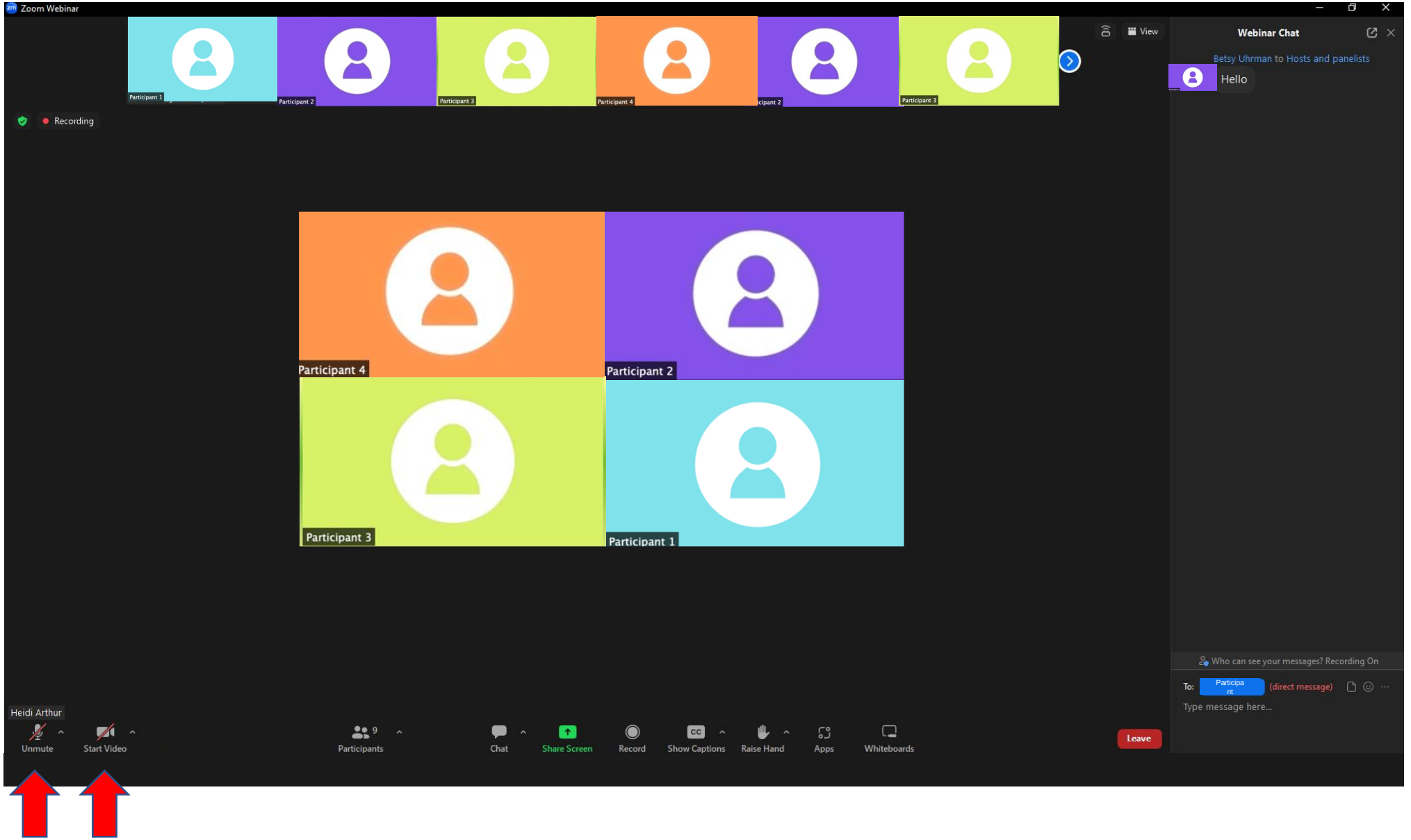
CalHHS

Workgroup 3: Integration

Meeting 3

April 12, 2024

Webinar: Panelist View



Webinar View: Attendee

- Workgroup members will be able to utilize the chat function throughout the meeting. Chat messages cannot be seen by non-workgroup members, but they will be captured in the public meeting summary.
- Workgroup members will be asked to use the "raise hand" function when you would like to speak.

