# Final Technical and Operational Plan

## National 988 System: Crisis Call Center and Behavioral Health Integrated Referral System

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

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## Acknowledgements

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# Final Technical and Operational Plan
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# Executive Summary

Across the country, and in Washington State, suicide and incidence of other mental health crisis remain an urgent priority. Suicide was among the 10 leading causes of death in the United States in 2020 among persons aged 10–64 years, and the second leading cause of death among children and adolescents aged 10–14 and adults aged 25–34 years.[1] As part of the response to these crises:

- In 2020, the Federal Government passed legislation designating 988 as the number to call to reach the National Suicide Prevention Lifeline (NSPL) and access assistance. The NSPL is a national network made up of trained providers that offer free and confidential support services for individuals in crisis. On July 16, 2022, 988 went live across the country.
- On May 13, 2021, the Washington State legislature passed the "Crisis Call Center and Services Act" (E2SHB 1477) related to the implementation of the national 988 system and to enhance and expand behavioral health crisis response and suicide prevention services statewide.

E2SHB 1477 requires enhancements to the crisis call and response platform and the behavioral health integrated client referral system. In addition, it requires that Health Care Authority (HCA), in collaboration with Department of Health (DOH), produce a Technical and Operational Plan that defines the technology tools, platforms, and systems necessary to manage and operate the behavioral health crisis response and suicide prevention system.

Section 109 of E2SHB 1477 requires the submission of a Draft and Final Technical and Operational Plan and specifies the topics included in these plans.

The Draft Technical and Operational Plan was submitted in February 2022 and described what was known regarding the crisis call and response platform, related behavioral health systems, and gaps in information that needed to be addressed.[2] The Draft Plan described the need for a "System of Systems" approach to integrate and interoperate systems to support requirements in E2SHB 1477.

As described in more detail below, the Final Plan describes:

- Technology tools currently used in Washington and other states to support crisis call and response systems;
- The technical functional requirements needed to achieve the vision of E2SHB 1477;
- Research conducted of the vendor landscape to meet those requirements; and
- Technical considerations related to implementing crisis call and response services including security, privacy, data access and management, interoperability, and other considerations.

[1] National Center for Health Statistics. About multiple cause of death, 1999–2020. Hyattsville, MD: US Department of Health and Human Services, CDC, National Center for Health Statistics; 2021. Accessed December 27, 2021. https://wonder.cdc.gov/mcd.html

[2] https://www.hca.wa.gov/assets/program/draft-leg-report-988-operational-plan.pdf

**The Final Plan articulates a vision** for an enhanced behavioral health crisis call and response system, and summarizes:

- Federal environment and requirements for implementation by the NSPLs of the new 988 crisis call line number and other activities related to the crisis call lines; and
- State law requiring, in part:
  - Enhancements to:
    - Crisis call and response system (including use of the Washington Indian Behavioral Health Hub); and
    - Behavioral health integrated client referral system; and
- The technical and operational plan needed to support these systems.

**The Final Plan describes the information gathering activities** that were conducted to enhance our understanding of the technical systems needed to support requirements in E2SHB 1477, including:

- Capabilities and needs of the crisis call and response systems in Washington State, including:
  - NSPLs (including the Native and Strong Lifeline);
  - Regional Crisis Lines (RCLs); and
  - Behavioral health crisis responders.
- The infrastructure and standards that support geolocation technology used in the 911 emergency response system to route calls based on location and not today's routing of crisis calls based on area code. The National Emergency Number Association (NENA) establishes standards and requirements that enable geolocation, including the Emergency Services IP Network (ESInet) and Public safety Answering Points (PSAPs);
- Technical and operational activities underway in other States regarding the crisis call and response systems that these States have or will be implementing; and
- Technology vendors that describe having tools that could address functional requirements in E2SHB 1477, including the anticipated capabilities of the Vibrant Unified Platform (UP) that will be utilized by the NSPLs.

**The Final Plan Identifies the functional requirements** needed for the crisis call center platform and behavioral health integrated client referral system required in E2SHB 1477 including:

- Supporting a call center platform that provides omni-channel communication between individuals in crisis and call centers;
- Supporting call routing to crisis call centers and tracking of responders;
- Creating and closing referrals and appointments;
- Enabling document exchange on behalf of crisis callers between the callers, responders, and different resources supporting callers; and
- Standardizing reporting.

**The Final Plan summarizes the technical, exchange, and clinical content standards** needed to support the integration and interoperability of the myriad systems and information that needs to be exchanged to support E2SHB 1477; including:

- Content standards (such as LOINC, SNOMED CT, ICD-10); and

- Document exchange standards (e.g., HL7 Clinical Document Architecture (CDA), Fast Health Interoperability Resources (FHIR)).

**The Final Plan describes needed technology** requirements to:

- Standardize and make interoperable key crisis documents referenced in E2SHB 1477;
- Efficiently and securely implement and integrate needed interoperable systems;
- Ensure data privacy and Tribal data sovereignty;
- Ensure appropriate data management, including data access and re-use; and
- Enable needed data reporting.

**The Final Plan Articulates a Business Plan Analysis.** The analysis describes:

- The business and clinical workflows to respond to crisis call services in Washington State;
- Metrics that will be considered for monitoring the enhanced crisis call and response system;
- Needed technology tools and platforms for the enhanced crisis call and response system; and
- The need for on-going close collaboration with and between HCA, DOH, OCIO, the Governor's Office, and the CRIS Steering Committee and Subcommittees.

**The Final Plan includes an Implementation Plan and Recommendations** section that identifies three categories of options that HCA and DOH considered for selecting and implementing the crisis call center systems needed to address the requirements in E2SHB 1477. The three categories are:

- Category 1: Select a Single Vendor Solution
- Category 2: Select a Primary Vendor and Vendor Partners, and Explore Use of NENA i3 Solution Architecture to Prepare for Future Federal Use of this Technical Infrastructure for 988 Crisis Calls and Response in Washington State
- Category 3: Completely Modular

For each category, the Implementation Plan identifies pros and cons, provides an analysis, and offers considerations related to each category.

**HCA and DOH recommend proceeding with Category 2.** HCA and DOH believe that the options in Category 2 provide the most viable approach to achieve the objectives laid out in E2SHB 1477. Category 2 presents options related to:

- Selecting a primary vendor (i.e., Vibrant or a different commercially available solution) that would partner with other technology vendors to offer a solution that meets the requirements in E2SHB 1477; and
- Analyzing the NENA i3 Solution Architecture, including the Emergency Services IP Network (ESInet) and equipment in the PSAPs, that enable the technical infrastructure needed for geolocation. This analysis will help Washington State monitor the efforts at the National level around call routing and ensure Washington's technology solution will align with any changes to the National technical call infrastructure for 988 crisis calls and responses. This analysis will help prepare Washington's technology solution to meet the requirements of E2SHB 1477 to track local response.

HCA and DOH recommend that the state proceed with:

- Requests for Information (RFIs) followed by Requests for Proposals (RFPs) from primary vendors (including Vibrant Emotional Health and other commercial vendors) to partner with other vendors to offer a crisis call center platform to meet the technical functional requirements in E2SHB 1477; and
- Exploring the use of the NENA i3 Solution Architecture, including the ESInet and PSAPs, in Washington State while monitoring federal discussions about any potential use of this technical call infrastructure for 988 crisis calls and response.

The Implementation Plan also identifies areas for which additional funding is needed to support technology and data management related activities for the envisioned integrated behavioral health crisis call and response system (e.g., including funds for staffing resources, standardizing and making interoperable documents needed for crisis call and responses, providing training and technical assistance to crisis providers).

HCA and DOH recommend that the state proceed with:

- Publishing Requests for Information (RFIs) from primary vendors (including Vibrant Emotional Health and other commercial vendors) to partner with other vendors to offer a crisis call center platform to meet the technical functional requirements in E2SHB 1477.
- Coordinating and collaborating with the OCIO to use information gathered through the RFI process to finalize more granular, executable technical specifications needed for a definitive path forward for Washington to implement the enhanced crisis call and response technology platform and tools envisioned in E2SHB 1477.
- Based on information learned via the RFI process and the final technical specifications that emerge from that process and are approved by the OCIO, publish RFPs to select the primary vendor to address the requirements in E2SHB 1477. The RFP would request technology vendors submit proposals describing the technology tools and platforms (including costs and timelines) that they would implement to support integrated and interoperable technical functionality required in E2SHB 1477, including any partnerships with other vendors.
- Obtaining other needed software solutions/products (e.g., closed loop referral, bed registry, resource directories);
- Creating interoperable documents needed for crisis call and responses (e.g., crisis plans); and
- Securing agency staff to support the acquisition, implementation, and management of the technology systems and tools.

**The Final Plan identifies the following next steps**:

- Obtain approval from the Office of the Chief Information Officer (OCIO), the director of Office of Financial management (OFM), and the Steering Committee of the Crisis Response Improvement Strategy (CRIS) Committee to implement this Plan.
- Continue to obtain clarification from Vibrant Emotional Health regarding the functionality of the Vibrant Unified Platform (UP) and timeframes by which these capabilities will be released.
- Continue collaboration with the Tribal Partners, OCIO, OFM, CRIS Steering Committee, and State Legislature clarifying the vision and legislative requirements for the state's crisis call and response system.

- Using information gathered through the RFI process, coordinate and collaborate with the OCIO to finalize more granular, executable technical specifications needed for a definitive path forward for Washington to implement the enhanced crisis call and response technology platform and tools envisioned in E2SHB 1477.
- Based on information learned via the RFI process and the final technical specifications that emerge from that process and are approved by the OCIO, RFPs would be published to select the primary vendor to address the requirements in E2SHB 1477. The RFP would request technology vendors to submit proposals describing the technology tools and platforms (including costs and timelines) that they would implement to support integrated and interoperable technical functionality required in E2SHB 1477, including any partnerships with other vendors.
- Secure funds from the State Legislature to:
  - Hire HCA and DOH staff needed to implement the Technical and Operational Plan;
  - Develop and publish RFIs, RFPs, and award contracts for a lead call center vendor and partnering vendors;
  - Acquire technology tools; and
  - Create and maintain needed interoperable documents.

## Vision for the Washington State Crisis Call and Response System

Washington State envisions a crisis call and response system that ensures that persons in crisis have:

**Someone to talk to**  **Someone to respond**  **A place to go** 

To realize this vision, the enhanced crisis call and response system must be supported by technology platforms and tools to ensure timely response and delivery of needed and coordinated services on behalf of persons in crisis.

The crisis call and response system described in this plan will:

- Support NSPL service provision;
- Rely on a robust behavioral health and social service delivery system; and
- Leverage interoperable technologies to ensure prompt crisis call responses and coordinated and seamless access to behavioral health crisis response and suicide prevention services.

Each element of the vision for the Washington State Crisis Call and Response System (i.e., someone to talk to, someone to respond, a place to go) is described below and broken out into phases:

- Phase 1 reflects activities for each element of the vision that are currently being implemented and will be supported, as needed, using the technology tools at a future date; and
- Phases 2 and 3 will be implemented or identified as needed policy and program changes emerge and/or new technology tools become available.

The specific timing of Phases 2 and 3 will be determined as part of the implementation of this final Technical and Operational Plan.

The Washington State Crisis Call and Response System will:

**1. Provide someone to talk to**

- Phase one and Currently:
  - On July 16t, 2022, the 988 call number went live and persons with a Washington State area code who call 988 are routed to one of the three NSPLs in Washington State.
    - 988 calls that are not answered within the 30 second response time are routed to a national back-up NSPL crisis center. Crisis calls to NSPLs are answered by trained counselors prepared to respond to crisis calls. All national back-up centers will be trained to have knowledge of the Native and Strong Lifeline.
    - A caller may also text or chat and a WA based NSPL is authorized to respond via text and chat.
    - If a caller wants a mobile crisis response (MCR), defer to section 2 below in Someone to Respond.
    - A person in crisis can call 988 and/or any of the other currently available crisis line phone numbers available in the State. See Appendix A for the other crisis lines in the State.
      - □ People who are affiliated with Washington tribal communities can call 988 and elect to be routed to the Native and Strong Lifeline will be able to do so when this line goes into effect (projected implementation date is Fall 2022).
      - □ Veterans calling 988 may elect to be routed to the national Veterans' Crisis Line.
      - □ People who speak Spanish who call 988 can elect to be routed to the national Spanish Language Lifeline.
      - □ LGBTQ+ youth and young adults can elect to be routed to the national LGBTQ+ affirming counseling Lifeline.
    - If the caller would like information regarding local resources and/or services, the NSPL (or Regional Crisis Line (RCL)) will ask the caller's address or zip code to identify and share information about local resources and services.
    - NSPLs and RCLs will continue to make referrals to currently available information and resources to local:
      - □ Community based services;
      - □ Outpatient mental health (MH) and/or substance use disorder (SUD) services; and
      - □ Indian behavioral health services through the Washington Indian Behavioral Health Hub.

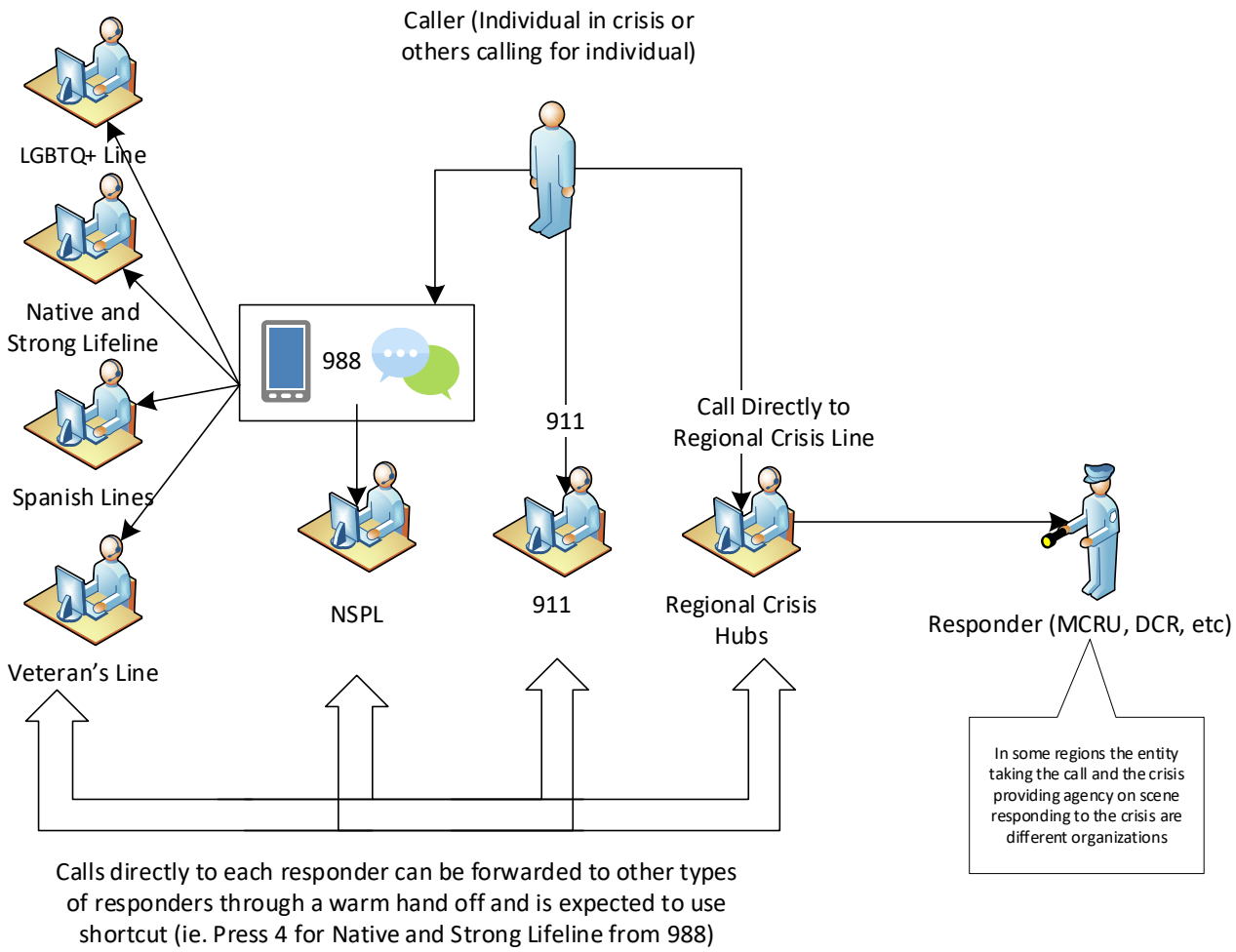


*Figure 1 Someone to talk to*

- Phase two:
  - HCA and DOH will work with the federal 988 vendor Vibrant, and the Washington Military Office/911 Coordinator to better understand how the 911 geolocation technical infrastructure routes calls based on location. HCA, DOH, Vibrant, and the Washington State 911 Coordinator will work to identify opportunities and challenges that, if addressed, could ready the state and the federal Vibrant routing to use geolocation call infrastructure for crisis call routing and response services (when permitted by the Federal Government) in a way that appropriately protects the caller's information and fulfills the goal of routing calls based on caller location and not area code like it works now.
  - HCA and DOH will continue to monitor national discussions around 988 and NSPL call routing and identify opportunities to communicate Washington's specific needs regarding the requirements in E2SHB 1477.
  - The crisis center platform used by the NSPLs will provide improved services, up to or including continuing education, content, or specialty lines, to increase access to culturally, geographically and linguistically appropriate services for people affiliated with Tribal communities, youth, LGBTQ+ persons, hearing impaired people and persons in agricultural and rural communities.

- Phase three:
  - All 988 calls placed in Washington State will be answered by a Washington State NSPL (i.e., technology will enable all 988 calls made in Washington to be answered in Washington regardless of the area code of the caller's cell phone). This geo-routing functionality is currently being worked on at the National level.
  - The crisis call system at the NSPLs will enable seamless referrals to MCR teams, specialty lines and/or services.
  - Tools will be deployed to enable access to real-time information about available community-based social and behavioral health (both MH and SUD) services, including tribal and other culturally appropriate services in partnership with the Indian Behavioral Health Hub.

**2. Someone to respond**

Mobile Crisis Response (MCR) teams provide community-based interventions to individuals experiencing a crisis wherever they are. The goals of these services are to help individuals experience relief quickly and resolve the crisis situation, provide less restrictive services in a location and environment where the person is comfortable and avoid unnecessary law enforcement involvement and emergency department use. MCR teams provide valuable eyes-on for the person in crisis and are skilled in establishing rapport. They provide de-escalation, risk assessment, safety planning, and involve family and natural supports in implementing safety plans.

In alignment with the Mobile Response and Stabilization Services (MRSS) model, when a youth calls or a caregiver/parent calls on behalf of youth, the NSPL shall offer the caller an MCR team in-person and without law enforcement. An in-person MCR team shall be a priority over any law enforcement response or sending the youth or family to an ED. In any case of a state dependent (Department of Children, Youth and Families (DCYF)) youth in foster care, at risk of losing that placement due to behavioral health symptoms, the family should receive an in-person response by an MCR team.

- Currently and Phase 1:
  - Crisis Centers support callers in crisis with the least restrictive approach possible. All processes are consensual unless active rescue is required for the safety of the person in crisis or others. If the call center identifies imminent risk of harm requiring **active rescue** for a person in crisis or others, the NSPL and/or RCL will:
    - Ask callers for their location and, as needed make every effort to determine the location of the caller.
    - Coordinate with 911 to dispatch a tribal and non-tribal first responder to resolve the emergency.
  - For callers presenting with **emergent** concerns but not in need of an active rescue, the NSPL will coordinate with an RCL to dispatch MCR teams.
    - When the RCL receives the call, they will follow their protocols and may:
      - Ask the location of the person and any information about the location to pass onto the MCR team, ask consent to dispatch an MCR team; and
      - Refer to a mobile crisis provider to dispatch a mobile crisis response (MCR) team **within 2 hours**.
  - For calls presenting **urgent** concerns without the need for active rescue the NSPL will coordinate with an RCL to dispatch MCR teams.
    - When the RCL receives the call, they will follow their protocols and may:

        - □ Ask the location of the person and any information about the location to pass onto the MCR team, ask consent to dispatch an MCR team; and
        - □ Refer to a mobile crisis provider to dispatch a mobile crisis response team within **24 hours.**
    - **After any MCR team or in person response is dispatched, the following shall occur:**
        - MCR teams will respond in-person and assess for immediate needs and follow MCR protocols.
        - RCL will follow up with the MCR team to ensure services have been provided. MCR will coordinate with Tribal Nations for individual in crisis.
        - RCLs and the Washington Indian Behavioral Health Hub will follow up with the provider to ensure services have been provided.
    - **Statewide standards/criteria will be developed and implemented for:**
        - Defining imminent risk; and
        - Identifying criteria for deploying different types of response teams, including:
            - □ Mental health only (including mobile crisis response (MCR) and designated crisis responders (DCRs);
            - □ Co-responder teams (including MCRs, DCRs and fire, emergency medical services (EMS), law enforcement); and
            - □ Crisis protocols for working with Tribal governments (Tribal Crisis Coordination Protocols).
- Phase two:
    - Geolocation will be used by the NSPLs to deploy and monitor appropriate crisis response services, including:
        - Mobile crisis response (MCR) teams;
        - Designated crisis responders (DCR's); and
        - Fire department mobile integrated health teams.
    - Information will be shared with crisis responders, as determined appropriate, in real time about:
        - Previous crisis history;
        - Safety concerns;
        - Mental health advanced directives;
        - Crisis or safety plans;
        - Wellness Recovery Action Plans (WRAPs);
        - Wraparound With Intensive Services (WISe) team contact info, and current WISe safety plan, if enrolled;
        - Tribal Crisis Coordination Protocols; and
        - Other important information for the response.

**3. A place to go and ongoing stabilization**

- Currently and phase one:
    - Persons calling the NSPLs and RCLs:
        - Will be offered mobile crisis response as indicated above. If it is determined by the responding MCR team that a placement in a facility is warranted and the person agrees,

the MCR team will refer the person to a facility. If accepted, transportation will be arranged to the facility or to an Emergency Department for medical clearance.
    - If it is determined the person would benefit from a placement in a facility, but they decline, MCR teams will make a safety plan with the person to ensure safety.
    - For Tribal members, MCR teams will follow any relevant Tribal Crisis Coordination Protocols.
    - Involuntary Treatment Act (ITA) investigation by a DCR will only be initiated for a person if the MCR team cannot build a safety plan that addresses risk and if it is determined there is an imminent risk. In most situations an ITA evaluation is not necessary and the MCR team will work with person to find a safe solution to their crisis.
    - Facilities or other appropriate locations where medical clearance may not be a prerequisite might include:
        - Remaining at home with supports in place (in-home) stabilization;
        - 23-hour walk-in facility;
        - Crisis Stabilization facility;
        - Detox or Withdrawal facility; and
        - Other placements as appropriate.
    - If the MCR team assesses that the person does not need placement, or the person declines placement, the MCR team will follow up with the person for up to 72 hours in a manner established between the team and person in crisis as clinically appropriate and desired by the person.
        - Persons self-presenting directly for crisis services will be offered or connected to crisis response or stabilizations services as outlined above.
        - Next day appointments will be available as a diversion option starting in January 2023.
- Phase two:
    - By providing real time bed availability information, a bed tracker solution will reduce the amount of time crisis response needs to find a placement. This resource must be available to Tribal partners per SB 6259, Washington Indian Behavioral Health Act.
    - A referral system will be used to automate the referral process and close the referral loop.
    - Next day appointments will be built into the referral tool.
    - Alternatives will be created for using Emergency Departments as a point of entry.
    - The need for medical clearance for admission will be reduced and facilities will be better equipped to accept people with disabilities and co-occurring disorders.
    - In home stabilization will be more available, serving as an option for people in crisis.
    - Mobile crisis teams will be able to provide transportation to facilities.

The vision for the Washington State crisis call and response system will be supported by the implementation of the Technical and Operational Plan that will provide tools for use by the Crisis Call Center Hubs and crisis responders. The solutions needed for the crisis call and response system in Washington State include tools that:

- Support crisis calls (including calls, texts, and chats) received by the Hubs.

- Supports routing of crisis calls for specific populations (e.g., AI/AN persons, LGBTQ+, youth and Veterans).
- Support interoperable exchange and the integration and re-use of information, including information from clients, health care, behavioral health and emergency service providers, and resource directory information, to support high-quality crisis intervention services, triage, care coordination, referrals, including closed-loop referrals, and connections to individuals contacting 988.
- Support interoperability across crisis and emergency response systems used throughout the state, such as 911 systems, emergency medical services systems, and other non-behavioral health crisis services.
- Comply with HIPAA, 42 CFR Part 2, and Washington State Law regarding consent for mental health and substance use disorder services, including services for adolescents.
- Comply with Tribal data sovereignty requirements.
- Provide a user-friendly interface that aligns with call flow and supports the various handoffs and interoperability features needed to support efficient and effective client support.
- Support prompt dispatching and monitoring of crisis responders.
- Identify real-time behavioral health provider bed availability/capacity.
- Identify social service resources.
- Support geolocation technical infrastructure.

# Background

## Federal Environment and Requirements

In recognition that suicide is a leading cause of death in the United States and that this public health crisis has been exacerbated by the COVID-19 pandemic:

- In July 2020, the Federal Communications Commission (FCC) designated 988 as the dialing code for individuals in crisis to connect with suicide prevention and mental health services.
- In October 2020, the National Suicide Hotline Designation Act of 2020 was signed into law requiring all telephone service providers to direct all 988 calls to the existing NSPLs by July 16, 2022.
- In 2021, Vibrant Emotional Health made grant awards available to states to plan for the implementation of 988. Washington State Department of Health was awarded $190,000 to prepare for the long-term sustainable success of 988 implementation. In April 2021, the Federal Communications Commission issued a report entitled, "988 Geolocation Report — National Suicide Hotline Designation Act of 2020" that states:

  > "Based on our analysis of the record, we conclude that transmitting geolocation information, including dispatchable location information, with 988 calls would have significant benefits. We therefore recommend the establishment of a multi-stakeholder advisory committee, with experts tasked with developing detailed recommendations on how to address several challenging matters...." [3]

- In November 2021, the FCC required NSPL's chat and text services to be connected to 988 and go live July 16, 2022.
- In 2022, SAMHSA:
  - Awarded $282 million in grants to help States transition the NSPLs to 988, support the telephone, call/chat infrastructure, and strengthen call center staffing;
    - Washington State DOH received $2,674,720 to support the NSPL infrastructure and staffing.
  - Published playbooks to prepare for 988 implementation, including playbooks addressing States/Tribal Officials, MH and SUD providers, NSPLs, and Public Safety Answering Points (PSAPs).
- On May 24, 2022, the FCC, in collaboration with SAMHSA, held a public forum to discuss the challenges and opportunities related to the use of geolocation for 988 calls and technical challenges of transmitting location information for calls to 988 and possible solutions[4].
  - Participants in the forum included representatives from: FCC, SAMHSA, Biden Administration officials, Vibrant, 911 Coordinators, Poison Control, National Alliance on Mental Illness (NAMI) and other mental health advocates representing the caller's voice.
  - The meeting focused on the following topics:
    - Why is 911 Relevant to 988?

[3] https://www.fcc.gov/document/988-geolocation-report-national-suicide-hotline-designation-act; p.3.

[4] Forum: https://www.youtube.com/watch?v=HjHXXPGEuus

- Evolution of the Nation's 911 System
- 911 Geolocation Information: Routing the Call and Locating the Caller
- Wireline and Wireless E911: Routing and Location
- Recent Developments in Wireless E911 Location
- Next Generation 911
- Comparing 911 and 988

- Throughout the meeting there was widespread agreement on:
  - The need for geolocation and PSAP infrastructure to support and interoperate with the 988 infrastructure for routing calls/texts/chats. For example, a representative from Vibrant Emotional Health stated:[5]
    *"Location based routing is essential to connect callers to the crisis center nearest to them, so that they can be efficiently connected to local behavioral health, crisis, and emergency services as soon as possible.*
    *Nearly 1% of Lifeline callers at imminent risk of suicide are unable or unwilling to collaborate with counselors to provide their location, and serious harm or death could result if emergency services are unable to locate them."*
    *"[Most] of our Centers are working at some level, either formally or informally, with local PSAPs – another reason for location-based routing. If you can get the caller closest to the Center who is working with those local PSAPs, either formally or informally, the ability for us to properly dispatch and follow-up is going to be much greater than if we are remote and calling from another State and try and help somebody in a community that we're unfamiliar with."*
  - Using the geolocation infrastructure would:
    - □ Enable in-state call routing; and
    - □ More timely crisis response and provision of services
  - The need for work on several topics, including:
    - □ Defining appropriate and inappropriate use of geolocation to identify the caller, privacy and security issues, use and retention of location data, technical considerations, and costs; and
    - □ Recommended using a Federal Advisory Board to address these issues.
  - The FCC and SAMHSA indicated that they would develop a phased approach for moving towards the use of the geolocation:
    - □ Phase 1: Build out crisis center and staff
    - □ Phase 2: Develop a plan for call routing
    - □ Phase 3: Roll out
- During a webinar held on September 9, 2022, by Vibrant Emotional Health titled the "Unified Platform Update and Q&A," Vibrant noted that:

[5] John Draper, Ph.D., Vibrant Emotional Health. May 24, 2022, FCC Forum. https://www.youtube.com/watch?v=HjHXXPGEuus (at approximately the following times: 1.18 and 1.26)

- In the Fall of 2022, Vibrant will pilot use of geolocation as an overall network improvement to support better call routing on behalf of people who have out of state mobile phones; and
- Later in 2023, Vibrant will:
  - explore ways to integrate with PSAPs and protect caller privacy and have a PSAP look-up tool.

## E2SHB 1477, Section 109 - Plan Overview

E2SHB 1477 Section 109 requires DOH and HCA to create a Technical and Operational Plan for the purpose of developing and implementing the required technology and platforms to support an enhanced crisis call system and integrated referral system. E2SHB 1477 Section 109 requires that DOH and HCA:

- Create a sophisticated technical and operational plan; and
- Prior to initiating any new information technology development, submit the Technical and Operational Plan to the Governor, Office of Financial Management (OFM), CRIS Steering Committee, and appropriate policy and fiscal committees of the Legislature.

Section 109 requires that the Plan be approved by the Office of the Chief Information Officer (OCIO), Director of the OFM, and CRIS Steering Committee prior to any funds being expended for the solutions identified in the Plan.

Finally, as described in more detail below, E2SHB 1477 Section 109 provides a list of topics the Draft and Final Technical and Operational Plan are to address. See Appendix B for more details.

### Draft Technical and Operational Plan - Overview

The Draft Plan was submitted to the State legislature in February 2022. A copy of the Draft Plan is found here: https://www.hca.wa.gov/assets/program/draft-leg-report-988-operational-plan.pdf. The Draft Plan describes what was known about crisis call and response systems and the additional information needed to develop a sophisticated Technical and Operational Plan to acquire the systems to support the enhanced crisis call response and suicide prevention systems in the State as specified in E2SHB 1477.

