Draft Technical and Operational Plan

National 988 System: Crisis Call Center & Behavioral Health Integrated Referral System

Engrossed Second Substitute House Bill 1477; Section 102, 109; Chapter 302, Laws of 2021

January 1, 2022

Acknowledgements

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Executive Summary

In response to the increasing incidence of suicides across the United States, the National Suicide Hotline Designation Act of 2020 established a national 988 system where all telephone service providers are required to direct all 988 calls to the existing National Suicide Prevention Hotline (NSPL) by July 16, 2022.

The Washington State legislature passed House Bill 1477 (E2SHB 1477), the Crisis Call Center Hubs and Crisis Services Act, to enhance and expand behavioral health crisis response and suicide prevention services for all residents in Washington State. The E2SHB 1477 was signed into law on May 13, 2021 and certain parts became effective on July 25, 2021.

E2SHB 1477 Section 109 requires the Department of Health (DOH) and the Health Care Authority (HCA) to create a sophisticated technical and operational plan for purpose of developing and implementing the required technology and platforms. HCA was tasked with developing the draft and final technical and operational plan. The legislation requires the agency contract for the critical analysis of the "development and implementation technology and platforms and operational challenges to best position the solutions for success."

The E2SHB 1477 Section 102 requires the DOH and HCA to collaborate to determine the technology and platforms necessary to manage and operate the behavioral health crisis response and suicide prevention system, including:

- An advanced behavioral health and suicide prevention crisis call center system for Crisis Call Center Hubs; and
- A behavioral health integrated client referral system for crisis call center hubs and the other entities involved in behavioral health care

Subsection E2SHB 1477 102(6)(f) requires "when appropriate, consultation with Tribal Governments to ensure coordinated care in Government-to-Government relationships, and access to dedicated services to Tribal members."

The legislation requires this Draft Technical and Operational Plan be submitted no later than January 1, 2022, and a final plan by August 31, 2022.

This Draft Technical and Operational Plan (i) uses a "Systems of Systems" approach to describes what is known about the technology platforms and systems and what needs to be learned to address the requirements in E2SHB 1477; and (ii) identifies next steps to address gaps in information about needed systems.

Background

National Legislation

Congress passed the National Suicide Hotline Designation Act of 2020 (Act) in October 2020 designating the 988 number as the universal number within the United States for the purpose of accessing the National Suicide Prevention and Mental Health Crisis Hotline system that is maintained by National Suicide Prevention Lifeline (NSPL). The 988 NSPL number is effective July 16, 2022. The Act authorizes states to collect a fee on commercial mobile services or Internet protocol-enabled voice services for:

1. ensuring the efficient and effective routing of calls made to the 988 National Suicide Prevention and Mental Health Crisis Hotline to an appropriate crisis center; and
2. personnel and the provision of acute mental health crisis outreach and stabilization services by directly responding to calls to the crisis centers.

Washington Law

To implement this national Act, the Washington State legislature passed House Bill 1477 (E2SHB 1477) to enhance and expand behavioral health crisis response and suicide prevention services for all residents in Washington State. The E2SHB 1477 was signed into law on May 13, 2021, and certain parts became effective on July 25, 2021[1]. Washington's law seeks to address the rising suicide rates and provide equitable care, particularly for young people, the growing number of people experiencing behavioral health crises including historically disadvantaged populations (e.g., American Indians/Alaska Natives, veterans, LGBTQ youth) and persons living in rural communities, and the reliance on emergency departments and law enforcement to respond to many of these crises.

This Draft Technical and Operational Plan addresses requirements in Sections 102 and 109 of E2SHB 1477. Section 102 describes the capabilities needed to support the advanced crisis call center system and behavioral health integrated client referral system and Section 109 establishes general requirements for the systems needed for the crisis call centers and the client referral system.

Section 102: Technology and Platforms

Subsection 102(5) of E2SHB 1477 requires the Washington State Department of Health (DOH) and Health Care Authority (HCA) to coordinate to develop the technology and platforms necessary to manage and operate the behavioral health crisis response and suicide prevention system.

- Subsection (5)(a) requires an advanced behavioral health and suicide prevention crisis call center system (Crisis Center System) that uses interoperable technology across crisis and emergency response systems throughout the State (e.g., 911 systems, emergency medical services systems, other non-behavioral health crisis services.) for crisis call center hubs; and
- Subsection (5)(b) requires a behavioral health integrated client referral system (Integrated Referral System) capable of providing system coordination information to crisis call center hubs and the other entities involved in behavioral health care.

[1] See Appendix A for the sections and timelines of E2SHB 1477.

Subsection 102(6) requires that the technologies described above must include the following functionality:

- Access to real-time information relevant to the coordination of behavioral health crisis response and suicide prevention services, including:
    - Real-time bed availability for all behavioral health bed types, including but not limited to, crisis stabilization services, triage facilities, psychiatric inpatient, substance use disorder inpatient, withdrawal management, peer-run respite centers, and crisis respite services, inclusive of both voluntary and involuntary beds, for use by crisis response workers, first responders, health care providers, emergency departments, and individuals in crisis.
    - Real-time information relevant to the coordination of behavioral health crisis response and suicide prevention services for a person, including the means to access:
        - Information about any less restrictive alternative treatment orders or mental health advance directives related to the person;
        - Information necessary to enable the crisis call center hub to actively collaborate with emergency departments, primary care providers and behavioral health providers to establish a safety plan for the person in accordance with best practices and provide the next steps for the person's transition to follow-up non-crisis care. Input from the confidential information compliance and coordination subcommittee will be considered to establish information-sharing guidelines.
    - Means to request deployment of appropriate crisis response services, which may include mobile rapid response crisis teams, co-responder teams, designated crisis responders, fire department mobile integrated health teams, or community assistance referral and educational services programs under RCW 35.21.930, according to best practice guidelines established by the authority, and track local response through global positioning technology.
    - Means to track the outcome of the 988 call to enable appropriate follow up, cross-system coordination, and accountability, including as appropriate:
        - Any immediate services dispatched, and reports generated from the encounter;
        - Validation of the safety plan established for the caller in accordance with best practices;
        - Next steps for the caller to follow in transition to non-crisis follow-up care, including a next-day appointment for callers experiencing urgent, symptomatic behavioral health care needs; and
        - Means to verify and document whether the caller was successful in making the transition to appropriate non-crisis follow-up care indicated in the safety plan for the person, to be completed either by the care coordinator provided through the person's managed care organization, health plan, or behavioral health administrative services organization, or if such a care coordinator is not available or does not follow through, by the staff of the crisis call center hub.
    - Means to facilitate actions to verify and document whether the person's transition to follow up non-crisis care was completed and services offered, to be performed by a care coordinator provided through the person's managed care organization, health plan, or behavioral health

administrative services organization, or if such a care coordinator is not available or does not follow through, by the staff of the crisis call center hub.
    - The means to provide geographically, culturally, and linguistically appropriate services to persons who are part of high-risk populations or otherwise have need of specialized services or accommodations, and to document these services or accommodations.

Finally, Subsection 102(7) requires:

- "To implement this section the department and the authority shall collaborate with the State enhanced 911 coordination office, emergency management division, and military department to develop technology that is demonstrated to be interoperable between the 988 crisis hotline system and crisis and emergency response systems used throughout the State, such as 911 systems, emergency medical services systems, and other nonbehavioral health crisis services, as well as the national suicide prevention lifeline, to assure cohesive interoperability, develop training programs and operations for both 911 public safety telecommunicators and crisis line workers, develop suicide and other behavioral health crisis assessments and intervention strategies, and establish efficient and equitable access to resources via crisis hotlines."

Coordination with Tribal Governments

E2SHB 1477 Subsection 102(6)(f) requires that in developing the new technologies for the expanded and enhanced crisis call centers and integrated behavioral health referral system the DOH and HCA must provide for the following: "when appropriate, consultation with Tribal Governments to ensure coordinated care in Government-to-Government relationships, and access to dedicated services to Tribal members." Subsection 103(8)(a) also requires that the CRIS Steering Committee establish a "Washington Tribal 988 Subcommittee, which shall examine and make recommendations with respect to the needs of tribes related to the 988 system, and which shall include representation from the AIHC."

DOH and HCA will secure input from the Tribal Subcommittee (Tribal Centric Behavioral Health Advisory Board) on the Final Technical and Operational Plan.

Current Landscape of Crisis Call Centers in Washington State[2]

National Suicide Prevention Lifeline (NSPL)

The NSPL Network is a nationwide network of more than 180 crisis call centers across the country. The centers are supported by local and state, and public and private sources, as well as by Congressional appropriations through the United States Department of Health and Human Services (US DHHS) Substance Abuse and Mental Health Services Administration (SAMHSA). Vibrant Emotional Health establishes and maintains the minimum standards nationwide for becoming an accredited NSPL member center. See Appendix A for the basic requirements that crisis centers must meet to become members of the NSPL Network.

[2] Information obtained from Washington State 988 Case Referral & Management System Discovery and Report. Third Sector report prepared under contract to Ballmer Group (released 10/29/2021) and other sources (e.g., VA and DOH)

There are three NSPLs in Washington State:

- Crisis Connections – Serving King County
- Frontier Behavioral Health – Serving Greater Spokane Region (six counties in Eastern Washington)
- Volunteers of America (VOA) of Western Washington – Serving the remaining 32 counties of the State.

