and/or other staff) causes a sense of exclusion for you at your workplace?**
    - *Yes*
    - *No*

9. **If yes, do you have any suggestions on how to alleviate it?**

10. **Do you feel you have a clear job description?**

11. **Are you experiencing 'burnout' to a degree that you consider quitting your job?**
    - *Yes*
    - *No*

12. **How does your lived experience enhance your work as a CPC?**

13. **How does your lived experience challenge your work as a CPC?**

14. **Are you experiencing other challenges in your CPC work?**

15. **Would a 'community of peers' group in the North Sound region be helpful to you?**
    - *Yes*
    - *No*

16. **What else would help you in your work? This could be a type of support, training, or anything else you can think of.**

Certified Peer Counselor Support Survey (Provider Version)

The North Sound Behavioral Health Administrative Services Organization (North Sound BH-ASO) would like to learn what kind of support is currently needed by Certified Peer Counselors (CPCs) in our area. We are hoping to gain insights directly from those employing CPCs. This survey is intended for employers currently providing CPC services in the North Sound area of Washington State. This includes Whatcom County, Skagit County, Snohomish County, San Juan County, and Island County. A separate survey will be sent to CPCs.

1. **Please provide your agency contact information.**
    - *Your Name*
    - *Company*
    - *Address*
    - *City/Town*
    - *State/Province*
    - *ZIP/Postal Code*
    - *Email Address*

2. **In what North Sound county(s) do you provide CPC services?**
    - *Island County*
    - *San Juan County*
    - *Skagit County*
    - *Snohomish County*
    - *Whatcom County*
    - *None of the above*

3. **How many CPCs do you employ?**

4. **What type of CPC services do you provide?**
    - *Crisis*
    - *Outpatient*
    - *Triage*
    - *WISe*
    - *Other (please specify)*

5. **What challenges are your Supervisors encountering in their supervision of CPCs?**

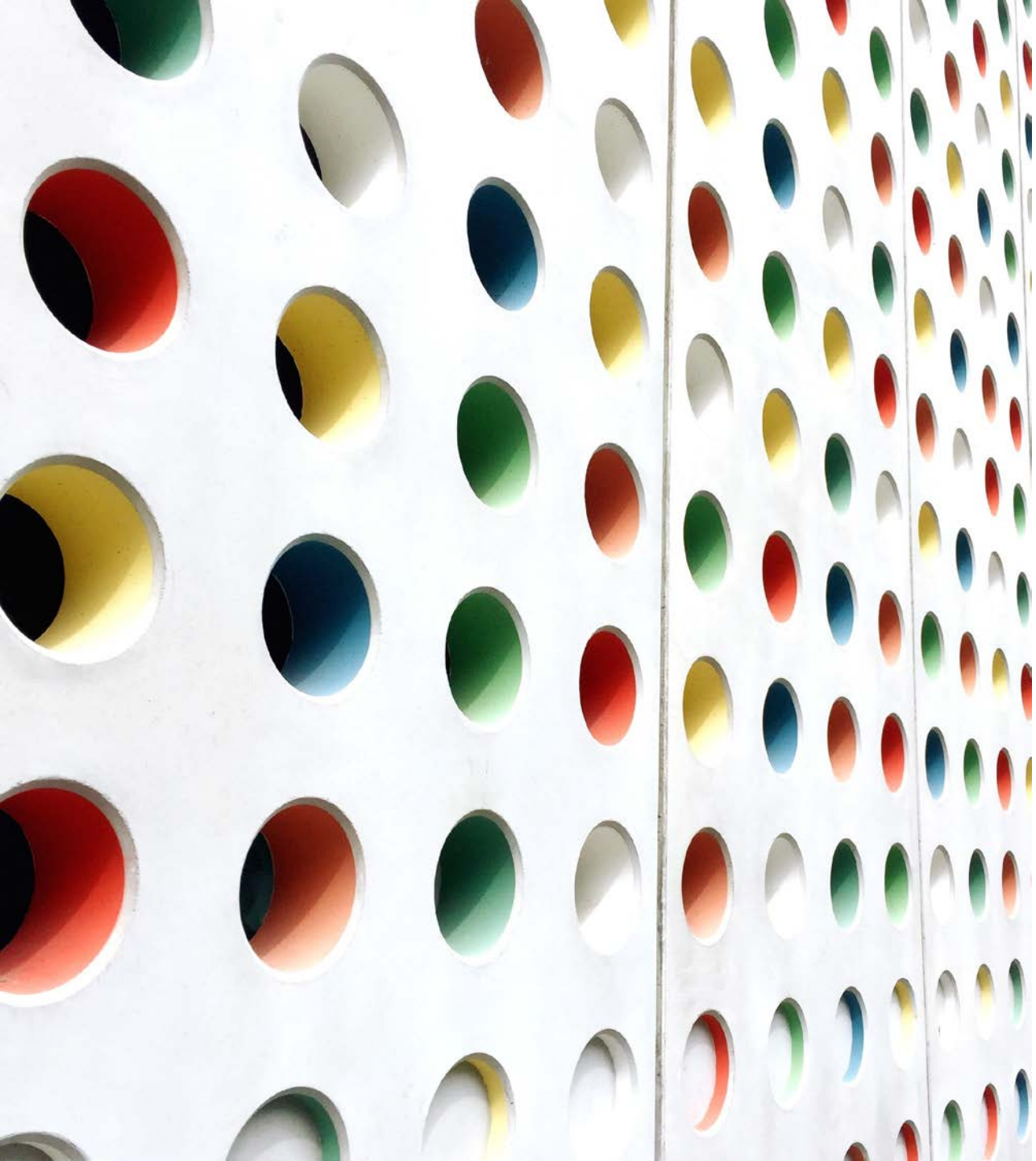
6. **What other challenges are you experiencing in your employment of CPCs?**