## Draft Technical and Operational Plan

The Draft Plan recommended pursuing a "System of Systems" approach and indicated that several systems would be needed to meet the requirements in E2SHB 1477. As depicted in Figure 1, E2SHB 1477 requires technology systems and tools for the: Crisis Call Center Hubs managed by DOH (i.e., the Crisis Call Center Platform); creation, exchange and access to information needed by crisis providers (i.e., the behavioral health integrated client referral system); and interoperable exchange of information between crisis call centers and providers, and between crisis providers and other providers (i.e., ancillary systems).

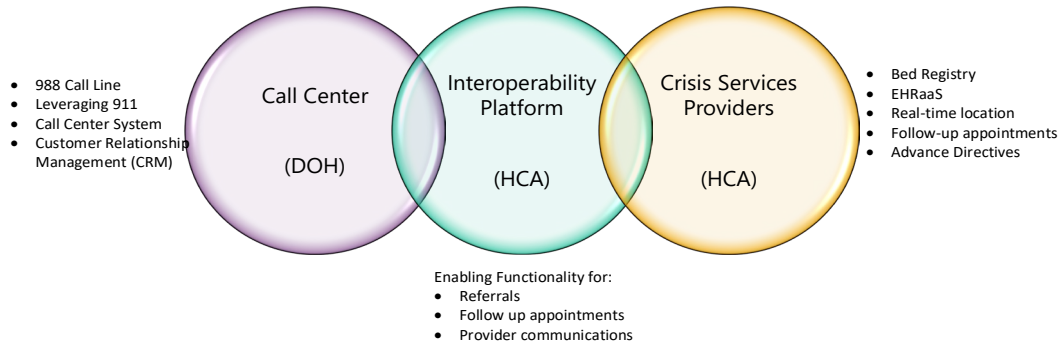


*Figure 2 Systems of Systems*

- **988 Crisis Call Center System Platform** (Crisis Call System): The 988 crisis call center system platform will be used by an NSPL to:
  - Receive calls, texts and chats via the 988 telephone number;
  - Document the call information including the safety plan;[6]
  - Provide for early identification of tribal affiliation;
  - Share relevant information with the Integrated Referral System; and
  - Create and share reports (e.g., related to outcomes).
- **Behavioral Health Integrated Client Referral System** (i.e., the Integrated Referral System): An Integrated Referral System is needed to:
  - Establish needed connections;
  - Support information sharing and coordination;
  - Follow protocols for Tribal members outlined in the Tribal Crisis Coordination Protocols;
  - Support referrals; and
  - Produce needed reports (including outcomes).
- **Ancillary systems** are needed to support and facilitate information exchange to and amongst these two primary systems, including for example:
  - Referrals are envisioned to be supported by and will leverage several future interoperable systems including:
    - Resources for bed availability;

[6] See glossary.

- Provider resource directory;
- Sharing information about:
  - The least restrictive alternative (LRA) treatment orders
  - Mental health advance directives
  - Crisis/suicide assessments
  - Crisis plans
- Use of EHRs (including EHRaaS[7]), and
- Other systems.

## Final Technical and Operational Plan - Overview

During the six-month period following submission of the Draft Technical and Operational Plan, HCA and DOH staff gathered information from multiple entities to better understand the technical systems needed and available to address crisis call and responses systems as specified in E2SHB 1477. Notes from these interviews are found in Appendix D, Appendix G, Appendix H, Appendix J, Appendix K, and Appendix M.

The Final Technical and Operational Plan includes an "Implementation Plan and Recommendations" section. The Implementation Plan:

- Presents three categories of options (and associated pros and cons) that were considered to frame and guide decisions regarding the technology acquisition process;
- Provides an analysis of the options, gaps that need to be addressed, and the implications for implementing the requirements in E2SHB 1477;
- Makes recommendations regarding the categories of options;
- Identifies the areas for which funding will be needed; and
- Identifies a path for the technology acquisition process using Requests for Information (RFIs) and Requests for Proposals (RFPs). The process allows the incorporation of feedback received from the CRIS Steering Committee and State leadership for needed technology solutions to support the Crisis Call Center Platform, Integrated Referral System, and Ancillary Systems.

[7] See glossary.

# Plan Methodology

To develop the Final Technical and Operational Plan:

- HCA and DOH reviewed the legislative requirements in E2SHB 1477 and identified the technical and functional requirements that vendor solutions would need to support.
- HCA and DOH engaged in several information gathering activities (including interviews, demonstrations, document reviews). The Table below identifies the entities/sources from which we gathered information, including:
    - information from the CRIS Steering Committee; Technology Subcommittee, Lived Experience Subcommittee (through which we gathered information from individuals and family members with lived experience); and
    - the types of technology solutions about which we gathered information.

| **Information Gathering Activities** | | | | |
|---|---|---|---|---|
| **Crisis Call Lines** | **Providers/ Responders** | **States** | **Technology Solutions** | **Other** |
| NSPLs<br>BH-ASOs/ Regional Crisis Lines (RCLs)<br>Native and Strong Lifeline<br>Other lines (e.g., 911, 2-1-1) | Crisis Providers<br>BH Providers<br>Responders (e.g., Law Enforcement) | AZ<br>CO<br>GA<br>IL<br>IN<br>MI<br>OK<br>OR | • Single vendor solutions (including Vibrant UP)<br>• Call Center as a Service/ Telephony<br>• CRM / Contact Management Software<br>• Computer Aided Dispatch (CAD)<br>• EHRs/EMRs<br>• Bed registries<br>• Provider resource directories | Community Information Exchange<br>Case management/ care coordination systems<br>Tribal Centric Behavioral Health Advisory Board<br>Indian Behavioral Health Hub |
| Additional Information Gathering Activities: | | | | |
| **Tribal Government-to-Government Process** | Tribes and urban Indian Organizations | WA | Tribal EHRs | Tribal Roundtable and Consultation |
| **Crisis Response Improvement Strategy (CRIS)** | Steering Committee; Technology Subcommittee; Lived Experience Subcommittee; Cross-System Crisis Response Subcommittee; Confidential Information Compliance and Coordination Subcommittee; Tribal 988 Subcommittee (facilitated through the Tribal Centric Behavioral Health Advisory Board) | | | |

*Figure 3 Information Gathering Activities*

The information described above informed the following sections of the Plan:

- Landscape Analysis;
- Functional Requirements; and
- Technology Requirements.

HCA and DOH used this information to identify the following:

- Three categories of options for selecting the crisis call center platform and the ancillary systems needed for the behavioral health crisis call and response system envisioned; and
- Additionally needed technical tools and service delivery expansions.

# Landscape Analysis

### National Suicide Prevention Lifeline (NSPL)

The NSPL is a nationwide network of more than 200 crisis call centers across the country[8] that provides 24/7 access to free, confidential support for people in suicidal crisis or emotional distress, as well as prevention and crisis resources for people or their loved ones. The centers are supported by local, state, public, and private sources, as well as Congressional appropriations through the United States Department of Health and Human Services (U.S. DHHS) Substance Abuse and Mental Health Services Administration (SAMHSA).

- Vibrant Emotional Health, the NSPL Administrator, establishes and maintains the minimum standards nationwide for becoming an accredited NSPL member center. See Appendix C for the basic requirements that crisis centers must meet to become members of the NSPL Network. NSPLs are staffed 24 hours a day, seven days a week, and clinical supervision is provided to all trained counselors who staff the program.

There are three organizations that provide NSPL services in Washington State:

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

[8] The number of crisis call centers across the country continues to grow as States build capacity, especially in areas that may not have had much historical capacity or investment in NSPLs.

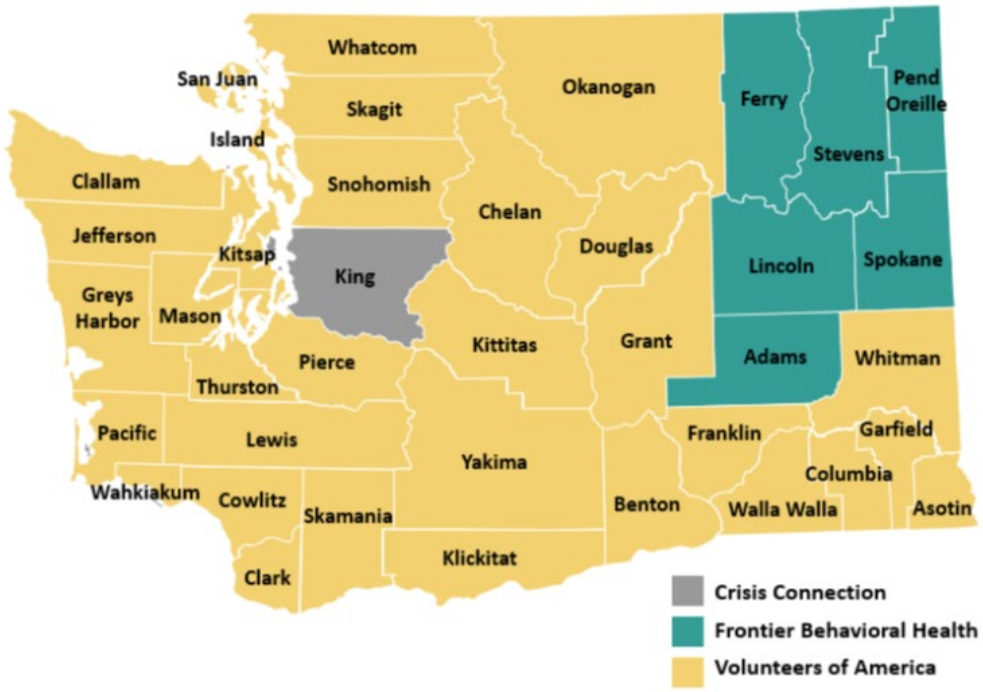


*Figure 4 Location of Crisis Call Center Platforms*

As part of the initial research and information gathering sessions, meetings were held with the three centers that provide NSPL services in Washington State to gain a better understanding of how they manage their NSPL crisis lines, specifically their current workflows, technologies, and relevant processes and policies. By better understanding the current state, we were able to work toward successfully introducing Washington's approach to 988 as outlined in E2SHB 1477 and ensuring that 988 functionality, workflow, and technology align with the NSPL crisis centers. Although each center provides a variety of crisis services, these discussions focused primarily on their NSPL services. The following is a summary of the discussions about each center's NSPL services.

For a detailed review of the discussions with each of the NSPLs please refer to Appendix D

## Crisis Connections

Crisis Connections is one of the oldest crisis lines in the nation. It offers five programmatic areas focused on serving the emotional and physical needs of individuals across Washington State:

- 24-hour crisis line
- King County 2-1-1
- Teen Link
- WA Recovery Help Line
- WA Warm Line

Crisis Connections is contracted to answer some youth crisis provider lines in Pierce and Clark Counties and refers youth to MCR teams.

Frontier Behavioral HealthFrontier Behavioral Health (FBH) serves the Greater Spokane area. It is a nonprofit trauma-informed care organization that provides clinically and culturally appropriate behavioral health care and related services. One of the services provided by FBH is the 24/7 Regional Crisis Line. FBH recently acquired a new EMR.

### Volunteers of America Western Washington

One of the key services that Volunteers of America (VOA) Western Washington provides is 24/7 access to crisis services by phone and chat.

VOA uses Cisco as its telephony call center platform and has a proprietary electronic health record (EHR) called CCDS. CCDS is a cross between a customer relationship management (CRM) tool and database with components that fall in line with clinical and medical data sets. It was created to focus on the needs of VOA counselors (e.g., enables access assessment tabs and transmits encounter data to Medicaid and Administrative Service Organization (ASO) partners).

### Washington Indian Behavioral Health Hub and the Native and Strong Lifeline

The Washington Indian Behavioral Health Hub (Indian BH Hub) and the Native and Strong Lifeline are operated by the Volunteers of America (VOA) Western Washington call center in Everett, are operated independently and serve indigenous and Tribal affiliated individuals. The Indian Behavioral Health 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. Crisis Connections and Frontier Behavioral Health and national NSPL centers will be trained to follow warm referral processes to connect individuals to the Native and Strong Lifeline and Indian Behavioral Health Hub as appropriate.

The Indian BH 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 will launch the Native and Strong Lifeline, anticipated early November 2022.This line serves indigenous and tribal affiliated members in the entire state via the 988 system and provides prevention and post-crisis resources and support in coordination with the Washington Indian Behavioral Health Hub, creating a more comprehensive set of supports. This partnership, led by Tribal elders through the TCBHAB, will continue to guide the implementation of crisis response services related to Native and Strong Lifeline and the Indian BH Hub.

Individuals calling into the Washington State 988 line, and who wish to access the Native and Strong Lifeline, will have a dial pad option that will be provided by Vibrant (i.e., “push X to be connected to the Native and Strong Lifeline”). Implementation of the Native and Strong Lifeline dial pad option is expected to be completed in the Fall of 2022. The E2SHB 1477 bill provided $1 million in funding as well as a grant by the National Association of State Mental Health Program Directors (NASMHPD) ($250,000) to support the Native and Strong Lifeline. DOH distributed funding to VOA. The State will develop a comprehensive media campaign for these resources to share at a regional, state, and national level.

### NSPL Summary of Interviews

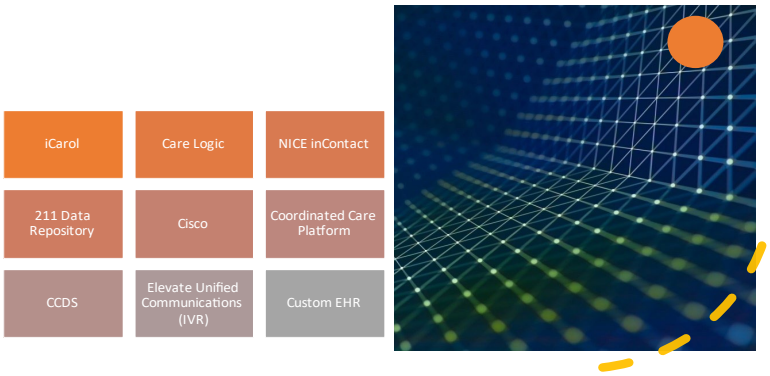


*Figure 5 Current Technology Implemented by the NSPLs*

The three NSPLs in Washington State all provide similar services to the regions they serve; however, their current technology and infrastructure differ. Crisis Connections and Frontier Behavioral Health have similar technology in place. Both are using Nice xONE as their Call Center as a Platform provider and iCarol as their CRM to provide the base of their technology. Each have additional integrations in place with Washington 2-1-1 and EHR integrations. VOA is currently using Elevate Unified Communications (IVR) as their telephony solution and have a custom (in-house) EHR solution called CCDS and describe it as a cross between a CRM and a database.

Although all three differ in their current technology, all agree that in the future they would like to see additional 988 functionalities (such as real time monitoring, crisis alerts, customized reporting, and more opportunity for integrations with service or registry providers and Community Information Exchanges (CIEs)). In addition, the NSPLs agree that any future technology should be easy to integrate with, scalable to allow for remote workers, and will be more valuable if the NSPLs can integrate across the 988 centers and function with teams across the State.

## Behavioral Health Administrative Services Organizations (BH-ASOs) and Regional Crisis Call Systems

The Washington Crisis System is a regionally based system administered by Behavioral Health Administrative Service Organizations (BH-ASOs) which contract with local providers to provide a diverse array of services to help a person experiencing a crisis. BH-ASO's are experts in crisis service delivery and should be stakeholders in E2SHB 1477.

BH-ASOs manage all contracting for regional crisis services due to 2014 legislation that mandated the full integration of all publicly funded physical and behavioral health systems.

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*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 areas in Washington State.*

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Under the fully integrated managed care system, MCOs (Managed Care Organizations) coordinate care across the full continuum of physical and behavioral health services for Medicaid enrollees who have selected an MCO only. Tribal AI/AN members are not required to select an MCO, and those services should be billed to HCA under fee for service. Each of the ten BH-ASO regions contract with between three and five MCOs to receive Medicaid funds to provide certain crisis services for the Medicaid MCO enrollees.

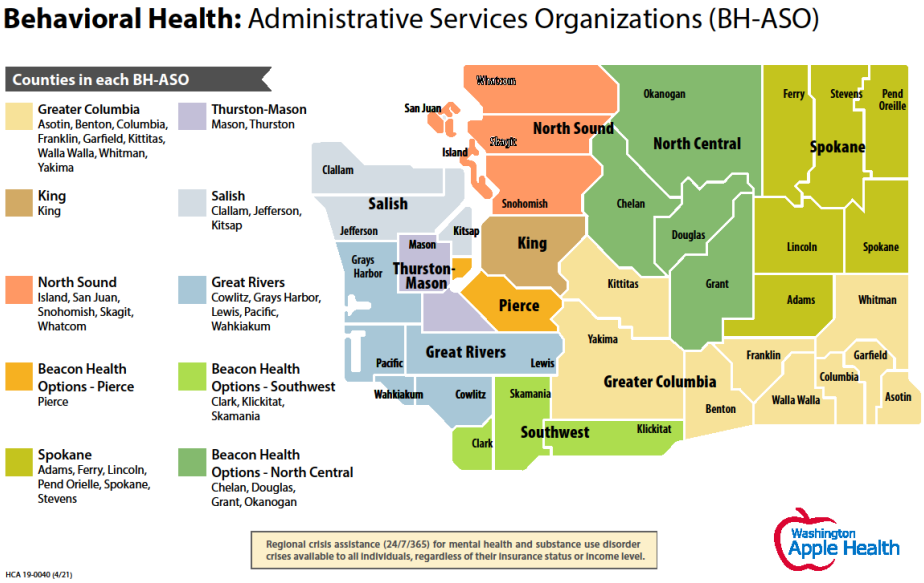


*Figure 6 BH-ASO Map*

BH-ASOs are responsible to ensure core behavioral health crisis services are available in their region. BH-ASO's contract with behavioral health crisis service providers to ensure crisis services are provided to all people, insurance blind, for the initial crisis response and sometimes a follow up window for up to 72 hours. Some of these services include mobile crisis services, involuntary services including DCR investigations, services for people underinsured, and regional crisis lines.

Other funding BH-ASOs receive is a mix of block grant, state dollars, and local funding that is blended to ensure services. In King, Thurston and Mason counties, some of these grant or local tax dollars go to in-home stabilization for youth under the mobile response and stabilization (MRSS) best practice model.

Some BH-ASOs contract to provide Regional Criss Line (RCL) services for their region, while others operate their own RCL. BH-ASO's receive call center funding when operating their own RCL and becoming experts in their regional needs.

- Seven out of ten BH-ASOs contract with a provider who is also accredited as a National Suicide Prevention Lifeline Crisis Call Centers (NSPLs) to provide crisis line services for their regions.
- The remaining three, Thurston Mason BH-ASO, Greater Columbia BH-ASO, and Great Rivers BH-ASO operate their own Regional Crisis Call Systems.

The table below identifies the RCL and 988 entities providing the crisis line services in the RCLs and NSPLs.[9]

| Region | 988 | RCL |
|---|---|---|
| **Great Rivers** | VOA | Columbia Wellness |
| **Thurston-Mason** | VOA | OHRS |
| **King** | Crisis Connections | Crisis Connections |
| **North Sound** | VOA | VOA |
| **Greater Columbia** | VOA | VOA (9/22) |
| **Spokane** | FBH | FBH |
| **Salish** | VOA | VOA |
| **Pierce** | VOA | Crisis Connections |
| **Southwest** | VOA | Crisis Connections |
| **North Central** | VOA | Crisis Connections |

*Figure 7 RCL and 988 Entities Across WA*

## BH-ASO and RCL Interactions and Workflow

RCLs are often the main access point for a person seeking behavioral health services and serve as a way for someone to navigate a complex system and find the support they need. RCLs assess crisis acuity and take appropriate steps which can include active rescues, crisis outreach, determining level of in-person response (often through a Mobile Crisis Response (MCR) Team), or resolving the crisis on the phone. In addition, RCLs often have partnerships that allow them to initiate outpatient enrollment or navigate options with callers to complete an intake. The diagram below depicts this workflow at a very high level.

[9] CRIS Cross System Subcommittee meeting 6/21/2022 (HMA slide)

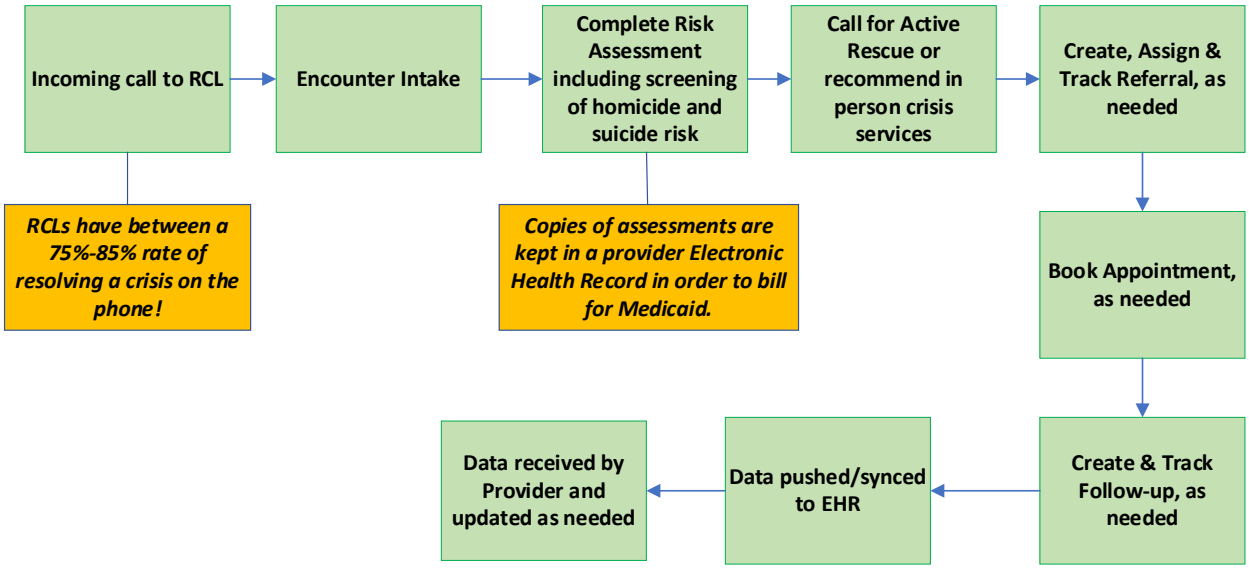


*Figure 8 RCL Process*

Each RCL is responsible for creating their own standards, protocols, and procedures for calls. This includes the process for handing off calls to 911 and getting consent to document the service or make a referral. The referral to mobile crisis is often done via a phone call to a dedicated phone line where the initial referral is staffed by a shift leader or supervisor. If a referral is accepted, then more information in the form of a referral packet is either faxed or electronically sent to the mobile crisis team. Some agencies have an RCL integrated into their agency and use a shared Electronic Health Record (EHR). Other RCLs have agreements in place to use secure email or other electronic means.

A person in crisis often creates a safety plan during the initial crisis contact when there is safety risk. Other documents that may be created or referenced include a crisis plan, a mental health advanced directive (MHAD), or a Wellness Recovery Action Plan (WRAP). These inform a crisis responder of the person's preferences in a crisis and provide helpful information to resolve the crisis. Currently, these important tools are often inaccessible to crisis responders or out-of-date.

The details of BH-ASO and their interaction with RCLs is complex. Additional history and information are available in Appendix E.

### Behavioral Health Provider Survey – Crisis Providers and Technology

To help gather information for this Final Technical and Operational Plan, information was gathered (via interviews and surveys) from behavioral health providers that provide crisis services and BH-ASO/RCL representatives.

The use of electronic tools and technology platforms to share information varies from region to region with most record sharing or referrals happening by fax or phone calls. Data is often submitted in the form of spreadsheets using data from providers' EHRs. Inputting this data can often be a long and arduous process for all involved.

Both mobile crisis and RCLs are faced with the administrative burden of calling around to find availability for a specific type of placement. This often can take hours of a responder's time. Once a bed is found

there is often a lot of time spent addressing admission requirements, including possible medical clearance, and ensuring the person has all necessary medications and items for the stay.

A survey of the technology solutions in the RCLs concluded that various technology platforms were being used. Figure 8 highlights the vendor categories and existing platforms being used by the RCLs. For a more detailed review of each of the BH-ASOs in Washington State refer to Appendix F.


*Figure 9 Vendor Categories*

## 2021/2022 Behavioral Health Provider Survey: Crisis Services and Technology

HCA, in collaboration with the Washington State University Social and Economic Sciences Research Center, designed and fielded the 2021/2022 Behavioral Health Provider Survey (BHPS). The 2021/2022 BHPS included a focus on crisis providers and technologies. The full survey report on crisis providers and technologies is located in Appendix F.

The survey gathered information from 662 certified, community-based mental health (MH) and substance use disorder (SUD) treatment agencies known to provide Medicaid and publicly funded behavioral health (BH) services in the State. Responses were received from 231 agencies for a total response rate of 35 percent. The survey included information about crisis stabilization services.

Of the 231 responding agencies, 76 agencies, 35 percent, provided crisis stabilization services. The authors note that this "level suggests that more agencies may have to be incentivized to meet a growing need and to deliver a more diverse range of crisis-support services." The report summarized the types of crisis services provided as including: "Crisis outreach is the most common service offered (76%) followed by crisis telephone support (66%), crisis peer support (41%), emergency involuntary detention (37%), and crisis stabilization unit (35%). Nine percent offer 23-hour crisis stabilization and 3% provide the Living Room Model."

Responding agencies reported receiving referrals for their crisis stabilizations services from a variety of sources. "The most commons means by which agencies receive clients in need of crisis stabilization is through self-referral, reported by 77%, followed by clients' family (76%), other behavioral health agencies/providers (67%), designated crisis responders (65%), acute care hospitals and emergency departments (62%), police departments (60%), schools (56%), mobile crisis response units (52%),

physicians (52%), and 911 (38%).” Other less frequent referral sources included referrals from NSPLs and other crisis lines. The multiplicity of referral sources for crisis stabilization services suggests both the opportunities and challenges of enabling interoperable and electronic referrals.

Further, agencies provide an array of services. The following data highlights the variety of services delivered by crisis providers. This data also suggests areas in which additional types of crisis stabilization service may be needed (e.g., peer services). Seventy-seven percent of agencies offering crisis stabilization services provide outpatient MH services to individuals following the immediate crisis. Agencies reported “providing crisis outreach (73%), crisis telephone support (63%), MH peer service (57%), referral to substance use disorder (SUD) residential program (57%), referral to inpatient MH services (57%), same-day walk-in behavioral health services (56%), SUD intensive outpatient program (42%), mobile crisis response follow-up (41%), and SUD peer services (23%).”

Fewer than 10% offer acute detox (9%) and sub-acute detox (7%), while 3% offer sobering unit, and 1.3% provide peer-run respite centers.” In terms of technology used by agencies providing crisis stabilization services, while most agencies (91%) report relying on an electronic health record (EHR) system for specific functions (e.g., electronic: screenings, assessments, care plans, discharge plans), most agencies (66%) use crisis telephone support “during an immediate crisis and in receiving referrals from clients needing urgent care.” Nearly half of the agencies providing crisis services reported being “very willing or somewhat willing to accept an offer of a free EHR license and technical assistance to support its use.”

### Tribal Governments, Indian Health Care Providers and Tribal Consultation Process

Each Tribal Government has a wide array of health services including crisis response services within their community. The services provided can be dependent on the ability for tribal and community members to access needed crisis services from regional crisis providers as well as their own capacity to stand up and sustain dedicated crisis services. It is challenging to implement services because crisis services are intensive, can require 24/7 support, and are funded by braiding state and federal resources. Most state dollars are not allocated to Tribes for crisis services, creating a gap in state funded resource to support Tribal crisis programs.

Tribes, urban Indian organization, and Tribal organizations have worked for decades on improvements to the tribal-centric behavioral health system to access needed behavioral health and crisis services for their tribal and community members. Through this work, these groups along with the State, Indian Health Services, the American Indian Health Commission, and the Northwest Portland Area Indian Health board created a Tribal Centric Behavioral Health Advisory Board (TCBHAB) to focus on further enhancing behavioral resources for tribal and urban Indian communities. Highlights of these activities are outlined in the Appendix E (see history section).

Upon request from tribal representatives of the Tribal 988 Subcommittee for formal consultation, HCA and DOH scheduled a series of five roundtable meetings and a consultation to end in September 2022. During the first three (3) roundtables, HCA went over may topics related to the technical and operational elements of the 1477 work. Appendix G shares a summary of feedback from the first initial roundtables. The upcoming roundtables will focus on reviewing this plan to ensure feedback is appropriately considered. Moving forward, the State will continue to seek opportunities to engage with

Tribal governments, urban Indian health organizations and other IHCPs including holding Tribal consultations and urban confer meetings as appropriate.

### High Level Process

There are many complex components and actors with their own complexities and workflows working differently. Figure 9 below (next page) shows a high-level process of how these complex systems and actors will work together. Each of the components and actors in the system may need to change its current processes to operate smoothly with other systems or components. New systems will need to account for the interoperability platform and have those features built into the solution and considered up front.

As the new system is developed, the State will need to evaluate each of the components connected to a particular system to ensure the data can flow at an appropriate security and privacy level, the system functionality supports the business goals, and work with the business to ensure that the business processes for each of these achieves the intended goals. The State seeks to share information with other States to be more effective. The State understands this will need to be a highly collaborative endeavor with partners such as NSPLs, BH-ASOs, Tribal governments, RCLs, local providers, Federal Government, community partners, vendors and other agencies.