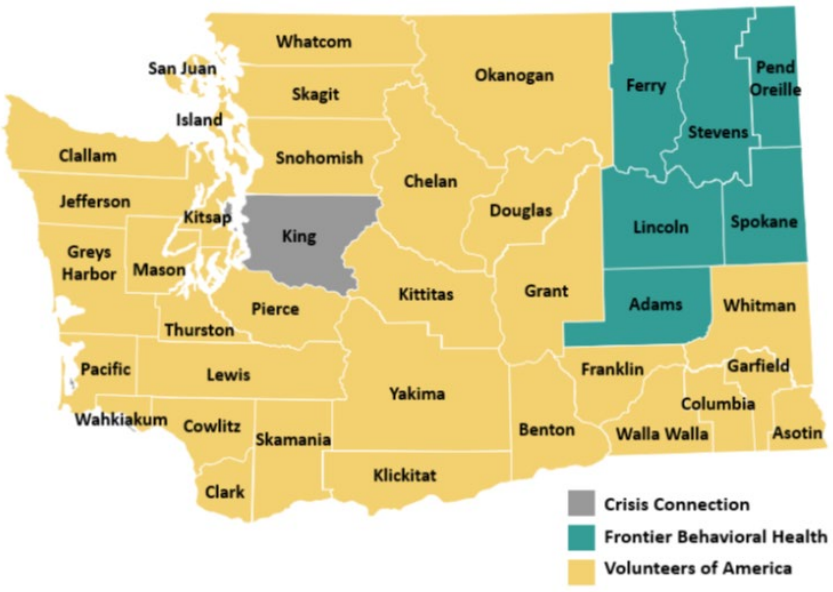

Figure 1 NSPL Crisis Call Center Coverage in Washington by County[3]

The Washington DOH holds the contracts for the three NSPL Crisis Call Center Hubs in the State. The national Act requires that 988 call centers must be NSPL accredited call centers. Each of the three NSPLs in Washington State are accredited by Vibrant. Third Sector notes, in its report prepared for Ballmer Group, that it takes approximately two years become an accredited Crisis Call Center.

The Washington DOH was the recipient of a SAMHSA grant, managed by Vibrant, to support the State and NSPLs in planning for the July 2022 implementation of the national 988 crisis line. Grantees were required to submit draft and final implementation plans using a template specified by Vibrant. The template asked grantees to address challenges, gaps, and opportunities in core areas including:

- Core Area 1: Statewide 988 Coverage
- Core Area 2: Funding for Call Centers
- Core Area 3: Capacity for Target In-State/In-Territory Answer Rates
- Core Area 5: Lifeline Standards, Requirements, and Performance Metrics
- Core Area 5: 988 Stakeholder Coalition
- Core Area 6: Comprehensive Resource Listings; Plan for Expanded Services
- Core Area 7: Follow-Up Services
- Core Area 8: Marketing 988

[3] Obtained from the Vibrant Emotional Health Report January 2021

DOH submitted to SAMHSA and Vibrant a Draft Implementation Plan for Washington. The final implementation plan will be submitted January 2022.

Washington Indian Behavioral Health Hub

The Washington Indian Behavioral Health Hub (Indian BH Hub), located in the Volunteers of America (VOA) call center in Everett, is operated independently and serves indigenous and Tribal affiliated individuals. The Indian BH Hub offers culturally appropriate aid to all Tribal and non-Tribal providers who support tribal members and communities in any behavioral health capacity. Washington State is working on plans for further implementation of geographically appropriate services for this hub, including considering incorporating regional representatives and support services from different regions of the State.

The Indian Behavioral Health Hub was developed through a partnership between the Tribal Centric Behavioral Health Advisory Board (TCBHAB), the American Indian Health Commission (AIHC), VOA, HCA, and DOH and went live on May 1, 2021. The same partnership is currently in the process of launching a Tribal Crisis Line for Washington State, to serve tribal members in the entire State via the 988 system and provide prevention and post-crisis resources and support in coordination with the Washington Indian Behavioral Health Hub, creating a more comprehensive set of supports. The Tribal Crisis Line will go live in July 2022.

Regional Crisis Call Systems

Behavioral Health Administrative Services Organizations (BH-ASOs) are entities selected by HCA to administer behavioral health services, including a 24/7/365 crisis hotline, mental health crisis services, short-term substance use disorder (SUD) crisis services, designated crisis responder (DCR) capacity, and involuntary treatment under the Involuntary Treatment Act (ITA), for ten regional services areas in Washington State. BH-ASOs may purchase crisis services through contracted provider agencies. BH-ASOs contract directly with Managed Care Organizations (MCOs) to ensure crisis services are provided to managed care enrollees. Through contract, HCA requires that each BH-ASO has:

- capacity for face-to-face crisis contacts in every county;
- a toll-free number for access crisis call center services;
- DCR capacity to provide ITA investigations in every county;
- capacity for Crisis Stabilization within the region; and
- access to Evaluation and Treatment and Secure Withdrawal and Stabilization services within the region or if unavailable, contract or establish an MOU to access those services.

Regional Crisis Call Systems are operated by the BH-ASOs with in-house staff or in partnership with local behavioral health providers. BH-ASOs are responsible for providing regional crisis call services for Washington State's ten integrated managed care regions. Seven out of ten BH-ASOs contract with Lifeline Crisis Call Centers (NSPLs) to provide crisis line services for their regions. The three BH-ASOs listed below each operate their own Regional Crisis Call Systems (instead of contracting with Crisis Call Centers in the NSPL network):

- Thurston Mason ASO – Serving Thurston and Mason counties and certain areas within the Great Rivers region.

- Greater Columbia ASO – Serving Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Walla Walla, Whitman, and Yakima counties.
- Great Rivers ASO – Serving Cowlitz, Grays Harbor, Lewis, Pacific and Wahkiakum counties.

These Regional Crisis Systems are not certified NSPL Crisis Center Hubs. Regional crisis systems are not expected to become a NSPL Crisis Center Hub in the near future due to the difficulty in attaining this certification. NSPL calls will not be routed from 988 to Regional Crisis Systems as they are not certified/accredited members of the NSPL network. However, the NSPL Crisis Call Centers may connect callers to the regional crisis centers for some services and to coordinate care and vice versa.

Technical & Operational Plan

Section 109: Technical and Operational Plan

E2SHB 1477 Section 109 requires the DOH and HCA to create a technical and operational plan for purpose of developing and implementing the required technology and platforms. In collaboration with DOH, HCA was tasked with developing the technical and operational plan as required in the legislation.

Section 109 requires that the Technical and Operation Plan include, but not be limited to the following:

(1) Data management;

(2) Data security;

(3) Data flow;

(4) Data access and permissions;

(5) Protocols to ensure staff are following proper health information privacy procedures;

(6) Cybersecurity requirements and how to meet these;

(7) Service level agreements by vendor;

(8) Maintenance and operations costs;

(9) Identification of what existing software as a service products might be applicable, to include the:

(a) Vendor name;

(b) Vendor offerings to include product module and functionality detail and whether each represent add-ons that must be paid separately;

(c) Vendor pricing structure by year through implementation; and

(d) Vendor pricing structure by year post implementation;

(10) Integration limitations by system;

(11) Data analytic and performance metrics to be required by system;

(12) Liability;

(13) Which agency will host the electronic health record software as a service;

(14) Regulatory agency;

(15) The timeline by fiscal year from initiation to implementation for each solution in this act;

(16) How to plan in a manner that ensures efficient use of state resources and maximizes federal financial participation; and

(17) A complete comprehensive business plan analysis.

In creating this Draft Technical and Operational Plan, HCA relied on several sources of information including, information gathered as part of HCA's work on behavioral health bed tracking (supported under a SAMHSA grant), reports from Third Sector (prepared on behalf Ballmer Group), other documents cited in this report, and interviews, discussions, and/or materials received from staff from the: HCA, DOH, the Military Department, NSPL VOA, and Accountable Communities of Health (ACHs).

Plan Overview

To meet the breadth and scope of the requirements of E2SHB 1477, the Draft Technical and Operational Plan takes a "System of Systems" perspective (see Figure 2). This System of Systems concept is designed with the following high-level approach:

1. The two primary systems needed to fulfill the requirements of E2SHB 1477: (a) the 988 Crisis Call Center System Platform (Crisis Call System) and (b) Behavioral Health Integrated Client Referral System (Integrated Referral System); and
2. The ancillary systems needed to support and facilitate information exchange to and amongst these two primary systems.

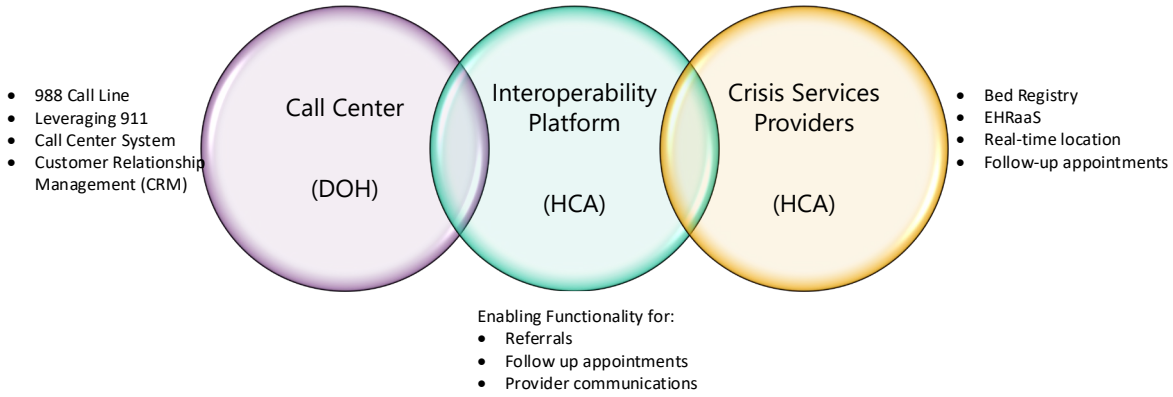

Figure 2 System of Systems

Process Overview of Crisis Response and Referral

Based on information gathered from key stakeholders including DOH, NSPL/VOA, DBHR staff; and extensive document review, the following is a high-level overview of the Crisis Call System and Integrated Referral System processes envisioned in E2SHB 1477 that will be supported by various technical solutions (also see figure 3).