7. **What are your CPC training needs?**

8. **What would help you hire additional CPCs?**

9. **What would help you retain your currently employed CPCs?**

10. **What assistance could you use to help your CPCs avoid burnout?**



North Sound
DREI Work Group
Advisory Board
UPDATE

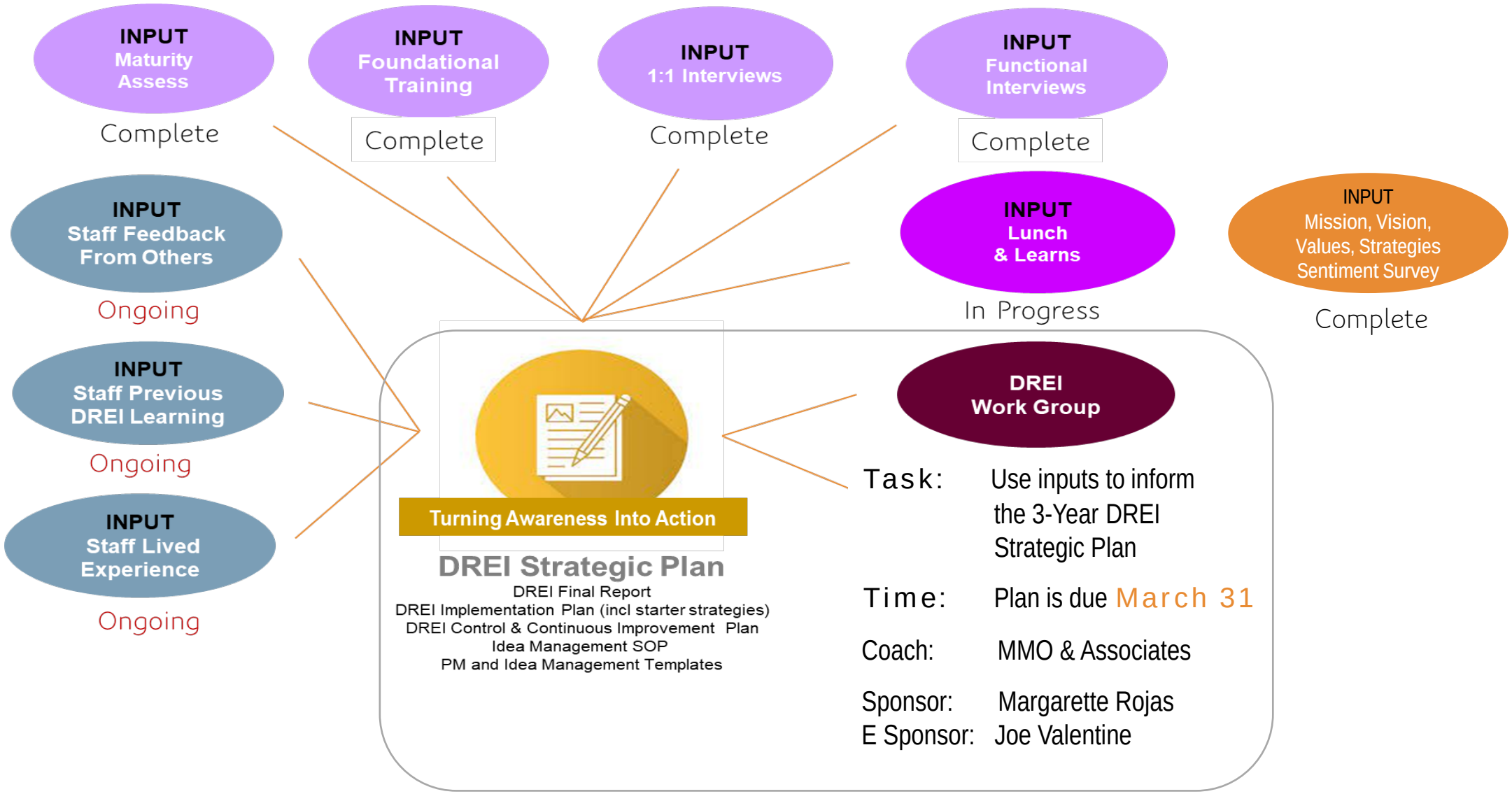
DREI STRATEGIC PLANNING

FEBRUARY 7, 2023

Michelle M. Osborne, J.D. & Associates, LLC

DREI PROJECT REPORT OUT

GOAL: DEVELOP AND SOCIALIZE A 3-YEAR DREI STRATEGIC PLAN FOR NORTH SOUND BY MARCH 31, 2023



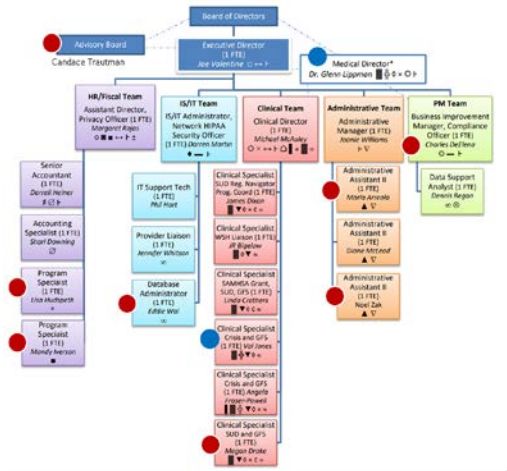
DREI PROJECT REPORT OUT

GOAL: DEVELOP AND SOCIALIZE A 3-YEAR DREI STRATEGIC PLAN FOR NORTH SOUND BY MARCH 31, 2023

8 WORK GROUP MEMBERS

Responsible to:

- Use inputs to generate ideas
- Engage staff
- Evaluate ideas
- Draft DREI Plan
- Gain approval and socialize