Meeting 3 Objectives

1. Review and discuss emerging recommendations
2. Discuss key transition points within the crisis care continuum
3. Hear public comment
4. Confirm action items and next steps

Workgroup 3 (Integration) Members

- **Co-Chair, Lan Nguyen,** County of Santa Clara Behavioral Health Services
- **Co-Chair, Doug Subers,** California Professional Firefighters
- **Andrew Holcomb,** EMS Administrator, San Francisco
- **Angela Kranz**, California Department of Public Health (CDPH)
- **Ben Conway,** California Department of Justice
- **Casey Heinzen,** Department of Health Care Services (DHCS)
- **Christine Gephart**, Department of Developmental Services
- **Connie Moreno-Peraza,** Department of Behavorial Health Services of Napa County
- **Corinne Kamerman**, Department of Health Care Services (DHCS)
- **Elena Lopez-Gusman**, California American College of Emergency Physicians (ACEP)
- **Elizabeth Basnett,** California Emergency Medical Services Authority (EMSA)
- **Hernando Garzon,** California Emergency Medical Services Authority (EMSA)
- **Jana Lord,** Sycamores
- **Jacqueline Alvarez,** California Community Colleges
- **Jessica Cruz,** NAMI
- **Keris Jän Myrick,** Inseparable
- **Kim Lewis,** National Health Law Program (NHELP)
- **Le Ondra Clark Harvey,** California Council of Community Behavioral Health Agencies (CBHA)
- **Lee Ann Magoski,** Monterey County
- **Melissa Lawton,** Seneca Family of Agencies
- **Michael Tabak**, San Mateo Sheriff's Office
- **Paul Rains,** Common Spirits
- **Peter Stoll**, Humboldt County Office of Education
- **Rebecca Neusteter**, University of Chicago Health Lab
- **Rhyan Miller**, Riverside County Department of Behavioral Health
- **Dr. Stacie Freudenbeg,** Sr. Clinical Director**,** The Trevor Project
- **Stephen Sparling,** CalYouth
- **Stephanie Welch,** California Health and Human Services Agency (CalHHS)
- **Tara Gamboa-Eastman,** Steinberg Institute
- **Victoria Kelly,** Redwood Community Services

Public Comment Overview

- **All comments—whether written or spoken—will be shared with the Workgroup in the meeting minutes.**
- We will take comments in the order in which we receive sign-ups.
- If you are on Zoom and would like to make a public comment, please raise your hand at any point throughout the discussion. We will then write down your name and call on you to speak during the public comment period.
- Each person will have 2 minute to speak. If you have a condition that may require an accommodation (such as additional speaking time), please notify the project team and we will do our best to provide that accommodation.
- If you would like to make a comment but prefer not to do it in front of a camera or microphone, you may email your written comment to the project email address: AB988Info@chhs.ca.gov.

Review AB988 Areas of Recommendation
1) Review and Refine Input from Workgroup Meeting 3
2) Coordination between 911 and 988