- A Future NSPL/ Crisis Call Center Hub System will receive calls (and texts and chats) via the 988 telephone number. This system will document the call information including the safety plan until it is

time for the referral, at which time relevant information will be passed to the Integrated Referral System.

- A Future Integrated Referral System will be used to generate needed connections, referrals, and reports. Examples of crisis calls received by 988 and Regional Crisis Lines, referrals made for follow-up services (including by whom and to which entities)).
- Referrals are envisioned to be supported by several Future Interoperable Systems including resources for: bed availability, provider directory, information about the least restrictive alternative (LRA) treatment orders, existence of mental health advance directives, use of an EHRs (including EHRaaS), and other systems.

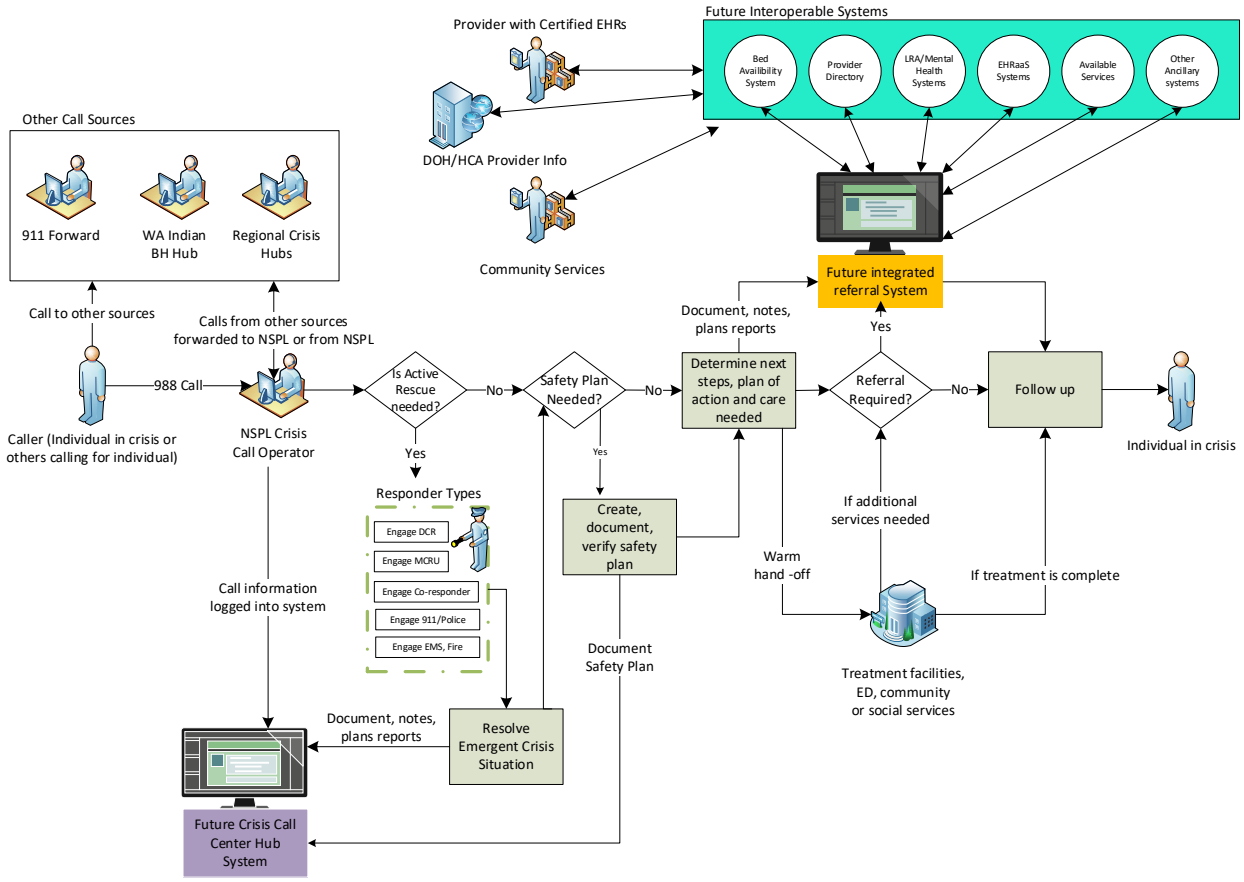

Figure 3 High Level Process Flow

Based on information gathered from key informants[4], document review[5], and assumptions based on the legislative requirements for the (i) advanced crisis call center system platform and (ii) enhanced and

[4] Key informants included: representatives from VOA/NSPL, DOH, HCA/ DBHR, Military Department

[5] Documents reviewed: WA State 988 Case Referral & Management Discovery and Report. Third Sector report prepared under contract to Ballmer Group (released 10/29/2021).

expanded behavioral health integrated client referral system[6], the Crisis Call System and Integrated Referral System processes envisioned in E2SHB 1477 will need to support the following:

- ***Crisis calls (calls or texts) can come from a variety of sources****:* Individuals in crisis can call or others may call on behalf of someone in crisis. Calls can be forwarded to and from the NSPL center from a variety of sources including 911, or other regional crisis centers. A future Crisis Call Center Hub system is needed to receive and track calls from multiple sources and be able to send relevant data between systems used from these variety of sources.
- ***Active rescue is needed for some calls:*** While active rescue scenarios do not make up a large percentage of call volume, they do happen[7]. When active rescue is needed, crisis responders (e.g., MCRU, DCRs, fire, law enforcement, co-responders) will resolve the emergent situation and determine whether a referral or safety plan is needed as a next step. The safety plan is an important component of responding to and ensuring the safety of the individual in crisis both in non-active rescue and after active rescue has been complete. The safety plan needs to be documented in the Crisis Center System, accessible to the Integrated Referral System, and accessable to individuals interacting with the caller to ensure the plan is ahered to and updated when necessary. Active rescue calls may require immediate warm hand-off to a treatment facility or could require next day appointment referrals and follow up.
- ***Non-Active rescue calls:*** If the crisis caller does not require active rescue the need for / existence of a safety plan is considered, but may not be required. This caller still may require social services or have social determinants of health challenges or require a next day appointment and follow up.
- ***Referral:*** In both active rescue and non-active rescue, if a referral is needed, information is needed about potential referral sources and the availability/ capacity of these referral sources to serve the caller, including which source would be the least restrictive option for the caller. EHR systems (such as the EHRaaS) include functionality that could support electronic referrals, including closed loop referrals, and needed follow-up.

Appropriate state laws, federal laws, security, privacy measures, and interoperability protocols will be aligned in the design, development, and implementation of the future Crisis Call Center Hub system, electronic integrated referral system, and interoperable system resources.

Training between all partners is needed to meet requirements of E2SHB 1477 and will be addressed in the Final Technical and Operational Plan.

System Features, Requirements and Considerations

Both the Crisis Center System and the Integrated Referral System require review of all the listed features, requirements, and considerations listed below. Systems implemented by Washington State must comply with applicable federal and state laws. As technology solutions are identified, they will be evaluated for the following features, requirements, and considerations:

[6] Legislative requirements: E2SHB 1477 Subsections: 102(5)(a) and (b), 102(6), and 102(7)

[7] Based on stakeholder interviews

Technical and Operational Plan Consideration

	Features, Requirements, and Considerations
Data Management	• Data segregation • Agreements needed: Service Level Agreements (SLAs), Data Sharing Agreements (DSAs), etc. • Scalability
Data Security	• Disclosure • Data Backup • Data Archiving for Security • Disposal of Data • Location Security • Redundant Utilities • Data Encryption (at rest and in transit)
Data Retention	• Statutory and policy/practices concerning length of time different types of information (including Protected Health Information (PHI)) is retained by various entities
Data Flow	• Determine data endpoints and how they are to connect • Entities providing input and output data • High-level preliminary Data Flow
Data Access & Permissions	• Configurable role-based access & permissions • Single sign on (SSO) supportability and integration • Authentication (Multi-Factor) and Authorization
Privacy & Protocols	• Audit Trail History • Automated Privacy Monitoring • Protocols to be defined with consideration to: o Health Insurance Portability and Accountability Act (HIPAA) and 42 Code of Federal Regulations Part 2 (42 CFR Part 2) and exceptions in the event of a medical emergency o Uniform Health Care Information Act (UHCIA), RCW 70.02 o RCW 39.26.340, which requires DSAs for Cat 3 or higher data (NOTE: this has cybersecurity implications as well as privacy and is related to Engrossed Substitute Senate Bill 5432 (ESSB 5432) implementation) o NSPL Policies & Protocols o Health Information Technology for Economic and Clinical Health (HITECH) o Patient consent (when required)
Cybersecurity	• Ensure compliance with federal and state laws • Alignment with any rules deemed by the office of cybersecurity in consideration of ESSB 5432
Integration or Interoperability	• Integration with Vibrant Unified Platform (and other platform as appropriate) and the future integrated referral system and interoperable system resources • Integration with the Regional Crisis Lines and the future integrated referral system and interoperable system resources • Integration with future integrated referral systems and interoperable systems (e.g., Bed Capacity solution, Statewide Provider Resource Directory) • Application Programming Interfaces (APIs), API management & Integration with Certified Electronic Health Records, Electronic Health Record-as-a-Service (EHRaaS), 911 Computer Aided Dispatch (CAD), other systems. • Use of established data standards (such as HL7 FHIR) for data exchanges whenever able
Data Analytics & Performance Metrics	• Crisis Center Hub Key Performance Indicators (e.g., Number of Calls Initiated, Number Answered In-State and Rate, Number Answered Out-of-State). • Consider the need for Key Performance Indicators for Regional Crisis Lines, and if needed, identify metrics. • Behavioral Health Integrated Referral System Performance Indicators (e.g., Client was referred to follow-up services; Client received follow-up services (e.g., received outpatient referral appointment within 24 hours), Follow-up with client completed and outcomes documented)