IDEAS > GOALS > ACTION

Using project management tools to ensure project is on time and task

- Established DREI Project Charter
- Created DREI *SWOT* at NS
- Assessed DREI *Project Risks*
- Identified DREI *Project Assumptions*
- Gained project Sponsor approval

Inspired by the "inputs" and guided by the Project Charter

- Generated 99 ideas
- Evaluated each idea on 3 criteria
  - High impact
  - Mission Critical
  - Likely to Succeed
- Gained feedback from sponsors and staff

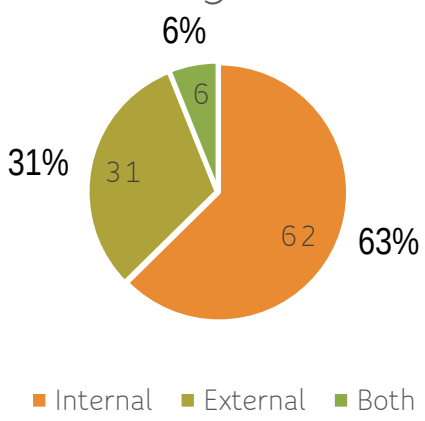
"INSIDE-OUT RULE"

Internal IDEAS 63%

Workforce and staff
Leadership and management
Operations (policies, process,...)

External IDEAS 31%

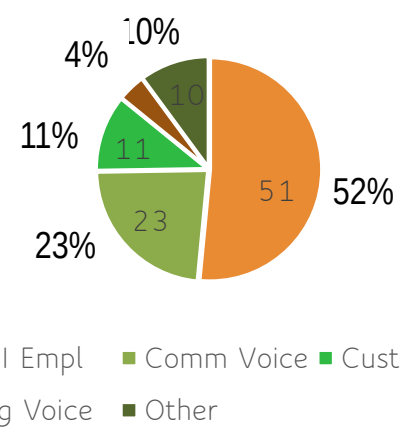
Client outcomes and experience
Community outcomes and experience
Partner effectiveness and experience



OPPORTUNITY AREAS

IDEA Buckets

52% DEI in Employee Lifecycle
23% Community Voices
11% Improve Customer Experience (CX)*
4% Integrate Values
10% Other
0% Service Insights
0% ASO Innovation



DREI PROJECT REPORT OUT

GOAL: DEVELOP AND SOCIALIZE A 3-YEAR DREI STRATEGIC PLAN FOR NORTH SOUND BY MARCH 31, 2023

JOURNEY TO CREATE THE DREI PLAN

- Maturity Assessment
  1:1 Interviews
  Functional Interviews
  Foundational Training
  Lunch &Learns
- WG Team Kick Off
- WG Team Level Setting
- WG Team PM Foundation

Generate & Gather Ideas

Eliminate Redundancies

Refine

Categorize

Establish Evaluation Criteria

Evaluate Ideas

Evaluation Matrix

Alignment with Vision, Mission, Strategies

Elevate Ideas > Goals

Rec to Sponsor
Rec to Leadership

Create Searchable Backlog

Create 3-Year DREI Strategic Plan

Written Plan
Implementation Plan
Control Plan
Continuous Improvement Plan

Socialize

Leadership
Staff
Board
A. Board

Transition Idea Management


Q
A

NORTH SOUND DREI JOURNEY
12 MONTH REPORT OUT

MATURITY ASSESSMENT SURVEY

Suggests that there is an opportunity to . .

- Increase shared understanding of DREI
- Increase ways to build in accountability
- Ensure DREI policies are in place
- Examine Worker Lifecycle for opportunities to improve representation and related DREI accountability
- Use effective DREI engagement (inside)
- Use effective DREI outreach (outside - A Board, Youth Advisory Committee, Tribal Health Conferences and more)

1:1 DREI STAFF INTERVIEWS

- Overall pleasure to work at NS
- Believe NS does important work
- Overall, a healthy work environment
- Eager to share personal histories related to racism and privilege (reasons to share vary)
- Desire to identify how to make services better (Efficient? Effective? Reach?)
- NS grappling with racism and how to handle
- Many lack full understanding of racism
- Spectrum of agreement that racism exists
- Some view DREI effort will go away
- Difficult to see how racism shows up at NS
- Concern that won't recognize racism
- Concerned (fear) that they could be chased from the organization because they are less relevant

FUNCTIONAL INTERVIEWS

Joe Valentine
Executive Director

Dr. Glenn Lippman
Medical Director

Michael McAuley
Clinical Director

Joanie Williams
Administrative Manager

Mandy Iverson
Program Specialist

Margaret Rojas
Assistant Director
Privacy Officer

Darren Martin
IS/IT Administrator,
Network HIPAA
Security Officer

Charles DeElena
Business
Improvement Manager
Compliance Officer

- How can antiracism can be incorporated into each team
- How can antiracism be a way of doing business
- How can DREI efforts help siloed / work-from-home teams
- How to handle funding uncertainty and its negative impact on the community and newer staff
- How DREI insights positively impact the transition to the 988 system as part of the crisis response landscape
- How to improve structural data collection to gain better insight into the "who" related to community work
- How DREI insights can help handle staff burn out

Quality Measurement in ***CRISIS SERVICES***

I. Introduction

Mental health crisis systems are becoming increasingly sophisticated and multimodal as localities invest in addressing issues such as emergency department boarding, unnecessary law enforcement involvement in responses to non-criminal health care crises, and inadequate and inequitable access to mental health care services. Crisis systems often share the goals of providing rapid access to care for individuals experiencing mental health challenges to alleviate distress as quickly, safely and effectively as possible. As these systems evolve, it is necessary to use performance metrics that can advance these goals in a consistent, measurable way.

All systems are essentially an aggregation of linked processes working in concert to achieve and consistently replicate specific, intended outcomes. However, they are prone to error (human and otherwise), and few are as complex as the web of services that make up a mental health crisis care continuum. Measuring processes and outcomes provides the means to determine how closely these systems are adhering to their intended function and goals and to determine when deviations occur, so they can be corrected.