Workgroup 3: AB988 Required Recommendations

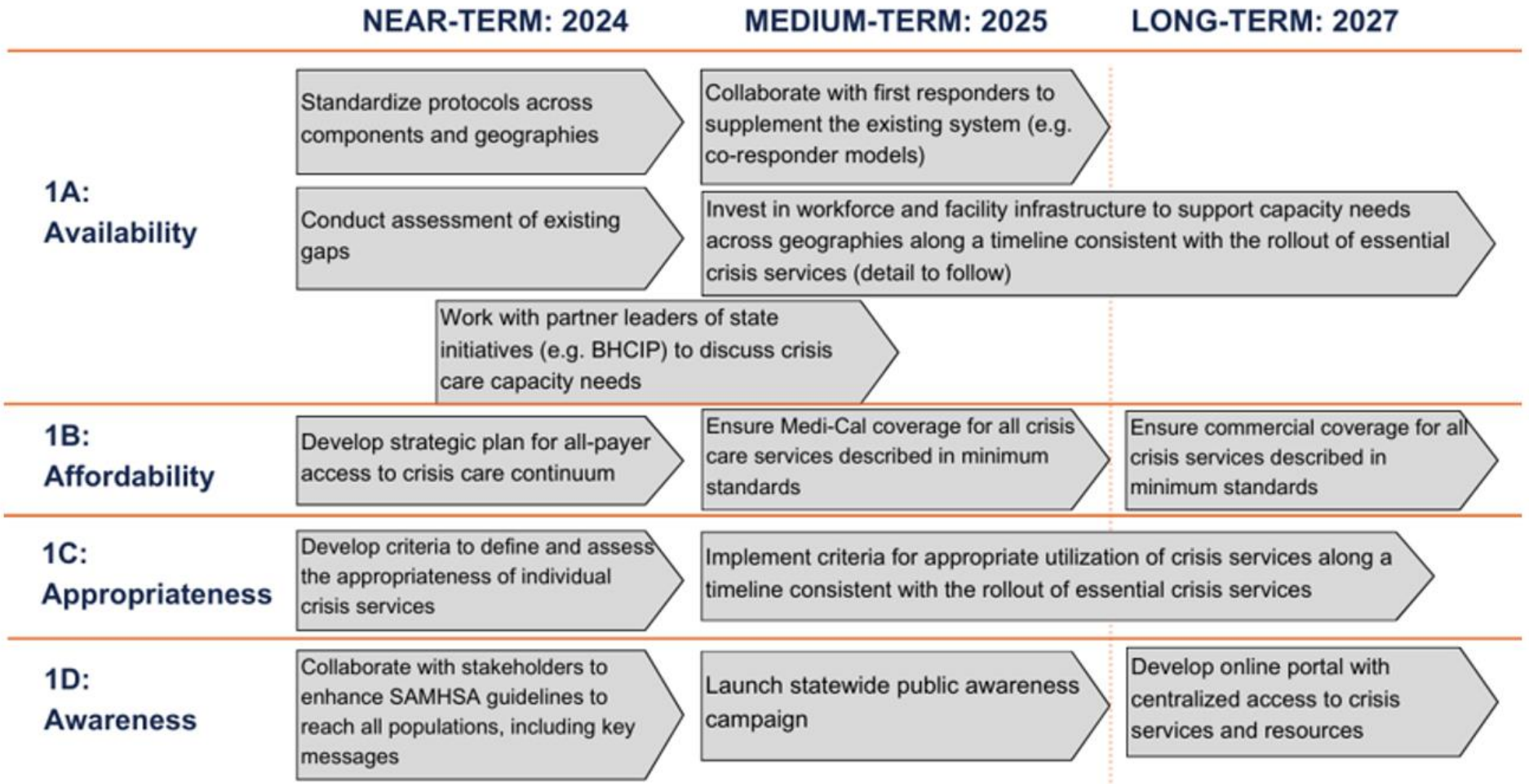
AB 988 Required Recommendations	How It's Being Addressed
(6) Access to crisis stabilization services and triage and response to warm handoffs from 911 and 988 call centers.	• Workgroup Meeting 3 • CalOES Technical Advisory Board • **Focus for Today**
(7) Resources and policy changes to address statewide and regional needs in order to meet population needs for behavioral health crisis services	• **Ongoing**
(9) Recommendations to achieve coordination between 988 and the continuum of behavioral health crisis services. Recommendations shall address strategies for verifying that behavioral health crisis services are coordinated for a timely response to clearly articulated suicidal or behavioral health contacts made or routed to 988 services as an alternative to a response from law enforcement, except in high-risk situations that cannot be safely managed without law enforcement response and achieving statewide provision of connection to mobile crisis services, when appropriate, to respond to individuals in crisis in a timely manner	• Workgroup Meeting 3

Timing of Implementation

- An outcome of our work – in conjunction with the work of the Policy Advisory Group, other Workgroups, the 988 Project Team, and others – is the creation of a 5-Year Implementation Plan.
- The 5-Year timeframe recognizes that change does not happen overnight.
- Activities will be sequenced so as to continue our progress toward a crisis system that meets the needs of *all* Californians, without overwhelming the system during the process.

Timing of Implementation – Example from CCC-P

The example below is provided to illustrate how efforts could be sequenced over time.



California Health and Human Services Agency, "Behavioral Health Crisis Care Continuum Plan" (2023), page 46.

What We Heard (3/22/24 Meeting) (1)

(6) Access to crisis stabilization services and triage and response to warm handoffs from 911 and 988 call centers.

1. Need for more guidance and flexibility for EMS to triage and transport to alternate destinations
2. Explore whether greater flexibility is needed related to the length of care for crisis stabilization (>23 hours, 59 minutes)
    1. DHCS legal team to provide legal interpretation as to whether this is viable
3. Need for established acceptance and denial criteria for crisis stabilization units
4. Need for protocol for scheduling follow-up at point of evaluation

What We Heard (3/22/24 Meeting) (2)

(9) Recommendations to achieve coordination between 988 and the continuum of behavioral health crisis services.