	• Custom reporting and dashboards
Hosting Platform	• Cloud-hosted Platform-as-a-Service (PaaS) where feasible • Ability to connect to both cloud-based and on-premises systems
Solution Architecture	• Microservices based architecture when possible • Use APIs to move data between services • Data architecture that aligns with industry best practices and is scalable, enables data analytics and reporting systems that support real-time monitoring data visualization capabilities • An integration architecture that meets industry standards for security and data exchange and enables secure, interoperable information exchange of PHI
Liability	• Liability types • Liability management and mitigation

System Requirements: Crisis Center & Integrated Referral Systems

Data Management

The Final Technical and Operational Plan will reflect the efforts of the CRIS and CRIS subcommittees. In addition, it will address a variety of data management issues including: what are the systems, users, storage, security, and documentation needs; how to ensure data quality and appropriate permissions for data access (particularly given the highly sensitive nature of this data). The Final Plan will consider the many actors and entities who are unique yet interdependent, and the specific data elements that need to be shared while ensuring data can be appropriately protected and segregated. Activities that will be undertaken to define needed data management requirements include identifying:

- data to be transmitted and accessed for different purposes (e.g., support referrals and coordination in care) and the system users for these purposes
- data transmission and exchange protocols (e.g., transmission and exchange standards (e.g., HL7, FHIR, C-CDA, other ONC Standards))
- how data will be integrated
- API's need for integration and API management technology
- Data segregation and segmentation based primarily on:
    - data type
    - sensitivity associated with the type of data
    - type of entry source (NSPL Crisis Hub versus Regional Crisis Center) for future integration considerations with Vibrant UP
- Identified custom reports and dashboards

While not all actors, data, systems, and interoperability needs have been identified in this Draft Plan, the key systems and potential entities that will be addressed in the Final Technical and Operational Plan are listed below.

Potential Integrated Systems

- 988 platform (e.g., the Vibrant Unified Platform (UP))
- Computer Aided Dispatch (CAD)
- Health Information Exchange
- Community Information Exchange Systems
- Referral Systems (e.g., Collective Medical, OpenBeds)
- Bed availability solutions (e.g., WA-TRAC, Open Beds)
- Provider directories (e.g., directories at the NSPLs, Regional directories, DOH Provider Registry)
- Provider health information technology systems (e.g., EHRs, EHRaaS, Collective Medical)
- Community service systems
- Case management/Care Coordination systems (e.g., used by MCOs, BH-ASOs)

Entities

- Health and Behavioral Health Care Providers. For example:
    - Emergency departments
    - Primary care providers
    - Crisis stabilization services
    - Triage facilities
    - Psychiatric inpatient
    - SUD inpatient
    - Withdrawal management
    - Peer-run respite centers
    - Crisis respite services
- DCRs
- MCRUs
- 911, Emergency Medical Services (EMS), Law Enforcement, Fire
- NSPL Crisis Call Center Hubs/Operators
- Regional Crisis Center Systems/Operators

Data Security

All vendor hosted solutions will be required to complete and pass an Office of Cyber Security (OCS) security design review before any production data can be stored, processed or transmitted in accordance and adherence with the OCIO 141.10 Policy. Considerations include, at a minimum:

- Disclosure
- Data Backup
- Data Archiving for Security
- Disposal of Data
- Location Security
- Redundant Utilities
- Encryption (at rest and in transit)

Data Access and Permissions

The technology platform and solutions will require robust role-based access control. Data must be accessible to treat and/or refer clients in active rescue (life threatening) and non-active rescue situations but on a need-to-know basis only and in accordance with federal and state law.

Policies, procedures, training, and compliance will be an integral part of maintaining the privacy and security of the technology systems and platforms.

The following table includes examples of some of the potential roles that could be required for accessing and using the technology platforms and solutions and the data in these systems. Each use case and each system used by the Crisis Call Hub and Integrated Referral System will be evaluated individually and treated separately in the Final Technical and Operational Plan.

Sample Roles and Permissions – High Level

Role	Description	Some Possible Permissions & Data Access
System Administrator	Role applied to users requiring full access to analytics, reporting, users, quality assurance portals, etc. (i.e., NSPL Crisis Call Hub administrator/supervisor) Integrated Referral System will have different administrators with the same types of permissions	• Full control of reporting & analytics • User management access (add/delete users, assign any role or data restriction). • Ability to grant administrator permissions to users • Read/Write/Delete permissions
NSPL Operator	Role applied to NSPL Crisis Call Center Hub Operators	• Read/Write permissions
Regional Crisis Line Operator	Role applied to Regional Crisis Center Operators	• Read/Write permissions
Provider	Role applied to registered providers in Washington	• Access to upload/amend bed availability data • Access to upload/amend provider service data • Ability to send, receive and respond to referrals
DCR	Role applied to Designated Crisis Responders	• Access to active response data • Access to upload encounter notes/reports
MCRU	Role applied to Mobile Crisis Response Units	• Access to active response data • Access to upload encounter notes/reports
EMS/911/Fire	Role applied to Emergency Medical Services, 911, and Fire responders	• Access to active response data
Community Providers	Providers of community services such as housing, domestic violence centers, or food banks	• Access to see available services to refer people for help • Ability to send, receive and respond to referrals
Individual	Individuals in crisis and persons acting on their behalf	• Access to provider resource directory

Data Flow

Implementation of E2SHB 1477 will require data-centric systems that allows data to be shared smoothly between systems and people involved in the care of the individual in crisis. The data flow depicted in figure 4 is a high-level view of where data entry, data integration, or system to system data exchange will need to occur.

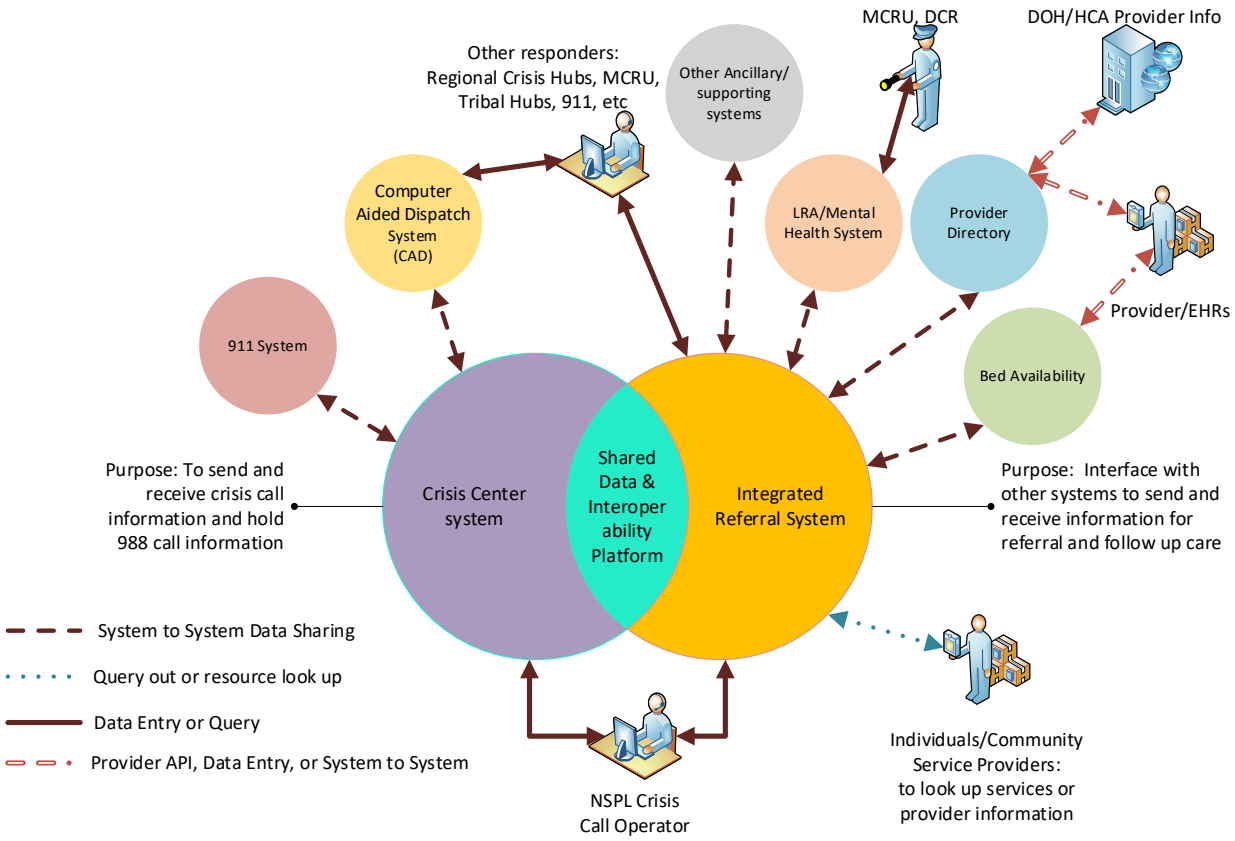

Figure 4 Data Flow

While there are telephone numbers individuals in crisis can call other than 988 (e.g., telephone numbers for regional crisis lines), 988 calls can be forwarded to and from the NSPL call center, therefore relevant data will need to flow to and from all these sources. The Shared Data and Interoperability Platform and the Integrated Referral System resources would be available for use by the Regional Crisis Lines to enhance and expand behavioral health crisis response and suicide prevention services statewide.

The ancillary systems would get data from other sources through data entry, API's, or other secure data exchange protocols that meet established standards. Each ancillary system would manage a type of data that would need to be used in the Integrated Referral System. When needed this data would easily be accessed by the Integrated Referral System. The Integrated Referral System would also capture data needed from Regional Crisis Lines to support needed reporting.

The data exchange in this process is complex and dependent on the appropriate infrastructure being in place, including in rural settings, and statewide partnerships with providers and organizations such as MCO's and BH-ASO's. Constraints of this system include but are not limited to rural connectivity, access to EHRs, and agreements needed for these exchanges.