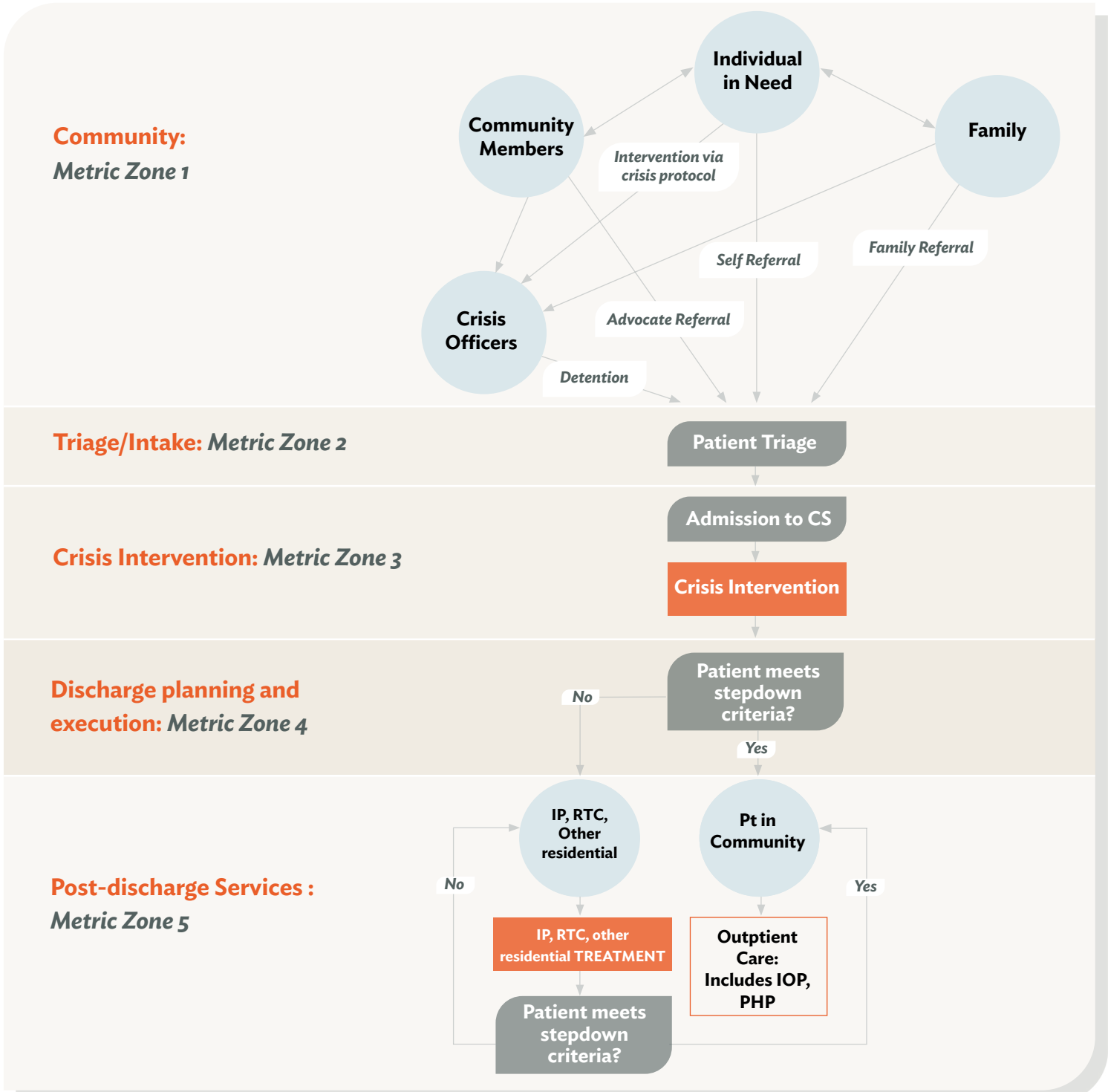
As crisis systems mature across the US, there are increasing demands for measuring their quality, including:

- Reporting mandates tied to funding and accreditation.
- Demonstrating success and value (or the lack thereof).
- Identifying weaknesses to inform continuous quality improvement (CQI) and plan-do-see-act cycles.
- Maintaining a focus on the needs of service recipients based on their own recovery goals.

For optimal performance, crisis systems should employ a "balanced scorecard" approach, i.e., an approach to measuring success that tracks system performance across a combination of different types of metrics. This brief report provides a framework for developing a set of metrics.

II. A Conventional Framework for Crisis Metrics

Health care delivery has been distinctly late in adopting foundational human engineering principles to ensure quality outcomes. An objective view of current crisis service outputs, outcomes, gaps and best practices is a critical starting point for most communities. Whether enhancing crisis services or designing them "from scratch," many funding streams, political pressures and community factors must be considered. In this section, we'll use a workflow engineering orientation to broadly define the organizational and treatment inputs that support optimal patient outcomes.



Five distinct zones along the workflow display critical data groupings:

Community: Is the community aware of crisis services, and can they use the services easily?

Triage/intake: Does the triage function facilitate efficient entry into the appropriate intervention?

Crisis intervention: Is the intervention effective and expertly tailored to the patient's condition and circumstance?

Discharge planning and execution: Did the patient arrive at the post-crisis service venue safe, without delay in service continuity, and able to participate in the services of the new venue?

Post-discharge services *(This metric lays the groundwork for local health system adequacy determinations):*

- Are the available ***service slots adequate*** for the volume of crisis service discharge referrals?
- Is the ***service intensity*** array optimal for patient outcomes post-discharge from crisis services?
- Are ***specialized services*** available to facilitate optimal outcomes for crisis service patients post-discharge?