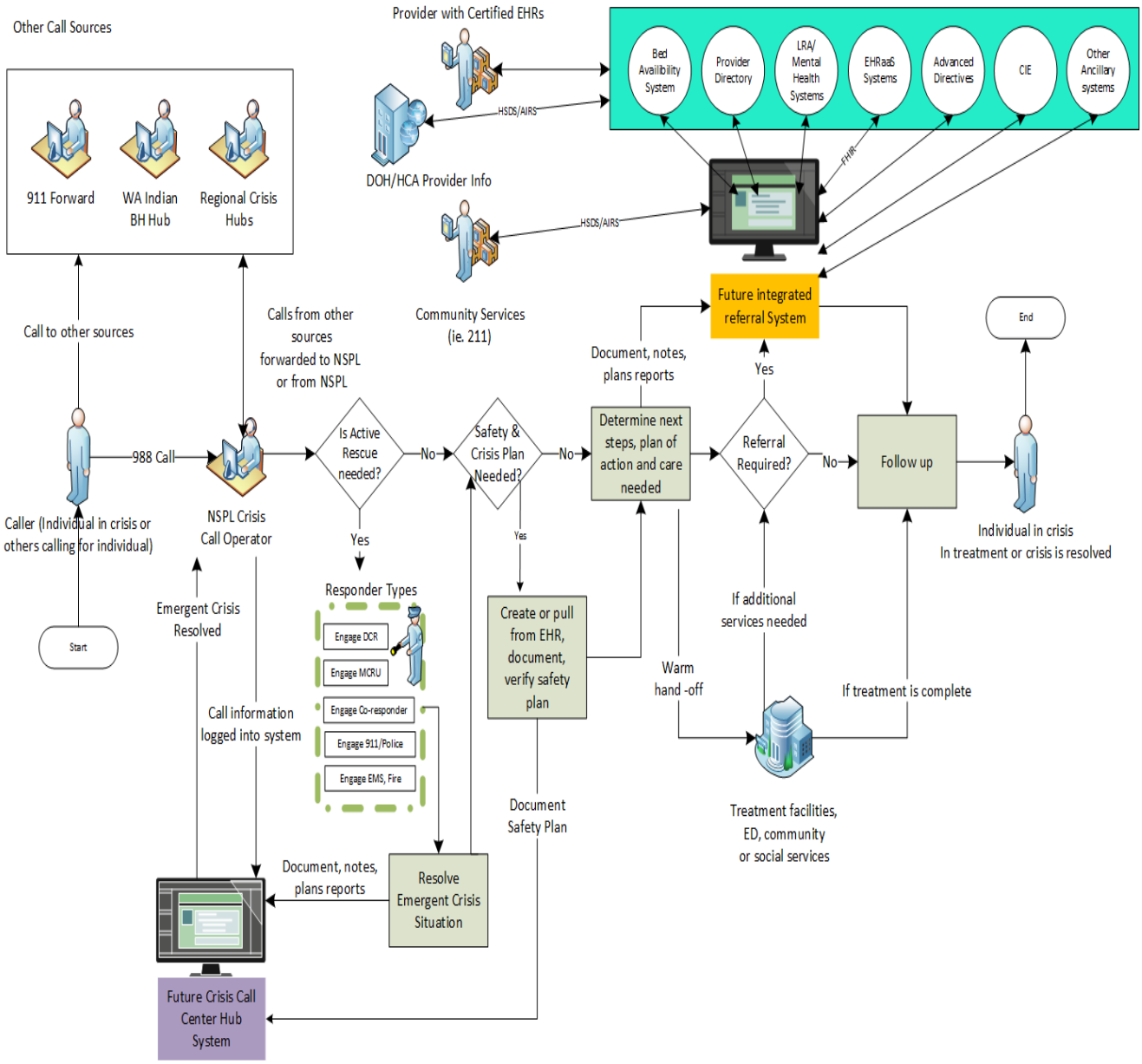


*Figure 10 High Level Process of the Complex Crisis Call and Response System in Washington State*

## Community Information Exchange (CIE)

### Health Care Authority

The Health Care Authority received funding through a budget proviso to continue planning for a Community Information Exchange (CIE). The proviso outlined a broad group of stakeholders and directs HCA to consult with the stakeholders to determine which CIE platforms already exist within the Washington public and private health care system and determine the interoperability needs and fiscal impacts of implementing a CIE solution.

In response to the proviso, HCA is developing three documents: 1) CIE Landscape Review, 2) Options and Recommendations on a statewide CIE strategy, and 3) draft RFP language associated with the recommendations. CIE planning will be completed in the fall of 2022 and will likely inform the development of a decision package to be considered for the biennial budget submitted by the Governor. The options and recommendations explored in response to the CIE proviso will support the application for renewal HCA submitted to the Centers for Medicare & Medicaid Services (CMS) for the Medicaid Transformation Project (MTP), a Section 1115 Medicaid demonstration waiver. The implementation of community hubs proposed in the MTP renewal will benefit from CIE technology.

HCA will also consider alignment and coordination with 988 implementation (including the Indian Behavioral Health Hub) as CIE planning efforts move forward. An individual experiencing a behavioral health condition may, for example, also have a hungry family. A community worker could then search the CIE directory to find a healthy source of food and refer an individual to a local food bank. The CIE would help the worker track the referral and inform the worker when the food is received ("closing the loop"). A CIE may also serve as an essential tool to coordinate services and solve problems. An individual, for example, may encounter barriers to receiving food. After a referral is initiated, a CIE can alert a community worker to potential problems like a lack of transportation and help a worker intervene and find ways to close the referral.

### Department of Health

The Department of Health is connected to the HCA CIE Planning project as members of the Health and Human Services (HHS) Coalition. At the HHS Coalition, DOH will be representing the resource directory work (including WA2-1-1 and other directories) that has been established as part of the COVID response and other DOH program initiatives that includes Care Connect Washington.

## 2-1-1 Resource Directory

### 2-1-1

2-1-1 is the most comprehensive source of information about local resources and services in the country.[10] In 2000, the FCC designated 2-1-1 as the 3-digit number for information and referrals to social services and other assistance. Nationally, 2-1-1 call centers provide callers with information and referral to variety of social services including services and supports for: crisis and emergency, housing, food, health (including mental health and substance use), financial assistance, and transportation. See Appendix H for details.

[10] https://www.211.org/

## Washington 2-1-1 (WA2-1-1)

WA2-1-1 has operated In Washington State since 2006 and is guided by Washington State RCW 43.2-1-1. WA2-1-1 is a community information and referral network that created, uses, and maintains the most current and comprehensive database of community resources in the State with more than 32,000 records as of May 2022.

The WA2-1-1 system is a decentralized model comprised of seven independent non-profit organizations that operate 2-1-1 contact centers across the State under an agreement with WA2-1-1. Three of these contact centers are co-located at the NSPLs in the State.

The WA2-1-1 technical infrastructure includes:

- Nice InContact as the telephony/Call Center as a Service (CCaaS) platform;
- Visionlink is the platform to store all call data and support information and referral using the database of statewide community resources;
- Uses the national AIRS standards of operation and the AIRS adopted Taxonomy of resource data standards to organize its database records;[11]
- Uses the HSDS schema to host their online resource directory www.wa211.org;
- Uses Tableau for generating custom reports on metrics using caller data; and
- Provides translation services in over 240 languages.

WA2-1-1 is considering an "Active Referral" process with the 9-8-8 crisis lines that would (i) enable sharing caller records via Visionlink and (ii) support open and closed loop referrals. This type of Active Referral process would require funding.

### Broadband Infrastructure Use of Telehealth, HCA, and Washington State Broadband Office

As a result of the COVID-19 public health crisis, health care providers, including IHCPs, rapidly transitioned to using telehealth to enable access to health care services. Providers used video and phone-based communication tools to engage, assess, and treat patients and clients. The CMS reported, "[a]pproximately 34.5 million telehealth services were delivered to Medicaid and CHIP beneficiaries from March through June 2020, representing an increase of 2,632% compared to March through June 2019."[12] Insurers, including the Washington State Medicaid program, expanded coverage to cover services using audio-only and audio-visual tools.

[11] https://211taxonomy.org/

[12]Centers for Medicare and Medicaid Services. Services Delivered via Telehealth Among Medicaid & CHIP Beneficiaries During COVID-19. Accessed: January 2021. Available: www.medicaid.gov/resources-for-states/downloads/medicaid-chip-beneficiaries-COVID-19-snapshot-data-through-20200630.pdf

However, the ability to access health, including behavioral health, services using telehealth was found to be limited by several factors. Surveys in Washington State[13] identified the following barriers to using telehealth for accessing behavioral health services:

- Lack of internet and insufficient internet capacity were barriers for behavioral health providers and persons in need of behavioral health services;
- Inability to afford internet service fees and cell phone data plans; and
- Lack of devices (e.g., computers, laptops, cell phones) needed for telehealth encounters.

In addition, during information gathering activities with NSPLs, BH-ASOs, and crisis service providers, the lack of internet and insufficient internet capacity were identified as barriers to using telehealth on behalf of people in crisis. During these information gathering activities, some informants also expressed an interest in using audio-visual, streaming capabilities when responding to persons in crisis.

### Health Care Authority

To increase use of telehealth, HCA provided the following supports:

- **Cell Phone Program:** HCA distributed approximately 6,000 smart phones to Medicaid clients (including tribal members).
- **Loaner Laptop Program:** HCA distributed approximately 800 loaner laptops to providers (including Indian Health Care Providers and tribal members).
- **Zoom Licenses:** HCA provided free-of-charge 2,000 Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliant Zoom licenses to providers, prioritizing behavioral health professionals or paraprofessionals.
- **HCA Technical Assistance and Other Activities:** HCA provided webinars to provide technical assistance and information to service providers, including behavioral health providers
- **HCA supported the UW/Harborview Behavioral Health Institute (BHI):** To provide technical assistance, training, and needs assessment to behavioral health providers and the individuals they serve in using telehealth.

### Washington State Broadband Office

In 2019, the Washington Legislature established the Washington State Broadband Office. The goal of the Washington State Broadband Office is to ensure that residents and businesses have access to affordable, reliable broadband. The Revised Code of Washington (RCW 43.330.536) requires:

- By 2024: 25/3 (download/upload) megabits per second (Mbps) scalable
- By 2026: 1/1 gigabit per second (Gbps) for all anchor institutions[14]

[13] Surveys conducted by the Behavioral Health Institute on use of telehealth for behavioral health service. The survey report can be found at: https://bhi-telehealthresource.uwmedicine.org/

[14] Anchor institutions include flagship community institutions, including but not limited to schools, health care centers, and libraries. Anchor institutions are sometimes connected to fiber, even when fiber service is not commercially available in the community. Because of this, they can act as a connection to the Internet backbone. (source: https://www.commerce.wa.gov/building-infrastructure/washington-statewide-broadband-frequently-asked-questions-office/)

- By 2028: 150/150 Mbps for all residents and businesses

The Washington State Broadband Office makes available funding and distributes information to increase access to broadband in unserved and under-served communities (including tribal reservation lands) across the State. Funds may be used for a variety of activities to build out the broadband infrastructure, including: [15]

- Increasing service speeds;
- Extending internet service where service is lacking;
- Enhancing unreliable service;
- Creating more low-cost broadband service options;
- Making available funds to make the internet more affordable through the Affordable Connectivity Program[16] (ACP); and
- Addressing the digital equity and inclusion needs in communities across the State.

See Appendix I for details.

### Global Positioning Technology/Geolocation Call Infrastructure

E2SHB 1477 Subsection 102(6)(b) specifies that DOH and HCA are to designate a primary technology system that enables:

- 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 … and track local response through global positioning technology.

This section of the Plan focuses on the technology to receive crisis calls and deploy, and track the deployment of, crisis responders.[17]

Members of the CRIS Technology Subcommittee advised that global positioning technology (GPS) technology or a system using GPS is used as a source of location information, expressed in terms of latitude, longitude and possibly altitude. In contrast, "geolocation" uses cell phone towers and Wi-Fi access points to identify the location of electronic devices (e.g., cell phones). Geolocation can be used to identify the physical address of the person using these electronic devices.

Geolocation technology could be used in combination with other technology tools to support additional requirements (e.g., identifying and dispatching the appropriate responder).

[15] For definitions of key terms: https://www.commerce.wa.gov/building-infrastructure/washington-statewide-broadband-frequently-asked-questions-office/

[16] https://www.usac.org/about/affordable-connectivity-program/

[17] Community assistance referral and education systems are discussed in the 2-1-1 Resource Directory section in the Plan.

For purposes of this Final Plan, HCA and DOH are interpreting the phrase "Global Positioning System Technology" (GPS) in E2SHB 1477 to mean the functionality that is typically referred to by the phrase "geolocation."

The 911 call infrastructure is an example of a system that supports the use of geolocation to identify the location of callers and responders and can also identify available resources and dispatch needed services.

HCA and DOH staff met with and gathered information from staff from the Washington State Military Department and other First Responders to consider whether and how the geolocation technical infrastructure could support the crisis call and response system in Washington State. The detailed interviews are found in Appendix J.

911 Standard: The National Emergency Number Association (NENA) i3 Solution Architecture (also known as the standard for Next Generation 911[18]) is the essential suite of standards that enables the functionality and interoperability of Next Generation (NG) 911 calls.

- "The i3 solution supports end-to-end IP connectivity; gateways are used to accommodate legacy wireline and wireless originating networks that are non-IP as well as legacy Public Safety Answering Points (PSAPs) that interconnect to the i3 solution architecture. NENA i3 introduces the concept of an Emergency Services IP network (ESInet), which is designed as an IP-based inter-network (network of networks) that can be shared by all public safety agencies that may be involved in any emergency and a set of core services that process 911 calls on that network (NGCS – NG911 Core Services). The i3 PSAP is capable of receiving IP-based signaling and media for delivery of emergency calls conformant to the i3 Standard." (p.2)

The NENA i3 Solution Architecture – from the call-maker to the call-taker – can support the ability to identify in-state calls placed to 988 and the ability to route these calls to the appropriate NSPL.

Further exploration of the i3 Standard for Next Generation 911 is needed to determine exactly how the NG 911 standard could best support 988 calls.

PSAPs

The 911 call infrastructure relies on accredited Public Safety Answering Points (PSAPs) to receive and route calls/texts/chats to the closest responders. PSAPs:

- Triage calls;
- Capture electronic notes regarding callers;
- Transfer calls and associated information, when needed and appropriate, to the appropriate entity (e.g., crisis call center); and
- Can, when appropriate, share the location of the caller with the entity to which the call was transferred (e.g., in the case of crisis calls to an NSPL and/or crisis responder (e.g., DCR)).

[18] https://cdn.ymaws.com/www.nena.org/resource/resmgr/standards/nena-sta-010.3b-2021_i3_stan.pdf

PSAP accreditation standards ensure consistency in procedures while allowing flexibility at the local level to respond in a manner that considers local resources.

The Washington Secretary of State establishes record retention requirements, including for records that result from 911 calls.[19] PSAP records at the network level are not retained for more than 24 hours at which point they are purged per state requirements. PSAP records are retained at the county level.

As previously mentioned, the Federal Government concluded the May 24, 2022, FCC Forum on 911 and 988 by identifying a series of activities to be pursued to enable the integration of the 911 infrastructure into the 988 call platform.[20]

## State Interviews

Several meetings were held with States that were identified as "Exemplars" in the Third Sector Report based on the actions they have been taking to move forward with implementing a 988 Crisis Line. In addition, some States were selected for interviews if they seemed to have information that was pertinent to Washington State.

The following is a summary of information gathered from selected States. Appendix K includes the notes from the conversations with each State.

The following table (next pages) provides an overview of the key findings from the State discussions:

[19] https://www.sos.wa.gov/office/search/default.aspx?q=911

[20] Forum: https://www.youtube.com/watch?v=HjHXXPGEuus

| | Arizona - Solari | Colorado | Georgia | Maryland | Michigan | Oklahoma | Indiana |
|---|---|---|---|---|---|---|---|
| **Program/ Operator** | Solari (nonprofit) covers two regions; Nursewise / Centene Health covers the third region | Colorado Crisis Services (Department of Human Services, Office of BH) | Georgia Crisis and Access Line (Department of Behavioral Health & Developmental Disabilities) | Maryland Department of Health, BHA | BH and Developmental Disabilities Admin | TBD | TBD |
| **System Structure** | Region-based, not statewide; Managed care entities contracts with crisis line services | Statewide; BH-ASOs and MSOs also contract with CDHS to provider BH services | Statewide call center integrated into the local healthcare system | Statewide call line with 2-1-1 | Statewide call line integrated with 2-1-1 with provider portal | RFI/RFP in Progress | RFI/RFP in Progress |
| **Services Offered** | 24/7/365 line with GPS; ability to dispatch mobile response | 24/7/365-line mobile response, walk-in centers, CSUs, respite | 24/7/365-line mobile response, single point of entry for CSUs and state hospitals | 24/7/365-line mobile response, walk-in centers | TBD | RFI/RFP in Progress | RFI/RFP in Progress |
| **Software** | Solari: Custom-built CRNexus operates a call tracking through interactive intelligence for call tracking with GPS that connects to a Dispatch Management System, and an EHR through CoCENTRIX | Currently Solari and soon to transition to custom-built Zoho, operates call tracking; no integrated EHR | BH Link operates the call tracking, GPS for mobile crisis dispatch, and EHR for real time disposition tracking, outpatient scheduling and bed inventory | iCarol operates call center software | Salesforce; Custom built to handle intake, referrals, provider logins, assessments. | Solari, RFI/RFP in Progress | Currently iCarol for NSPLs |
| **Call Center Platform** | La Fronterea and Solari | Solari/ Zoho | GCAL (BHL Built) | iCarol | Accenture Salesforce | Solari | Building own unified platform for all centers - vendor to provider tech to build it (IT will oversee and implement and work closely with chosen vendor) |
| **Referrals and Appointments** | Referrals Only | None | Yes | Up to each call center | Referrals Only | Solari, RFI/RFP in Progress | Solari, RFI/RFP in Progress |

| | Arizona - Solari | Colorado | Georgia | Maryland | Michigan | Oklahoma | Indiana |
|---|---|---|---|---|---|---|---|
| **Bed Registry** | Being Built | No | Yes (Live Bed Board) | None | No | Solari, RFI/RFP in Progress | Solari, RFI/RFP in Progress |
| **Responder Dispatching** | Yes | Yes | Yes | None | No | Solari, RFI/RFP in Progress | Solari, RFI/RFP in Progress |
| **Reporting** | Standard | Standard | Standard | Standard | Standard and Custom | Solari, RFI/RFP in Progress | Solari, RFI/RFP in Progress |
| **Plan to Use Vibrant UP?** | No | TBD | No | No | No | No | TBD |

*Figure 11 Key Findings of State Discussions*

It is important to note that each State interviewed is in a different phase of implementing 988 and each State has their own specific requirements and regulations, therefore this section is not meant to be a comparison. The goal is to provide an overview of current 988 activities and inform the 988 considerations underway in Washington State.

### Arizona

**State Structure**: Several Crisis Lines: Two NSPLs, Three RBHAs (Regional Behavioral Health Authorities) Call Centers, Tribal Call Centers (TRBHAs), multiple local lines

- **Current BH Process & Technology:**
  - AZ NSPL vendor (Solari) will adopt Vibrant.
  - Call Centers working to develop direct agreements and processes with (i) the 911 PSAPs across the State and (ii) the Arizona Health Care Cost Containment System (AHCCCS), AZ Medicaid agency), and working to align expectations for partnership
- **Future State:**
  - Solari will support: Call Center, Referral Provider/Service Registry, GPS capabilities
  - State Health Information Exchange (HIE) organization (Contexture) will be used to support some integrations (e.g., bed registry & closed loop referral module)
  - Would like centralized statewide data to track crisis call and response metrics

### Colorado

**State Structure: One Call Center (Rocky Mountain Crisis Partners) and four Administrative Service Organizations (ASOs).**

- **Current BH Process & Technology:**
  - Given the current level of investment, would like to keep what they have; it is flexible, easy to collect additional information and modify.
  - Zoho is the call center platform being used by Rocky Mountain Crisis Partners
- **Future State:**
  - Currently taking a "wait and see" approach with Vibrant – monitoring interoperability capabilities and the data ownership model.
  - Working on building a Bed Registry, would like to provide access to Emergency Departments (Tentative go live Summer 2022. Using Dimagi as the vendor)
  - Reviewing how to move forward with GPS Technology; need to ensure 988 addresses call routing (25 percent of population has out-of-State area codes)

### Georgia (GCAL)

**State Structure:** The Georgia Crisis Access Line (GCAL) addresses all NSPL calls and is available 24/7/365. GCAL began using 15 years ago a custom built, modular solution developed by Behavioral Health Link (BHL).

- **Current BH Process and Technology and Future State:**
  - GCAL uses BHL for: Call Tracking, GPS, EHR for real time disposition tracking, outpatient scheduling and bed inventory

        - GCAL will not be adopting Vibrant UP. Current platform is highly integrated and would lose functionality if platform was changed (i.e., referrals and appointments, live bed board, responder dispatching)
    - GCAL and the State 911 association (Georgia Emergency Communications Authority (GECA)) are working to better define roles and responsibilities between 911 and 988.

### Illinois

**State Structure**: CESSA – Community Emergency Services and Supports Act (CESSA)– Illinois law that requires 911 to coordinate with mobile mental health response services being developed by the Illinois Department of Mental Health.

- There are 11 emergency services medical regions in the State. Within each region, there are resource hospitals, and each resource hospital has a medical director and providers / responders with whom they work.

The Illinois law (CESSA) is very prescriptive. It requires a statewide advisory committee and 11 regional committees. The statewide advisory group serves a technical support function; and decision making resides with the 11 regional committees / medical directors

- Illinois will have some statewide processes and standards, and some will be customized per region.
- Illinois is currently developing an alternative/community-based model the CAHOOTs model in OR).

### Indiana

**State Structure**: Three NSPLs in the State that provide 24/7 coverage in 89 counties.

- **Current BH Process and Technology:**
    - Currently using 2-1-1 and Aunt Bertha to provide resource directory services.
    - Governor is pushing to improve broadband (as a parallel initiative) because of poor connectivity in rural communities
- **Future State:**
    - Final decision regarding Vibrant is pending, ideally would like to integrate with Vibrant as much as possible
    - Published an RFP for a 988 vendor to build one unified platform for all NSPLs, including a system that has “Air Traffic Control” capabilities and connects individuals in need with mobile crisis units
    - Published an RFI for a Care Coordination Platform
    - Would like to have 2-1-1 and 988 on the same platform

### Maryland

**State Structure**: Eight Call Centers (NSPL and 988) and 2-1-1 (Press 1)

- **Current BH Process & Technology:**
    - iCarol being used by 2-1-1 and 5 NSPLs.
    - iCarol operates call tracking, GPS for mobile crisis dispatch.

- EHR used for real-time disposition tracking, outpatient scheduling and bed inventory 2-1-1 uses iCarol for the provider registry

- **Future State:**
  - Working on bed registry to track residential facilities and statewide registry for next day appointment availability

### Michigan (MiCAL)

**State Structure:** MiCAL is the statewide crisis, support and information and referral line. Published RFP Summer 2020, began build in July 2020 and in 2021 went live with MiCAL. Will be statewide by October 2022.

- **Current BH Process & Technology:**
  - Accenture Behavioral Health System (ABHS) platform and NICE inContact are used as the Call Center as a Service (CCaaS) and CRM Platforms.
  - MiCAL provides a warm handoff with mobile crisis providers.
  - Implemented a Partner Portal for referral management.
- **Future State:**
  - Currently developing best practice standards for 988 and 911 Interactions.
  - Working on maximizing data reporting. Currently working with Dashboards that MiCAL built out.

### Oklahoma

**State Structure**: In Oklahoma, The Department of Mental Health (DMH) partners closely with the OK Health Care Authority. The DMH provides state match for Medicaid services.

- Oklahoma is not a managed care state.
- Directly operate 11 different facilities across the state, including a network of community mental health facilities of which four are state operated and state and residential crisis services.
- Oklahoma was an early adopter of the CCBHC (Certified Community Behavioral Health Center) model. CCBHCs are a Medicaid provider type designed to provide a comprehensive range of mental health and substance use disorder services to individuals at higher risk of experiencing negative outcomes.
  - There is a financial incentive for creating better crisis service models. Currently building up capacity to ensure they can support the population.
  - Oklahoma should have 23 urgent recovery centers across the state by end of this year (2022).
    - Community-based crisis care, and mobile crisis care are also components under CCHB.
  - Currently the two NSPLs are operated separately from the rest of crisis system.
    - 1 NSPL in Tulsa
    - 1 in Oklahoma City
    - Calls can be directed to either NSPL depending on time of day and day of week.
    - Oklahoma is addressing and resolving process differences between the 2 NSPLs and has mapped out a crisis continuum plan.
  - Oklahoma State made the decision not to implement Vibrant UP as it was decided that Vibrant' s implementation timeline was not in line with Oklahoma's 988 planning dates.

- Through an RFP process, Solari was selected as the Call Center platform for 988 in Oklahoma.

### Oregon

**State Structure:** Oregon currently has a de-centralized system, which was described by Oregon State representatives as making it difficult to implement a statewide 988 solution. The team is having to work with individual regions to collect information and Key Performance Indicators (KPIs) that will, ideally, support moving towards a statewide solution, or minimally support decisions towards statewide processes instead of regionally based processes for 988.

- Oregon currently has two 988 NSPLs. One of the call centers covers the entire state. The other covers 2 counties.
  - NWHS: Northwest Human Services
  - LFL: Lines for Life
- The NSPLs do not dispatch crisis responders; this is currently managed through County Mental Health Programs (county behavioral Health providers) which employ and deliver crisis services including the responsibility for dispatching crisis services.
- Future State Planning: Oregon anticipates that for the first year after implementation of 988 that the state will employ a hybrid model where both calling the county crisis lines and the 988/NSPLs will be supported.
- The State is developing KPIs for 988. Some of the KPIs that will be tracked are:
  - Who requested the dispatch?
  - Was the team dispatched? If no, why not?
  - Once the team was dispatched, who stayed with the individual?
  - When co-responders are required, (e.g., law enforcement, EMS) were they dispatched?
- KPIs will support collecting information and data on how the 988 implementation is supporting the regions operations goals, and ideally the results will lead to changes in the current process.
- The State required the two NSPLs in the State to develop policies and procedures, including the protocols for dispatching mobile crisis teams. Over the next couple of years Oregon will evaluate these policies and procedures and propose changes accordingly.

## Vendor Interviews and Demonstrations

### Market overview

As described above in the Vision Section, when people reach out to 988 by call, text or chat they will be connected to trained counselors who will proceed with protocols to respond to the particulars of the call including, as needed, coordinating with regions and providers to send mobile crisis response (MCR) teams in person, providing support and resources and as necessary, referring the person to an appointment or other needed community or facility-based services. This referral will need to be closed not only with the person or patient but with a care team. Out of this process, came five crucial domains that vendors would need to address: call center, referrals and appointments to resources, bed referral/registry, responder dispatching, and reporting.

Telecommunication carriers and Voice over Internet Providers (VoIP) service providers were required to activate 988 by July 16th, 2022. Still considerable work remains to be done when it comes to implementing an efficient and robust platform that will serve as a call center, referral service, care coordination hub and resource directory.

Given these requirements, the Washington State 988 team identified the following vendors to be interviewed regarding their product offerings in five key domains (as described in the Vendor Categorization section below)
to meet the E2SHB 1477 requirements. This list of vendors was compiled by considering the short list of vendors listed in the Ballmer Report and other vendors that were referenced in interviews with States. The list of vendors is presented below and a table describing each of these vendors is included in Appendix L.

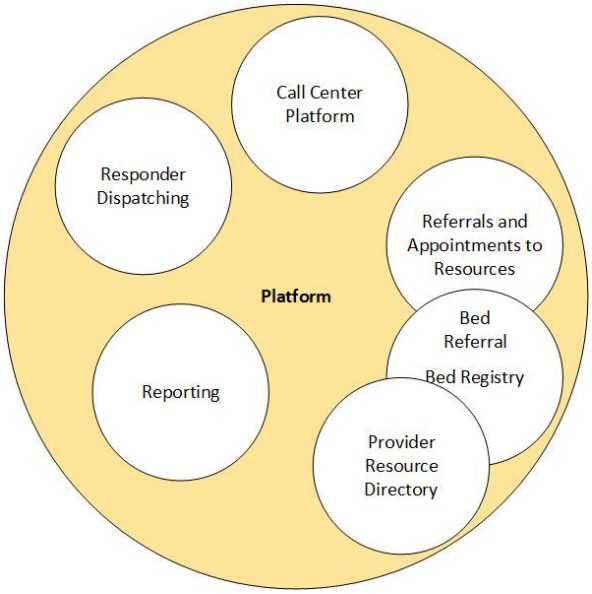


*Figure 12 Platform and needed components*

- VibrantUP
- Nice CxOne
- Cisco
- MiTel
- Genesys
- Salesforce
- Accenture BH Solution (ABHS)
- iCarol
- BH Link
- Collective Medical
- NetSmart
- Epic
- Care Logic
- Solari
- WA2-1-1
- OpenBeds (Bamboo)
- WA 911
- UniteUs
- Care Connect WA
- Ilrs

## Vendor Categorization

Each of the vendors offer some type of crisis call center, crisis response and coordination, electronic health record (EHR) and/or information exchange functions, each with various strengths and weaknesses. Many described their products as offering "full suites" and packages that include some or most of the functional requirements (Appendix O). However, they differ in their area of focus. Therefore, these vendors have been categorized into five different groups or aspects of services needed to implement the "system of systems" approach for Washington's comprehensive crisis call and response system: 1.) Call Center as a Service (CCaaS)/Telephony, 2.) CRM/Contact Management Software, 3.) Service Tools and Registries, 4.) EMR/EHR, and 5.) Provider Portal/Integration. See the Glossary for a definition of these categories.

Based on research, it was identified that most of these vendors were primarily focused on one domain or area but also had capabilities in additional areas. In this case, they were categorized by their primary functions to better understand what they can and cannot do. The groupings are as follows:


*Figure 13 Call Process Icons*

The selected vendors primarily focus on these categories, however there is some overlap. Vendors range from major corporations with multiple complex enterprise solutions to smaller organizations that offered simpler, single focused solutions.

Please note, every effort was made to meet with the vendors. However, due to either no response or scheduling conflicts, meetings with some of these vendors were not scheduled. Any analysis of these vendors is based on either email communication and review of materials shared with the team or independent research. The vendors that did not participate in a demonstration session under the auspices of the 1477 work are: Vibrant UP,[21] Genesys, Cisco, MiTel,[22] Care Logic and Epic.[23]

Detailed notes of the discussions with the vendors the team was able to meet with can be found in Appendix M.

[21] However, as described below, Vibrant Emotional Health did share some spreadsheets and email communications that allowed us to analyze what we believe the plans for the Vibrant UP (as of July 2022).

[22] The HCA 1477 project team spoke with MiTel on August 2, 2022 (after the Final Plan was beginning the review and clearance process).

[23] HCA staff have had numerous discussions with and demonstrations by Epic. That information was used to inform content in this document regarding Epic.