The specific technology solutions and platforms that enable the creation, exchange and use of data needed for each step in the Data Flow depicted in Figure 4 will be identified in the Final Technical and Operational Plan.

Privacy and Protocols

Washington State privacy laws, HIPAA and 42 CFR Part 2 govern data access and sharing.

Washington State Privacy Requirements

- Washington State law contains specific requirements that govern confidentiality of information related to mental health services (RCW 70.02.230)
- Under state law, heightened standards of confidentiality (beyond HIPAA) are required when using or disclosing PHI pertaining to mental health records. There are limited exceptions for which disclosure is permissible (e.g. to law enforcement agencies when a person's health and safety is threatened, or in emergent situations that pose a significant and imminent risk to the public).

HIPAA Requirements

HIPAA incudes requirements that pertain to the privacy and security of health information. Some of these requirements include:

- HIPAA requires that access to all data in EHRs are restricted only to those with valid reasons for viewing these records, so encryption and strong access controls are must. The standards put in place will not only apply to records when they are within the database, but also when data are shared, so steps must also be taken to ensure activities such as emails and file transfers are fully monitored, protected and controlled.
- HIPAA requirements also provide for full audit trail detailing interactions with data. Event log and records kept every time a file is changed alerting organizations to any potential security breaches as soon as the occur.

42 CFR Part 2

- 42 CFR Part 2 requires that consent be secured to share SUD data by programs that hold themselves out as SUD programs. Patient consent can be obtained to share protected SUD information with designated providers or health information exchange organizations.
- There are requirements to account for disclosures and re-disclosures of protected SUD information.
- It can be difficult to know if Part 2 is applicable because that question is based on whether data was generated from a Part 2 Program, so the source of the data must be known in order to know whether the law is applicable.
- Emergency considerations need to be considered where there may be an applicable active rescue and consent may not be obtained.

Cybersecurity

All technology solutions must complete and pass an Office of Cyber Security (OCS) security design review for compliance with OCIO 141.10 Standards. Additionally, legislation ESSB 5432 and E2SHB 1477 requires all agencies to align any state agency data products with these new industry standards effective July 1, 2022. HCA and DOH IT security teams will provide consultation, guidance, and facilitate on compliance and navigation of OCIO 141.10. The security design review will address:

- Physical and Environmental Protections
- Data Security
- Network security
- Access Security

- Application security
- Operations Management
- Security Monitoring and Logging
- Incident Response

Service Level Agreements (SLAs) or Data Share Agreements (DSAs)

SLAs and DSAs are needed between any parties needing to share sensitive data. Work is needed to identify specific SLA's and DSA's for entities (HCA, DOH, BH-ASO's, etc.) involved in sharing of data for this effort as some do not currently exist or if agreements exist, they are not sufficient to cover the needed scope of requirements in E2SHB 1477. The Final Technical and Operational Plan will identify the vendors needing SLAs, and the parties requiring DSAs. Samples of considerations regarding, and elements of, SLAs and DSAs (including consent and privacy considerations), include:

SLA:

- Business objectives
- Performance standards
- Reporting mechanisms
- Critical failure processes
- Change processes
- Uptime/Availability
- Time to recovery and response
- Continuity of services
- Disaster recovery/failover

DSA:

- Authority
- Access provisions
- Confidentiality & disclaimers
- Timeframe for agreement
- Authorized use and disclosure
- Data retention and disposal

Maintenance and Operations Costs

Maintenance and operations costs cannot be determined until systems are architected, infrastructure is determined, vendors are selected, and support for these components are defined. The Final Technical and Operational Plan will identify where the maintenance and operational costs would exist and, when possible, estimate the associated costs with the specific technology solutions and platforms identified to meet the requirements of E2SHB 1477.

Technology Vendors for Needed Systems

Third Sector, in the report prepared for Ballmer group, identified the vendors listed in the table below as reporting the capabilities of meeting requirements of E2SHB 1477. Systems were described as focused on healthcare, behavioral health care, and/or case management, referrals, and/or bed capacity management. Some vendors described the capability of creating customizable tools to meet the requirements in E2SHB 1477. Additional vendors may be identified as work on the Technical and Operational Plan progresses.

HCA prefers cloud-based vendors for this effort where possible. Where necessary custom built systems are an option, however the preference is to procure systems given that they meet requirements. The evaluation and eventual selection process will be done in accordance with HCA's and DOH's procurement policies and procedures.

Vendor Overview[8]

Vendor Name	Vendor Summary	The System that the Technology May Support
Healthcare or Crisis Response Specific Software		
herpic	EHR platform, including health information exchange, used by acute care, primary care, and behavioral health care providers (and others)	• Interoperable System
iCarol	Helpline software for crisis, referral, and emotional support lines	• Crisis Call Center
Netsmart	Platform consists of multiple modules including electronic health record platforms, health information exchange and integration across providers. Used by behavioral health (and other) providers	• Interoperable System
Neuroflow	Specializes in long-term collaborative, integrated behavioral health with engaged patients	• Interoperable System
Opeeka	Specializes in post-care that unifies and tracks care plans across health, social and human services	• Integrated Referral System
OpenBeds / Appriss Health	Specializes in bed management and referral software for healthcare	• Integrated Referral System • Interoperable System
ProtoCall	ProtoConnect platform supports telephonic behavioral health services	• Crisis Call Center
Social Solutions	Specializes in case management software for health and human services agencies through their Apricot platform	• Interoperable System • Integrated Referral System
Solari	Specializes in data-driven crisis and human services programs	• Interoperable System • Integrated Referral System
UniteUS	Coordinated care network of health and social service providers focusing on social determinants of health	• Interoperable System
Non-Healthcare Specific Software		
Amazon Web Services	Cloud computing platform	• Crisis Call Center • Integrated Referral System • Interoperable System
Aunt Bertha	Connected social care platform	• Interoperable System
Eustace Consulting	Specializes in customer relationship management (CRM) and cloud consulting solutions	• Crisis Call Center • Integrated Referral System
Microsoft (Dynamics)	Specializes in CRM	• Crisis Call Center • Integrated Referral System

[8] Data obtained from Washington State 988 Case Referral & Management System Discovery and Report, Vendor Assessment Section October 2021 prepared by Third Sector under contract Ballmer Group

Vendor Name	Vendor Summary	The System that the Technology May Support
		• Interoperable System
NavigatorCRE	Specializes in data management, integration, and analytics	• Integrated Referral System • Interoperable System
Salesforce	Specializes in CRM and cloud consulting solutions	• Crisis Call Center • Integrated Referral System • Interoperable System
Zoho	Specializes in CRM and cloud consulting solutions	• Crisis Call Center • Integrated Referral System • Interoperable System

As work on the Final Technical and Operational Plan progresses:

- additional information will be gathered about the systems offered by these (and other) technology vendors, including the functionality and capabilities of, and pricing for these systems; and
- when appropriate/feasible additional information will be gathered from current users of these systems.

Crisis Call Center System Platform

E2SHB 1477 requires that the crisis call center platform to be used in crisis call center hubs use technology demonstrated to be interoperable across crisis and emergency response systems used throughout the State (e.g., 911 systems, EMS systems, and other non-behavioral health crisis services). This platform must include the capacity to receive crisis assistance requests through phone calls, texts, chats, and other similar methods of communication that may be developed in the future that promote access to the behavioral health crisis system. Washington prefers the routing of crisis calls to stay within the State for more effective response.

DOH and HCA will evaluate Vibrant's ability to meet requirements outlined in the bill once their system capabilities are specified. In the event that the Vibrant system does not meet these requirements, Washington State has explored utilizing existing 911 capabilities and other key systems to achieve these requirements. The 911 system option may be feasible, however, 911 capabilities will need to be further analyzed and architected to make a more informed determination. DOH and HCA will collaborate with the Military Department to ensure the feasibility of this option and determine costs. Supporting interoperable ancillary systems may be needed for this solution as well, and will be defined as more information is obtained. The State will continue to assess other system options, including but not limited to, some of the solutions listed in the table above.

Vibrant Emotional Health (Vibrant)[9]

Vibrant, in their role as the national administrator of the NSPL, plans to develop a national unified platform (UP) in support of the NSPL call centers that consists of a Contact Center System (CCS) and a Customer Relationship Management (CRM) system. Both initial and ongoing costs and support will be covered by Vibrant and their chosen vendors. Call centers must provide adequate internet bandwidth by a local Internet Service Provider (ISP) but should see savings in telecom reduction costs. The call centers are expected to aid in: UP installation, center data cleansing and migration, change management for center personnel, assisting in upgrades and providing local hardware/infrastructure support (e.g., PC's, wired/wireless local area network, etc.). Call centers may not be obligated to adopt the Vibrant UP. However, if they develop their own systems, they may be required to integrate with it. There is no information at this time about the difficulty or cost associated with these efforts. Because of the minimal costs for implementing the CCS and CRM and the high risk of integrating another system with the Vibrant UP. DOH has been very intersted in Vibrant's UP; however, timing will be a key factor in determining how to move forward.

The Final Plan will more completely consider the capabilities and costs of implementing the Vibrant solution 911 capabilities and other potential systems that may meet needs of NSPL centers.