Metrics are also categorized and sorted:

Structural components and metrics include traditional infrastructure such as buildings/space, software, computers and space configuration. "Structural" also describes key functional areas with role-based accountabilities.

Process engineering and metrics refer to the design of workflows and automatic inputs as well as rapid, expert exception recognition and management.

Outcomes metrics refer to well-chosen, critical-to-success service result measures. Outcomes can be standalone items that are considered critical to the crisis program. The following categories are used to distinguish the types of outcomes commonly measured:

- ***Clinical:*** *Did both objective and subjective signs of the clinical condition(s) improve?*
- ***Satisfaction:*** *Did [stakeholder] find crisis services to be [positive attribute]?*
- ***Efficiency:*** *Were there fewer steps, transitions, later hospitalizations because of the service?*

III. Person-Centered Approach to Crisis Metrics

Crisis system metrics must look at the performance of the entire crisis system, as well as the performance of each individual service process or component. While they may follow the more conventional structure already described, there is a strong argument that measuring the quality of crisis services should be based on the experience of primary and secondary customers: the people served, their families and loved ones, first responders and other service providers with whom the crisis system collaborates.

By framing metrics from the customer's perspective, the crisis system's performance can be aligned with the values described by service recipients, as described in Table 1, which uses the mnemonic ACCESS TO HELP to describe a core set of measurement concepts that can guide metric development.

Table 1. When I (or the person I am involved with) experience a mental health or substance use crisis, I (we) experience ACCESS TO HELP.

	Value	Meaning	Examples
A	***Accessible/ Affordable***	I am welcomed wherever I go. I am not turned away.	• Percentage of help-seekers who receive appropriate care vs. all who have sought care. • Percentage of persons seeking care who are turned away due to lack of coverage vs declined due to not being able to afford care.
C	***Collaborative***	Helpers work in partnership with me, my family, my caregivers, and other responders.	• The programs assess consumer/family satisfaction surveys and/or net promoter scores.
C	***Comprehensive***	I get help for all my issues that are part of the crisis.	• Access to medical screening. • Able to treat co-occurring substance use disorder (SUD), intellectual/developmental disorder (I/DD), etc.
E	***Equitable***	The quality of services I receive are not affected by my race, ethnicity, gender, sexual orientation, etc.	• Stratify outcome metrics (e.g., return to crisis centers, access to care) by race/ethnicity and other key demographics (e.g., ZIP code). What percentage of poor outcomes are disproportionately influenced by performance in underrepresented populations?
S	***Safe***	My experience of help is safe and not harmful. I am never traumatized by asking for help.	• What percentage of individuals presenting in crisis end up injured, hurt or killed while doing so?
S	***Successful***	The care I receive meets my needs.	• Readmission rates. • Symptom reduction.

	Value	Meaning	Examples
T	*Timely*	I get help quickly enough to meet my needs.	• Time to intervention (e.g., call answer times, mobile dispatch times, facility door-to-doctor times). • Abandonment rate (e.g., call abandonment, left without being seen, etc.). • Lag time between seeking care and receiving care.
O	*Ongoing*	I receive help to move from my crisis situation to ongoing support that wrap around me to help me thrive.	• Successful linkage to continuing care at adequate intensity: 3-, 7-, 30-, 60-, 90-day follow up.

	Value	Meaning	Examples
H	*Hopeful*	I am helped to feel more hopeful, and I make better decisions as a result.	• Decrease in suicide, violence, self-harm. • Personal Outcome Measures (POMS).
E	*Engaging*	I am treated as a valuable customer, with respect and dignity.	• Complaints, adverse incidents, escalation.
L	*Least Intrusive*	I receive help in a place that is designed to meet my needs.	• Avoidance of inappropriate emergency department use or arrest diversion, voluntary conversion.
P	*Publicized*	I know who to call and/or where to go.	• Information about call lines and walk in centers, increased use of 988 vs. 911.

IV. How to Select Crisis System Metrics

Given that every system is different and has its own values, and because crisis systems involve multiple systems and stakeholders, it is essential to begin by developing consensus in defining the system's values and desired outcomes. A useful process for building consensus follows:

- Convene a stakeholder group composed of all users (providers, payers, service users and their families, law enforcement, emergency medical services, hospital systems, crisis workers, call center leads, mental health system leads).
- Define and memorialize the system's values, goals and intended results. These will serve as a foundation and framework for the system's definition of quality benchmarks.
- Determine component pieces of the system.
- Determine optimal operational flow through the system. (Logic models can be very effective here.)
- Assess current gaps. (Process maps, such as Ishikawa charts, also called fishbone diagrams, can be very helpful in this regard.)
- Define success and agree on how it is to be measured. Goals and intended results should be specific, measurable, actionable, realistic and time-bound (SMART).

For example, in Philadelphia's crisis system redesign, the stated values for the system include:

Reducing trauma. Relevant metrics include the rate of law enforcement involvement in behavioral health crisis situations and the use of coercive treatment (e.g., involuntary commitment).

Achieving equity. Relevant measures include tracking disparity at all levels in the system.

Increased crisis resolution in the community. Relevant metrics include call center metrics such as call answer rate, percentage of calls resolved by speaking with a counselor, rates of referral to community mental health services such as, mental health outpatient services.

Mobile team-specific metrics. These include timeliness, as measured by the time from dispatch to engagement of the individual on the scene. Other relevant metrics include the number of dispatches that result in a resolution of the crisis as compared to those that result in referral to a higher level of care.

Crisis Center Metrics. These reflect the value of reducing trauma and resolving crises at the least-restrictive level of care. They include facility door-to-care time, average length of stay and rates of referral to higher-level services such as inpatient care.

Increased individual, family, community satisfaction with crisis response: Relevant metrics include the percentage of service users who rate services as being at least satisfactory (i.e., 3 on a 5-point Likert scale).