1. Need for minimum standards (and accompanying templates/framework) for effective, streamlined transfers (including transfers to follow-up care)
    1. Includes bidirectional communication protocols
2. Need for standard criteria for warm hand-offs (whether in-person, telephonic, or client override) for 988 Crisis Centers and mobile response
    1. In-person used sparingly; de-escalatization and stabilization is the goal
3. Need for criteria for when 988 Crisis Centers or mobile response should engage emergency medical response
    1. Clarify what falls under the bucket of mobile response [clarity around terms, in general]
    2. Maintain flexibility of who can provide mobile crisis so long as they meet the standards (requires oversight
4. Consider regional approach
5. Need for thresholds for what necessitates an in-person response
6. Need for protocol for coordinating mobile crisis dispatch, including in cases where the 988 Crisis Centers cannot dispatch mobile crisis directly
7. Explore requiring hospitals to accept non-wet signatures for 5150s’
8. Success looks like: Resources provided in the right language and cultural context and with access in mind, linkage to the appropriate level of care, limited wait time, reduction in ED visits, etc.

Discussion: Differentiating between AB988 Required Recommendation Areas

(6) **Access** to crisis stabilization services and triage and response to warm handoffs from 911 and 988 call centers.

(9) Recommendations to achieve **coordination** between 988 and the continuum of behavioral health crisis services. Recommendations shall address strategies for verifying that behavioral health crisis services are coordinated for a timely response to clearly articulated suicidal or behavioral health contacts made or routed to 988 services as an alternative to a response from law enforcement, except in high-risk situations that cannot be safely managed without law enforcement response and achieving statewide provision of connection to mobile crisis services, when appropriate, to respond to individuals in crisis in a timely manner

Discussion Notes/ Themes:

- 988 Crisis Line as a BH crisis line – beyond suicide talk line; acknowledged the broader federal mandate and inclusive of the whole continuum
- Intended to decriminalize our response to mental health crises; at present, law enforcement plays a significant role
- Previous iterations more prescriptive; there was a decision to not include that level of detail in statute
- **Goal is to have clear protocols that do not rely on law enforcement (LE)**
- In crafting the language
  - 6 – Making sure we have the system integration; do people know who they can call
  - 9 – Intended to hold space for specific protocols around LE response
- Legislation may presume first party callers when, in reality, there are many second- and third-party callers; our approaches need to respond to many calls and callers
- 911 – physical response v. 988 (historically) – conversation response. Need to be cognizant of different premise of each – in how we design and how we communicate

Coordination between 911 and 988

911 and 988

988 911 COMPARISON	
988	**911**
12 California 988 centers (about 1000 staff)	450 Public Safety Answering Points (PSAPs)
340,000 contacts during the first year of 988 implementation	27 million 911 calls per year

What We've Heard (Workgroup 4, Meetings 1-3)

Coordination between 911 and 988

1. Need for transfer protocols from 911 Dispatchers to 988 Crisis Counselors that reflect the focus on both mental health and substance use disorder
    1. Clarify what constitutes a transfer (and recognize transfer may require ongoing engagement)
2. There should be a backline option for direct transfers to any 988 Crisis Center
3. A co-triage and approach (vs direct handoffs from 911 to 988) enables the caller to decide if they are having an emergency while creating space to determine if there's a health emergency
4. Need for bilingual and bicultural response to avoid unnecessary 5150 holds
5. Need to account for the unique needs of those who have IDD and who are Deaf and Hard of Hearing
6. Explore the value of a "crisis caller's bill of rights" that details what people can expect when they call 988 and/or 911
    1. Need to inform people about the limitations of "least restrictive"
7. Non-911 calls to 988 need to count for 988 volume as it impacts key performance indicators (KPIs) and workforce
8. Need for training for 911 and 988 on warm handoffs (and how to do so within KPIs related to timeliness)

Coordination between 911 and 988: Triage and Warm Handoff

General Themes	
	What quality standards need to be in place? Clinical protocols? Request/ recommend that County BH providers be at the table for these conversations No current standards- at this time (high degree of variation) Need transfer protocols – help callers know what to expect when transferred
1) Should there be uniform triage/ response to crisis? Standards for what happens when a caller calls 988 *or* for when 911 transfers caller to 988 **Identify the sequence of how things occur (in planning and implementation)**	Need that people receive the right level of care Need a plan that builds on the things that are working currently – high level plan with guardrails/ general agreements. Need flexibility (sample template would be good – not a proscriptive process Sequential Intercept process? All 988 centers must follow Vibrant protocols – new CA protocols should align and be consistent with federal standards Could model after PSAPS. EMSA has base standards, local PSAPS can adapt to local resources and realities Need to temper flexibility with the need to ensure there is a standard minimum level. Model after two-tiered system used by EMSA. Minimum quality assurance standards – overseen by state Chief Medical Officer- with local Medical Director who can tailor the protocol to the realities of the local community No current required triage protocol/ criteria for PSAPS to determine when refer to 988 versus dispatch, etc. Statewide workgroup working on protocols/ standards
2) What is the state role in supporting/ensuring that those processes take place?	Call routing and electronic interfaces to solve for handoffs (back line) functionality – technology being developed/ informed by technical advisory board (no current "special" interoperability between Call centers and 911 at this time)- being developed in the future. Not a lot of press about 988 in the community – does this result in a reduced the level of call volume. Could education increase awareness (and as a result, volume)? Education could be vital to saving people's lives. (workgroup 4 focus). Should state be more involved in supporting standards? Broad points/ guidance yes, more detailed requirements, not as helpful- need to be careful about being too proscriptive. Communities have different infrastructure
3) What does success look like (measures)?	