Vibrant identified the following key features and functional requirements ahead of their solicitation of vendors:

Vibrant CRM & CCS Key Features and Functional Requirements as of June 2021

Features and Requirements	CRM	CCS
Core Functionality	• Clinical Assessments • Information and Referrals • Crisis Plans and Safety Plans • Mobile Crisis Team (MCT) Referrals • Client Records with Minimal Data, Follow-Up Activities, Appointment Tracking, Call Notes	• ACD, Interactive Voice Response (IVR), Visual IVR • Omni Channel (Calls, Chats, Text, Email) Combination, Integration and Uniformity (Growing from Current PureConnect Uniformity on Chats, Text) • Skills-Based Routing
Data	• Reporting Platform (e.g., Tableau) • Standard and Customizable Report Capabilities	• Custom Reporting and Dashboards • Real-Time Monitoring
System Access and Controls	• User Role Hierarchy and Provisioning • Single Sign on Supportability (SSO and Integration)	• Configurable Role Based Access • SSO Integration
Administration	• Management Administration Capabilities (Drag and Drop) • User Capability Configuration • View, Add, Edit, Activate, Inactivate, Delete Functions • Audit Trail History	• Quality Management/Optimization • Administrator Application (Drag and Drop) • Workforce Management • Audit Trail History
Infrastructure	• CCS and External Integration / API Capability • Cloud / Scalability Operations and Capacity	• CRM and External Integration / API Capability • Telecom and Data with Carriers, Intermediaries • Cloud Based and Disaster Recovery / Availability

[9] Released by Vibrant CRM & CCS released June 2021 on Community Learning website for grantees (988 State Planning Grant)

	• Integrated Vendor / Vibrant Support Capability • Artificial Intelligence Capabilities for Future Usage	• Integrations /API's / API Management

Note: Vibrant is still in the process of defining their systems. Once these system capabilities are specified, Washington State will evaluate if the Vibrant UP platform meets the needs of E2SHB 1477.

Vibrant UP Development and Roll-Out Key Milestones:

The following are key milestones and timelines identified by Vibrant. In early January 2022, Vibrant announced the vendors selected for the Unified Platform system design to coordinate 988 services nationwide. The vendors chosen are Salesforce for the Customer Relationship Management (CRM) and Genesys PureCloud for the Contact Center System (CCS) Functionality. Additionally, Volunteers of America of Western Washington, one of the National Suicide Prevention Lifeline crises call centers in Washington State, has been selected by Vibrant to participate as a member of the Unified Platform Advisory Committee (UPAC). This group will function in providing content considerations and subject matter knowledge in the building of Vibrant's Unified Platform.

Timeline	Milestones
End of May 2021	SAMHSA awarding of 988 contract to Vibrant
Early June 2021 – early October 2021	Questionnaire, Request for Proposals (RFPs) as determined from questionnaire and vendor evaluations for the CCS and CRM
Early October 2021	Vendor selections
Mid October 2021 – July 2022	• Close vendor contracts • Design • Development • Integration • Testing • Data migrations
October 2022 – December 2022	Initial Phase I go-lives
2023	Expanded roll out

The following Staging and Phasing activities were identified by Vibrant:

- Sign-ups and readiness assessments in 2022
- Phasing of additional go-lives in waves, 2023, TBD
- Integration planning for non-migrating centers – 2022 through 2023, TBD

Behavioral Health Integrated Client Referral System

To comply with E2SHB 1477, the required Behavioral Health Integrated Client Referral System must be capable of providing system coordination information to crisis call center hubs and other entities involved in behavioral health care. As described in the Draft Technical and Operational Plan, the Integrated Referral System will use data from a number of ancillary systems. These various systems will send or connect to the Integrated Referral System through accepted interoperability protocols (that will be

identified in the Final Plan). An inventory of the interoperable ancillary systems needed to support the Integrated Referral System, including a description of the systems capabilities and whether these solutions will comply with all parts of E2SHB 1477 will be compiled as part of developing the Final Technical and Operational Plan.

Potential systems that may be explored for the Final Technical and Operational Plan regarding their ability to support the required Behavioral Health Integrated Client Referral System include:

- 988 platform (e.g., the Vibrant Unified Platform (UP))
- Computer Aided Dispatch (CAD)
- Health Information Exchange
- Community Information Exchange Systems
- Referral Systems (e.g., Collective Medical, OpenBeds)
- Bed availability solutions (e.g., WA-TRAC, WA Health, Open Beds)
- Provider directories (e.g., directories at the NSPLs, Regional directories, DOH Provider Registry)
- Provider health information technology systems (e.g., EHRs, EHRaaS, Collective Medical)
- Community service systems
- Case management/Care Coordination systems (e.g., used by MCOs, BH-ASOs)

Ancillary and Supporting Systems

Many of these ancillary and supporting systems do not exist and planning for these systems may or may not have started yet. Some systems are in various stages of development and/or implementation that could potentially help inform the design and implementation of Supporting Systems needed for the Crisis Call Center System Platform and Behavioral Health Integrated Client Referral System in Washington State.

Planning has not started for:

- an integrated system that would provide information about less restrictive alternative treatment orders; and
- a statewide comprehensive provider directory that includes providers who deliver services to individuals in crisis.

Systems with current options or have some work underway:

- Electronic consent management system: A plan for an electronic consent management system has been developed and funds to implement are being sought. However, the system has not yet been implemented; and
- Provider directories: There are regional provider directories that are currently used across the State. More information is needed about these directories (including their content and structure) to explore the feasibility of integrating or re-using information from the regional directories into the statewide directory.
- Bed availability: Bed availability options exist. The use of any of the bed availability software applications is associated with provider burden of needing to regularly update bed availability. Additional work is needed to explore the alternative software solutions for bed capacity management and options for reducing/mitigating provider burden. For example:

- WATrac Tracking and Alert System: The WATrac Tracking and Alert System hosted and managed by the DOH enables statewide collaboration daily and during emergency responses.[10] The system is intended to track on a daily basis bed availability at acute care hospitals and emergency departments.
- WA Health: WA Health was stood up during the public health emergency caused by COVID-19 to, among other things, create visibility to hospital system capacity.

- Bed Registries and Referral Systems; Several states are reported to have implemented different technology solutions to support different functionality needed associated with bed registries and/or referral systems . Two key functions that these systems can support include:
  - A searchable database that includes information on behavioral health providers/crisis bed facilities, their locations, services, availability, and contact information. Users call the provider to request a bed; and
  - Both a searchable database on bed availability and referral systems. These systems provide information on bed availability and support authorized users to submit HIPAA-compliant electronic referrals to request beds and enable the providers to respond electronically to referrals.
    - OpenBeds is an example of a software solution that is being used in several states for capacity management of behavioral health beds and/or electronic referral systems. OpenBeds was reported to be used for bed capacity management by 18 of the 23 states in the SAMHSA/ NASMHPD report entitled, "Improving Access to Behavioral Health Crisis Services with Electronic Bed Registries". In addition, in stakeholder conversations convened by DBHR staff, OpenBeds was identified as a useful bed capacity management vendor. Finally, DBHR staff note that there are three pilots underway in Washington State involving OpenBeds (each pilot is reportedly implementing different functionality). Additional information will be gathered from OpenBeds and other bed availability/bed capacity management vendors and users of these systems.
- Collective Medical: Many providers in the State use tools offered by Collective Medical. Use of these tools could assist with collaboration withbetween emergency departments, primary care providers and behavioral health providers within managed care organizations and BH-ASOs (as required in Subsection 102(6)(d)). A pilot is underway by the North Sound BH-ASO to implement Collective Medical tools to support information sharing on behalf of people in crisis.[11]

- EHRs: All health systems with EHRs have internal bed capacity tracking capabilities, but with no interoperability across organizations. Many behavioral health providers report using EHRs, including certified EHRs. However, very few behavioral health providers report using their EHRs to support electronic referrals, including closed loop referrals. More information is needed about the use of

[10] Cite: https://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/EmergencyPreparedness/WATrac and https://www.doh.wa.gov/Portals/1/Documents/1400/WATracFeatures_march2017.pdf

[11] Collective Medical Presentation Feb 2021

certified EHRs by specific types of behavioral health providers (e.g., crisis responders, SUD treatment providers) and their use of electronic and closed loop referrals.

- EHR as a Service (EHRaaS): The State is planning to support behavioral health, tribal, rural health, and long-term care providers use of a service called EHR as a Service (EHRaaS). One of the expected uses of the EHRaaS solutions would be to support providers in receiving referrals for and delivering services on behalf of persons in crisis and in need of behavioral health services.

Electronic Health Record as a Service (EHRaaS Hosting)

The HCA has requested funding, which has been included in the Govonors supplemental budget proposal, to implement an Electronic Health Record as a Service (EHRaaS) solution. This platform will meet a variety of needs, with an initial focus on supporting behavioral health, rural, tribal, and long term care providers. These providers serve many of our underserved communities, yet often don't have the resources to procure or maintain this type of solution. This platform will be hosted in a commercial cloud platform including adequate backup and recovery processes, scalability, resilience and stability of the host, and security requirements of the platform. Making available the EHRaaS will further the State's ability to provide equitable, real-time, coordinated, and integrated services as required by E2SHB 1477 (particularly for providers that are still using paper processes). Information that is expected to flow (e.g., related to referrals and follow-up on post-crisis service delivery), could be received through the use of EHRs, including use of EHRaaS.

Providers have expressed interest in using the EHRaaS for several reasons including the high cost of EHRs (if the provider had to procure the system on their own), their current EHRs do not meet their needs, and the anticipated implementation support expected to accompany the EHRaaS.

Building on an existing collaboration with Epic from the Rover App and EpicCare Link, the HCA seeks to procure expanded features of the Epic platform to include modules such as the behavioral health, clinical, SDOH, analytics, and patient services to enable better care coordination and patient services.

HCA will implement this service using a lead organization (LO) who will operate this on behalf of Washington State, herherherherAs noted, the initial targeted providers for the EHRaaS will be rural, behavioral health, long term care,herd tribal providers.

Cost and Pricing for Needed Technology

As the Final Technical and Operational Plan continues to be developed, cost and pricing information will be gathered for each of the technology solutions and platforms needed for the enhanced and expanded behavioral health crisis response and suicide prevention services for all residents in Washington State envisioned in E2SHB 1477. High-level cost and pricing information will include planning stake holder engagement, implementation and maintenance costs as well as other cost information for a time span of 5 years. Vibrant Emotional Health modeled first year costs for a Crisis Call Center Platform in Washington State. These costs ranged from a low of approximately $6 million to a high of $6.6 million.[12]

[12] Washington 988 State Volume and Cost projection Report from Vibrant Emotional Health. January 2021

Additional training between all partners involved to meet the requirements of HB1477 implementation, and strategic utilization of technology, may be necessary and will be included in the Final Technical and Operational Plan.