CASE EXAMPLE: CALL CENTER METRICS

Systems that value crisis resolution in the community might choose to engage individuals in crisis by phone. Evidence suggests that up to 80% of crises can be resolved telephonically. Such systems might choose to track metrics such as call type, frequency, answer rate and approximate measures of acuity such as call duration and outcome. Paired with quality assessment processes such as randomized review of recordings, this set of call-related metrics would permit that system to track the functioning of the system's telephonic resolution of crisis calls.

V. How metrics inform CQI and Plan-Do-Study-Act (PDSA) cycles

Implementing quality improvement begins with stakeholders' consensus on chosen metrics. Next steps include collecting and sharing metrics, selecting members of the quality committee, determining quality improvement methodology, piloting interventions to improve performance and reviewing pilot results.

Methods for obtaining and calculating metrics need to be transparent and communicated to all stakeholders in a timely manner. For metrics involving the wider crisis system, members of the quality committee should represent all involved services, such as first responders, mobile crisis services, crisis centers, inpatient providers, outpatient providers and care transition providers, among others. It should also include key staff, such as psychiatrists and medical directors, content experts and those doing the work at the ground level. Reviews of metrics should occur at a frequency that supports sound patient care and timely piloting of corrective interventions.

Although one type of quality improvement methodology is not superior to any other, sustained focus on the goal of improved care and a multi-dimensional analysis of root causes — before jumping to conclusions or corrective actions – is essential. In addition, the system may need to validate the quality of the metrics, collect new metrics and/or review individual charts to clarify the source of the problem.

A deeper discussion of using crisis services metrics to improve system performance (both for individual crisis programs and the system as a whole) will be addressed in a subsequent publication from this group.

VI. Complexity in Measurement

Crisis services are among the most intersectional areas of health care, with interfaces between emergency and mental health specialty call centers, emergency medical services, mobile crisis teams, police and jails, and many other agencies.

Determining how well we are serving our clients goes beyond defining metrics using existing data — we must consider novel approaches to linking data systems to strengthen informatics opportunities. Measuring the performance of a crisis system requires a robust ability to share, aggregate and manage information across multiple types of providers. Best practices for linkages include matching along key identifiers (name, date of birth, social security number), though these data are rarely collected in full by call centers. Therefore, systems need to implement call-specific IDs that bridge data systems to facilitate retrospective linkages that can traverse call center, mobile unit, health system and criminal justice data systems. Fortunately, recent and pending changes to HIPAA, Office of the National Coordinator for Health Information Technology (ONC)/ Centers for Medicare & Medicaid Services (CMS) interoperability and 42 CFR part 2 and the common expanded permissions when the episode of care is an emergency make sharing information more feasible and efficient.

Such approaches allow for going beyond performance measures like response times and get into more meaningful process measures (e.g., post-crisis routine care utilization, post-crisis acute/crisis care reutilization, post-crisis arrest/jail entry, etc.) as well as actual outcomes (all-cause morbidity/mortality, housing status, patient-reported outcomes).

Interpreting such measures can be a complex task. Reutilization, for example, may be interpreted as a negative outcome since the crisis service was unable to divert from higher intensity care settings, but post-crisis acute service utilization for appropriate reasons (e.g., worsening symptoms, risky behaviors) should be encouraged. There is need to understand at a population level what a "reasonable" benchmark rate is for these key process outcomes. Furthermore, service providers may adopt practices akin to cherry-picking, in which certain groups are excluded from engaging with services; these practices can be accounted for in measurement with strategies such as risk adjustment.

Finally, equity must be an essential aim for crisis services measurement. To understand potential disparities in delivery of crisis care, it is necessary to routinely collect relevant demographic data such as gender identity, sexual orientation, race, ethnicity and language preferences. Reporting of metrics outcomes should be stratified by sub-groups to allow for identification of disparities and, when found, monitoring should ensure that remedies are effective at advancing equity in service delivery.

VII. Conclusion

Measuring the quality of care in crisis systems is no easy task. Fortunately, multiple approaches are available to systems that seek to ensure high-quality, person-centered, equitable delivery of crisis care. Whether using conventional or more person-centered approaches, systems can benefit from overcoming barriers to measurement and ensuring that they are employing CQI practices to improve crisis care for all.

VIII. Contributors from MDI Crisis Services Subcommittee

Matthew Goldman, MD (co-chair)
San Francisco Department of Public Health

Sosunmolu Shoyinka, MD (co-chair)
Department of Behavioral Health and Intellectual Disability Services

Brian Allender, MD
Behavioral Health and Recovery Division of King County

Margie Balfour, MD, PhD
Connections Health Solutions

Jeffrey Eisen, MD, MBA
Behavioral Health Network at MultiCare Health System

Ken Hopper, MD, MBA
Texas Christian University

Ken Minkoff, MD
Zia Partners, Inc.

Joe Parks, MD
National Council for Mental Wellbeing

Angela Pinheiro, MD
Community Mental Health of Central Michigan

Daniel Rosa, MD
Acacia Network

Billina Shaw, MD, MPH, FAPA
Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services

For more information, to request technical assistance, consulting or to contact the Crisis Services Subcommittee, please email communications@thenationalcouncil.org.

North Sound BH-ASO
2021 E. College Way, Suite 101, Mt. Vernon, WA 98273
Phone: (360) 416-7013 Fax: (360) 899-4754
www.nsbhaso.org

Crisis Service Voice Project – User Experience of Crisis Services

Project Overview Jan 2023 - *Draft*

Background

As a follow-up to our 2020 and 2021 Crisis Annual Assessment, North Sound BH-ASO and our Advisory Board identified an opportunity to develop a workplan to assess and incorporate individual and family voice for North Sound BH-ASO strategic plan for crisis services.