To help illustrate how the Functional Requirements and the Vendor Categorizations are linked, the diagram below provides a swim-lane view of a "typical" call scenario:

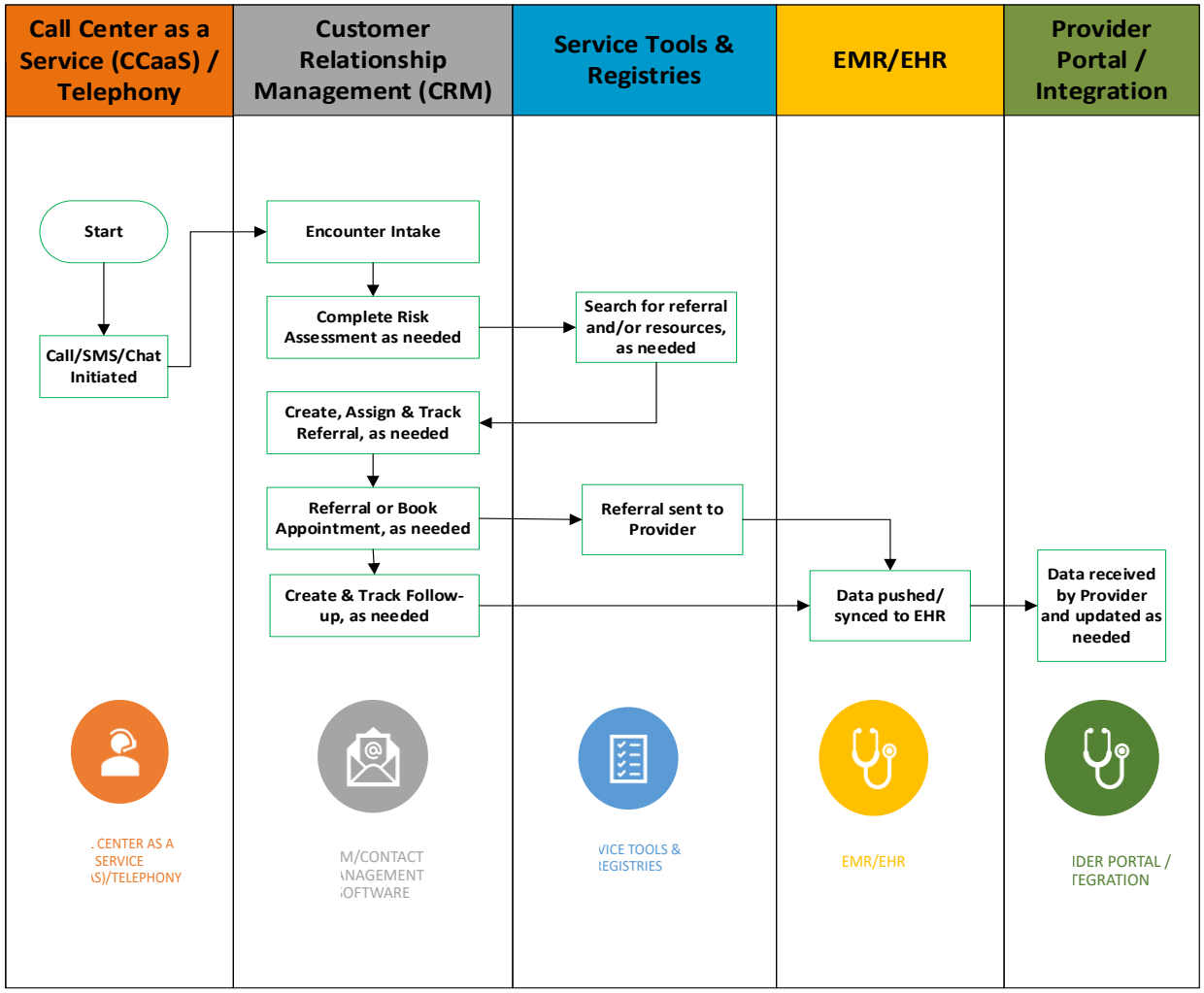


*Figure 14 Call Process*

## Analysis of Vendor Alignment with Functional Requirements

The below table provides an initial (high-level) analysis of the vendors that the project team was able to meet with. In the case of the Vibrant UP, Vibrant Emotional Health shared information about the Vibrant UP. The focus of these meetings was on information gathering only related to the functional requirements outlined in E2SHB 1477. Analysis is based on vendor statements, not on platform validation.

| Vendor | Key Characteristics | Analysis |
|---|---|---|
| Vibrant UP | Please refer to the Vibrant section below for details. | Please refer to Vibrant section below for details. (As of writing, unable to coordinate a demo session. Analysis is based on information shared by the vendor via email) |
| Nice CxOne | Can route phone, chat, SMS and integrate with other platforms | Wide range of features including skill and priority assignments, call, SMS, chat routing, and reporting. Can integrate directly with CRMs as well as be used standalone. |
| Salesforce | Call Center Platform, acts as “Air Traffic Controller,” needs System Integrator. | Development platform that requires building an application from the ground-up with a System Integrator. Capable of meeting all of HB 1477 requirements. |
| ABHS | Call Center Platform, acts as “Air Traffic Controller” | Built solution that meets almost all of HB 1477 requirements, highly customizable and flexible. |
| iCarol | Call Center Platform, acts as “Air Traffic Controller” | Built solution that meets all of HB 1477 requirements, customizable but interface is a bit dated. |
| BH Link | Call Center Platform, acts as “Air Traffic Controller” | Built solution that meets many of HB 1477 requirements, customizable. |
| NetSmart | Call Center Platform, acts as “Air Traffic Controller” | Built solution that meets many of HB 1477 requirements, customizable and features EHR integration with industry standards such as HL7/FIHR. |
| Solari (Co-Centrix) | Solari's CRNexus is a call center platform and Co-Centrix is their custom EHR that focuses on BH. | Offers customized dashboards and forms. CRNexus can capture call information as well as store records long-term for historical needs. CRNexus can also integrate with Health Information Exchanges or start eligibility information sources. Solari has also developed their own EHR with a focus on BH (Co-Centrix) |
| Collective Medical | Care Coordination Platform with an emphasis on ED and referrals | Supports collaboration and can be utilized to streamline communication process between crisis teams; allows for sharing crisis plans across platforms (when integrated) |
| 2-1-1 Directory | Washington social service resource directory | Vast WA State social service directory with fully built-out taxonomy, will require integration if not used as a standalone. |
| OpenBeds | Bed Registry and Referral platform, can also perform CRM functions. | Bed registry and referral system, currently in 13 states and three regions in WA State, customizable and capable of integrating with other Bamboo Health Modules, EHR solutions. |

| Vendor | Key Characteristics | Analysis |
|---|---|---|
| WA 911/Geolocation call routing | Call Routing | Ability to utilize existing call routing tools and infrastructure to support geolocation requirements, resource availability, and note taking/sharing |
| UniteUs | Solution for Social Care (Community Information Exchange platform) | Capable of supporting closed loop referrals and care coordination activities; strong footprint in WA State |
| Care Connect Washington and Washington Resource Data Collaborative | Currently has a statewide infrastructure to address citizen needs | The methodology employed by the Washington Resource Data Collaborative (WRDC) could potentially help align resource directories in the future |
| ILRS | Integrated Licenses Regulatory System in Washington State. | Department of Health registry used in WA State to manage provider licensing, currently being decommissioned, and will be replaced by a more robust platform. |

*Figure 15 Vendor Alignment with Functional Requirements*

## Vibrant Unified Platform: Functional Requirements and Timeline

Since 2005, Vibrant Emotional Health (referred to as Vibrant) has been the administrator of the NSPL network. There are over 200 NSPL centers across the county. In 2020, Vibrant recommended that the NSPLs adopt a shared technology platform that would support:[24]

- Multi-channel crisis communication (i.e., phone, text, chat);
- Equitable and efficient connection to counselors across all channels and services for populations;
- Seamless coordination with local crisis response services for individuals requiring urgent care;
- Follow-up and community resource linkages for persons needing continuing support after contacting 988;
- Interoperability across channels (i.e., transfers between communication methods such as calls, chats and texts, warm transfers, etc.) and between services (e.g., connections to follow-up care, mobile crisis teams, crisis/emergency receiving facilities);
- Unify provider data collection and reporting to effectively, efficiently, and continuously monitor (across all channels) that consumer crisis needs are measured across all communities across the country; and
- All counselors responding to 988 contacts have access to the same training, resources, and announcements.

In January 2022, Vibrant announced the vendors selected for its Unified Platform. The chosen vendors are:

- Salesforce for the Customer Relationship Management (CRM); and
- Genesys PureCloud for the Contact Center System (CCS) Functionality.

[24] https://www.hca.wa.gov/assets/program/unified-platform-public-final-press-release.pdf

In July 2022, Vibrant shared three spreadsheets[25] identifying the functional requirements that the Unified Platform (UP) is expected to support and whether these requirements are targeted for Release 1, 2, or a future date. We used two of the three spreadsheets to inform the analysis of the Vibrant UP.[26] On July 14, 2022, Vibrant Emotional Health indicated that it "is working on a comprehensive timeline, but our initial plans are for R1 to be deployed in late October as a pilot with voice only (no chat/text), and R2 (added functionality – chat/text TBD) to be deployed tentatively in January 2023."[27]

Based on the information shared by Vibrant, we include in Appendix P high-level tabular summaries of the functional requirements in E2SHB 1477 and the:

- Requirements that the Vibrant UP is expected to support and when (Figure 61);
- Functionalities that would be implemented on a piloted basis in the Vibrant UP R1 (October 2022) (Figure 62); and
- Functional requirements that appear to be out-of-scope for Vibrant and for which there are no timelines specified by Vibrant (Figure 63).

Figure 15 below summarizes, based on an analysis of the preceding information (in the context of the functional requirements for E2SHB 1477), what the Vibrant UP may be able to support (at some point) and what this platform is not expected to support.

It is very important to note the spreadsheets that Vibrant shared:

- are working documents and thus subject to change;
- do not represent a final set of functional requirements for the NSPL crisis call centers;
- include functionalities that are not intended for the NSPLs; and
- are challenging to interpret.

However, based on a review of an earlier version of Figure 61 in Appendix P, Vibrant remarked that it saw "no significant errors or issues" but "the definition of a particular functional requirement may differ."[28]

HCA and DOH analysis:

- Reviewed and cross-referenced the requirements related specifically to LifeLine functionality in the Vibrant "LifeLine Core Fields" spreadsheet. The LifeLine spreadsheet includes several categories of information (e.g., demographics, suicidal/homicidal ideation, safety plan, crisis plan);

[25] DRAFT LifeLine Core Fields v0.7; DRAFT User Profile Matrix – LifeLine; and DRAFT Vibrant User Stories_Requirements for Salesforce presented by Coastal Cloud

[26] DRAFT LifeLine Core Fields v0.7; DRAFT User Profile Matrix – LifeLine; and DRAFT Vibrant User Stories_Requirements for Salesforce presented by Coastal Cloud

[27] July 14, 2014, Email communication with Vibrant Emotional Health to HCA and DOH staff.

[28] We shared an earlier draft of the table below with Vibrant. In a July 20, 2022 email, Vibrant remarked that it saw "no significant errors or issues. My caveat would be that the definition of a particular functional requirement may differ; as they say, the devil is in the details. At this point, I would not have any specific updates."

- Reviewed the Vibrant spreadsheet "User StoriesRequirements for Salesforce presented by Coastal Cloud." The Coastal Cloud (CC) workbook was the primary source of information for the Figure 64 in Appendix P;
- Makes assumptions about the Vibrant UP functionality based on descriptions in the spreadsheets (e.g., the description that the Lifeline will include "location" is assumed to support the functionality of a "resource map"); and
- Includes notes in Figure 64 in Appendix P that reference requirements in the CC spreadsheet that led to the conclusion that a particular functional requirement would be supported by the Vibrant UP. These notes are included for requirements that were particularly unclear in the Vibrant spreadsheets.

**Summary of Vibrant UP Functionality.** Based on the preceding information including the: (i) assumptions that were made regarding the Vibrant functional requirements, (ii) analyses reflected in Figures 61 - 64 in Appendix P, and (iii) requirements in E2SHB 1477; the table below summarizes what the Vibrant UP may potentially support (at some point) and what this platform is not expected to support.[29]

| WA State Functional Requirement | Vibrant UP may support | Vibrant UP may NOT support |
|---|---|---|
| **Call Center Platform: Create, Assign & Track(follow-up)** | • Encounter Intake (Call/SMS/Chat). However, no timeline is provided for text and chat.<br>• Telephony/ Interactive Voice Response (IVR) and Computer Telephony Integration (CTI) Integration<br>• Intake Extensibility<br>• Suicide Risk Assessment<br>• Safety / Crisis Plan<br>• Follow-up Queue<br>• Interoperable With Existing Systems | • Crisis Alerts<br>• Least Restrictive Alternative (LRA)<br>• Mental Health Advance Directives<br>• Provider Integration (e.g., integration with provider EMRs/EHRs) |
| **Responder Dispatching: Search, Dispatch & Track** | • Resource Map<br>• Interoperable With Existing Systems<br>Note: Interoperability for all WA State requirements is dependent on Vibrant requirements that have not yet been specified | • Dispatch Coordination<br>• Provider Portal<br>• Provider Integration (e.g., integration with provider EMRs/EHRs) |

[29] The reader is reminded to keep in mind the caveat that regarding the Vibrant UP functionalities.

| WA State Functional Requirement | Vibrant UP may support | Vibrant UP may NOT support |
|---|---|---|
| • **In-state call routing**<br>• **Use of GPS/geolocation (of callers and responders)** | | • Note: Federal decision making by the FCC and SAMHSA is needed to integrate geolocation functionality into Vibrant UP |
| **Referrals and Appointments: Search, Create, Assign & Track** | • Track & Remind Only for next day appointments<br>• Field to assist with tracking referrals made<br>• Resource Directory (provider and social services)<br>• Interoperable With Existing Systems | • Provider-to-Provider Referrals (i.e., referrals to and from any type of health/behavioral health provider)<br>• Stronger integration to other entities is out of scope<br>• Closed Loop Referrals (includes referrals to health and social services)<br>• Its unclear whether/when the Vibrant functional requirements will include links to local (WA State) provider and social resource directories<br>• Provider Portal<br>• Provider Integration |
| **Bed Registry: Search, Schedule & Report** | • Bed Availability<br>• Bed Metrics/Data<br>• Interoperable With Existing Systems<br><br>Note: Interoperability for all WA State requirements is dependent on Vibrant requirements that have not yet been specified | • Provider Portal<br>• Provider Integration |
| **Reporting: Create, Customize & Share** | • Standard Reports<br>• Custom Reports<br>• Dashboards<br>• Survey<br>• Potential Interoperability with Existing Systems<br><br>Note: Interoperability for all WA State requirements is dependent on Vibrant requirements that have not yet been specified | • Provider Portal<br>• Provider Integration |

| WA State Functional Requirement | Vibrant UP may support | Vibrant UP may NOT support |
|---|---|---|
| **Recommended Functionality** | | • Level of Care Assessments<br>• Services Registry (information on services provided)<br>• Public Facing Website (i.e., for (i) provider resource directory, (ii) social service resource directory, and (iii) bed registry<br>• Functional Requirements to be available for Regional Crisis Lines (in addition to NSPLs) |

*Figure 16 Washington Requirements and Vibrant Crosswalk*

## Functional Requirements


*Figure 16 Function Icons*

HCA and DOH specified a baseline list of functional requirements based on a review of requirements in E2SHB 1477. The requirements were refined/validated through extensive information gathering and sharing with providers, NSPLs, RCLs, BH-ASOs, other states, vendor interviews, and discussions with the CRIS Technology Subcommittee.

Articulating the functional requirements needed for the Crisis Call Center Platform, Integrated Referral System, and supporting Ancillary System will:

- Ensure that Federal and State requirements related to the crisis call center and behavioral health integrated client referral system are met; and
- Guide the RFI and RFP processes related to identifying and acquiring the technology tools and platforms needed to support E2SHB 1477.

To provide the residents of Washington State with the Crisis Call System and Integrated Referral System processes discussed above, the 988 solutions in Washington will need to account for the following:

- **Crisis calls (calls, texts, or chats) 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 will need to receive and track calls from multiple sources and send relevant data between systems managed by a 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.[30] When active rescue is needed (i.e., there is imminent risk of serious harm to self or others), call centers will coordinate with 911 (including tribal emergency management) to dispatch a first responder to resolve the emergency situation. Call centers may track where the person has been taken to ensure behavioral health follow up occurs.
- **Crisis Outreach (i.e., non-active rescue):** When the caller requests an in-person response, the call center will request the location of the caller and get permission to dispatch mobile crisis responders (e.g., MCRU, or co-responders). By July 2023, best practice guidance (which is under development) will be in place to determine the correct response. The responding entity is expected to resolve the situation and coordinate with whomever dispatched them. Outcomes may include: brief interventions, referrals to services, in-home or facility-based services, or other services. Encounters will be documented into an EHR along with any safety plans and referrals. Call centers should be aware of and coordinate appropriately with Tribal DCR and Tribal MCR teams.
- **Crisis follow up:** Crisis responders or the call center will 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 crisis outreach and after active rescue has been completed. The safety plan needs to be documented in the Crisis Center System, accessible to the Integrated Referral System, and accessible to individuals interacting with the caller to ensure provider responsibilities in the plan are adhered to and updated as necessary. Active rescue and crisis outreach calls may require immediate warm hand-off to a treatment facility, a next day appointment, referral, or follow-up. If a Tribal member is the crisis caller, follow-up should be coordinated appropriately with Tribal Indian Health Care Providers.
- **Phone crisis resolution:** Currently the majority of crisis calls to an NSPL are resolved on the phone. The NSPL website notes that less than two percent of Lifeline calls involve emergency service, and when emergency services are involved, over 50 percent of these emergency dispatches occur with the caller's consent.[31] It should be noted that for youth and families, referral to mobile crisis response (MCR) teams for an in-person response, is in alignment with the national best practice youth model of crisis care, mobile response and stabilization services (MRSS), is considered to be best practice.[32] If the crisis caller does not require an in-person response, 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:**Crisis responders will assess a person for needed supports and interventions. If it is identified a referral to another provider or resource is needed, the responder will get permission from the person and complete a referral with the person. The person in crisis will be asked for information to complete the referral. Information is gathered about interventions provided so

[30] Based on stakeholder interviews

[31] FAQ : Lifeline (988lifeline.org)

[32] https://www.nasmhpd.org/sites/default/files/TACPaper8_ChildrensCrisisContinuumofCare_508C.pdf

far. The responder will look into service availability and capacity, they will assess the person for the appropriateness of services based on corresponding level of care and restrictions. The responder will document this assessment. The needs assessment will contain the needed information for the referral to be completed and may contain current situation information, demographics, risk, and formal assesments.

- **EHR systems:** For crisis callers who require active rescue or crisis outreach, EHR systems (such as the EHRaaS) are one of the technology tools that could support needed health information exchange.
- **Community information exchange:** For crisis callers who may or may not require active rescue or crisis outreach, community information exchange could support access to information to support referrals to additional community-based services, such as food, housing, child care, immunizations and other public health services.

## Summary of Products and Platforms Required

Figure 17 provides an overview of the categories that make up the functional requirements; the detailed requirements are addressed in the Vendor Evaluation section of this report, along with supporting documents available in Appendix N and Appendix O.

| Requirement Category | Description |
|---|---|
| **Call Center Platform** | • The recommended Call Center Platform or Call Center as a Service (CCaaS). Product will be a unified (ideally cloud based) platform built to support omnichannel communication between the citizens contacting 988 and the counselors responding to the Call, Chat or Text.<br>• Call center platform also needs to support, tribal call center hub and tribal crisis lines; and specialty call lines for underserved and high-risk populations who need extra support.<br>• Ideally should also allow for In-state call routing, so that calls from within Washington State would be routed and answered by local responders. |
| **Call Routing and Responder Dispatching** | • The platform must have the ability to dispatch MCU's and DCR's in accordance with dispatch standards and guidelines, coordinate with outside agencies (such as Law Enforcement, Paramedics etc.) as needed; and the ability to track MCU's and DCRs in real-time using geolocation.<br>• The platform should also be able to determine the location of callers if available to route calls to the appropriate NSPL when possible. It can also be used to identify nearest responders, based on location of the responder. |
| **Referrals and Appointments** | • The platform must have the ability to search, create, assign, and track both referrals and appointments.<br>• The platform must have the ability to close referrals. |
| **Bed Registry** | • The platform must have the ability to search, schedule and report bed availability information (including specific content such as for youth/adult, male/female), and capture specific bed metrics and other data. |
| **Reporting** | • The platform must provide standard reporting as well at the ability to create, customize and share reports and dashboards. |
| **EHR/EMR** | • The platform must support care coordination across all impacted providers. Smaller providers, such as behavioral health, rural, and Tribal, need access to an EHR. This access allows for equitable healthcare services, as well as detailed health information needed by Mobile Response Teams to provide care.<br>• An electronic health record (EHR) or Electronic Medical Record (EMR) is a digital version of a patient's health care record (primary care, behavioral health, and SDOH). EHR/EMRs are real-time, patient-centered records that make information available instantly and securely to authorized users. This includes provider's EHRs and HCA's planned EHRaaS. |
| **Recommended Functionality** | |
| **Services Registry** | • The platform should be able to search for social and provider services offered in Washington. |
| **Level of Care Assessments (LOA)** | • LOA is needed to support triaging callers |
| **Crisis Documents for Exchange** | • Less restrictive alternative treatment orders or mental health advance directives.<br>• Safety plans and next steps for transition to follow-up noncrisis care. |

| Requirement Category | Description |
|---|---|
| | • Suicide and other behavioral health crisis assessments.<br>• Crisis plans.<br>• Tribal Crisis Coordination Protocols. |
| **Public-facing website** | • A website should be available that provides a one-stop public-facing shop for resources and information. |

*Figure 17 Categories of functional requirements*

## Geolocation

Different technology tools are available and in use to support the geolocation of callers and responders, identify available capacity, and support referrals to needed services.

Staff in the Washington State Military Department with expertise in 911 note that, "over time and through hard-learned lessons, the 911 community has determined that commercial off-the-shelf solutions, which work great for non-critical, non-life safety uses, are wholly inadequate to a critical, potentially life safety system."

Vibrant: The Vibrant Emotional Health selected Genesys PureCloud as the vendor for the Contact Center System (CCS) tool as part of the Vibrant UP. The functional requirements in the Vibrant CCS RFP include (but are not limited to) requirements for Automatic Call Distribution (ACD). ACD is a telephony technology that automatically receives incoming calls and distributes them to an available agent. The Vibrant UP routes based on area code of the phone used by the caller.

The Vibrant UP does not support the ability to track the location of callers or responders, it supports routing by area code.

FCC and SAMHSA Forum on 988/911: Follow-up: Following the May 24 FCC/SAMHSA Forum on 988/911, HCA, DOH and Washington Military Department staff, and CRIS Steering Committee and Technology Subcommittee members participated in a conversation to de-brief on the May 24th meeting. In the de-brief, it was suggested that agency staff explore what needs to be done in Washington State to prepare for using the 911 geolocation technical infrastructure for 988 call routing and response.

SAMHSA Update: SAMHSA, the National Council on Mental Wellbeing (NCMWB), and the National Association of State Mental Health Program Directors (NASMHPDs) presented a webinar on July 6, 2022, during which the following was discussed:[33]

- 988 will:
  - Integrate with other systems (911 for example) to reduce gaps in care systems and enhance case coordination to best serve communities' needs;

[33] Recording Link for Part One: https://us06web.zoom.us/rec/play/XcfvEhpYq3YI3O4P1C1r2PKEhfz05Y4vNYsPrer5pB_irb85h0Sr6aU3L7h24vyBIlYUkpjdtm9Woj_A.DMagYh9g3DeIZwYD

Recording Link for Part Two: https://us06web.zoom.us/rec/play/igkRBcKV1cX076Js_Oy65YGCrfKjIo0ZtTFakmdFIQyZ28_7h898aaNiYkQ1TJoWAWjWNyodOJhqr3Lh.OOQWdFILMNJ0-dNq

    - Work to ensure all callers are served in as timely and effectively a manner as possible;
- 988 will not replace other systems (e.g., 911, Fire, EMS);
- State and local decisions are needed on how 988 fits into existing infrastructure including PSAPs; and
- Activities to support the SAMHSA 5-year vision which includes a focus on electronic health information/data and technology, and PSAP coordination.

### Electronic Health Record as a Service (EHRaaS)

The Electronic Health Record as a Service (EHRaaS) is HCA's Epic implementation that is made available to targeted providers in the state. It is an essential part of Washington State's planned implementation of the E2SHB 1477. The goal of EHRaaS is to deliver equitable services to all citizens within the State. Care Coordination and interoperability are other key components of the EHRaaS role in the implementation of the E2SHB 1477.

Equitable services include services to all underserved populations in our State, including BIPOC, LGBTQ+ persons, youth and families, Tribal members, incarcerated persons, unsheltered persons, migrant workers and rural populations including farmers. Providers in these communities may have barriers to procure and maintain EHRs that can support care coordination and integration. Providing the EHRs to providers allows providers to facilitate shared clinical decision-making and improved communication with patients, families, and among health care providers for these underserved populations.

Data collection in EHRs allows correct names and pronouns to be linked to patient records, utilizes possible features including EHR banners, alerts, automated salutations, letter templates and patient instructions that effectively display correct names and pronouns in each context. EHRs can also flag various chronic conditions, such as diabetes, hypertension, and several cancers for screening. EHRaaS further seeks to achieve health equity by minimizing cultural and linguistic barriers that may impede patient-clinician communication. EHRs are focused on an individual provider and allow a provider the capacity to manage records and share data, where CIE's focus is care coordination tools that bring together providers and data from the health and social services sector.

While participation in the EHRaaS is not required for providers, those providers facing obstacles to procuring an EHR have expressed interest in using the service. These obstacles include the high cost of EHRs, bandwidth, current EHRs not meeting their needs, or challenges obtaining resources to implement and operate an EHR. Some providers are still using paper processes. This results in having to piece together information about their patients' medical history, particularly if there is a language barrier. With an EHR, the clinician can easily access a patient's medical history and does not burden the patient with having to share details of their history, or cases where it may not be culturally appropriate for the clinician to ask. Enabling these providers to have EHRs will allow integration and coordination with them in support of the Integrated Referral System.

In 2021, HCA contracted for a survey to be conducted among rural and behavioral health providers regarding their challenges with current EHRs and the provider's readiness to transition to a different EHR. This followed implementation of the Promoting Interoperability Program (PIP); formerly known as the HITECH EHR Incentive/Meaningful Use program, where many healthcare medical providers in Washington State adopted a certified electronic health record (EHRs), supported by federal incentive

payments. Unfortunately, certain providers including behavioral health ("BH" – mental health and substance abuse disorder providers) were not eligible for the HITECH Incentive payments.

As a result, if these ineligible providers wanted to implement an EHR, they had very few available choices designed to suit their specific needs. Many settled for EHRs with limited and generic functionality. Results from this survey support the frustration from this, showing that 70% of respondents expressed they are frustrated with their current EHR systems and the poor "fit," because the systems are too generic and don't always fit their specialized workflows and meet organizational needs. The survey also shows that the resources are limited within some of these organizations, especially when discussing IT support.

Further, the 2021/2022 Annual Behavioral Health Provider Survey (referenced earlier in this document), found that nearly 50 percent of responding behavioral health agencies offering crisis services reported being very willing or somewhat willing to accept an offer of a free EHR license and technical assistance to support its use.

As part of Health Care Authority's (HCA) commitment to further improving whole person care and the alignment of both physical and behavioral health, as well as improving care coordination, Epic EHR was identified to address these issues. Epic has done a large amount of work analyzing the requirements of the various provider types and created a tailored offering to meet those needs. Epic Solutions is a dominant provider of electronic health record solutions and comprises roughly 45 percent of all EHR systems for office-based providers currently in use in Washington State. This includes most of the major health care providers operating in the state. Epic's complete EHR system supports providers in care coordination, health information and data, result management, order management, decision support, electronic communication, patient support, administrative processes, financial processes, and various types of reporting including for administrative reporting, federally required reporting, state reporting, and reporting for population health.

When providers implement Epic software, they typically rely on third-party lead organizations to help the provider tailor the Epic solution to their needs. Epic's experience working with these types of entities positions them to understand the capabilities and qualities that would support a successful EHR implementation. Their experience in the Washington State market will allow providers in Washington to maximize interoperability, maximize the usage of health information technology, and address their challenges, including information exchange. Implementation of the Integrated Referral System and Interoperability Solution will leverage Epic's extensive coverage across Washington to build communication and interoperable connections more easily between providers and systems including vendors needed for the full range of services needed for the E2SHB 1477. In the team's interviews of some viable vendors for the call center, integrated referral system, and auxiliary systems needed to meet the requirements of the bill, many of them understand this need for interoperability and have already started ensuring that their systems will be interoperable with Epic.

If HCA receives funding for the Epic instance, it will take about 2-3 years to fully implement and onboard providers, which would be ready in time for other E2SHB 1477 systems to utilize the data. Delay of EHRaaS funding could push interoperability and usage of this system out, possibly incurring additional costs to ensure the E2SHB 1477 technical systems are interoperable. Implementation timelines will be dependent upon RFP/RFIs for the bill, and HCA hopes to have the EHRaaS live prior to go live of the other E2SHB 1477 technologies.

HCA has already found much needed value in utilizing an EHR. In response to the pandemic, HCA, working with partners, recently implemented Epic's Rover App and EpicCare link. These are required modules to support ongoing use in Adult Family Homes (AFH), Supported Living Agencies (SLA), and Long- Term Care (LTC) facilities. Of note for Crisis Support, Designated Crisis Responders were recently added to this initial implementation to facilitate their work of responding to mental health crisis situations. All of these providers will be incorporated to the full EHRaaS implementation. The initial targeted providers for this EHRaaS will be behavioral health, rural, long-term care, and tribal providers.

The EHRaaS platform is the responsibility of HCA and will be hosted in a commercial cloud that meets the needs of the platform including adequate backup and recovery processes, scalability, resilience and stability of the host, meeting privacy and security needs. Crisis services can happen throughout the state and occur in many underserved and rural communities. Having providers in these communities with certified interoperable EHRs will improve the crisis response and longer-term care of individuals. Assisting providers in utilizing an EHR, where they otherwise could not, will further the state's ability to provide equitable, real-time, coordinated, and integrated services as required by E2SHB 1477.

### Crisis Documents for Exchange

E2SHB 1477 Section 102 requires that HCA and DOH coordinate to develop the technology and platforms necessary to manage and operate the behavioral health crisis response and suicide prevention system, including technologies for "a behavioral health integrated client referral system capable of providing system coordination information to crisis call center hubs and the other entities involved in behavioral health care." E2SHB 1477 requires, in part, that needed technology is interoperable and provides access to:

(A) Information about any less restrictive alternative treatment orders or mental health advance directive;
(B) Safety plans and next steps for individuals as they transition to follow-up noncrisis care; and
(C) Suicide and other behavioral health crisis assessments and crisis plans.

In addition, during interviews with NSPLs and others, HCA and DOH heard that the following additional documents could be usefully shared:

- Wellness Recovery Action Plan (WRAP): WRAP documents are most appropriately created when a person is not currently in crisis. WRAP documents may be a useful reference when individuals are in crisis; and
- Tribal Crisis Coordination Protocols: Access to Tribal Crisis Coordination Protocols by non-Tribal DCRs providing ITA and crisis services on tribal reservation lands to appropriately follow protocols for tribal members.

There is general agreement about the type of information included in these different document types. However, at present, there is no agreement on specific document templates.

These electronic documents could be:

- Created by or with the individual (as appropriate);
- Shared with family members/significant others;
- Shared with clinicians; and
- Accessed in real-time by emergency responders.

Consensus is needed on the content to be standardized for these documents.

Linking standardized content to available standards (e.g., standards specified by the Federal Government in the United States Core Data for Interoperability [USCDI][34]) will support interoperable health information exchange and re-use. The Office of the National Coordinator for Health IT (ONC) has established a Health IT Certification Program.[35] The Certification Program identifies "certification criteria" including for EHRs. Technology developers certify their Health IT Modules by demonstrating conformance to these certification criteria, using test procedures (that may have associated test tools and/or test data) approved by the ONC. Certification criteria include the content and exchange standards to enable interoperable information exchange.

Health IT standards are available to make needed content interoperable including content standards (such as LOINC, SNOMED CT, ICD-10) and document exchange standards (e.g., HL7 Clinical Document Architecture (CDA), Fast Health Interoperability Resources (FHIR)).

Other technology resources are available / could be developed to make these documents available at the time of crisis (e.g., using EHRs, repositories, web-based tools, QR codes, smart cards).