Limitations

At present, there are several gaps and uncertainties regarding the technical solutions needed to support implementation of E2SHB 1477. Content in this Draft Technical and Operational Plan is limited by the following gaps in information and will be addressed in the Final Plan as additional information is acquired.

Uncertainties Regarding the National 988 Platform

The Federal Government has not yet decided on which vendor will provide the routing structure for the national 988 crisis line. Until a national vendor is selected, the capabilities and limitations of the vendor solution remain unknown. A significant impact to this Draft Plan is that the capacity of other needed technology solutions to interoperate with the national 988 solution cannot yet be determined.

Uncertainties Regarding Supporting (Ancillary) Systems

Additional business requirements and the overall conceptual plans are needed to support the enhanced and expand the behavioral health integrated client referral system (including capabilities, limitations, costs) to meet all the requirements of Subsection 102(6). Further, needed Supporting (Ancillary) Systems will be impacted by programmatic decisions emerging from the CRIS. For example, these decisions could impact who gets access to what data, and what they are able to do with it.

Cross- System Analyses Needed

Additional analysis is needed to review the systems to support the NSPL Crisis Call Centers, Regional Crisis Lines, and providers and payers in the delivery and coordination of crisis services.

In addition, HCA and DOH will need to work with the Military Department, responsible for 911 services, to ensure a seamless transition and appropriate integration and interoperability, between the 911 and regional crisis lines, NSPL, dispatch services, CAD systems, and Tribal Crisis Line. These systems and entities will need to coordinate care, send data, and hand off callers to other services smoothly.

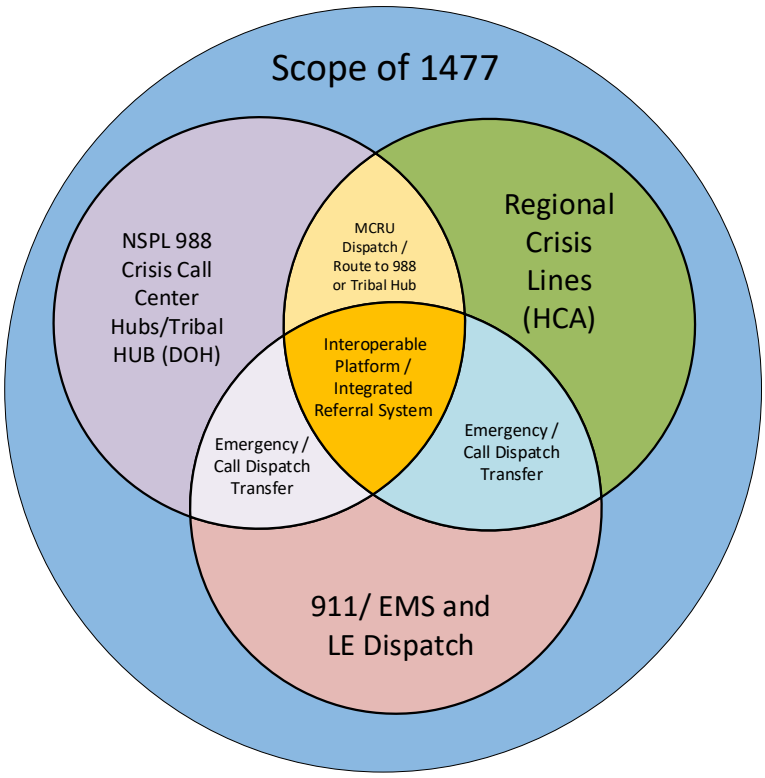

Figure 5 Entity Coordination

Data Analytics & Performance Metrics to be Required by System

Additional information will be obtained from interviews with key stakeholders, including the CRIS Committee and staff from VOA, HCA DBHR, DOH, providers, and others to identify current and future data analytics and performance metrics required by the system to support requirements in E2SHB 1477. At a minimum, structure, process, and outcome performance metrics are expected to be specified for the NSPL crisis center hub, regional crisis lines, and the behavioral health integrated client referral system. The systems and platforms decribed in this Draft Technical and Operational Plan are expected to make avaialble data needed to construct metrics.

At a minimum, the following potential metrics are expected[13] but not limited to:

Crisis Center Hub Key Performance Indicators

- Number of Calls Initiated
- Number Answered In-State and Rate
- Number Answered Out-of-State

[13] Potential metrics were identified through E2SHB 1477, Crisis Call Center staff (VOA), 911, and other State Crisis Line programs.

- Number of Calls Abandoned and Rate
- Number of calls transferred
- Average Answer Time
- Average Handle Time
- Routing of calls
- Average response times
- Call outcomes (e.g., follow up, cross-system coordination, and accountability, any immediate services dispatched)

Behavioral Health Services Metrics

- Client received outpatient referral appointment within 24 hours
- Follow-up with client completed and outcomes documented
- Safety plan established for the caller

Liability

The Final Technical and Operational Plan will consider potential liability issues that may arise for state agencies, health and behavioral health service providers, Tribal organizations, vendors, and others when using the technology systems and solutions to respond to crisis events. Scenarios that could result in liability will be identified, discussed, and plans that could mitigate or reduce the potential issue will be identifed. Consultation with the legal departments of DOH and HCA will inform this section in the Final Technical and Operational Plan. Areas identified for review include:

Demarcation Liability: In the event of an issue clear demarcation points are important to understand who had responsibility. In certain instances, if there are two entities responding simultaneously there may be join responsibility. These demarcation points apply to entities involved as well as technical flow of data.

Vendor Liability: Demarcation points as it relates to technical flow will determine vendor liability. Systems are required to send and receive data, therefore if one system send the call and the receiving system did not receive it, determination of who has responsibility will need to be determined. Mitigation strategies of how messages receival is confirmed by the sender will need to be implemented where possible.

Call Handler/Responder Liability: Call handlers and responders have liability as this involves lives. Clear responsibility for an act or failure to act—regularly arise during emergency response situations. DOH and HCA will need to address the concerns of volunteers and others involved in emergency responses process.

Agency Liability: DOH, HCA or local governments may be included in lawsuit because HCA or DOH is involved. These scenarios will need to be discussed and plans put in place to address this.

Technical Liability: Uptimes, service availability, continuity of service, security failures or breaches may result in liability. SLA's specifying 99.99% availability is important in an emergency response process. System may go down as a result natural causes, malicious causes will need to be protected and address.

Government Liability: Government to Government partnership is prevalent within this process with Washington Indian Behavioral Health Hub and Tribal Governments needs to be considered.

Regulatory Agency

The Final Technical and Operational Plan will specify the role of regulatory agencies responsible for the implementation of various systems needed for the expanded and enhanced crisis call center system platform and behavioral health integrated client referral system. These regulatory agencies include those that directly impact the systems, as well as those that may impact the project indireclty such as federal agencies providing funding or have applicable laws for these systems.

- Regional Crisis Lines (HCA)
- 911/EMS (MIL)
- NSPL Crisis Call Center/ Washington Indian Behavioral Health Hub (DOH)

Risks and Mitigation

The following are considered high impact risks affecting the project and mitigation strategies that may impact the Final Technical and Operational Plan.

Risk	Mitigation Strategy
Aggressive implementation dates	Seek guidance from legislature
Rapidly evolving landscape with a variety of decision-makers involved (Federal, State, local, etc.)	Will monitor information, coordinate across agencies, and establish back-up plans
NSPL crisis call centers are unable to adopt the Vibrant 988 call system platform (or if the Vibrant 988 platform lacks needed functionality)	Explore alternatives to the Vibrant platform
Needed interoperable solutions may not be available to support functionality needed for Behavioral Health integrated Client Referral System	Assess, and as needed request funds to develop needed solutions
Coordination between state agencies will be crucial for project success	Ensure each agency has the resources needed to coordinate efforts
Needed coordination with CRIS Subcommittees, including Technical and Tribal Subcommittees	Coordinate with Subcommittees
Evolving environments and impact on Technical and Operational Plan	Identify potential impacts and inform decision makers
Need to execute data sharing agreements between physical health, behavioral health and social service providers in a timely manner	Begin conversations as early as possible; inform decision-makers about challenges as they arise
Funding needed to acquire, implement, and maintain needed crisis call center platforms	Assess, and as needed request funds
Funding needed to acquire, implement, and maintain solutions needed for the Integrated Referral System	Assess, and as needed request funds
Funding needed to acquire, implement, and maintain needed Interoperability Solutions	Assess, and as needed request funds
Funding needed to acquire, implement, and maintain needed ancillary/supporting systems	Assess, and as needed request funds
Funding needed to implement and support maintenance and operations for the EHRaaS	Assess, and as needed request funds

Summary and Next Steps

Achieving interoperability, outcomes tracking, real-time identification of services and information, and referrals along with the other requirements of E2SHB 1477 will require continued requirements analysis, design and validation sessions, vendor selection and engagement with providers and other partners to be successful. Additional information will be gathered, and guidance sought, to produce the Final Technical and Operational Plan for the advanced crisis call center system and behavioral health integrated client referral system required in E2SHB 1477 including:

- Determining the vendor and system functionalities needed for the Washington State 988 crisis call centers, including how the future Crisis Call Center Hub System will interoperate with regional crisis lines;
- Identifying the types of system users for the 988 and regional crisis call lines and the Behavioral Health Integrated Client Referral System, and their roles and responsibilities (including access to and use of information in these systems);
- Identifying vendors and costs that could be support: real time bed availability information, a statewide comprehensive provider directory, electronic referrals, and other ancillary systems needed for information exchange to respond to persons in crisis and enable continuity of care; and
- Determining data governance and establishing all necessary agreeements..