Coordination between 911 and 988: Triage and Warm Handoff for Co-Occurring BH and Physical Health Needs

1) What's needed for triage and warm handoff (regardless of the number called)?	• Develop use cases whereby mobile crisis would be a good response. Clearly communicate guidelines for responses • Ensure those who do screening/ triage are well trained in MH/ SUD/ physical health, and language competencies – what is the threshold for a mobile response • Describe a scenario for physical health and co-occurring BH to walk through the decision tree for which team to connect ***caller*** to... • If there is any question on physical health response, should err on the side of response. (this can be different from BH) • Comes down to the primary concern, are they experiencing a life-threatening emergency (breathing, conscious, bleeding?) If not in physical danger, connect with mobile response • Some Centers have robust protocols. Is there variation or uniformity of the protocols in CA? • (National guidelines) If a physical health emergency, transfer over to 911. Crisis counselors will always check in on physical safety. • Crisis counselors stay on the line continuously with the caller while a supervisor contacts PSAP, fire/ police/ EMS. • Assessing BH risk requires more time/ empathy, 988 call could be at the end of a string of failed attempts to find human connection, 911 need efficient, immediate response – might be a first call (philosophy is different because people/ callers need it to be). • Is there a venue for coordination across 988/ 911 transfers? Not uniformly • LA County has an Alternative Crisis Response workgroup that is creating protocols for on-the-scene interactions and hand-offs between mobile response teams
2) What is the state role in supporting/ensuring that those processes take place?	

Where We Go From Here

Where We Go From Here (1)

- Feedback gathered from this Workgroup will be shared with CalHHS, who will in turn engage their state partners in review.
- Feedback gathered will also be shared with the Policy Advisory Group for further review and input. The Workgroup Co-Chairs will support this effort.
- The outcome of the state and Policy Advisory Group review processes will be a set of recommendations that will inform the development of the Five-Year Implementation Plan.
- **Additional, final meeting: Tuesday, July 30, 1-3PM – Calendar hold forthcoming**

Where We Go From Here (2)

Other Ways to Stay Involved

- Attend upcoming Policy Advisory Group meetings (next meeting is April 24).
- Consider attending meetings of the next set of Workgroups:
  - Communications
  - Data and Metrics
  - Funding and Sustainability
- Continue to share your thoughts and perspectives at AB988Info@chhs.ca.gov.

Public Comment Period

Public Comment Guidelines

- **All comments—whether written or spoken—will be shared with the Workgroup in the meeting minutes.**
- If you prefer, you may email your written comment to the project email address: AB988Info@chhs.ca.gov
- Each speaker is allocated 2 minutes to speak unless adjusted by the meeting facilitator.
- A speaker may not share or relinquish any remaining time they have not used to another speaker.
- Speakers may share one time during the public comment period.
- If time in the agenda remains after all individuals who signed up to speak have been called, the facilitator may invite other members of the public to raise their hand to speak. The facilitator will call individuals in the order they raise their hand.
- Speakers shall be civil and courteous in their language and presentation. Insults, profanity, use of vulgar language, or gestures or other inappropriate behavior are not allowed.
- Speakers should not ask questions of Workgroup members or ask Workgroup members to respond to their comments directly.

Public Comment Sign-Ups

1. Matt Taylor

Adjourn

Workgroup 3: 988/911 BH-CCC Integration

Key Terms

- **PSAPS** – Public Safety Answering Points
- **SUD** – Substance Use Disorders
- **Warmline** - A service, often peer-run, that offers callers emotional support
- **Crisis receiving or stabilization services** - Provide short-term (under 24 hours) observation and crisis stabilization services in a home-like, nonhospital environment
- **Emergency and Crisis**
  - **Emergency:** A serious, unexpected, and often dangerous situation requiring immediate action
  - **Crisis** – A time of intense difficulty, trouble, or danger that can be experienced *both immediately and over time*