Prior to using standardized and interoperable documents, protypes will need to be tested and the exchange of interoperable documents will need to be piloted. Finally, interoperable documents will need to be integrated into the NSPL call center platform and tools used by crisis responders.

See Appendix Q for additional information on needed electronic, interoperable crisis documents.

### Technical, Exchange, and Clinical Content Standards

Systems must use nationally accepted technical, data, operational, and clinical standards. The systems included in E2SHB 1477 that the state will purchase must support these national standards to facilitate interoperability and integration. Due to the large number of organizations and various types of professionals involved in responding to immediate crisis needs and the longer-term care needs of callers, data exchange is needed to support coordination of response and care across these organizations, systems and professionals. Generally, the data will be housed in the system of record and use the standards as the method of exchange.

For technical standards and data exchanges, Application Programming Interfaces (APIs) will be used to integrate different systems including (but not limited to):

- Certified Electronic Health Records hosted and used by community providers
- The future Electronic Health Record-as-a-Service (EHRaaS) hosted by HCA and used by community providers and state agencies
- 911 Computer Aided Dispatch (CAD)
- Referrals to and from 2-1-1, and
- Other systems both existing and planned.

[34] https://www.healthit.gov/isa/united-states-core-data-interoperability-uscdi

[35] https://www.healthit.gov/topic/certification-ehrs/certification-health-it

As described above, interoperability standards such as HL7 FHIR will be used for data exchanges including for document exchange (e.g., Mental Health Advance Directives, Safety Plans). The "System of Systems" approach needed to implement the numerous and comprehensive requirements in E2SHB 1477 will require that content and documents be standardized and linked to health IT standards to be efficiently shared and re-used between systems. HCA plans to leverage existing investments in API management. Data management and governance will be needed to ensure the system functions effectively through data sharing agreements with crisis partners and Tribal governments.

The technical, exchange, and clinical content standards used by various organizations and systems based on information gathered so far include the following (see definitions and details about these Standards in Appendix R).

### Technical and Interoperability

**Health Level 7 International (HL7)** (https://www.hl7.org)**:** An international health care standards development organization that creates and maintains several different data standards (V2, CDA, FHIR) used by many health care organizations and systems, including EHRs, to support interoperable information exchange.

**HL7 Fast Healthcare Interoperability Resources (FHIR)** (https://fhir.org)**:** This standard is used by many health care organizations and systems, including EHRs.

**National Emergency Number Association (NENA) i3** (https://www.nena.org)**:** This standard is used by 911 related organizations and systems.

**United States Core Data for Interoperability (USCDI)** (https://www.healthit.gov/isa/united-states-core-data-interoperability-uscdi)**:** This standard is used by systems used by many health care organizations, including in EHRs.

### Content and Clinical

**Alliance of Information and Referral Systems (AIRS)** (https://www.airs.org)**:** This standard is used by 2-1-1 and other organizations providing information and referral services.

**Logical Observation Identifiers Names and Codes (LOINC)** (https://loinc.org)**:** This standard is used by many health care organizations and systems, including EHRs.

**Systematized Nomenclature of Medicine -- Clinical Terms (SNOMED CT)** (https://www.snomed.org)**:** This standard is used by many health care organizations and systems, including EHRs.

**Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR)** (https://www.psychiatry.org/psychiatrists/practice/dsm/dsm-5)**:** This standard is used by many health care organizations and systems specifically in the area of behavioral health.

**Current Procedural Terminology (CPT)** (https://www.ama-assn.org/practice-management/cpt)**:** This standard is used by many health care organizations and systems, including EHRs.

**Healthcare Common Procedure Coding System (HCPCS)** (https://www.cms.gov/medicare/coding/medhcpcsgeninfo)**:** This standard is used by many health care organizations and systems, including EHRs.

**International Classification of Diseases (ICD)**
(https://www.who.int/standards/classifications/classification-of-diseases and https://www.cms.gov/Medicare/Coding/ICD10)**:** This standard is used by many health care organizations and systems including in the area of behavioral health.

# Technology Requirements

The sections below detail the overall system requirements and the future Crisis Center System and Integrated Referral System. During the RFI/RFP phases, the following information (including requirements related to Data Stewardship) will be shared in the procurement documents, and the vendors respond to questions in the following topic areas. In addition, vendors of the technology are expected to meet federal and state quality standards.

## Quality Assurance and/or Independent Verification and Validation services

Large projects in Washington State require Quality Assurance and/or Independent Verification and Validation services (IV&V). In addition, this project is a federal Health and Human Services Coalition project and is subject to Quality Assurance and/or Independent Verification and Validation services.

## Data Governance

**Data segregation:** Data segregation allows for the creation of separate access rules for sets of data or different groups of users, ensuring that only those who are authorized can view, access, remove, or alter the data. The required systems to implement E2SHB1477 will need to store large amounts of data with access by various groups. Data segregation and multi-tenant design will be considered to ensure that data is protected at the appropriate level based on its classification as well as appropriate access is granted based on least privilege concepts and HIPAA's minimum necessary provision.

**Data and Service Level Agreements:** Service Level Agreements (SLAs), Data Sharing Agreements (DSAs), and Non-disclosure Agreements (NDAs) are examples of needed agreements to support appropriate identity and access management to this protected data. These agreements should incorporate datasovereignty principles and tribal governments should be included in the organizations that receive any data sharing agreements. RCW 39.26.340, which requires DSAs for Category 3 or higher data, has cybersecurity implications as well as privacy and is related to Engrossed Substitute Senate Bill 5432 (ESSB 5432) implementation. DSAs must cover data being passed to different entities. The final architecture will involve communications and data sharing, therefore appropriate legal and contractual agreements and standards must be in place to ensure this sharing is appropriate. These specific agreements and what data will be shared needs to be determined as a part of these agreements.

## Data Security and System Management

All vendor hosted solutions will be required to complete and pass an OCIO 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 Policy 141.10. All systems holding data about callers will need to have required security process, procedures, or system controls in place to protect the data and provide high availability services. Requirements include, at a minimum:

**Data Disclosure:** Data sharing agreements are formal contracts that detail what data are being shared, who will have access to the data, the timeframe that the data sharing will occur, the appropriate use of the data, data sanitization requirements and must be in place between all entities sharing data.

**Business Impact Analysis (BIA):** Used as a starting point for the disaster recovery planning to define key parameters such as maximum tolerable downtime (MTD), recovery time objectives (RTO), recovery point objectives (RPO) and resources/materials needed for business continuity. It is also used to support the development of other continuity plans associated with the function, including, but not limited to, Disaster Recovery Plans (DRP), and Continuity of Operations Plan (COOP). The BIA will be completed by the 988 Program and provided to the implementation team to define the data backup and recovery strategy and the disaster recovery plan.

**Data Backup and Recovery:** Data will be stored in the original system of record and shared to other systems and stored for use and backed up accordingly. Data backup is the practice of copying data from a primary to a secondary location, to protect it in case of a disaster, accident, or malicious action. This system's data is essential, and losing data can cause massive damage and disrupt business operations. Data backup and recovery procedures and plans need to be in place and in compliance with contract and state requirements, 24/7/365, due to the nature of crisis response.

**Disaster Recovery Plan (DRP):** A written plan for processing critical applications in the event of a major hardware or software failure or destruction of facilities. The DRP must include the following components:

a. Activation and Notification Phase – Activation of the DRP occurs after a disruption or outage that may reasonably extend beyond the Recover Time Objective established for a system. The outage event may result in severe damage to the facility that houses the system, severe damage or loss of equipment, or other damage that typically results in long-term loss.

b. Once the DRP is activated, system owners and users are notified of a possible long-term outage, and a thorough outage assessment is performed for the system. Information from the outage assessment is presented to system owners and may be used to modify recovery procedures specific to the cause of the outage.

c. Recovery Phase – The Recovery phase details the activities and procedures for recovery of the affected system. Activities and procedures are written at a level that an appropriately skilled technician can recover the system without intimate system knowledge. This phase includes notification and awareness escalation procedures for communication of recovery status to system owners and users.

d. Reconstitution – The Reconstitution phase defines the actions taken to test and validate system capability and functionality at the original or new permanent location. This phase consists of two major activities: validating successful reconstitution and deactivation of the plan.

e. During validation, the system is tested and validated as operational prior to returning operation to its normal state. Validation procedures may include functionality or regression testing, concurrent processing, and/or data validation. The system is declared recovered and operational by system owners upon successful completion of validation testing.

f. Deactivation includes activities to notify users of system operational status. This phase also addresses recovery effort documentation, activity log finalization, incorporation of lessons learned into plan updates, and readying resources for any future events.

**Continuity of Operations Plan (COOP) --** Continuity of Operations Planning (COOP) is the effort within individual agencies to ensure they can continue to perform their mission essential functions during a wide range of emergencies. It's the initiative that ensures that governments, departments, businesses and agencies are able to continue their essential daily functions. COOP requires planning for any event – natural, human-caused, technological threats and national security emergency – causing an agency to relocate its operations to an alternate or other continuity site to assure continuance of its essential functions. This system will require all vendors and partnering organizations to have a COOP plan in place and support a 24/7 uptime model.

**Technical Support**: SLAs must include technical support to ensure that appropriate assistance is needed to support 24/7 operational and uptime model, and response times are appropriate to the technical support needed by users of the system. Each system must ensure that it can meet high availability and 24/7/365 up-time requirements due to the nature of crisis systems and that uptime is 99.99% at a minimum. Response to errors and system downtime must be immediate and appropriate measures are in place to quickly resolve issues.

**Maintenance:** Washington State law requires all systems to be properly maintained meaning that all patches, upgrades, and software versions be up to date and supported by the vendor. Updated software and hardware prevent vulnerabilities in the system that could be exploited and allows the systems to run optimally.

**Data Archiving for Security:** Archiving moves the old data, that must be retained, out of the operational datastores to the data archive. Data Retention procedures must be in place to comply with federal and state regulations (7 C.F.R. Part 246.25 as well as state and county retention schedules).

**Disposal of Data:** Purging deletes data from the operational datastores and data archive that does not need to be retained. Data Retention procedures must be in place to comply with federal and state regulations (7 C.F.R. Part 246.25 as well as state and county retention schedules).

**Location Security:** Location security checks a user's rights to access information based on the location of case and client information. Location security also checks the location of a user. Both these aspects are important to this project as the desire for anonymity is an important topic for callers as well as the protection of caller information. While location is needed to track responders and ensure the crisis response is timely, the location of responders needs to only be disclosed on a need-to-know basis. Some responder's location such as 911 and Fire will not be disclosed due to health and safety reasons. This will need to be considered and evaluated in the system as a requirement.

**Redundancy:** Technology or backup equipment or links that immediately take over functions of equipment or systems when components fail. This system requires up times of 24/7/365 therefore will need to be a consideration for all vendors selected in this system. Cloud-based architectures can allow for immediate recovery if a significant outage occurs in the primary production environment.

**Encryption (in transit and at rest):** Data encryption is a security method where information is encoded and can only be accessed or decrypted by a user with the correct encryption key. Encrypted data, also

known as ciphertext, appears scrambled or unreadable to a person or entity accessing without permission. Data contained in this system is highly confidential and must be encrypted and protected both in transit while it's being shared across systems, and at rest when it is stored in any system.

**Data Sources:** Data sources will need to be clearly defined as each system is added and sharing is defined. To the extent possible, unique sources of truth will be defined to reduce update and issues relating to inaccuracy. Data must be as accurate as possible to ensure responders have access to the most relevant and updated information possible to provide assistance as quickly as possible.

**Data Interoperability Requirements:** There is currently no single system that meets all the requirements for Washington State's system. The RFP/RFI process will help the state define where the system boundaries and overlap in functionality may occur. During information gathering the state has defined that interoperability is necessary. HCA will be responsible for operations and maintenance of the interoperability platform. Although different systems have different data standards (FHIR, HL7, AIRS, NENA, etc.), to the extent possible, HCA will leverage current investments to assist in interoperability of systems through use of API and API management capabilities. Due to the number of connections and components needing to be interoperable for this architecture, the state will likely need to procure services of an integrator to ensure data can flow smoothly through the system and work with integration staff from different vendors.

**Extensibility, Scalability, and Availability:** Extensibility is an ability of the software system to allow and accept the significant extension of its capabilities without major rewriting of code or changes in its basic architecture. An extensible system provides technology, tools, languages that are designed so that developers can expand or add to its capabilities. Scalability is defined here as the measure of a system's ability to increase or decrease in performance and cost in response to changes in application and system processing demands. Since this system is a high availability system; the technology must be able to auto scale to meet high traffic performance needs. This system will be new and changes in law or policies either at the state or federal level will require a modular design where components can be replaced or changed when needed, without having to replace the whole system therefore the system will need to include extensibility, scalability, and availability requirements.

### Data Access and Permissions

User access and permissions are important to ensuring the privacy of the data that will be contained within these systems. For access, single sign-on (SSO) will be used where possible to avoid users having to login in multiple times to different systems delaying data retrieval while responding to crisis calls. Multi-factor authentication is a requirement for state systems per OCIO 141.10 policy and will be required where applicable.

Within each user organization and each separate system there will be a hierarchy of roles: Organization Admin → Supervisors/Managers → Staff/Volunteers, however depending upon the organization structure or security requirements there may be more levels and branches needed to support needs. Each system will have a designated authority for controlling the addition and removal of users, to prevent unauthorized access. For example, unless authorized, users will be unable to call a different organization and grant access to patient information, only the organization administrator would be able to do that. The segregation of access will also need to prevent one organization mistakenly granting access and due to single sign-on functionality inadvertently granting unauthorized access in another organization. While onboarding responders as fast as possible is needed, there is a balance to be struck

between rapid onboarding and data retrieval and appropriately granting data access due to the highly sensitive nature of the information contained in these systems. HCA and DOH staff will review each system chosen to ensure that data is properly protected, and rights are properly granted, including ensuring data sovereignty principles are recognized during this process. Sample access Roles are listed in Appendix S.

Data access will follow least privileged access principles where each user should only be given access for what they need to do, nothing more. Access will be granted just in time where access is only granted for the duration of the activity and not beyond. In procuring systems, periodic audits will be required to ensure that data access is appropriate and only valid users have access.

**Identity Access Provisioning & Management** – Due to the nature of this data, appropriate permission and provisioning procedures must be in place to protect confidential data pursuant to state and federal law for data security and privacy controls as well as address Tribal data sovereignty requirements.

**Data Flow**

The data flow diagram below shows a high-level data exchange expected and the endpoints for each source. Detailed data flows will be defined as vendors are selected and elements are defined for each data exchange. The state prefers data exchange to be API based and automated as much as possible but understand that various data sources and legacy systems from the provider could be an obstacle to full automation and API based data flow.

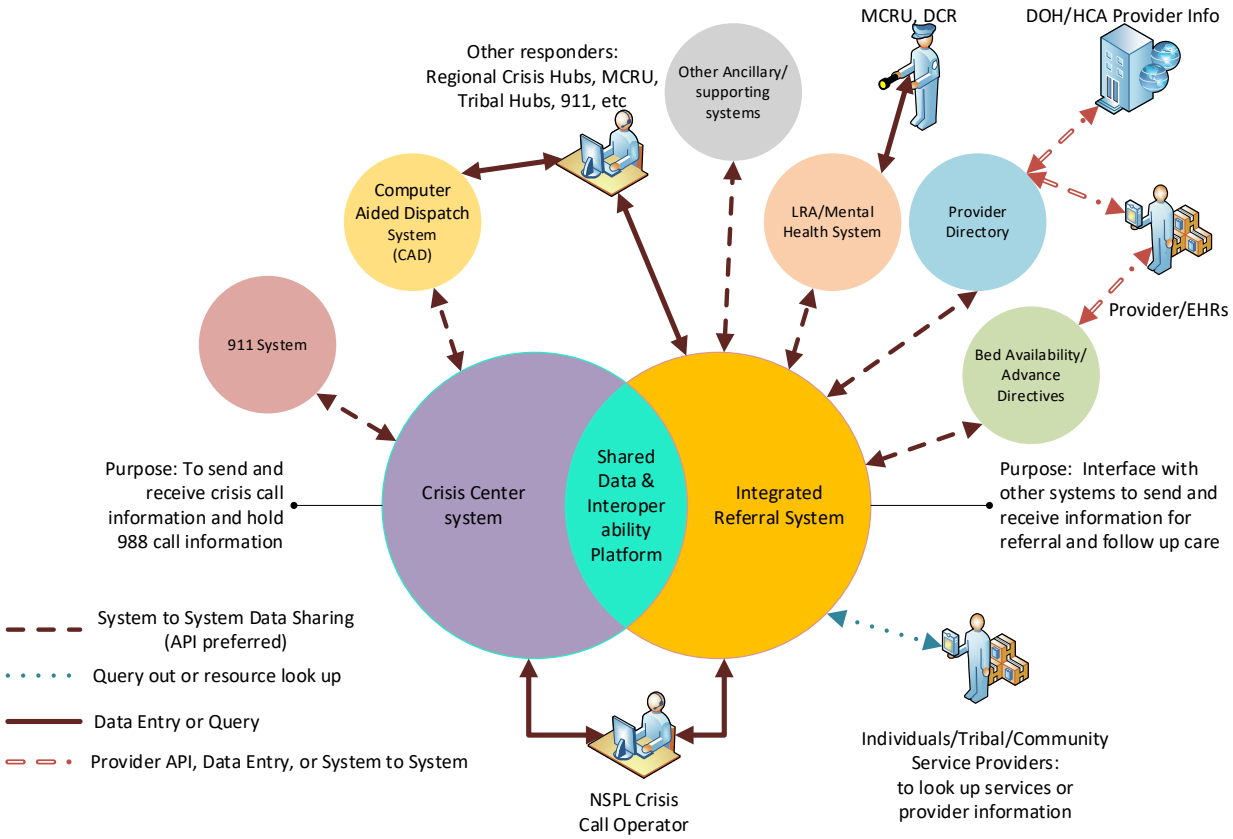


*Figure 18 High Level data flow of Systems*

## Privacy and Protocols

Washington State privacy laws and federal laws (such as HIPAA and 42 CFR Part 2) govern data access, confidentiality, security, and sharing. Generally, protected health information cannot be disclosed by a covered entity without the consent of the individual. The systems will be required to have features that can accommodate these needs such as a consent process and adequate security managemen tools to ensure adequate access and data management. As the Federal Government addresses the use of geolocation for crisis calls, additional privacy requirements will likely be established.

### Washington State Privacy Law

1. Washington State law, most importantly the Uniform Health Care Information Act (UHCIA), contains specific requirements that govern confidentiality of information. The AIHC is seeking to include Tribal Public Health Authorities into the UHCIA in 2023 through legislation.
2. Under state law, heightened standards of confidentiality (beyond HIPAA) are required when using or disclosing health care information pertaining to mental health records for ages 13 and up (RCW 70.02.230). 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).

### Federal Privacy and Security Laws

#### *HIPAA*

HIPAA incudes requirements that pertain to the protection of privacy and security of protected health information. Most health care providers and their business associates must comply with all HIPAA privacy and security rules.[36] Entities that are subject to HIPAA requirements (i.e., covered entities and business associates) are "generally prohibited from using or disclosing protected health information unless authorized by patients, except where this prohibition would result in unnecessary interference with access to quality health care or with certain other important public benefits or national priorities. To avoid interfering with an individual's access to quality health care or the efficient payment for such health care, the Privacy Rule permits a covered entity to use and disclose protected health information, with certain limits and protections, for treatment, payment, and health care operations activities."[37]

In addition, covered entities may use or disclose protected health information without patient consent when the covered entity, acting in good faith and consistent with ethical conduct, believes the use or disclosure: (a) is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public, and (b) is to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Callers to 988 can remain anonymous, and discussions are confidential. Information gathered during 988 crisis calls is protected by privacy policies and laws. To be a part of the NSPL network, agencies are required to be certified or accredited.[38] In Washington State the three NSPL agencies that currently

[36] https://www.hhs.gov/hipaa/index.html

[37] https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/disclosures-treatment-payment-health-care-operations/index.html

[38] https://988lifeline.org/wp-content/uploads/2017/07/Appendix-1-Lifeline-Requirements-for-Membership.pdf

conduct 988 services are certified/accredited by the American Association of Suicidality[39] and/or the International Council of Helplines[40] and are HIPAA covered entities. Accreditation processes and NSPL policies require that every effort should be made to protect a person's privacy; disclosure of private or protected health information must follow all applicable policies and laws, including but not limited to HIPAA. When a caller is experiencing imminent risk of suicide, the crisis counselors make efforts to establish rapport and support the caller's collaboration in securing their own safety with the least invasive intervention. If necessary, the crisis counselor may initiate active rescue to initiate life-saving services. For the very small percentage of NSPL crisis calls that require active rescue, as noted, HIPAA permits the use or disclosure of information without the consent of the individual when it is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public, and information is shared with persons who are reasonably able to prevent or lessen the threat.

In Washington State, crisis response services are dispatched by Regional Crisis Lines. Calls made to 988 that result in the need for crisis response services are transferred through direct conversation between the crisis counselor and the appropriate Regional Crisis Line.

Regional Crisis Lines are subject to HIPAA. All crisis calls received by RCLs, including calls transferred to RCLs from 988 Suicide and Crisis Lifelines, are Medicaid billable services. In addition, crisis services dispatched by RCLs are Medicaid billable services.

### *42 CFR Part 2*

42 CFR Part 2 (Part 2) requires that information protected by Part 2 be kept confidential and allows far fewer disclosures without patient consent compared to HIPAA. Part 2 information is patient information generated by Part 2 Programs. Part 2 Programs are federally assisted programs that hold themselves out to the public as providing substance use disorder (SUD) diagnosis, treatment, or referral for treatment. Patient consent generally must be obtained to share protected Part 2 information with designated providers or health information exchange organizations.

Part 2 Programs must allow the patient to grant or revoke consent for one or more parties named in a multi-party consent form while leaving the rest of the consent in effect. In a non-Health Information Exchange (HIE) environment, this can be accomplished simply by the Part 2 Program indicating on the consent form or in the patient's record that consent has been revoked with respect to one or more named parties. In an HIE environment, the revocation with respect to one or more parties should be clearly communicated to the Health Information Organization (HIO) as well as noted in the patient's record by the Part 2 program. There are requirements to account for disclosures and re-disclosures of protected SUD Part 2 information.

It can be difficult to know if Part 2 is applicable when re-disclosing information because that question is based on whether data was generated from a Part 2 Program. The source of the data must be known to know whether the law is applicable.

[39] https://suicidology.org/

[40] https://councilforhelplines.org/

Disclosures may be made without patient consent in certain bona fide medical emergencies when patient consent cannot otherwise be obtained, or in limited circumstances when the Part 2 Program is closed due to a state of emergency. Certain procedures must be followed in these circumstances. Emergency considerations need to be considered where there may be an applicable active rescue and consent may not be obtained. This is known as "break the glass" in the context of 42 CFR Part 2, where a life-threatening emergency situation eliminates the requirement for obtaining consent from the individual.

## Tribal Data Sovereignty

Tribal governments, urban Indian health organizations, and tribal organizations have worked towards educating the state on data sovereignty principles and the importance of implementing these principles in the state's practices on information gathered for tribal members. These organizations have also shared the importance of careful data gathering and sharing methodologies for AI/AN individuals.

Many of these data sovereignty principles were established by: (i) The National Congress of American Indians and (ii) are reflected in the "Best Practices for AI/AN Data Collection."[41] Below is a summary of key highlights from the literature.

- Importance in Tribal sovereignty as it pertains to tribal data - "Tribes have inherent authority to protect their Tribal citizens' health and wellness and provide public health services as they determine best."[42]
- Importance of "establishing data partnerships."[43]
- "Establishing data governance principles" from the NCVHS Stewardship Framework.[44]
- AI/AN data collection best practices include:[45]
    - requirement of race and ethnicity in health data,
    - defining AI/AN in combination with other race/ethnicities, consideration for collection of tribal affiliation in consultation with Tribes,
    - ensuring data sharing agreements prior to disseminating tribal specific data,
    - aggregate data on AI/AN populations,
    - use of weighted sampling, and
    - oversampling and conduct mix-methods research.

Tribal partners and the American Indian Health Commission recommend that these data sovereignty principles and agreements be extended to State contractors and subcontractors working on behalf of the State, and that each Tribal government must have a DSA.

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[41] https://www.uihi.org/resources/best-practices-for-american-indian-and-alaska-native-data-collection/

[42] *Network for Public Health Law, https://www.networkforphl.org/resources/data-governance-strategies-for-states-and-tribal-nations/?msclkid=d41c5fbda92d11ecb58179dd429446a4

[43] ibid

[44] **PolicyLink, 10-Design-Principles-For-Online-Data-Tools.pdf (nationalequityatlas.org) page 14, 15

[45] ibid

DOH has already engaged in the development of data sharing agreements for public health data with Tribal governments in partnership with the AIHC and the two Tribal epidemiological centers in the State. Once this DSA is completed, they will be requesting a DSA development with HCA for health-related data.

Once HCA receives this request, they will engage with Tribal governments to enable information sharing and reuse on behalf of tribal members experiencing crises; consideration will be given to these data sovereignty principles while also addressing federal and state requirements and the business needs of the crisis system.

A DSA template that may be used as a model is under development with the Department of Health. Included in this work is further discussion on how HCA/DOH consider data sovereignty for Tribes outside of WA State who have tribal members accessing crisis and behavioral health services. Partners that are included in any DSAs including state agencies will need appropriate training on these government-to-government data sharing protections, these principles and established DSAs. HCA and DOH are committed to considering that data sovereignty measures and principals are reflected as a part of the implementation of the technology and operations plan.

### Cybersecurity

All technology solutions must complete and pass an Office of Cyber Security (OCS) security design review for compliance with OCIO 141.10 Standards. 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 examines the following areas: Physical and Environmental Protections, Data Security, Network Security, Access Security, Application Security, Operations Management, Security Monitoring and Logging, Incident Response, and Service levels.

### Integration and Interoperability

Integration and interoperability are fundamental for the systems to address the requirements of E2SHB 1477 to operate effectively. There is no single vendor or platform that supports the full -to-end-to-end system Requirements in E2SHB 1477. This system must be modular and include products/services from several vendors with additional added components functioning as middleware for the purposes of integration and interoperability. Where possible, existing technology investments will be leveraged, and, where necessary, new technology will be procured or required as part of a vendor system's components. Integration with the Vibrant Unified Platform (UP) (or other primary vendor) and other platforms and systems as they are selected is a requirement. Whether Vibrant UP is chosen as the delivery system for the call center platform or not, any system chosen for the call center or referral system must be interoperable with the Vibrant UP where applicable.

Integration is a requirement with the future referral system and supporting systems including bed capacity and availability solutions, statewide provider resource directory, statewide social service directory, LRA, and MHADs systems, as well as integration with the Regional Crisis Lines and any 911 systems. Some of these systems do not exist currently and will need to be handled as separate but related projects to establish. Many of these systems already use established health care data standards, and any system added to this architecture will have a requirement to support applicable data exchange standards such as HL7 Clinical Document Architecture (CDA) and/or FHIR, USCDI, clinical data content standards, and other architectural standards to enable secure and interoperable information exchange).

Since vendors have not yet been selected, the specific architectural, content, and exchange standards cannot be currently mapped. These will be defined as a requirements of vendor contracts in the integration part of implementation for each system and component. Applicable connections and data share agreements will be updated as vendors are added, and connection endpoints are defined.

## Data Analytics & Performance Metrics

Analytics involves interpreting data where reporting is presenting factual, accurate data. Analytics answers why something is happening based on the data, whereas reporting tells what's happening. All systems must be able to deliver the state and user organizations factual accurate data to measure the effectiveness of systems and programs. Both business metrics as well as technical performance metrics need to be measured and reported to the legislature for the purposes of identifying business and system gaps and funding requests to address and improve the overall system. Technical reports and data collection need to be able to effectively communicate business metrics and support the goals of the system and vision defined by the various committees governing the implementation of this plan. This group will work with Tribes on identifying appropriate and relevant data analytics and outcome measures based on tribal data sovereignty principles.

As depicted in the table below, in the current environment, NSPLs and RCLs have a series of metrics on which they report, including:

| NSPL Metrics | RCL Metrics |
|---|---|
| • Number of Calls Initiated<br>• Number Answered In-State and Rate<br>• Number Answered Out-of-State<br>• Number of Calls Abandoned and Rate<br>• Number of calls transferred<br>• Average Answer Time<br>• Average Handle Time<br>• Routing of calls<br>• Average response times<br>• Call outcomes (e.g., follow up, cross-system coordination, and accountability, any immediate services dispatched) | • Total number of calls to crisis line<br>• Total number and percent of calls to crisis line answered<br>• Average answer time of calls to crisis line (in seconds)<br>• Total number of calls to crisis line answered live within 30 seconds<br>• Percentage of calls to crisis line answered live within 30 seconds<br>• Total number of calls to crisis line abandoned<br>• Percentage of calls to crisis line abandoned |

In addition, BH-ASOs are required to report on certain metrics related to:

- Mobile crisis outreach services;
- Percentage of emergent mobile crisis outreach service requests/referrals that were responded to within two (2) hours;
- Percentage of urgent mobile crisis outreach service requests/referrals that were responded to within twenty-four (24) hours; and
- Metrics related to Involuntary Treatment Act (ITA) investigations.

These and other metrics (including time and distance response metrics) will be taken into account for the future crisis call system in Washington State. The Governor's Office is leading work to identify metrics for the enhanced crisis call and response system required under E2SHB 1477.

## Hosting Platform

Washington State prefers cloud-based software solutions and Cloud-hosted Platform-as-a-Service (PaaS) where feasible. The systems must have the ability to connect to both cloud-based and on-premise systems and data sources. In the state's initial review of vendor solutions, many vendors do offer cloud-based solutions. Auxiliary systems that are needed to support this functionality are not all cloud based. Providers do not all have cloud based interoperable systems and not all regional crisis lines and responder groups will have modern systems. This is the reason functionality for connection is needed to both cloud-based and on-premises systems

## Solution Architecture

The state will evaluate and choose vendors and systems that align with the state and HCA/DOH Enterprise Architecture Principles and use microservices and modular based architecture when possible. Microservices is an architectural and organizational approach to software development where software is composed of small independent services that communicate over well-defined APIs. These services create an architectural style that structures an application as a collection of services that are:

- Highly maintainable and testable
- Loosely coupled
- Independently deployable
- Organized around business capabilities
- Owned by a small team

The microservice architecture enables the rapid, frequent and reliable delivery of large, complex applications. It also enables an organization to evolve its technology stack.

Similar to microservices, modular design can be characterized by functional partitioning of a system's parts into discrete scalable and reusable modules, rigorous use of well-defined modular interfaces, and making use of industry standards for interfaces.