Qualitative evidence measuring crisis services from the individual or family's point of view has been limited. In 2022, North Sound BH-ASO initiated action plans to evaluate and develop a 'User Experience" initiative for 2023 that will focus on several preliminary objectives:

- Convene stakeholder and partner groups that represent the diversity of the North Sound region to assess and develop a standardized survey method for community, family, and individuals to evaluate key aspects of the crisis system.
- Define our system's values, goals and intended outcome of a regional/coordinated crisis system.
- Partner with several regional behavioral health advocacy and system partners to establishes a series of community forums ("local town halls") where individuals, family and community voice can be heard and integrated into our strategic planning
- Evaluate strategies and tools for crisis providers to assess and capture user experience following RCL and Mobile Crisis Response interventions.

Purpose

To develop a *Crisis Service Voice* workplan and action recommendations to integrate individual, family, and allied system voice into our North Sound's BH-ASO strategic plan for crisis services.

Measurement Concepts

Understanding or developing metrics from the individual or family's perspective, we can bridge the experience of folks interacting with the crisis system to our desired measurements and outcomes. Examples included in the 2023 **National Council for Mental Wellbeing** report (January 2023) include whether crisis services are:

- Accessible and Collaborative
- Trauma Informed
- Achieve Equity
- Timely and offer follow up supports
- Community response focused
- Hopeful, Safe and least Intrusive

Several Goals and Values were noted in **HCA 2022** Mobile Crissi Response Program Guide in response to HB 1477 (988) to include:

- Reduce dependency on Law enforcement, fire, EMS and ED for BH Crisis
- Expand Multi-disciplinary mobile Crisis Response teams to include Peers, mental health care professionals, etc.
- Dedicated specialized response – child, youth, and family crisis support.
- Expanded capacity for Crisis Prevention Planning and follow-up supports.

National Level/Research

1. This is a best practice toolkit published by SAMHSA **"Guidelines for Behavioral Health Crisis Care."**
2. This is foundational research underscoring the importance of follow up to determine the effectiveness of Call centers for Consumers experiencing an mental health crisis:
    - **Establishing Standards for the Assessment of Suicide Risk Among Callers to the National Suicide Prevention Lifeline - Joiner - 2007 - Suicide and Life-Threatening Behavior - Wiley Online Library**
    - **The National Council – Quality Measurement in Crisis Services**
3. Various client satisfaction surveys reviewed:
    - **csq.pdf (recoveryanswers.org)**
    - **Home (force.com)**
    - **Measure: Client Satisfaction Questionnaire (force.com)**

Proposed Project Timeline:

- December 2022: ASO Advisory board Introduction
- January 2023 ASO Advisory Board Recommendations
- February 2023: Clarify HIPPAA guidelines to receive consent for follow up contacts.
- May 2023: Regional Town Hall meeting to coincide with Mental Health Awareness Month
- May 2023: Regional Training "How to Communicate with People having a Behavioral Health Crisis: Part of Mental Health Awareness Month
- September 2023: Regional Training "How to ask the question about Suicide. Part of Suicide Prevention Month.

Advisory Board Input

Ongoing input from North Sound BH-ASO's Advisory Board to help guide our planning, implementation and participating in regional community forums.

Key Stakeholder Involvement

- Virtual Town meeting to solicit Stakeholder feedback regarding the current regional crisis system. Scheduled during Mental Health Awareness Month.
- Regional Training offered "De-escalation and Communication techniques for People in a Behavioral Health Crisis."
- Regional Training offered for "Asking the Question about Suicide: to coincide with Suicide Prevention Month.

North Sound Behavioral Health Administrative Services Organization
Advisory Board Budget
2023

	Total	All Conferences	Board Development	Advisory Board Expenses	Stakeholder Transportation	Legislative Session	Community Projects
		Project # 1	Project # 2	Project # 3	Project # 4	Project # 5	Project # 6
Budget	**$ 20,000.00**	$ 7,000.00	$ 4,500.00	$ 6,000.00	$ 800.00	$ 1,500.00	$ 200.00
Expense	(152.80)			(152.80)			
Under / (Over) Budget	$ 19,847.20	$ 7,000.00	$ 4,500.00	$ 5,847.20	$ 800.00	$ 1,500.00	$ 200.00
		All expenses to attend Conferences	Advisory Board Retreat/Summit	Costs for Board Members (meals mileage, misc.)	Non- Advisory Board Members, to attend meetings and special events	Shuttle, meals, hotel, travel	

For Board Approval:

Summary:

Vote for Chair and Vice Chair

Nominations received as of 2/3/2023 were for Peter Browning (Chair) and Barry Buchanan (Vice Chair)

Motion #23-11

Approve Peter Browning as Chair and Barry Buchanan as Vice-Chair of the Board of Directors for 2023

North Sound BH ASO Executive Director's Report

February 7, 2023

1. LEGISLATIVE UPDATE

Bills being watched:

Bill	Title	Status
HB 1134	Implementation of the 988 behavioral health crisis response system	House Health Care & Wellness – February 8 Executive Session
SB 5120	23-hour crisis relief centers	Referred to Ways & Means – January 30
SB 5130	Assisted Outpatient Treatment	Passed to Senate Rules Committee on January 20
HTM House Bill 1515	Contracting and procurement requirements for behavioral health services in medical assistance programs [including network adequacy]	House Health Care and Wellness – public hearing - February 3

- **HB 1515** includes detailed requirements to be included in the next procurement for MCOs – including requirements for network adequacy. Jill Johnson is one of the county commissioners who testified in support of the bill.