Summary

The Draft Plan describes and summarizes what is known about and what additional information is needed regarding the technology and platforms required to implement the enhanced and expanded behavioral health crisis response and suicide prevention services envisioned by the State Legislature.

The Draft Plan identifies:

- The key systems needed to implement E2SHB 1477 and the need to further specify the technical features and requirements for each of these systems to implement E2SHB 1477;
- Some of the potential technology vendors and the need to identify other vendors that could support implementation of E2SHB 1477 and the need to identify the technical features and capabilities of each of these vendors;
- Some of the potential roles for various system users;
- The need to specify privacy issues, considerations and requirements that would apply to each of the systems and the various system users;
- Data management considerations related to the various systems; and
- Areas in which additional information is needed to create the Final Technical and Operational Plan.

Next Steps

Significant additional work is needed to create the Final Technical and Operational Plan required in E2SHB 1477 Section 109.

To develop the required Final Plan, additional information will be provided by or gathered from:

- DOH will provide updates regarding the Vibrant UP; and

- Information will be gathered from:
    - Crisis call center staff and service providers (e.g., NSPLs, regional crisis lines, and behavioral health providers);
    - Technology vendors that could support the envisioned crisis response and behavioral health integrated referral system in Washington State;
    - Users of these technology solutions (e.g., in other States);
    - Payers of crisis services (e.g., managed care organizations and BH-ASOs);
    - State policymakers; and
    - The Crisis Response Improvement Strategy (CRIS) Subcommittees, including the Technical and Tribal Subcommittees.

Additional information will be gathered to describe the technology and platforms, including operational challenges, in implementing the systems needed for the enhanced and expanded behavioral health crisis response and suicide prevention system in the State.

The Final Technical and Operational Plan will:

- include a strategy, roadmap, and decision making process for selecting, prioritizing, and implementing the systems needed to implement the advanced Crisis Call Center System and Behavioral Health Integrated Client Referral System required in E2SHB 1477; and
- address needed technology solutions (including system requirements), acquisition principles (e.g., cloud first solutions, use of commercial off-the-shelf products), data, implementation methods and approaches (including the engagement of various partners (e.g., state agencies, providers, vendors)), timelines and project management.

Topics about which additional information will be gathered include:

- Determining whether the Vibrant technology solution is a timely option for the crisis call center line in Washington State and/or if other systems should be pursued.
- Determining whether, and if so, how the future NSPL/Crisis Call Center Hub System will be interoperable with regional crisis lines; and whether the regional crisis call lines will be able to access the Integrated Client Referral and Interoperable Systems and technology solutions.
- Determining the type of information that: (i) individuals in crisis need and may provide; and (ii) NSPL/crisis call centers, regional crisis lines, and the Behavioral Health Integrated Referral System may need, create, maintain, and exchange.
- Identifying requirements for different Interoperable Technology Solutions needed for the enhanced Crisis System in Washington State, and the vendors and their capabilities and costs that could support the needed functionalities for ancillary systems.
- A statewide comprehensive provider directory, including exploring the feasibility of re-using and/or integrating information from regional provider directories into the statewide directory.
- Technology tools that support the capabilities to:
    - request deployment of appropriate crisis response services; and
    - verify and document whether the individual's transition to follow up non-crisis care was completed and services offered

- Systems that enable needed information exchange to respond to persons in crisis and support continuity of care, including systems that:

  (i) support electronic referral and follow-up to non-crisis care;
  (ii) make available information about any less restrictive alternative treatment orders and mental health advance directives;
  (iii) support collaboration between the Crisis Call Center Hubs and emergency departments, primary care providers and behavioral health providers to establish safety plans for individuals; and
  (iv) provide and document geographically, culturally, and linguistically appropriate services to persons who are part of high-risk populations.

  Systems that will be explored include:

  - Certified EHRs to support electronic and closed loop referrals;
  - Event notification solutions to support information exchange for persons experiencing crises; and
  - availability of the EHRaaS

- Metrics that will be needed to track the outcomes of the 988 call and enable appropriate follow up, cross-system coordination, and accountability.

Appendix A: E2SHB 1477 – Sections and Effective Dates

Section Number	Section Title/Focus	Effective Date
Part I	**Crisis Call Center Hubs and Crisis Services**	**July 25, 2021**
Sec. 101	Findings of the Legislature	
Sec. 102	Establishing the state crisis call center hubs and enhancing 21the crisis response system	July 25, 2021
Sec. 103	Crisis Response Improvement Strategy (CRIS) Committee	May 13, 2021
Sec. 104	CRIS steering committee monitor and make recommendations related to the funding of crisis response services out of the account created in section 205	July 25, 2021
Sec. 105	DOH and HCA annual report to the Governor and Legislature regarding the usage of the 988 crisis hotline, call outcomes, and provision of crisis services	Beginning each November beginning in 2023
Sec. 106	Health plans requirements to make next-day appointments available to enrollees experiencing urgent, symptomatic behavioral health conditions to receive covered behavioral health services	Plans renewed on or after January 1, 2023
Sec. 107	Governor appointed 988 hotline and behavioral health crisis system coordinator for project coordination and oversight of the 988 crisis hotline, other requirements of this act, and other projects supporting the behavioral health crisis system.	July 25, 2021 through June 30, 2024
Sec. 108	Deeming state agency employees in carrying out duties to the public when acting on statutory requirements in E2SHB 1477	
Sec. 109	Requirements for Technical and Operational Plan	Draft technical and Operational plan submitted no later than January 1, 2022 and final plan by August 31, 2022
PART II	**Tax**	
Sec. 201	Definitions	Oct. 1, 2021
Sec. 202	Tax Imposed	Oct. 1, 2021
Se. 203	Collection of Tax	Oct. 1, 2021
Sec. 204	Payment and Collection	Oct. 1, 2021
Sec. 205	Account Creation	Oct. 1, 2021
Sec. 206	Preemption	July 25, 2021
Part III	**Appropriations**	
Sec. 301	Appropriations to DOH and HCA	For fiscal biennium ending June 30, 2023

Sec. 302	Conditions and Limitations on Appropriations to DOH and HCA	For fiscal biennium ending June 30, 2023
Sec. 303	Appropriation to OFM	For fiscal biennium ending June 30, 2023
Part IV		
Sec. 401	Definitions and Miscellaneous	Expires July 1, 2022
Sec. 402	Definitions	Takes effect July 1, 2022
Sec. 403	DOH license or certify mental health peer-run respite centers that meet state minimum standards	
Sec. 404	Sec. 201 through 206 constitute a new chapter in Title 82 RCW	
Sec. 405	Sec. 201 through 205 take effect October 1, 2021	
Sec. 406	Section 401 expires July 1, 2022	
Sec. 407	Section 402 takes effect July 1, 2022	
Sec. 408	Section 103 necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and takes effect immediately	

Appendix B: Crisis Center Requirements[14]

This following outlines the basic requirements that crisis centers must meet to become members of the Lifeline network based on information from Vibrant.

Certification/Accreditation

The crisis center must provide proof of certification/accreditation from one of the following:

- American Association of Suicidology (AAS)
- CONTACT USA
- Alliance of Information and Referral Systems (AIRS)
- The Joint Commission
- Commission on Accreditation of Rehabilitation Facilities (CARF)
- Council on Accreditation (COA)
- Utilization Review Accreditation Commission (URAC)
- DNV Healthcare, Inc.
- State/county licensure, as approved by the Administrator

Centers without certification/licensure may still be able to join the network, assuming there is a demonstrable need for a center in that area, and the center signs the provisional status amendment, by which it agrees to obtain certification within a set time frame.

Insurance

The center must have liability insurance that covers directors and officers, as well as staff and volunteers who respond to crisis calls in the amount of at least $1,000,000 per occurrence and $3,000,000 aggregate, unless otherwise approved by the Administrator.

Coverage Capacity

The crisis center must have the ability to consistently cover a geographic region; designated by county, area code, zip code, or state.

Dedicated Staff & Guidelines

The organization is required to have a distinctive call operation with the capacity to identify, receive and respond to calls from individuals in distress, preferably 24/7. The crisis call operation must utilize its own policies, procedures and training protocols and have identified staff and an administration that is responsible for the oversight of the operation.

Training

The crisis center must provide for basic training of call center staff (for both new and active staff members).

Network Participation

The crisis center must be willing to engage in a contractual agreement with the Administrator by signing the Network Agreement.

Quality Assurance

The crisis center may not practice any of the following to manage incoming Lifeline calls:

[14] https://suicidepreventionlifeline.org/wp-content/uploads/2017/07/Appendix-1-Lifeline-Requirements-for-Membership.pdf (accessed December 20, 2021).

- Utilize an answering service or cellular telephones;
- Utilize an automated attendant or any other system that requires a caller to press a telephone key to be connected with center staff/volunteers;
- Forward incoming Lifeline calls to a third party; or
- Allow a receptionist or any center staff/volunteers that have not been trained to assist callers to answer/triage calls.

Quality Assurance Evaluation

The crisis center must be willing to participate in National Suicide Prevention Lifeline network evaluation activities to promote quality assurance for network operations (e.g., call logs).

Crisis Center Liaison

The crisis center must provide at least one contact at the crisis center that will serve as a liaison to the National Suicide Prevention Lifeline and will provide all possible contact information (name, title, email, and phone numbers) for said contact.

Referrals

The crisis center must be able to offer callers referrals to service providers in its designated coverage area.

Suicide Risk Assessment

The crisis center must ask all Lifeline callers about suicide at some point during the course of the call and, if the caller answers affirmatively, conduct a more thorough suicide risk assessment by using an instrument which incorporates the principles and subcomponents of the Lifeline's Suicide Risk Assessment Standards.

Assisting Callers at Imminent Risk of Suicide

Effective as of 2/1/2012, the crisis center will need to adhere to the Lifeline's new Policy for Assisting Callers at Imminent Risk, which provides specific guidelines for assisting the Lifeline's high-risk callers.