These two concepts together are important in this system. 988 is new nationally and in this state, and many changes in the landscape, technology, and program are ahead. Choosing systems that are based on the microservice approach and modular design allows Washington State to evolve quickly as changes come. Regardless of which system or combination of systems the state chooses, changes are inevitable. If the state chooses a call center vendor that is not Vibrant UP, eventually integration with the Vibrant UP will be needed. If the state chooses Vibrant UP for the call center, additional technology tools are expected to address gaps in the Vibrant UP and fulfill all the functionality needed to address the E2SHB 1477. Additional modules will need to integrate and interoperate with the Vibrant UP and the call center platform if not Vibrant. Implementation of the comprehensive system and any additionally needed modules will need to allow other organizations that provide services coordinated through the Crisis Call Center Hubs to access the elements of these system to facilitate their service provision. These other organizations may bring other needs and changes requiring the state system to evolve. Having system components decoupled allows the State to replace and enhance functionality as needed to address new needs and changes.

Where possible HCA and DOH will utilize technology and data architectures that aligns with industry best practices, and each agency's Enterprise Architecture principles, policies and standards. In today's technical environment HCA and DOH need to deliver quality, reliable software and projects quickly

without sacrificing stability with a built-in security that ensure that IT can more effectively support the needs of the business. This is particularly important in this effort where a system is needed that contains highly confidential data and provides much needed crisis services. The state's preference is for purchasing a SaaS platform that is preferably a leader in its domain based on industry reviews and ratings. Of the many varied technologies available in today's marketplace, choosing a technology partner that have SaaS solutions meeting needs greatly decreases time investment and allows systems to be up and running within weeks, not months.

Since a SaaS vendor works across a large consumer base, it gains efficiencies that aren't attainable with one-off applications and the subscription fee covers all costs and charges for ongoing maintenance and bug fixes maximizing the state's investments and taxpayer dollars. Many SaaS vendors in the market offer flexible configurations and integrations to meet requirements and specific goals as outlined by E2SHB1477. Although control over a third-party software platform or its product roadmap is limited, the benefits of a quicker launch and the opportunity to review subscriptions and pivot as the business and crisis environment changes. This is one of the reasons the state has chosen a buy approach to software systems and components versus a build approach.

API integration facilitates interaction between systems and devices, delivering data while facilitating reliable connectivity between programs. The API defines the types of requests that can be made, how to make them, and the data formats that must be used which could be private, partner, or public. APIs are key to facilitating data exchanges within and between the systems of systems needed to deliver the needs of E2SHB1477. HCA and DOH plans to use APIs to move data between services leveraging existing state investments. The state has made investments in Universal API management (UAPIM) which enables organizations to work with any API regardless of its origin or protocol.

### MuleSoft

The state is currently using the MuleSoft API platform is which is a leader in the Full Life Cycle API Management Magic Quadrant for other similar use cases. MuleSoft is owned by Salesforce but operates as an independent unit. They offer the AnyPoint Platform, which combines API management, development, and integration capabilities. The state plans to use this UAPIM as one of the tools in the interoperability platform to integrate different systems within the system of systems approach allowing these systems with different standards to communicate with each other and share data.

### Preventing Functional Overlap in Solutions

Through the RFP/RFI process, various vendors will be evaluated to ensure that their solutions can meet the functional requirements of E2ESHB1477 and be interoperable with other systems or components. Conceptual future state architecture and solution architecture diagrams will be created from detailed requirements and as vendors are selected for various components of the system of systems ensuring interoperability. One of the challenges in the solution architecture is the overlap of functions. Many of the different vendors have overlapping functions. Choosing the right mix of vendors to provide all services and resolving overlapping functions will be difficult. A reason for the difficulty will be that some of these systems have highly integrated functionality meaning decoupling various functions, specifically functions needed by the state may be difficult or not cost effective for the vendor to support.

Where there are overlapping functions, the state's preference is to only use the function from one of the vendors to avoid confusion and provide one source of update and one source of truth. For example,

if providers are required to update information, and there are multiple portals for updating information, this could possibly lead to multiple groups in the organization using different portals for updating. Even if the system and data is interoperable, overlapping functions could lead to different groups overwriting each other's information, resulting in inaccurate data. As vendors are added and systems are defined a more detailed diagram will be needed which includes vendors and components. '

## Liability

**Technology Liability**: In the area of technology, the state will be seeking vendors to fulfill as many of the requirements as possible and therefore shifting much of the liability to the vendor. The vendor will be responsible for all of its obligations under the relevant contract with the state, including the system deliverables, system availability, and data security, regardless of whether a subcontract or supply agreement is made or whether the vendor relies upon any subcontractor to any extent. Where transfer of liability is not possible, the state will work with DOH and HCA legal counsel and the Attorney General's Office (AGO) to mitigate or insure against those risks.

**Confidentiality and Breach Liability**: An unauthorized party gaining access of the assets present in the technology system or in the transmission of handoff information known as a "breach" as defined by HIPAA. This is, in part, liability of the technology and liability of the staff and their processes and training.

**Integrity Violation**: An unauthorized party accessing and tempering with an asset used in the system.

## Business Plan Analysis

As described in the section entitled, "Vision of Future State for Washington Crisis Call and Response System" the Plan describes the business and clinical workflows in the current and future enhanced crisis call and response system in Washington State.

In addition, the section above titled, "Data Analytics & Performance Metrics," describes current metrics that are being used to monitor the performance of NSPLs, RCLs, and the BH-ASOs in responding to crisis calls, and notes that these metrics will be considered for monitoring the future enhanced crisis call and response system.

Further, to achieve the vision articulated in E2SHB 1477, and as described in the sections above including Functional Requirements and Vendor Analyses, the business plan relies, in part, on acquiring and implementing the technology tools and platforms for the enhanced crisis call center system and improved integrated behavioral health client referral system. The Implementation Plan and Recommendations Section below describe the processes and next steps to acquire needed technology tools.

Finally, to implement the business plan strategy, HCA, DOH, the Governor's Office, OCIO, and the CRIS Steering Committee and Subcommittees will need to continue to closely collaborate to refine and support implementation of needed services and technology tools. By so doing, we will gather feedback from consumers, families, and others about how the system is designed and implemented.

# Implementation Plan and Recommendations

## Summary

HCA, in collaboration with DOH, present the following Implementation Plan and Recommendations for consideration by OCIO, OFM, CRIS Steering Committee, and the State Legislature, and Tribal governments, to identify, fund, select, and implement technology tools and platforms needed to support the functional requirements in E2SHB 1477. The Implementation Plan and Recommendations are based on information, as described above, gathered from Washington State NSPLs and RCLs, Tribal governments, Urban Indian Health Programs, providers, other states, technology vendors, (including Vibrant Emotional Health), and others.

HCA and DOH considered three broad categories of options related to identifying and selecting the crisis call center platform, the behavioral health integrated client referral system, and the ancillary systems required in E2SHB 1477.

As described in detail below, HCA and DOH recommend pursuing the options identified in Category 2: Select Primary Vendor and Vendor Partners and Explore Use of the NENA i3 Solution Architecture, including the ESInet and PSAPs, in Washington State to prepare for future federal use of this technical infrastructure for 988 crisis calls and response in the State. Specifically, HCA and DOH recommend to the OCIO, OFM, CRIS Steering Committee, and State Legislature that the state move forward with the following:

### Identify and Select Primary Vendor and Vendor Partners

1. **Publish RFIs** to request vendors, including Vibrant Emotional Health and other commercially available solutions, describe whether, how, and when their solution would support the functionality required in E2SHB 1477.
    - Responders would be required to:
        - Describe the partnerships with any other technology vendors to completely address all functional requirements in E2SHB 1477;
        - Demonstrate the ability to integrate and interoperate the solution offered by:
            - The primary vendor (i.e., Vibrant UP or other commercially available solution) with the modules offered by partnering vendors, and any future modules and vendors that will be needed to support other requirements in E2SHB 1477; and
            - Commercial solution with the Vibrant UP;
        - The ability for the primary vendor to add, change or decouple features and components, as needed, to integrate and interoperate with tools/modules offered by partnering vendors, including EHRs;
        - Submit a strategy and timeline for implementing all tools/modules needed to meet all requirements in E2SHB 1477; and
        - Submit full and granular cost information (i.e., licensing and hosting fees, implementation and support (including of costs to integrate and interoperate), and maintenance) for their offering and the estimated costs for acquiring, integrating, and interoperating with other vendors for any additional modules needed to support the E2SHB 1477 requirements. The request would ask responders to submit cost

information in granular format that describes any potential phase in of functionality and costs.

2. **Finalize more granular, executable technical specifications** using information gathered through the RFI process, coordinate and collaborate with the OCIO. The final more granular, executable technical specifications are needed for a definitive path forward for Washington to implement the enhanced crisis call and response technology platform and tools envisioned in E2SHB 1477.

3. **Publish RFPs** based on information learned via the RFI process and the final technical specifications that emerge from that process and approved by OCIO. RFPs would be published to select the primary vendor to address the requirements in E2SHB 1477. Technology vendors would be requested to submit proposals describing the technology tools and platforms (including costs and timelines) that they would implement to support integrated and interoperable technical functionality required in E2SHB 1477, including any partnerships with other vendors.

### Explore Use of the NENA i3 Solution Architecture, including the ESInet and PSAPs, to Prepare WA State for Future Federal Use of this Solution Architecture

- Given that the Federal Government is pursuing activities to enable use of Public Safety Answering Points (PSAPs) for the 988 crisis call and response system, this option recommends an analysis of the architecture solution underlying PSAPs. The analysis would help prepare Washington State for the future federal use of PSAPs for the 988 crisis call and response system.
- Specifically, the analysis would:
    - consider information related to the: National Emergency Number Association (NENA) i3 Solution Architecture, utility of the Emergency Services IP network (ESInet), and PSAPs and whether these solutions could better support 988 crisis call routing and response in Washington State.
        - identify the pros and cons of using this technical call infrastructure to:
            - □ Receive and route 988 calls to NSPLs in Washington State;
            - □ Identify the location of 988 crisis caller;
            - □ Enable the dispatch of crisis responders;
            - □ Identify available resources (e.g., bed availability); and
            - □ For other purposes;
    - Identify actions in Washington State to integrate the use of PSAPs, the ESInet, and the NENA i3 solution with the crisis call and response system; and
    - Develop a plan that would, if implemented, enable potential future use of this technical call infrastructure (i.e., use of the NENA i3 solution architecture, ESInet and PSAPs) to:
        - Identify the location of crisis callers;
        - Route the call to the NSPL in the caller's region;
        - Increase in-state crisis call answering;
        - Identify and dispatch the appropriate, local responder;
        - Protect individual caller privacy and data;
        - Integrate and interoperate with the Vibrant UP; and
        - Estimate the costs to implement this technical call infrastructure for 988 crisis calls in Washington State.

- The analysis would be submitted to the OCIO, OFM, CRIS Steering Committee, and the State Legislature.

In addition to recommending the options identified in Category 2, HCA and DOH include recommendations to support additional technical tools, services, and resources needed for the Enhanced Crisis Call and Response Systems envisioned in E2SHB 1477. For details, see the table in Figure 19 below.

## Categories of Options

The following section describes the categories of options considered by HCA and DOH. Specifically, the following describes:

- Considerations applicable to all categories of options;
- Each of the three broad categories of options related to selecting the crisis call center platform, the behavioral health integrated referral system, and the ancillary systems:
  - Category 1: Select a Single Vendor Solution
  - Category 2: Select Primary Vendor and Vendor Partners, and Explore Use of the NENA i3 Solution Architecture to Prepare for Future Federal Use of this Technical Infrastructure for 988 Crisis Calls and Response in Washington State
  - Category 3: Pursue Completely Modular Approach

Areas which need additional funding to support technology and data management related activities required for the envisioned integrated behavioral health crisis call and response system, including funds for:

- Needed tools (e.g., closed loop referral, bed registry, resource directories);
- Creating interoperable documents needed for crisis call and responses (e.g., crisis plans); and
- Agency staff to support the acquisition, implementation, and management of the technology systems and tools.

**Considerations applicable to all categories of options**

The following considerations influenced the identification of the three categories of options regarding the technology platform and tools needed to address the requirements in E2SHB 1477 for the crisis call centers and behavioral health integrated referral system.

During the six-month period leading up to the development of this Final Plan, HCA and DOH had an opportunity to collect information related to the technical requirements in E2SHB 1477. HCA, in coordination with DOH, gathered this information and assessed the availability of technical solutions for the major requirements in E2SHB 1477 for the crisis call center platform, the behavioral health integrated client referral systems, and all related subsystems.

1. **Systems assessed were partial solutions:** As noted above, HCA and DOH assessed solutions in use in Washington State and other states, and products identified by vendors to meet the needs of E2SHB 1477. Based on our review, given the numerous requirements in E2SHB 1477, all of these solutions were, at best, partial solutions.

2. **More Information is needed:** As described throughout this Plan, information was gathered about the types of systems and tools needed, available, and used to support crisis call, response, and referral systems. Nonetheless, additional information is still needed about the functionality supported by specific vendors and their costs before selecting a platform and tools to support the requirements in E2SHB 1477.

3. **Vibrant UP has a product roadmap but most of this functionality is not an actual working product:** The crisis call center platform functionalities that will be supported by the core Vibrant Unified Platform (UP) are not yet specified. Further, Vibrant Emotional Health has not released a timeline by which key functionalities will be available and rolled out nationally. As a result, it is not possible, at this point, to identify the functionality that will be supported by the Vibrant platform and what additional components will be needed to compliment the Vibrant UP and support the requirements in E2SHB 1477.

4. **Costs will be associated with the Vibrant UP solution**: Although Vibrant is offering the Vibrant UP at no cost, we expect that there will be costs associated the Vibrant UP. While DOH and HCA hope the Vibrant UP will support core crisis center functionality established in E2SHB 1477, additional functionality (i.e., other components/modules) will be needed to address these requirements.

    - As Vibrant Emotional Health more clearly communicates the functionality of the Vibrant UP, it will become clearer what additional modules will be needed to address the requirements in E2SHB 1477.
    - There will be costs associated with implementation of Vibrant UP including technical configuration and project staff costs.
    - There will be costs associated with acquiring additional modules to supplement functionality not supported by Vibrant UP.
    - These additional components will need to integrate and be interoperable with the core Vibrant UP crisis system. There will be costs associated with integrating and enabling interoperability between the Vibrant UP and the additional components.
    - While the costs of the additional components and costs of integrating and enabling interoperability are not yet known, these costs could be significant.

5. **Modular technology solutions and technology vendor partnership will aid in a flexible solution.** The modular technology solutions that will need to supplement and interface with the call center platform to support the requirements in E2SHB 1477 will:

    - Depend on which crisis call center platform is selected and the functional components included in the selected platform.
    - Technology vendors for modular solutions that will complement the Vibrant UP will likely design their products to integrate and interoperate with the Vibrant UP. The costs of these additional capabilities are often passed on to the customer.
    - Use of existing state technologies could be possible once the crisis call center platform is selected. The Plan described systems in which entities in Washington State have invested significant resources that could potentially be usefully linked to the crisis call centers. However, because a crisis call center platform has not yet been selected for the state, we did not/could not explore the feasibility and costs of integrating/ expanding

existing tools into the call system platform to address some of the requirements in E2SHB 1477.

6. **Vendors would not provide a cost estimate outside of a procurement mechanism:** The team was unable to collect information related to the costs of implementing and maintaining different technology products. Typically, technology cost estimates are collected during a Request for Information (RFI) process and binding costs collected through a Request for Proposal (RFP) process. Cost information is also highly dependent on the needs of each organization, therefore estimates obtained outside of a procurement process would not necessarily be applicable. The alternative explored was to collect cost information from other states, however other states were unwilling or unable to provide cost information. Often this detail is not disclosable as part of confidentiality agreements with their vendors.

7. **Anticipated costs**: The types of costs that should be anticipated with implementing any technology vendor product(s) for crisis call centers and response and referral services include:

    - Licensing fees associated with vendor products (licensing fees are not expected to be incurred for the core Vibrant UP product);
    - Creating interoperable and secure connections between the crisis line and needed ancillary products (i.e., core referral system to bed registry software);
    - Where ancillary products or system don't exist or do exist but don't fully support the needs of E2SHB 1477, smaller enhancement projects or new projects will be needed;
    - Standardizing shared content and making that content available to support information exchange and re-use;
    - On-boarding organizations and supporting continued implementation of the tools;
    - Operations and maintenance pertaining to each technology product; and
    - Staff, contractors, professional services, training, and project costs to perform implementation tasks (i.e., project management, integrators, business analysts, etc.).

8. **Changes to E2SHB 1477 could change the technology requirements:** If future legislation modifies the requirements of E2SHB 1477, it is possible that those changes could impact the functional requirements needed to support an amended vision of the crisis call center and integrated referral system. If the scope of functional requirements changes, the type(s) and costs of needed technology tools and vendors to support the new requirements could also change.

## Categories of Options for the Call Center Platform

The following presents the three categories of options that HCA and DOH considered as part of identifying the technology solutions for the crisis call center platform. For each category, there is a discussion of the pros and cons, an analysis, considerations, and recommendation.

### Category 1

**Select a Single Vendor Solution**

During our information gathering activities, we interviewed, saw demonstrations, and/or reviewed information from technology vendors and others regarding technology solutions that were described as meeting many of the functional requirements in E2SHB 1477, including:

- The Vibrant UP:
  - Vibrant Emotional Health:
    - Shared a few spreadsheets and a message that presented functionality of the Vibrant UP, including what HCA and DOH analysis assessed as "core" functionality that will be made available to the NSPLs; and
    - Has not yet, but is expected to identify and communicate the core functionality included in the Vibrant Unified Platform (UP); and
- Other commercially available solutions that span multiple functional areas

**Vibrant UP:**

- **Pros:**
  - The "core" components of the Vibrant UP are expected to be freely available to the states and NSPLs electing to use this platform.
  - Persons involved in planning for E2SHB 1477, including NSPLs, have expressed serious interest in the Vibrant UP, especially as it is designed for the purpose of providing NSPL services.
  - NSPLs have expressed a preference for the Vibrant UP.

- **Cons:**
  - Vibrant Emotional Health has not yet specified the "core" functionality that will be made available for "free" to NSPLs.
  - Assumptions made regarding the core functionality of the Vibrant UP could change as Vibrant Emotional Health continues it work to refine and specify these requirements.
  - The Vibrant UP that will be deployed nationally: is still being defined, is a technical solution that is under development, and has not been deployed.
  - As a result of Vibrant not being deployed, the state will need to delay timelines to wait for Vibrant to not procure duplicate functionality.
  - Additional information is needed regarding what functionality will be included in the core components of the Vibrant UP and what the release cycles will be for these components.
  - The lack of clarity regarding the Vibrant UP core functionality is a barrier to identifying what additional functionality will be needed to complement the Vibrant UP to meet requirements in E2SHB 1477.
  - The state will not have control of changes to the system functionality or additions of State specific needs, it will only have input into them.
  - There will be costs associated with acquiring any needed additional functionality and ensuring that the additional functionality is interoperable with the core Vibrant UP.
  - There will be costs associated with implementation of the solution.

**Other commercially available solutions**

- **Pros:**
  - Commercially available solutions are available.
  - Commercially available solutions that support much of the functionality required in E2SHB 1477 have been implemented in other states.

- Robust commercially available solutions will minimize the number of additional modules that will need to be acquired and thus minimize the interoperability challenges and costs associated with linking together unaffiliated systems.
- For commercial software covering multiple functional areas smooth integration is already built in.

- **Cons:**
  - Many of these solutions are highly integrated therefore decoupling portions of these solutions may not be feasible or cost effective for the vendor.
  - There will be significant cost associated with acquiring any of the commercially available solutions.
  - No commercially available solution can support all the requirements in E2SHB 1477.
  - Customization on an available solution for WA specific needs will be costly.
  - Additional expenditures will be needed when using commercially available solutions to:
    - Acquire the additional modular capabilities to support requirements in E2SHB 1477;
    - Enable the integration and interoperability of the additional component(s)/module(s) with the selected commercially available solution; and
    - Enable integration and interoperability of the commercial solution with the Vibrant UP.

**Analysis**: For the scope defined in E2SHB 1477, there is no viable single solution that will meet Washington's needs. The Vibrant UP will not meet the complete set of needs defined in E2SHB 1477. To meet the requirements in E2SHB 1477, the implementation of the Vibrant UP or commercially available solutions will require the acquisition of additional components. The acquisition of additional components will also require investments to ensure that they can interoperate with the primary system. In HCA/DOH review of the technology solutions used in other states to support their crisis call and response systems, all states used multiple technology tools to support their crisis call center platforms and crisis response services.

**Consideration:** Based on this analysis, HCA/DOH does not believe the use of a a "Single Vendor Solution" is a viable approach.

**Recommendation:** HCA/DOH recommend against pursuing a "Single Vendor Solution."

### Category 2

**Select a Primary Vendor and Vendor Partners; and Explore Use of the NENA i3 Solution Architecture to Prepare for Future Federal Use of this Technical Infrastructure for 988 Crisis Calls and Response in Washington State**

This category describes multiple options related to:

- Category 2A: Identifying and selecting a primary vendor. This option considers two approaches in which a primary vendor (either Vibrant or a different commercially available solution) would be selected and would partner with other technology vendors to offer a solution that meets the requirements in E2SHB 1477.
  - The Primary vendor would be able to meet most of the critical functionality or the majority of the requirements and would partner with other vendors to secure and implement additionally needed modules; and

- Category 2B: Explore the use of the NENA i3 Solution Architecture, including the ESInet and PSAPs, in Washington State to prepare for future federal use of this technical infrastructure for 988 crisis calls and response in the State the 911 call infrastructure. This category proposes a series of analyses to explore leveraging and integrating NENA i3 Solution Architecture, including use of the ESInet and PSAPs, to prepare for future federal use of this technical infrastructure for 988 crisis calls and response in the State.

## Category 2A

**Identifying and Selecting a Primary Vendor and Vendor Partners**

**Vibrant UP**

The core components of the Vibrant UP are expected to be freely available to the States and NSPLs electing to use this platform. Vibrant Emotional Health has not yet published the core components of the Vibrant UP. However, Vibrant Emotional Health shared some information regarding the functional requirements that are expected to be included in the core requirements of the Vibrant UP. As described earlier in the Technical and Operational Plan, based on a review of that information, HCA, in coordination with DOH, attempted to describe what may be included in the core Vibrant UP and what seems to be out-of-scope for the core Vibrant UP.

- **Pros:**
  - Vibrant Emotional Health will make available the core components of the Vibrant UP at no charge to states and NSPLs.
  - Use of the Vibrant UP components will satisfy the requirement that NSPLs be interoperable with the Vibrant system at least with respect to those components.
  - Technology modules are available and implemented that would address some of the anticipated gaps in the core Vibrant UP and will be needed to address E2SHB 1477 requirements (e.g., bed registries, closed loop referrals, local provider and social service resource directories).
  - Vibrant Emotional Health would likely make available, at a cost, some additional modules that will be needed to address some of the E2SHB 1477 requirements.
  - Using modules developed by Vibrant Emotional Health would likely minimize concerns about integrating and interoperability with the Vibrant UP.

- **Cons:**
  - It is not yet possible to know all the additional modules that will be needed to supplement the core components of the Vibrant UP to meet the requirements of E2SHB 1477.
  - Integrating modules with the Vibrant UP will require work and costs to ensure interoperability between the Vibrant UP and selected module(s).
  - Given constraints at the Federal level, the Vibrant UP does not support in-state call answering independent of the area code of the caller's cell phone.[46] As a result, the time to answer and respond to calls will be delayed.

**Other Commercially Available Solutions**

[46] Approval from the Federal Government is needed to use information regarding the location of the 9-8-8 caller.

HCA and DOH information gathering activities included interviews with and demonstrations by commercially available vendors that offered platforms that would support many, but not all, of the functions needed under E2SHB 1477 (e.g., integrating with telephony systems, supporting assessments and planning, enabling referrals (including closed loop referrals)).

- **Pros:**
  - Commercially available solutions are available.
  - Commercially available solutions that support much of the functionality required in E2SHB 1477 have been implemented in other states.
  - The use of robust commercially available products would minimize the number of additional modules that would be needed and thus reduce the challenges and costs associated with integrating and interoperating with multiple vendor products.
  - Many commercially available solutions can be customized at a cost to add additional modules, thus minimizing concerns about integrating and interoperating with the core system offered by that vendor.
  - Robust commercially available solutions demonstrated the ability of their tools to integrate and interoperate with other technology vendors to increase the functionality of their core products.

- **Cons:**
  - Commercially available solutions will likely not support all of the requirements in E2SHB 1477.
  - Commercially available solutions, and customized modules, will have potentially significant costs.
  - Decoupling and resolving overlapping functionality between two potential vendors will be challenging.
  - There will be costs associated with enabling interoperability between the commercial solution and the future (unknown) requirements of the Vibrant UP.
  - Given constraints at the Federal level, commercially available solutions do not support in-state call answering independent of the area code of the caller.[47] As a result, the time to answer and respond to calls will be delayed.

### Category 2B

**Explore Use of the NENA i3 Solution Architecture to Prepare for Future Federal Use of this Technical Infrastructure for 988 Crisis Calls and Response in Washington State**

SAMHSA and the FCC are working through policy issues to enable the use of the technical infrastructure for emergency call for 988 crisis calls and responses, including the use of Public Safety Answering Points (PSAPs). The NENA i3 architecture solution, which supports the ESInet and PSAPs, could potentially be used and configured to support parts of the 988 crisis call system technical infrastructure and made to integrate and be interoperable with the selected 988 crisis call center platform (i.e., Vibrant UP or a commercially available solution). The following describes the PROs and CONs of exploring the use of the

[47] Approval from the Federal Government is needed to use information regarding the location of the 9-8-8 caller.

NENA i3 architecture solution, ESInet, and PSAPs to support the 988 crisis call center platform that could be provided by either the Vibrant UP or other Commercially available solution.

- **Pros:**
  - NENA standards and PSAPs have been in place and used for many years, meaning the system is well tested, has been very successful with emergency and non-emergency call intake and routing, and has solved many of the problems facing the new 988 crisis call system infrastructure.
  - NENA standards support the receipt and routing of emergency and non-emergency calls.
  - A call infrastructure based on NENA standards enables calls to be answered locally and promptly (i.e., calls answered within state regardless of the area code of the caller's phone).
  - The NENA i3 updates and standardizes the structure and design of the functional elements that make up the software services, databases, network elements and interfaces needed to process multi-media emergency calls.
  - The NENA i3 solution supports end-to-end Internet Provider (IP) connectivity.
  - The NENA i3 solution uses gateways to accommodate legacy wireline and wireless originating networks that are non-IP as well as legacy PSAPs that interconnect to the i3 solution architecture.
  - The ESInet (included in NENA i3) is designed as an IP-based network of networks that can be shared by all public safety agencies that may be involved in any emergency and a set of core services.
  - Washington State has adopted the NENA i3 architecture solution.
- **Cons:**
  - The NENA i3 Solution only recently became an ANSI approved standard (approved in October 2021).
  - The concept of an Emergency Services IP network (ESInet) was introduced in the NENA i3 Architecture Solution.
  - Implementing the i3 solution requires a transition from existing legacy originating network and emergency PSAP interconnections to next generation interconnections.
  - Work will be needed in Washington State to determine how legacy PSAPs, originating networks, Selective Routers (SRs), and Automatic Location Identification (ALI) systems can evolve to support the NENA i3 Architecture Solution.
  - Federal, State/Provincial, and local laws, regulations, and rules (e.g., those specifically referring to ALI and Selective Routers) may need to be modified to support system deployment
  - While Vibrant Emotional Health expressed support for the technical call infrastructure based on the NENA standards, Vibrant has been using an alternative, less functional call system infrastructure for the NSPLs.
  - The scope of the capabilities supported by the NENA i3 Architectural Solution is not well understood by persons working in the health IT and behavioral health sectors.
  - Changes to the 988 call infrastructure to use the technical call infrastructure based on NENA i3 architecture solution may take a considerable length of time.

**Analysis:** The lack of specification regarding the Vibrant UP requirements creates many uncertainties (e.g., what capabilities will be implemented and when). These uncertainties make it impossible at this

time to identify with confidence what additional components/modules will be needed to supplement the Vibrant UP to meet the requirements in E2SHB 1477. The lack of implementation of the Vibrant UP creates significant risk regarding the capabilities of the platform.

Given the potential benefits of the Vibrant UP, HCA and DOH staff have not closely analyzed the commercial products and what additional modules would be required to support the requirements in E2SHB 1477.

Some commercially available solutions have demonstrated their ability to integrate and interoperate with other technology solutions in a way that would address some (but not all) of the requirements in E2SHB 1477.

Pending approval and guidance from the Federal Government to make available the technical call infrastructure that is based on the NENA standards for 988 crisis calls, the Vibrant UP and other commercially available solutions will route 988 crisis calls based on the area code of the phone being used by the caller, meaning that crisis callers in Washington State with an out-of-state cell phone will be routed to out-of-state NSPLs. This routing process will delay any needed crisis response.

The technical call infrastructure used for emergency calls is robust and has a longstanding track record of successful implementation. The NENA i3 Architectural Solution would seem to support (i) interoperable information access and exchange across multiple platforms; (ii) many of the functional requirements envisioned in E2SHB 1477; and (iii) the ability to route calls based on the location of the caller (rather than area code of phone).

HCA and DOH have not had an opportunity to fully analyze the capabilities of the technical call infrastructure used for emergency calls in Washington State and the functionalities supported by the NENA i3 Architectural Solution to determine whether and how the NENA i3 Architecture Solution could supplement the Vibrant UP or other commercially available solution, and if so, what the near and longer-term costs and savings would be.

**Considerations:** Based on this analysis, at this time, HCA and DOH believe moving forward with the Vibrant UP presents significant uncertainties including:

- It is unknown what functionalities the Vibrant UP will support.
- The Vibrant UP has not been implemented.
- Timelines for implementation of the Vibrant UP have not been specified.

HCA and DOH believe that, given this context, taking time to make the right decisions would be appropriate.

In addition, HCA and DOH do not know the:

- Costs of Vibrant modules; or
- Costs of a commercially available solution and modules.

Finally, HCA and DOH have not analyzed the technical call system infrastructure used for emergencies and non-emergencies in Washington State, the functionalities of the NENA i3 Architecture Solution, the work that would be needed in Washington State to support implementation of the NENA i3 Architecture

Solution for 988 crisis call routing, and how the NENA i3 Architecture Solution could supplement the Vibrant UP/other solution and what the costs/savings of doing so would be.

**Recommendation:** Based on the preceding, HCA and DOH recommend to the OCIO, OFM, CRIS Steering Committee, and State Legislature that the state move forward with the options described above in Category 2A and 2B. Specifically:

- **Category 2A:** Publish RFIs that would request vendors (including Vibrant UP and other commercially available solutions) to describe whether, how, and when their solution would support the functionality required in E2SHB 1477.
  - Responders would be asked to:
    - Describe the partnerships with any other technology vendors to completely address all functional requirements in E2SHB 1477;
    - Demonstrate the ability to integrate and interoperate the solution offered by:
      - The primary vendor (i.e., Vibrant UP or other commercially available solution) with the modules offered by partnering vendors, and any future modules and vendors that will be needed to support other requirements in E2SHB 1477; and
      - Commercial solution with the Vibrant UP;
    - Describe the ability of the primary vendor to add, change or decouple features and components, as needed, to integrate and interoperate with tools/modules offered by partnering vendors, including EHRs;
    - Submit a strategy and timeline for implementing all tools/modules needed to meet all requirements in E2SHB 1477; and
    - Submit full and granular cost information (i.e., licensing fees, implementation and support (including costs to integrate and interoperate, and maintenance) for their offering and the estimated costs for acquiring, integrating, and interoperating with other vendors for any additional modules needed to support the E2SHB 1477 requirements. The request would ask responders to submit cost information in granular format that describes any potential phase-in of functionality and costs.
- Request for Proposals (RFPs) would be published to request technology vendors submit proposals describing the technology tools and platforms (including costs and timelines) that they would implement to support integrated and interoperable technical functionality required in E2SHB 1477, including any partnerships with other vendors.