Legislative Calendar:

- February 17 - Policy committee cutoff - house of origin
- February 24 - Fiscal committee cutoff - house of origin
- March 8 - Floor cutoff - house of origin
- March 29 - Policy committee cutoff - opposite house
- April 4 - Fiscal committee cutoff - opposite house
- April 12 - Floor cutoff - opposite house
- April 23 - Sine Die

2. BEHAVIORAL HEALTH SERVICES COORDINATING COUNCIL

- The Behavioral Health Services Coordinating Council [BHSCC] created two sub-groups to develop recommendations on how to improve network adequacy and access to care.
- One group is working on recommendations on how to "measure" improved access to care, e.g., appointment wait times.
- The other group is looking at how apply state quality improvement efforts to complement efforts to reduce wait time and improve access to care.
- The **BHSCC Network Adequacy Workgroup** is developing a sub-group to identify the data that is available measuring timely access to treatment. They will reach out to providers for input.

- The Network Adequacy Workgroup will also be gathering information on the parts of the state that have the most critical gaps in access to services.
- The **full BHSCC** held its quarterly meeting on January 30 and received a presentation on the state's new marketing campaign to encourage more persons to pursue careers as behavioral health professionals. As part of this campaign, the state had developed a career marketing "toolkit" that any of us can use to help promote careers in behavioral health. This can be found at: Explore your behavioral health career opportunities today. (startyourpath.org)

3. NORTH SOUND BEHAVIORAL HEALTH NEEDS ASSESSMENT

- The North Sound Behavioral Health Needs Assessment was reviewed by the county coordinators and representative of the Advisory Board on February 3 to develop recommendations for the Board of Directors on next steps.
- Some of the initial themes from this discussion were:
  - In order to address "capacity" you also have to consider the actual availability of inpatient beds or services – this relates to the "network adequacy" discussions.
  - The need for more supportive housing is just as critical as the need for services – advocacy efforts need to consider both.
  - While its useful to project the need for beds and services in the future, we first have to address current gaps in capacity.
  - In order to develop more accurate need projections, we need to advocate with the state to share some type of utilization data from the Medicaid data base.
- The links to the full report and the Executive Summary can be found at: North Sound BH-ASO Assessment | North Sound BH-ASO (nsbhaso.org)

4. APPLE HEALTH REDETERMINATIONS

- Beginning April 1, Health Care Authority [HCA] will begin mailing redetermination [renewal] notices to Apple Health recipients with a May renewal date. Approximately 60,00 Apple Health recipients will be required to renew their eligibility. HCA estimated that a10-15% will lose coverage, or 6,000 to 9,000 members. Redeterminations will happen in first 3 months.
- Some of the main reasons people may lose coverage include the fact they are no longer eligible for Medicaid or have moved and not provided their new address. For others, they became eligible for Medicaid during the public health emergency and have never had to fill out forms to continue their eligibility. They may disregard the redetermination letters.

5. CRISIS SERVICES UPDATE

- The Weekly Crisis Capacity Indicator snapshot through is attached [Attachment].

6. MODIFICATION TO INTERLOCAL AGREEMENT TO ALLOW USE OF HYBRID MEETINGS

- The modification approved by the Board of Directors on January 12 to the BH-ASO North Sound Interlocal agreement allowing for the use of a “hybrid” model for Board meetings has been sent to the county prosecuting attorneys for review and forwarding to their county elected officials.

North Sound BH-ASO
2021 E. College Way, Suite 101, Mt. Vernon, WA 98273
Phone: (360) 416-7013 Fax: (360) 899-4754
www.nsbhaso.org

North Sound Behavioral Health Advisory Board
2023 Legislative Priorities

– Peer Workforce Support

- Limited Trainings. Provide more training opportunities that work around individuals work/school schedule that will eliminate hardships, while ensuring standardized trainings.
- Supervision helps the peers to ensure safe boundaries and have successful tools in the workforce. Provide financial support to behavioral health agencies so they can provide the necessary supervision and training to Peers without the loss of revenue.
- Provide sufficient funding to behavioral health agencies to cover the administrative costs for hiring, training, and supervising Peers.

– Network Adequacy

- "Network Adequacy" refers to a federal requirement on Medicaid Managed Care Organizations (MCOs) that is intended to ensure an MCO has a network of providers that is sufficient in numbers and types, to ensure that ALL services are accessible to Medicaid clients without unreasonable delay.
- Wait list should be time limited with specified maximums for Outpatient treatment and Crisis stabilization services. If utilizing "wait list" -identify structured contact/support services in place until can start services.
- Recommend Inpatient Treatment Services should be able to accept referrals within maximum of 14 days or less than 72 hours for continuing crisis stabilization/evaluation to avoid unnecessary general hospitalization or jail when safety issues are of concern.
- Outpatient Treatment Services should be able to provide initial assessment and determination of start of care within specified timeframe from referral.
- Behavioral health professionals are frequently clustered around and in Urban locations. This creates access barriers geographically and/or transportation to/from services.

– Behavioral Health Provider Rates

- BH-ASOs strongly support increased provider rates, both for the Medicaid and non-Medicaid sides of the system.

- The legislature should direct that rate increases be used to support an increase in wages and benefits for frontline staff.
- Incentives to cover license cost, payment of supervision during practicum hours post-graduation and CEUs.
- Paid Peer supervision of Peer Workforce.
- Request HCA revise criteria for reciprocity of out of state licensure of mental health professionals.

ITA Court Costs

- Washington State's Involuntary Treatment Act (ITA) allows the court to commit individuals to a free-standing behavioral health evaluation and treatment (E&T) facility or psychiatric hospital against their will for a limited time period. In 2011, the State created a process by which counties would be reimbursed for their actual costs associated with county prosecuted ITA cases. This has traditionally been billed to the Behavioral Health Administrative Services Organizations (ASOs). However, since 2011, the number of ITA courts and ITA cases has significantly increased.
- The Health Care Authority (HCA), in collaboration with the BH-ASOs, has requested to address the increased statewide county Superior Court costs related to ITA hearings in the amount of $9 million for the biennium.
- While more is needed to offset this ever-increasing cost, HCA's decision package represents a good step forward in recognizing the issue and the funding need.