- **Category 2B:** In anticipation of and to prepare Washington State for Federal Government approval of using the NENA i3 Solution Architecture for 988 crisis calls, conduct analyses of the NENA i3 Solution Architecture, including ESInet and PSAPs, in Washington State and the applicability of this Solution to the 988 crisis call and response system. The analyses would:
  - Gather information about the NENA i3 Solution Architecture to:
    - Consider the pros and cons of using this Solution Architecture infrastructure to:
      - □ Receive and route 988 calls to NSPLs in Washington State;
      - □ Identify the location of 988 crisis caller;
      - □ Enable the dispatch of crisis responders;
      - □ Identify available resources (e.g., bed availability); and/or
      - □ For other purposes;

- Consider options for integrating the use of the NENA i3 Solution Architecture with the Vibrant UP; and
- Develop a plan for the use of NENA i3 Solution Architecture (i.e., use of the ESInet, Public Safety Answering Points) to:
  - Route crisis calls to the NSPL in the caller's region;
  - Increase in-state crisis call answering;
  - Identify the location of crisis callers;
  - Identify and dispatch the appropriate, local responder;
  - Protect individual caller privacy and data; and
  - Estimate the costs to implement the NENA i3 Solution Architecture for 988 crisis calls in Washington State.

The analysis would be shared with the OCIO, OFM, CRIS Steering Committee, and the State Legislature, and upon approval, and with funding, would integrate the NENA i3 Solution Architecture into the selected technology offered by the lead 988 technology vendor.

### Category 3

**Pursue Completely Modular Approach**

During our six-moth information gathering activities, the team acquired information from multiple vendors regarding their capabilities that meet elements of E2SHB 1477, including standards-based:

- Telephony systems (including systems that can manage calls, texts, and chats);
- CRM tools (including systems that can manage bed registries and referrals);
- Bed registries and referral tools, including closed loop referrals; and
- Provider and social service resource directories.

Some of the vendors offered products that were described as providing multiple functions. Some vendors described establishing partnerships with other entities (e.g., payers, technology solutions) to enhance the functionality of their solutions.

- **Pros:**
  - There are multiple technology vendors that have technology tools that are described as meeting most of the requirements in E2SHB 1477.
  - Some vendors have described and demonstrated the ability to enter into innovative partnerships to enhance the capabilities of their systems/tools.
  - A completely modular approach, while costly, would allow easier changes to components as technology or business needs change.
  - Selection of vendors who are excellent or best in a functional area can be selected.

- **Cons:**
  - While true for all three categories of options, ensuring seamless integration and interoperability of multiple vendors will likely be the most expensive approach, requiring tight coordination of solutions.
  - For some vendors, decoupling components of their systems is not feasible or cost effective if the state only wants specific components of the software.

- The involvement of more vendors will make the integrations more difficult.

**Analysis:** The difference between the options identified in Category 3 vs Category 2 is that Category 3 is likely to involve more technology vendors, more coordination between these vendors, and more challenges with ensuring integration and interoperability between products.

**Consideration:** Category 3 seems less efficient than Category 2 and could result in more challenges related to integration and interoperability than Category 2.

**Recommendation:** HCA and DOH recommend against pursuing a completely modular approach.

**Additional Technical Tools, Services, and Resources Needed for the Enhanced Crisis Call and Response Systems**

The table below summarizes areas for which funds are needed to support the enhanced crisis call and response systems envisioned in E2SHB 1477, including the crisis call center platform and additional technical tools, services, and resources.

| Agency | Topic and Description | Estimated Funding Request |
|---|---|---|
| HCA, DOH, WA Military Department | **Analyze Use of the NENA i3 Solution Architecture for 988 crisis calls.**<br>Funds will be used to gather information about the NENA i3 Solution Architecture and its implementation in WA State (e.g., ESInet, Public Service Answering Points (PSAPs)) to: (i) consider options/extensibility and barriers to support the 988 infrastructure for call routing, dispatching, identifying available resources (e.g., responders and bed availability), and other purposes; (ii) consider options for using the NENA i3 Solution Architecture to supplement Vibrant; and (iii) support planning and preparation for use of PSAPs to enable use of geolocation technology (if and when required by the Federal Government) to: (a) identify the location of crisis callers; (b) route the call to the NSPL in the caller's region; (c) increase in-state crisis call answering; (d) identify and dispatch the appropriate, local responder; and (e) protect individual privacy. | $500K<br><br>*The project team with input from the Emergency Management Division believe this to be a reasonable estimate.* |
| HCA/DOH | **Crisis Call Center Platform.** Core Call Platform used by NSPLs. This is the telephony systems (including systems that can manage calls, texts, and chats). | Not able to be estimated currently.<br><br>*Team believes the core Vibrant Up product will be free or reduced direct cost but system interfaces to other products will add "customization" costs*<br><br>*Other vendor solutions will only disclose an estimate within an RFI/RFP process and against published requirements that are* |
| HCA/DOH | **CRM tools** (including systems that can manage bed registries and referrals); | |
| HCA, DOH | **Resource Directory for Provider Referrals.** Provider and social service resource directories. | |

| Agency | Topic and Description | Estimated Funding Request |
|---|---|---|
| | | *typically released in their draft form with the RFI.* |
| HCA, DOH | **Bed Registry and Closed-Loop Referral Tool.**<br>Funds will be used to acquire, deploy, and maintain a statewide tool that supports bed registry and closed loop referrals, including for next day appointments. The tool will be required to integrate and be interoperable with the NSPL crisis call center platform, EHRaaS tool, and EHRs used by behavioral health providers.<br>(Note: This assumes the Vibrant UP either will not support this functionality and/or the inclusion of this functionality in the UP will not meet the State's timelines/needs.) | *We asked but have not received from Beacon Health information regarding their licensing fees for the OpenBeds product which is currently being used in three BH-ASO regions.* |
| HCA/HIT | **Standardize and make interoperable documents needed for crisis call and responses.**<br>Funds will support standardizing and linking content to HIT standards to enable interoperable creation and exchange of, and access to:<br>• Crisis/suicide assessments<br>• Crisis plans<br>• MH Advance Directives<br>• Wellness Recovery Action Plan (WRAP)<br>Funds will support user design, testing of prototypes, piloting, and integration into NSPL platform and tools used by crisis responders. | $5M (one time only costs)<br>$200K/yr. on-going operations and maintenance<br><br>*A similar HCA project has estimated costs of standardizing and making interoperable, piloting, and implementing a standardized document. Integration into the chosen call center platform was layered on to reach this estimate.* |
| HCA/HIT/DOH | **Training and Technical Assistance Resources to Tribes, and Crisis Providers (NSPLs, RCLs, Hub/NSL, Tribes)** | $600K (estimate subject to change) |
| HCA/HIT Staff | **HCA Health Information Technology Staff.**<br>Funds will support hiring three (3) FTE additional HCA staff:<br>• Two staff will be used to support planning, acquisition, and implementation of technology tools needed for the enhanced crisis call and response system; one staff will support data governance and privacy needs. | $850K/yr. |
| HCA/HIT | **Project Management**<br>Funds will support hiring two (2) project management staff:<br>• One Consultant / Vendor Project Manager or Delivery Lead: This position will be to lead the implementation of the project, report status, and ensure project is successful<br>• One FTE Project Manager from HCA: This position will be the contract manager for all staff and ensure implementation of solutions is successful | $300K/yr. |

| Agency | Topic and Description | Estimated Funding Request |
|---|---|---|
| HCA/HIT | **Change Management Team – Responsible for organizational change management activities for impacted agencies, RCLs and NSPLs.**<br>Funds will support hiring additional staff:<br>• One FTE O**rganizational** Change Management Lead from the Vendor<br>• One SME Change Management Lead from HCA:<br>• CM and training resources from HCA & Vendor/Consultant Resources: combination of change management staff from vendors and state resources, specific quantity will be dependent upon complexity of final solution, which includes how many systems the primary system will need to integrate with. Recommend deploying a train the trainer methodology to ensure knowledge transfer and availability of internal support and training resources | $750K/yr. |
| Vendor QA | **QA/IV&V – Responsible for QA and IV&V for project**<br>Funds will support hiring additional staff:<br>• One FTE QA/IV&V Lead from independent vendor | $500K/yr. |
| HCA/ETS | **Development, Functional, Testing Lead and Team – Responsible for all development related to applications**<br>Funds will support hiring additional staff:<br>• One Contracted Development Lead: This contracted position will lead the development and management for the system<br>• One Contracted Functional Lead: This is the contracted position will lead collection of the functional requirements<br>• One Contracted Testing Lead This is the contracted position will lead testing activities for HCA BH entities using the technology solutions.<br>• One SME Development Lead from HCA: This will be the IT staff responsible for overseeing functional requirements gathering of the necessary components to ensure that they meet agency standards and ensure that can support developed code<br>• One SME Functional Lead from HCA IT Team: This will be the IT staff responsible for overseeing development of the necessary components to ensure that they meet agency standards and ensure that HCA can support developed code<br>• Testing Resources from HCA & Consultant Resources: combination of testers from | $750K/yr. |

| Agency | Topic and Description | Estimated Funding Request |
|---|---|---|
| | contract and state resources, specific quantity will be dependent upon complexity of final solution<br>Team members from HCA will need to assist in in the collection of functional requirements | |
| HCA/ETS | **Integration Solution Technical staff**<br>Funds will support hiring four (4) additional HCA staff:<br>• One Business Analyst will assist with requirements gathering and specification<br>• One Technical Lead will serve as an integration architect<br>Two IT Application Developers to build and maintain APIs using MuleSoft related to 988/1477. | $600K/yr. |
| HCA/ETS | **Integrations Team – Responsible for integrations with other systems**<br>Funds will support hiring additional staff:<br>• One Integrations Lead<br>• One Integrations Lead from HCA:<br>• Testing Resources from HCA & Vendor/Consultant Resources: combination of integrators from vendors and state resources, specific quantity will be dependent upon complexity of final solution, which includes how many systems the primary system will need to integrate with | $750K/yr. |
| DOH Staff | **DOH Staff.**<br>Funds will support two (2) FTE additional DOH staff:<br>• One Business Analyst will be used to support planning, acquisition and implementation of technology tools needed for providing call center technology to the Crisis Center Hubs for NSPL services and coordinating with HCA on the other components needed.<br>• One NSPL Test lead will support lead NSPLs, and all end users of the system through system testing and quality. | $300K/yr. |

*Figure 19 Summary of Funding Needed to Support System Enhancements*

## Procurement

HCA and DOH recommend pursuing the options embedded in Category 2 which include:

- Publishing Requests for Information (RFIs) focused on collecting more detailed information on how Washington State can integrate and implement a 988 Crisis Call Center Platform and additional functionality required for the behavioral health integrated client referral system to meet national and state requirements; and
- Publishing Requests for Proposals (RFPs) to select and award a contract for a primary technology vendor and technology partners; and

- Analyzing the 911 call infrastructure in Washington State. The applicability of the 911 NextGen standards to the 988 crisis call and response system, and barriers to using the 911 call infrastructure for 988 calls.

Specifically, upon approval of this plan by the OCIO, Director of OFM, and the CRIS Steering Committee of the CRIS; and the appropriation of needed funds, HCA and DOH will:

- Publish RFIs regarding how technology vendors (including Vibrant UP and other commercially available solutions) will support the requirements in ESHB 1477. The RFI will provide an overview of the functional requirements embedded in E2SHB 1477 and request vendors to provide recommendations and information on how they would address these requirements. The RFIs will request vendors to:
    - Describe whether, how, and when their solution will support the functionality required in E2SHB 1477;
    - Describe their partnerships with other technology vendors to address the requirements in E2SHB 1477;
    - Describe how their solution and partnerships will minimize the need for additional modules to support the requirements in E2SHB 1477;
    - Describe how they will support the integration and interoperation of any needed additional modules;
    - Demonstrate the ability to integrate and interoperate with the (i) Vibrant UP and (ii) partnering vendors offering additional modules;
    - Provided full granular cost information that includes:
        - Licensing fees, implementation and support (including costs to integrate and interoperate), and maintenance for their offering (including partners that offer additional modules);
        - Estimated costs for acquiring, integrating, and interoperating with other modules needed to support the E2SHB 1477 requirements; and
        - Recommendations for phasing in the implementation of functional components and costs. HCA and DOH will publish Requests for Proposals (RFPs) to secure competitive offers for needed technology solutions.
- HCA and DOH will publish Requests for Proposals (RFPs) to secure competitive proposals for needed technology solutions.
- In collaboration with the Washington State Military Department, analyze the 911 call infrastructure in Washington State and the applicability of the 911 NextGen standards to the 988 crisis call response system in the state.

Details of the Procurement Approach and key items contained are found in Appendix T.

## Next Steps

- Obtain approval from OCIO, the Director of OFM, and the Steering Committee of the CRIS to implement this Plan.
- Continue to obtain clarification from Vibrant Emotional Health regarding the:

- Functionality of the Vibrant UP that is expected to be included in Release 1, 2, and subsequent releases; and
- Timeframes by which these capabilities will be released.

- Continue collaboration with the Governor's Office, OCIO, OFM, CRIS Steering Committee, and State Legislature:
  - Clarifying the vision and legislative requirements for the state's crisis call and response system including:
    - Clarifying the roles and responsibilities for NSPLs and RCLs;
    - Identifying any new technical requirements to support the refined vision/legislative requirements, including for the:
      - Call center platform;
      - Enhanced behavioral health integrated client referral system; and
      - Additionally needed technical tools, services, and resources.
        - HCA and DOH will consider HCA RFI and RFP templates in drafting the needed RFIs and RFPs for the enhanced crisis call and response systems.[48]
  - Secure funds from the State Legislature to pursue the options identified in Category 2 and funding for additional technical tools, services, and resources to support the requirements in E2SHB 1477 for the:
    - Selected call center platform option(s);
    - The behavioral health integrated referral system; and
    - Needed ancillary systems.
- Based on funds received from the State Legislature:
  - Hire HCA and DOH staff needed to support the use of technology needed for the enhanced crisis call center platform and behavioral health client integrated referral system.
  - Publish RFIs to acquire information needed to acquire and implement technology platforms and tools.
  - Using information gathered through the RFI process, coordinate and collaborate with OCIO to finalize more granular, executable technical specifications needed for a definitive path forward for Washington to implement the enhanced crisis call and response technology platform and tools envisioned in E2SHB 1477.
  - Based information learned via the RFI process and the final technical specifications that emerge from that process and are approved by OCIO, RFPs would be published to select the primary vendor to address the requirements in E2SHB 1477. The RFP would request technology vendors to submit proposals describing the technology tools and platforms (including costs and timelines) that they would implement to support integrated and interoperable technical functionality required in E2SHB 1477, including any partnerships with other vendors.
  - Issue contracts to:
    - Prepare Washington State for the potential extension by the Federal Government of the 911 call infrastructure for 988 crisis calls and support the use of geolocation; and

[48] The HCA RFI and RFP templates are available upon request.

- Standardize, make interoperable, and support statewide implementation of documents needed for crisis call and response.

# Appendices

## Appendix A: Other Crisis Lines In The State

**Teen Link:** For residents under 21, Teen Link is available for trained peer support. Users can also connect with an adult substance use specialist during designated days and times.

**Washington 2-1-1:** A comprehensive platform that provides information on and connections to health and human services in King County.

**Washington Listens**: A free, anonymous services for anyone in Washington State, providing emotional support to individuals and families during difficult times, such as the COVID-19 pandemic or Washington's recent experiences with wildfires and flooding.

**Washington Recovery Help Line:** Help and support for substance abuse, problem gambling and mental health.

**Washington Warm Line**: This line offers assistance for anxiety, loneliness, depression, problems with family or friends, and other emotional and mental health challenges.

**Washington State mental health crisis lines**: available to all Washingtonians, regardless of income or insurance status.

**Tribally operated crisis lines:** several Tribes have established crisis lines within their community with varying levels of services including varying times in which the crisis lines are available.

**Beacon Health Options**: provides county crisis call services to Chelan County, Clark County, Douglas County, Grant County, Klickitat County, Okanogan County, Pierce County, and Skamania County.

**Great Rivers BH-ASO**: provides county crisis call services to Cowlitz County, Grays Harbor County, Lewis County, Pacific County, and Wahkiakum County.

**Greater Columbia BH-ASO**: provides county crisis call services to Asotin County, Benton County, Columbia County, Franklin County, Garfield County, Kittitas County, Walla Walla County, Whitman County, and Yakima County.

**North Sound BH-ASO**: provides county crisis call services to Island County, San Juan County, Skagit County, Snohomish County, and Whatcom County.

**King County BH-ASO**: provides county crisis call services to King County.

**Salish BH-ASO**: provides county crisis call services to Clallam County, Jefferson County, and Kitsap County.

**Spokane County BH-ASO**: provides county crisis call services to Adams County, Ferry County, Lincoln County, Pend Oreille County, Spokane County and Stevens County.

**Thurston-Mason BH-ASO**: provides county crisis call services to Mason County and Thurston County.

### Lines supported by national partners

**Copline**: Confidential hotline for law enforcement personnel, supported by peer counselors.

**Crisis Text Line**: Crisis Text Line provides confidential text access from anywhere in the US to a trained Crisis Counselor.

**Disaster Distress Hotline**: Counseling and support for the COVID-19 pandemic, natural disasters, and associated concerns.

**Farm Aid hotline:** Farm Aid helps to keep farmers on their land by providing effective and immediate support services. Call center professionals are trained in crisis response as well as able to help farmers find resources related to markets, transitioning to more sustainable/profitable farming practices, surviving natural disasters, and more.

**Institute on Aging Friendship Line:** Support and crisis line for adults who are 60 or older or have disabilities targeted at inclusivity and feelings of connection for this population.

**LGBTQ+ National Youth Hotline:** (23 and under) 800-246-7743

**LGBTQ+ National Hotline:** 888-843-4564

**NAMI Helpline**: National Alliance on Mental Illness volunteer support for navigating a mental health crisis, offering support, and answering questions.

**SAGE LGBT Elder Hotline:** Peer support and local resources for older adults – 888-234-SAGE

**Trans Lifeline**: Peer support, run by trans people for trans people, that offers emotional and financial support to trans people in crisis.

**Trevor Project Lifeline**: 866-488-7386 Crisis intervention and suicide prevention services for LGBTQ+ youth and young adults under 25 True Colors United – 212-461-4401 True Colors focuses on supporting homeless youth.

## Appendix B Section 102: Technology and Platforms

E2SHB 1477 Sections (5) – (7) specify the statutory requirements for the technology and platforms required for the envisioned behavioral health crisis call and response system in Washington State and the entities and organizations that are required to coordinate and collaborate in the development of these systems.

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 in the State.

Section 102 Subsection 5 requires:

**Crisis Center 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

**Integrated Referral System**: 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.

Subsection 102(6) requires that the technologies described above must support the following functionalities:

**Access real-time information for coordination:** Subsection (6)(a) requires access to real-time information relevant to the coordination of behavioral health crisis response and suicide prevention services, including:

- Real-time bed availability information: 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 crisis response and prevention.** Real-time information relevant to the coordination of behavioral health crisis response and suicide prevention services for a person, including the means to access:
    - **Less restrictive alternative treatment orders or mental health advance directives:** Information about any less restrictive alternative treatment orders or mental health advance directives related to the person;
    - **Establish safety plan:** 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 noncrisis care. Input from the confidential information compliance and coordination subcommittee will be considered to establish information-sharing guidelines.

**Deploy crisis response services and track response:** Subsection 102(6)(b) requires the 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.

**Track outcomes:** Subsection 102(6)(c) requires the means to track the outcome of 988 calls 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 noncrisis 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 noncrisis 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.

**Verify and document transition to follow-up care:** Subsection 102(6)(d) requires the means to facilitate actions to verify and document whether the person's transition to follow up noncrisis 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.

**Provide and document geographically, culturally, and linguistically appropriate services to high-risk populations.** Subsection 102(6)(e) requires 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.

- Early identification of Tribal Affiliation and Crisis Coordination Protocols – In order to serve AI/AN individuals with culturally appropriate care and connection to their tribal governments and Indian Health Care Provider medical homes, it is imperative that there is early identification of tribal affiliation. Any system that is utilized should have a place where this can easily be identified and also include ways to access any tribal crisis coordination protocols.

**Tribal Consultation:** Subsection 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.

Section 102 Subsection 7 requires collaboration with State's 911 Office to ensure interoperability between the 988 and 911 (and other) systems and address other requirements:

- DOH and HCA are required to 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 non-behavioral health crisis services, as well as the NSPL, 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.
- Need of specialized services

### Coordination with Tribal Governments

As noted, 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, 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."

As part of this bill, HMA, HCA and the American Indian Health Commission (AHIC) quicky established the Tribal 988 Workgroup. During a Tribal Centric Behavioral Health Advisory Board meeting it was determined that the Workgroup would take on the work of the CRIS Tribal 988 Subcommittee. During the first couple of Tribal 988 Subcommittee meetings, the Tribal representatives requested formal consultation on both the Comprehensive Assessment and the Draft Technical and Operations Plan. HCA and DOH quickly scheduled roundtable and Consultation meetings. Consultation took place [add date here] with five roundtables leading to the Consultation. This assisted our teams to have many opportunities for collaboration and communication with Tribal and Urban Indian Organization representatives to help inform the content of this Plan. A summary of feedback can be found in Appendix G.

## Appendix C: NSPL Standards (Requirements)

The 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:

1. American Association of Suicidology (AAS)
2. CONTACT USA 58
3. Alliance of Information and Referral Systems (AIRS)
4. The Joint Commission
5. Commission on Accreditation of Rehabilitation Facilities (CARF)
6. Council on Accreditation (COA)
7. Utilization Review Accreditation Commission (URAC)
8. DNV Healthcare, Inc.
9. 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:

- 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.

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

## Appendix D: NSPL Discussions

### Crisis Connections

**Current Systems being used:**

- iCarol – chat functionality / texting only
- Care Logic – EHR / documentation
- Nice inContact – telephony / client information
- 2-1-1 Data Repository (more details in below notes)

**Overview**

- Five programs are offered:
  - 24 Hour Crisis Line
  - King County 2-1-1
  - Teen Link
  - WA Recovery Help Line
  - WA Warm Line
  - Over 400 trained volunteers and paid staff
- Volunteer rotation overseen by paid rotation for the crisis lines
  - Bachelor and masters level clinicians
- 988 fully paid staff model

**Current System/Technology Overview**

- How many call-in numbers? Multiple lines – a warm line, crisis line, client-facing section for 9 counties. Within regions, there are lines coordinated with ASOs – professional/business lines, lines for patient placement, and work with 2-1-1.
  - All are scaled and prioritized through In-Contact for routing
  - Calls are prioritized based on contract terms; the business/professional lines are different queue
- Crisis call comes in: what documentation is created? – creating something like an encounter (not considered an intake):
  - Call comes in
  - Client info goes into Care Logic
  - Phone numbers/telephony details go into inContact
  - The person that answers the call asks for contact information
- Challenges? – What happens when the same number calls multiple times in one day (frequent calls)? Once this starts to happen, it is flagged by inContact. The clinical side is different–it's a new engagement/encounter for each time a person calls.
- Is there a need for more integration between inContact and Care Logic? It depends on what clinical information is needed and what they want to see. Right now, we are in a holding pattern. Currently, we can get our metrics for the call center and the outcomes from the clinical side.
- We are now on a call – please describe:
  - Each region has different workflows – all operated by different agencies, different EHRs
  - Master level coordinator is helping to "triage" making decisions on what type of intervention is needed in an active rescue situation – handled manually through the phone

    - Clinical / BH side it is not very automated; it is a more manual process managed over the phone
- Resources / services – how do you find the right resources for the person in need?
    - Questions we consider:
        - Do they have insurance? If so, what kind?
        - Do they need immediate or next-day service?
        - Do they need food? (Goes to 2-1-1)
        - Do they need an appointment?
    - Only emergency contact information is kept / outpatient mental health providers, help find private therapist, link them back to outpatient care managers if we have that info
    - All basic support needs go to 2-1-1. 2-1-1 has a very sophisticated resource database with approx. 30,000 resources. There is also a MH repository and SUD resources that crisis line staff have access to. About 95% of the resource information is all housed in the same repository.
- Someone dials in and they are associated with a certain provider – they call in the evening and the next day they are going to see Provider X
    - 5 different MCOs
    - A lot of different ways the information flows out
    - Daily Crisis logs are cross-referenced through Provider 1 and try to get out reports. Reports are generated and then uploaded to shared drives, FTP, etc., and then go from there. This is a– very manual process.
    - Safety plan / risk assessment – is it a Level of care assessment? – this is based on NSPL risk assessment standards. It starts off as broad questions and then narrows down; all of this is built into the EHR. The average handle time on Lifeline calls is 15 mins with the crisis line at about 5 mins. The reason for the difference is the amount of information being asked for in the NSPL. More time is spent collecting information instead of addressing needs, and this difference increases the need for more staff, etc.
- How do you keep track of documentation that is closed, in progress or brand new?
    - We had many unassigned notes, the clinical information is being reviewed by paid staff (bachelor or masters level depending on the acuity)
    - Not connected to a complete safety plan because a call can be dropped / client can hang up etc. so a risk assessment may not get completed
    - Data entry / quality and process is dependent on the team, some are better at it then others.
    - Would you like a platform that has customizable / enforceable rules that would help with the quality of data? Yes, the ability to have customizable fields would be beneficial, but we need a system that is nimble (we don't need a developer to create a field, etc.).
- How do you handle follow-ups?
    - 2 processes
    - Process A – when a situation is clinically acute and we have requested law enforcement on an active rescue, welfare check – we will follow-up law enforcement to ensure it was done
    - Certified peer counsellors – 24-48 hours post crisis call that we will do a follow-up call this will be done based on client – if they want us to call and check in with them
    - At go-live this will be a manual process / excel document

    - Care Logic – does not have a follow up ability
    - Ideal would be a work cue for follow-ups that back-office staff manage / re-assign as needed and then close out in the encounter – this would be a business requirement.
- Currently log into a platform for bed availability?
    - This is only done in King County – very manual process
    - Bachelor level clinician manages this process and very administrative – they are calling and coordinating with facilities in King County
    - Not a real-time bed tracker
- Chats / SMS
    - Is the workflow similar for encounters that are created through a chat or SMS?
    - Currently on teens – chat and texts are taken and put into the EHR
    - This is mostly emotional support, majority info stays within Crisis Connections

**Wishlist**

- Skills routing
- Scheduling software fully built in
- QA needs to be in the platform
- Ability to monitor real time
- Screen audits in real time
- Ability to raise an alert – emergency alert / crisis alert during a call (real time)
- Documentation system or an easier more configurable HER – need a system that is easier to use, need better reporting system, real time data – to support clinical decisions based on data
- Ease of reporting in a repository / BI, tableau etc.
- Customizable reporting
- A fully integrated CTI with screen pops, voice recognition, omni channel etc. would be ideal – smart rally
- Interoperability to support the triage process, when requesting interventions during an active rescue situation (interoperability is currently lacking on the Clinical / BH side)
- Ability to have customizable fields would be beneficial, but need a system that is nimble (don't need a developer to create a field etc.)

## Frontier Behavioral Health

**Current Technology**

- Call Center Platform: Cisco
- EHR/EMR: Coordinated Care Platform (CCP)

**Future Technology**

- Will be implementing NIC CXOne and iCarol – an integration between the two already exists
    - This integration will support hiring remote workers and will help address current workforce issues.
        - Will have ACD & Routing

**Current Processes**

I. Baseline Scenario when a crisis call comes in: how is your present-day technology used to manage the call?
   A. Call comes in Cisco – ACD
      1. Answer calls
      2. Provides data for call times, drop calls etc.
   B. Where is the caller information documented? – In the CCP (Coordinated Care Platform)
      1. Call is answered
      2. User goes into CCP to document in EMR
      3. Currently no integration between Cisco and CCP
      4. Manual entry of patient demographics, *etc*.
   C. CCP – document info – active rescue is needed:
      1. If calling law enforcement – information is all documented in a prog note, information is provided to 911 and Crisis responder is dispatched
      2. This is done through CCP – goes through to DCR as an electronic referral record
      3. Any programs within FBH are all automated
      4. Anything outside of FBH the work is done through phone calls (manual process)
      5. Assessments – Suicide assessment / LOA – Columbia for suicide, Homicide risk assessment, a safety plan is documented within CCP
      6. If in the call it is determined a bed is needed – currently no access to a bed registry
         a. Internal processes in place working with local providers – it's not real time, it's more of a daily bed count Searching for providers or resources for caller
      7. Warm transfer to 2-1-1 system – without closed loop referral system we have created an internal list that the staff references
      8. 2-1-1 is the hub for collecting referrals for resources – it is not a closed loop referral system
   D. Referrals – currently no standard way to share information with the provider
      1. Fax, phone call etc. currently not consistent and not electronic
      2. Does CCP have a follow-up que system? – how do you do this today?
         a. Within CCP we can develop reports, a "Follow-up" report was developed – if the disposition is mentioned then it is added to the report
         b. We want a system that has a platform that automatically provides a que for follow-up (iCarol)
   E. Do you keep a status of an encounter (new, In progress, close)?
      1. No not doing it currently
   F. What are your current reporting capabilities?
      1. Static reports through a dashboard
      2. No analytical ability currently
         a. Something we would like in a new more robust platform
   G. Public facing website – is this where you envision chats being started from clients (anonymous)
      1. Currently all chats originate through NSPLS (crisis text line) – and then Vibrant routes them – currently a national pool – working on understanding how we can respond to Washington texts from within Washington.

H. Warm hand-offs
    1. Currently – within the current contract we do warm transfers and information sharing with DCRs.
    2. NSPL calls are handled within NSPLs by trained NSPL resources
    3. NSPL calls can be transferred to a resource where you can get the persons needs met
    4. NSPL will not transfer to another resource that is not a crisis line – call is managed and de-escalated through NSPL until it is resolved
    5. Warm hand-off can happen to a mobile crisis unit or a resource
    6. Would the NSPL resource stay on the line if the call needed escalation to 911 etc.
        a. In an active rescue usually one person on the phone with the client and their partner on the phone with 911
        b. Warm transfers can happen to 911 and the resource will not stay on the line

**Wishlist**

- Active rescue – Geo Tracking
- CIE or closed loop referral system
- A system where the RCL can talk to DCRs in real time (electronically not over the phone) – chat feature / video call
- Video option when talking to clients would be a nice feature
- Rural counties – some areas that don't have internet or cell reception – hard for them to log into a follow-up platform – how can rural regions have more improved cell and internet coverage? Is the state working on anything? Broadband office, office of equity – looking at something called "Digital Equity"
- If for some reason, we were on the line with someone who needed resources in another region – we would like to have resources that provide information across the state (for instance a statewide bed registry) – something broader than 2-1-1
- Omni channel component (text, chat) and potentially video

## Volunteers of America (VOA)

**Current Technology**

- Call Center Platform: IVR – elevate unified communications – web-based phone system allows ability for remote staff to log in
- EHR/EMR

**Current Processes**

I. Baseline Scenario when a crisis call comes in: How is your present-day technology used to manage the call?
    A. Call comes in Cisco – ACD
        1. Answer calls
        2. Provides data for call times, drop calls etc.
    B. Where is the caller information documented?
    C. Active rescue is needed:
    D. Referrals
        1. Follow-up queuing system? How do you do this today?

E. Do you keep a status of an encounter (new, In progress, close)?
F. What are your current reporting capabilities?
G. Public facing website – is this where you envision chats being started from clients (anonymous)
H. Warm hand-offs (RCLs, 911 etc.)
I. Would the NSPL resource stay on the line if the call needed escalation to 911 etc.

**Current Technology**

- CCDS Proprietary EHR – it is more of a cross between a CRM and DB with components that fall in line with clinical / medical data sets. Created by Michael White – created with the needs of the counselors needs and easy access to the assessment tabs (safety and risk assessments to capture clinical record) ability to transmit encounter data for Medicaid to ASO partners
- Some of the processes link to contract requirements with the BH-ASO's (dispatching, 24/7 etc.)
- Same system used for lifeline calls (Regional) – life calls can have a different dispatching requirement, all of the vibrant, NSPL built in and regional contractors (HCA, DOH, accreditation bodies etc.) all outcome data and reporting needs are met
- No chat or text integration – currently completely separated from the phone system
- Demographics – is Tribal status captured? – currently captured in notes, future will be building out system and incorporating demographics to capture Tribal status
- Front end capability – wish list (to help streamline collecting demographics to identify Tribal affiliations)
- Assessments – heavily influenced by Columbia and best practices at lifeline, VOA designed it to create the best scenario and gather the most relevant information for phone-based crisis work
- Warm transfer for referrals, when possible, if not wanted by caller, then we provide them with the necessary information
- Many calls from third parties and they are being walked through what the access points, supports available – provide education piece
- Resource Directory – own internal resource directory on a regional and statewide basis (BH-ASO regions); resources that can be referred to through links
- Not very streamlined or integrated with other systems, more of an internal document
- Do refer to 2-1-1 when appropriate
- Training on resources is provided – we move through triage process and during the process share resources that are applicable to the caller
- Follow-up is very caller dependent, it is always offered – check back in, can we call you back etc. depending on situation and clinical appropriateness
- Referrals / Dispatch – warm handoffs, no electronic hand offs – all done telephonically
- Can the caller call back and get the same counselor? It is possible, but we try to refer to whomever answered – concerns around identifying specific counselors etc. safety, privacy and clinical concerns
- A lot of customization is needed within the EHR when working with crisis lines; want to move in a direction with something that is built for our services and can be very integrated
- Chat & Text contained between the peer connect system operated by Lifeline or Vibrant – will become a cloud system that will be integrated (Genesys) – moving to pure cloud version, same vendor
- Geolocation, call routing – still area code based

- Crisis and Safety plans – they are different documents, crisis plans come from the region, can come from the providers (outpatient crisis plans) – safety plans are part of our phone-based intervention and work to create a safe scenario – we create crisis alerts – get them from providers, first responders etc. we put them into our system and then if that person calls, we get notification of that person and we can look up that record
- How do you receive the crisis plans? Secure method with Salish region, BH-ASO transmitting crisis plans via secure file and then manually inputted into our system
- Templates in the EHR? Tabs and templates in the system for crisis plans, safety plans, crisis alerts
- Documents that are being transmitted – how are the documents stored? – data storage? We try to operate on an electronic scale, deleted once entered into the record, and anything that is kept meets all the requirements of security / privacy – policies in place for record retention etc.

**Wishlist**

- Ideally have something that is designed for this type of intervention and incorporates the components we need for our triaging process
- Easily integrated with other systems
- Expansion capacity
- Flexible for reporting
- Overall, it would be valuable if we could integrate across the 988 centers and function with teams across the state
- A system that is functional for counselors. This is hard work at high volume, so we need a tool that makes their job easier – something that is quick, intuitive, easy to work concurrently in

## Appendix E: Detailed History & Information of Regional Crisis Lines & Behavioral Health Organizations

### Crisis Services in Washington: Summary

The Washington Crisis System is a regionally based system administered by BH-ASO who contract with local providers to provide a diverse array of services to help a person experiencing a crisis. In addition, Tribal governments have varying crisis services depending on the resources and capacity of the Tribe to stand up crisis services within their communities and their experience with accessing non-Tribal crisis services for their tribal and community members in the region. The State does not pass-through funding for crisis services to tribal governments and there are no examples of the regions supporting tribal crisis services outside of Medicaid reimbursements. Local providers often assemble a patchwork of funding with different reporting requirements and funding restrictions this has created an uneven availability of services and confusion identifying similar services in different regions. Tools and technology platforms vary from region to region with most record sharing or referrals happening by fax or phone calls. Data is often submitted in the form of spreadsheets made by reports from provider EHRs. Inputting this data can often be a long and arduous process for all involved.

Workforce issues continue to be the biggest problem for providers with workers often leaving crisis services for similarly or higher paying jobs in less stressful environments. This has a direct impact on the ability of providers and regions to train and familiarize their staff on systems that can potentially improve communication and coordination in the crisis system. Every provider in a region utilizes their own EHRs and deploys their own policy and procedures for documentation. Confidentiality standards vary by providers complicating the ability to communicate across system partners. Staff moving between providers and programs complicates this process as staff adjust to these subtle changes. A standard repository that can manage clinical records for a region would reduce the friction in sharing these records. Standard training on these systems will help reduce the time it takes staff to adjust to new provider systems for crisis workers.

Administrative burden for reporting and documenting services remains high for BH-ASOs. This is passed down to providers via contract requirements and service encounter requirements. Providers follow documentation and encountering standards, but they all use their own EHRs with different policies for how records are created and stored. To fulfill their reporting requirements, due to the various EHRs utilized by providers, data often must be manually corrected to be input into a region wide data reporting system utilizing staff time and increasing cost for reporting. Many reports require the same data, but in different formats. This also adds to the administrative burden on staff at BH-ASOs and on at the provider level, diverting attention and resources.

Most regions track availability of beds and other resources through manual processes of holding regular calls or meetings with resources to get manual updates on availability. Tracking is kept more to study trends due to the information being out of date quickly. Time is often wasted by crisis providers trying to locate placements or to follow up on referrals. Technology that can reduce the administrative burden by producing reports and streamlining tracking requirements. Systems that show availability would reduce referral time and improve the ability to track trends.

Safety is a big concern for anyone working in the crisis system. Providers and crisis responders are often only receiving a snapshot of a person's history when they respond. A person in crisis may also have shared vital information that was documented in one system that is not available to the current crisis

responder. This can be overcome with a robust information sharing system. GPS tracking and the ability for a crisis responder to call for help discretely supports responders' safety in the field.

The below is an overview of the decisions and steps taken that have created the current BH-ASO and RCL landscape in Washington State.

- Starting in the mid-1990s mental health services for Medicaid enrollees were managed by a Regional Support Network (RSN). RSNs, through licensed mental health agencies, would provide medically necessary mental health services to clients eligible for the Title XIX Medicaid program as well as some other individuals with a diagnosed mental illness. Services included:
  - Emergency crisis intervention, case management,
  - Counseling and psychotherapy,
  - Psychiatric treatment, including medication management.
- Starting in 2003, RSNs and contracted providers utilized Access to Care Standards to determine eligibility criteria for the authorization of services. During this same period SUD services were managed at a county level. This system led to poor coordination of care and health outcomes for individuals with co-occurring conditions, since the delivery systems for physical health, mental health, and SUD services were not designed to share information across systems.
- In March 2014 legislation was enacted that mandated the full integration of all publicly funded physical and behavioral health system by 2020. The first step in this process was the integration of mental health services (operated by the RSNs) and the county-operated SUD programs. This resulted in the creation of a system of Behavioral Health Organizations (BHOs) that took over the administration of mental health and SUD services in April 2016.
- In 2016, Tribal governments requested that the State follow federal law that AI/ANs are not required to be covered by a Medicaid managed care entity and the fee for service system was maintained. AI/ANs were not auto enrolled in managed care. Today, about 60% of AI/ANs Medicaid enrollees remain in a fee fer service program for behavioral health rather than managed care.
- These BHOs were responsible for authorizing services and contracting with providers to provide authorized services. These included inpatient and outpatient treatment, involuntary treatment and crisis services, jail proviso services, and services funded by the federal block grants. To move to full integration the State created two options for "early adopter" or "mid adopter" regions to integrate purchasing of physical health, mental health, and SUD services by 2016 or 2019, respectively with completion of the process by 2020.

Regional Crisis Lines were established when the state began implementation of full integration of Medicaid services moving from the historically bifurcated system where substance use disorder and metal health issues were provided in two different systems. The Behavioral Health Organizations (BHOs) brought mental health and substance abuse services under one system, providing Medicaid and non-Medicaid services. In the effort to move to full integration, all Medicaid services were contracted with the Managed Care Organizations (MCO) and the Behavioral Health Administrative Service Organizations (BH-ASO) were contracted to provide statewide crisis services and behavioral health services to non-Medicaid/low-income individuals using state and Federal Block Grant funding. The BHOs were eliminated.

During this transition process RCLs often replaced existing regional crisis lines that were county based and could be made up of volunteer staff. RCLs are still listed by county on HCA website to help individuals find their local resources quicker and easier. RCLs continue to be referred to as mental health crisis lines. The statewide Recovery Help Line is the established line for people looking for SUD resources. RCLs and previous crisis lines have always taken calls for SUD crisis, but they are more specialized for MH crisis based on the historic utilization of these lines.

The next section provides further details about the regional services being provided across Washington State.

Seven out of ten BH-ASOs contract with a provider who is accredited as a Lifeline Crisis Call Centers (NSPLs) to provide crisis line services for their regions. There is no requirement for a BH-ASO to contract with an NSPL provider for regional crisis line services and BH-ASOs are free to work with any qualified provider. Three BH-ASOs currently contract with other providers for their crisis line services. These regions are listed below, and each operate their own Regional Crisis Call Systems:

- ✓ 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.

Regional Crisis Lines serve many functions for a region. RCLs are funded through a blend of state, local and Medicaid funds. Most Medicaid funds are contracted through MCOs. For members enrolled in fee for service programs BH-ASOs will submit encounter data and bill HCA directly. Medicaid services are reimbursed using a unique service code that can only be used by agencies that are designated by a BH-ASO. Services provided over the phone are encountered per SERI instructions and submitted to the BH-ASO. BH-ASOs are required to compile crisis logs and other reports to be sent to the MCOs about services provided to their members. BH-ASOs have remarked in numerous meetings that the administrative burden of reporting requirements from MCOs and HCA often makes it difficult for them to spend time on other activities. *Technology that can automate reporting requirements and minimize the need for hands on time from the BH-ASOs can reduce this.*

RCLs are often the main access point for a person seeking behavioral health services. These crisis and non-crisis calls serve as a way for someone to navigate a complex system and find the support they need. RCLs will assess level of crisis and take appropriate steps This could include active rescue crisis outreach, determining level of in-person response, or resolving the crisis on the on phone.

RCLs often have partnerships that allow them to connect a person with an intake or will help the person find an appointment with a provider depending on circumstances and the person's insurance. Provider directories with real time service offerings will help RCL operators connect someone with the appropriate support. HB 1477 includes a requirement for next day appointments for people experiencing urgent behavioral health needs. This directory can store providers who offer next day appointments. This same tool can be made available to mobile crisis teams and other crisis services providers as identified to connect people to this new resource.

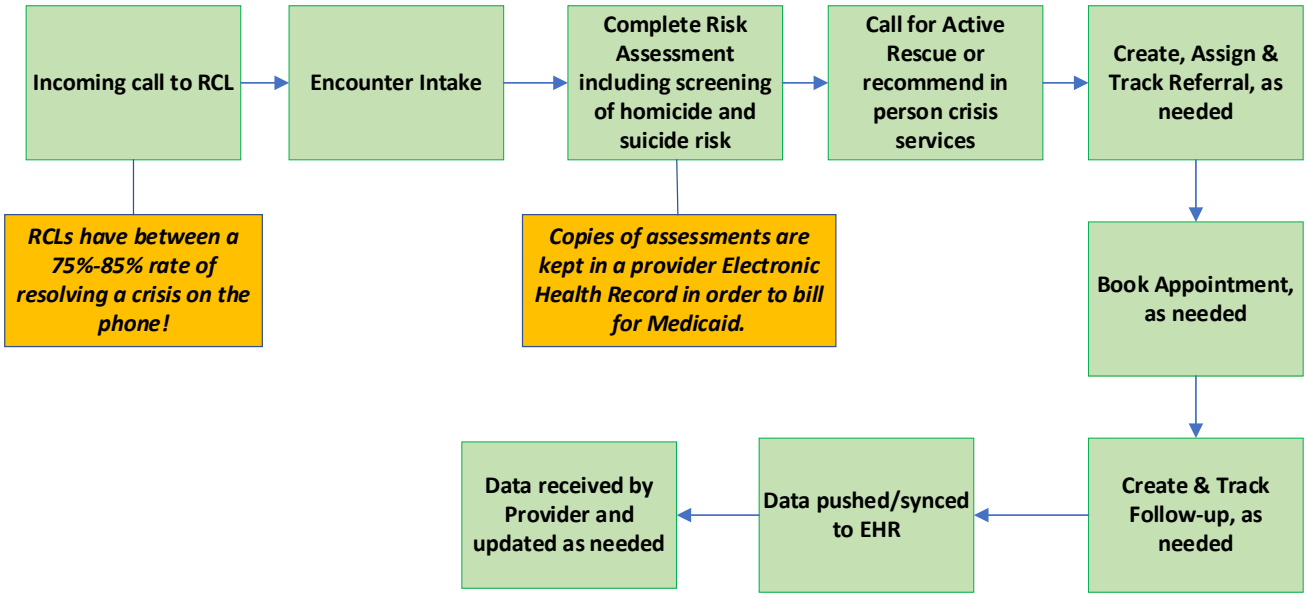


*Figure 20 RCL Process*

The lines provide phone-based crisis interventions to resolve crisis on the phone whenever possible. The below graphic provides an overview of how most RCLs will manage an incoming call; however, it is important to note that each RCL provider is responsible for creating their own standards, protocols, and procedures for calls. This includes the process for handing off calls to 911 and getting consent to document the service or make a referral.

Immediate concerns and these assessments are often passed on as part of a referral. The decision to refer someone to mobile crisis team is made using clinical judgement, tools created by agency to help with this decision, and mobile crisis team provider criteria.

The referral to mobile crisis is often done via a phone call to a dedicated phone line where the initial referral is staffed with a shift leader or supervisor. If a referral is accepted, then more information in the form of a referral packet is either faxed or electronically sent to the mobile crisis team. For some agencies they have an RCL integrated into their agency and use a shared EHR. Other RCLs have agreements in place to use secure email or other electronic means. These referrals contain pertinent information about the immediate concern but can lack historical information useful to the team. This can include information about history of violence, risk factors, other safety considerations, and even important treatment considerations. A person in crisis often creates a crisis plan with their provider and this could include a mental health advanced directive (MHAD) or a Wellness Recovery Action Plan (WRAP) that are meant to inform a crisis responder on the person's preferences in a crisis and provide helpful information to resolve the crisis. These important tools are often not available to crisis responders or can be out of date. Several tools can be used in this process. A comprehensive referral system that includes important information for safety and treatment recommendations would ensure crisis responders are well equipped to respond. Portals for people who have MHAD or WRAP plans can submit them to the system and a secure file storage can allow for the updating of crisis plans.

Mobile crisis teams are more likely to refer a person to a facility then a RCL due to many facilities having policies that a person must receive a face-to-face assessment prior to placement. Both mobile crisis and

RCLs will still deal with the administrative burden of calling around to find availability for a specific type of placement. This often can take hours of a responder's time. Once a bed is found there is often a lot of time spent meeting admission requirements including possible medical clearance and ensuring the person has all necessary medications and items for the stay.

The RCLs have been engaged throughout the information gathering process to ensure there is clear communication and alignment; the goal is to encourage open, transparent communication so we can work together to make 988 successful in Washington.

## Greater Columbia Region

The Greater Columbia region is situated in the south central and southeastern portion of the state. The region is made up of Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Walla Walla, and Yakima counties. This region's population of 743,767 is spread across 15,178 square miles, with significant portions of the region being rural and agricultural. Four cities in the region, Yakima, Kennewick, Richland and Pasco, account for 41% of the region's total population. A portion of the Confederated Tribes and Bands of the Yakama Nation reservation sits within this region in Yakima County. The Yakama Nation has approximately 6,300 members and their reservation covers 1.1 million acres.

Crisis services in the region are administered by Greater Columbia Behavioral Health, LLC. Regional crisis line services are provided by ProtoCall Services via a regional toll-free number as well as local numbers in each county. NSPL services are provided by Volunteers of America of Western Washington. In September Greater Columbia will contract with VOA for regional crisis line services as well. MCR and DCR services for Columbia, Benton, Franklin, Kittitas, Walla Walla, and Yakima counties are provided by Comprehensive Healthcare. MCR and DCR services in Asotin and Garfield counties are provided by Quality Behavioral Health. In Whitman County MCR and DCR services are provided by Palouse River Counseling. A co-responder team serves the cities of Kennewick, Richland, and Pasco police departments with grant funding through 2022.

Callers accessing the crisis system who might benefit from additional crisis services are connected to local crisis providers by the staff at ProtoCall Services. Each local team prefers to triage their referrals and will determine if a team will respond. The response type may vary by time of day or county. During daytime hours individuals can present directly to the MCR teams. In Walla Walla County law enforcement officers have a direct contact number for the local crisis service provider to ensure timely response.

Facility based crisis services are available in several counties in this region. There are three crisis stabilization/triage facilities and a total of 36 beds licensed for adults. None of these facilities provide <24-hour specific services. There are five Evaluation and Treatment and or hospital based inpatient psychiatric facilities in this region providing a total of 64 beds licensed for adults and 10 beds licensed for children and youth. There are three facilities with long term involuntary treatment beds with a total of 21 beds licensed for adults and 6 beds licensed for children and youth.

This region benefits from its several stabilization units and evaluation and treatment facilities, but these resources tend to be concentrated in the two urban areas of Yakima and the Tri-Cities (Kennewick, Richland and Pasco). Much of the eastern portion of the region is very remote and includes the lowest

population county in the state. In these areas crisis calls may be infrequent and when the need arises it can take several hours to get to the location and cellular coverage can be limited or non-existent.

### Great Rivers

Great Rivers BH-ASO covers five counties West to East from the Pacific Coast across I-5 all the way to the Cascade Range and South to the Columbia River basin ending just shy of Vancouver to the South. Cowlitz County is the most populated with Lewis and Gray's Harbor a close second. This region includes the traditional territory of three Federally recognized Tribal Nations including Quinault, Shoalwater Bay and Chehalis. The Quinault Nation includes the Quinault and Queets tribes and the descendants of five other coastal tribes: Quileute, Hoh, Chehalis, Chinook, and Cowlitz.

- Great Rivers Behavioral Health Administrative Services Organization. Counties covered include Grays Harbor, Pacific, Wahkiakum, Cowlitz and Lewis.
- RCL – Olympic Health and Recovery Services for DCR. Columbia Wellness RCL's cover all counties for MCR calls and dispatch. MCR's can be dispatched by referral through any phone line or by regional agency providers.
- Name of NSPL in the region – Volunteers of America.
- List of crisis service providers
    - MCR Adult – Greys Harbor, Cowlitz, Wahkiakum – Columbia Wellness. Pacific County – Willapa Behavioral Health. Lewis County – Cascade Community Healthcare.
    - MCR Youth – None reported
    - DCR – Olympic Health and Recovery Services
    - Co-responder teams – unknown
    - Identified Adult Facilities – Withdrawal management – 5, E & T – 2
    - Identified Youth Facilities – None

**Unique regional resources** – This region contracts their DCR services in five counties with the Thurston Mason RCL OHRS. Columbia wellness is the RCL that covers MCR services.

**Unique regional gaps** – From a geographical perspective the coasts of Grays Harbor, Pacific and Wahkiakum are remote and pose greater challenges in mobile response. Lewis County spans from Pacific County to the Cascade Range in the East.

**Unique regional needs** – No current youth and family MCR team in place. Great Rivers has been given proviso funding to stand up a youth mobile response team and is in the process of procuring services The region may benefit from strategically locating mobile response teams in key areas, along the Pacific Coast including Grays Harbor, along the Columbia River basin, and in Lewis County for maximum engagement & outreach and reduction in response times.

**Unique regional strengths** – The regional strengths as described by the BH-ASO is that providers often have intimate knowledge of high utilizers. These callers frequently reach out to provider crisis lines directly and receive individualized service. MCR teams can be referred through any appropriate channel and receive a response. The region reports that they will send MCR teams as a first response to assess the need for DCR evaluations prior to dispatching this specialized resource.

## King

The King region is limited to King County and administered by the King BH-ASO. It includes the Snoqualmie Indian Tribe, Cowlitz Indian Tribe, Muckleshoot Indian Tribe, non-federal recognized Duwamish, Seattle Indian Health Board, United Indians of All Tribes (Daybreak Star Indian Cultural Center), and Chief Seattle Club. The Cascade mountains and Puget Sound roughly demarcate the east and west boundaries. King County maintains uniquely centralized behavioral health services through its Behavioral Health and Recovery Division. The county's MIDD Behavioral Health Sales Tax Fund provides resources to many programs. Population concentrations, such as Seattle, often act as the hub for providers that extend services to lower-density areas. Crisis Connections provides both regional crisis line and NSPL services in distinct divisions. They also utilize the Extended Client Lookup Service, which records behavioral health agency enrollment and crisis system contacts.

County-operated Crisis and Commitment Services is responsible for Designated Crisis Responder services in King County. Adult mobile crisis response is provided in-person 24/7 by teams of two from DESC's Mobile Crisis Team. Teams can transport individuals in agency vehicles to a needed service or safe location. They do not perform follow-up services. DESC's Mobile Crisis Team receives referrals by phone from fire departments, law enforcement, Designated Crisis Responders, and Crisis Connections. Self-referrals, referrals from other provider types, or referrals for those currently incarcerated or admitted to a hospital or emergency department are not supported. Crisis Connections does not refer individuals enrolled in King County Behavioral Health Services.

YMCA of Greater Seattle operates Children's Crisis Outreach Response System (CCORS), a 24/7 youth and family mobile crisis service. Referral is through Crisis Connections. Youth enrolled with eligible Medicaid may receive Intensive Stabilization Services for up to eight weeks. An extension of CCORS, CCORS-YA, supports young adults, primarily experiencing homelessness, ages 18-24.

A variety of co-responder integrated mobile health, older adult response, and related intervention programs exist throughout King County. These services typically operate at a department or agency level and are dispatched according to their corresponding protocols.

King County has no current crisis triage or stabilization facilities. Resultant from the Trueblood Contempt Settlement Agreement, two facilities are under development or anticipated. DESC operates the Crisis Solutions Center, which accepts referrals from King County hospital emergency departments, fire departments, law enforcement, or Mobile Crisis Team. There are also evaluation and treatment services for adults and youth and adult withdrawal management facilities.

## North Central Region

The North Central region is made up of Chelan, Douglas, Grant, and Okanogan counties. This is a very rural region with a population of 263,239 scattered across 12,686 square miles. Wenatchee in Chelan County and Moses Lake in Grant County are the largest cities in the region but only account for 22% of the region's population. A portion of the Confederated Tribes of the Colville Reservation sits within this region in Okanagan County. The tribe has more than 9,500 enrolled members and about 50% live on or near the 1.4-million-acre reservation.

Crisis services in this region are administered by Beacon Health Options. They contract with Crisis Connections to provide regional crisis line services, but some counties have opted to have crisis calls

come directly to them during business hours and forward calls to the RCL outside business hours. NSPL services are provided by Volunteers of America of Western Washington. MCR and DCR services are provided by Catholic Charities in Chelan and Douglas Counties. They currently have no youth and family specific teams. Renew provides adult MCR, youth MCR and DCR services in Grant County. Okanogan Behavioral HealthCare provides DCR services in Okanogan County. Mobile Crisis Response services are available during daytime and evening hours and DCR services are available 24-hours a day, 7-days a week, 365-days a year.

Individuals in crisis can access the crisis system by calling the regional crisis line 24 hours a day. A provider and law enforcement specific crisis line is also available. Individuals in crisis can also present in person during business hours.

There is one crisis stabilization unit in this region located in Wenatchee and providing up to 14 days of facility-based stabilization.

With the support of Beacon Health Options MCR teams are transitioning from a more DCR focused approach to an MCR first approach. The development of a new youth specific team Grant County is also bringing a broader breadth of services. A gap in this region is the limited availability of facility-based stabilization. Additionally, the long distances and a dispersed, rural population can make response times challenging. Cellular phone coverage can be limited or non-existent in many remote areas of the region.

### North Sound

The North Sound BH-ASO includes Snohomish, Island, Skagit, San Juan, and Whatcom counties. Federally recognized tribes include Nooksack Tribe, Lummi Nation, Swinomish Indian Tribal Community, Tulalip Tribes of Washington, Stillaguamish Tribe of Indians, Samish Indian Nation, and Sauk-Suiattle Indian Tribe. Snohomish County operates its constituent crisis response services, whereas Compass Health is responsible for Island, Skagit, San Juan and Whatcom counties and its providers tend to be embedded in the community. The region is predominately rural and includes many inhabited islands. Regional crisis line and NSPL services are provided by Volunteers of America. North Sound also hosts the WA Indian Behavioral Health Hub.

Snohomish County staffs Designated Crisis Responders to provide both involuntary treatment services and voluntary mobile crisis response. Compass Health's Mobile Crisis Outreach Teams (MCOT) include both DCR and non-DCR mental health professionals and Certified Peer Counselors. Referrals for both providers come through Volunteers of America. North Sound has several WISe and transitional age youth providers but no current youth mobile crisis response teams.

Various co-responder models exist in the region and interest continues to grow. Like most co-responder models, dispatch is generally arranged based on constituent processes.

### Pierce

Pierce county has its own BH-ASO, administered by Beacon Health Options. Its population is concentrated in its western contiguous geography and some islands are only accessible by ferry. The region includes the Muckleshoot Tribe and Puyallup Tribe. Crisis Connections provides regional crisis line services and Volunteers of America covers NSPL operations. Historic reliance on law enforcement

services shape current help-seeking behaviors and expectations. Movement to promote earlier and less-restrictive intervention by behavioral health providers continues.

MultiCare provides Pierce's Designated Crisis Responder and 24/7 adult mobile crisis response services. Mobile crisis response teams may be comprised of both DCR and MCR staff; staffing patterns and dispatch protocols blur the distinction between the individual functions. Teams respond to hospital, jail, and community settings and are increasingly able to provide follow-up. Crisis Connections is the only referral mechanism for mobile crisis response. Youth mobile crisis response is provided 24/7 by Catholic Community Services and efforts are underway to expand stabilization services.

Additional behavioral health interventions include services for individuals with more frequent contact and services for youth. Some of the region's Designated Crisis Responders work as co-responders with the Pierce County Sheriff's Office. Tacoma and Lakewood have their own co-responder programs.

RI International operates crisis triage and stabilization facilities in Fife and Tacoma. The facilities include both crisis "recliners," emulating a living room model, and short-term beds. Referrals are accepted through a variety of sources, including first responders and walk-ins. RI's facilities reflect SAMSHA's best practices for facility-based stabilization. Pierce has both adult and youth E&T services and adult withdrawal management facilities.

### Salish

Salish Behavioral Health Administrative Service Organization covers the following counties: Clallam, Jefferson, and Kitsap. It is divided into 4 catchment areas; Kitsap County, Lake Crescent to Jefferson County, East Jefferson/Port Townsend/Hadlock/Ludlow/Quilcene, and West end which consists of Clallam County. This region includes the traditional territory of five Tribal Nations and includes the Hoh, Quileute, Makah along the Pacific coast and Lower Elwha and Jamestown S'Klallam on the Juan de Fuca coastline.

- Salish Behavioral Health Administrative Services Organization. Counties covered include Clallam, Jefferson, and Kitsap
- RCL – Volunteers of America
- Name of NSPL in the region – Volunteers of America.
- List of crisis service providers
    - MCR Adult – Kitsap County – Kitsap Mental Health Services, Lake Crescent to Jefferson County (majority of Clallam) - Peninsula Behavioral Health, East Jefferson/Port Townsend/Hadlock/Ludlow/Quilcene - Peninsula BH, West end Clallam County – Forks Community Hospital
    - MCR Youth – none reported
    - DCR – Kitsap - Kitsap MH Services, Jefferson and Clallam – Peninsula BH/Forks Community Hospital in Clallam only
    - Co-responder teams – unknown
    - Identified Adult Facilities – Withdrawal management – 2, E & T - 1
    - Identified Youth Facilities – Youth E & T - 1

**Unique regional resources** – Salish BH-ASO is comprised of 4 primary catchment areas for delivery of crisis services. Both Jefferson and Clallam counties run West to East from the Washington coast to Puget

Sound and encompass the Olympic National Park. Clallam county to the North traces the coastline of Juan de Fuca, making this the primary road access to the Pacific coastal residents. To the East, Kitsap is a more urban region with a rough population of 275,000. This geography makes response times challenging.

**Unique regional gaps** – No current youth and family MCR team in place. Kitsap has been given proviso funding to stand up a youth mobile response team and is in the process of procuring that. There are no stabilization facilities in the region as the BH-ASO reports these were cut due to financial reasons.

**Unique regional needs** – The region may benefit from strategically locating mobile response teams in key areas, along the Pacific Coast, the Juan de Fuca Coast and in Kitsap County for maximum engagement & outreach and reduction in response times. The Coasts of Juan de Fuca, and the Pacific coast are home to over five Tribal Nations so there should be significant consideration on justice system diversion and engagement and outreach with Tribal partners.

**Unique regional strengths** – Volunteers of America dispatches approximately 90% of mobile crisis responders. In Kitsap, law enforcement is dispatching MCR teams directly. This ease of connecting to mobile response teams offers true justice system diversion for Kitsap residents. DCR and MCR teams' function in a dual role which is common. Peers provide much of the case management follow up. Kitsap BH-ASO reports that teams do active outreach in the community, at hospitals and in schools. Kitsap county has a crisis triage facility.

### Spokane Region

The Spokane Region consists of Ferry, Stevens, Pend Oreille, Lincoln, Spokane, and Adams Counties. The designated Behavioral Health Administrative Organization (BH-ASO) is Spokane County's Community Services, Housing, and Community Development department. The region is mostly rural with a large population center focused on the state's second largest city of Spokane. The region's crisis line is operated by Frontier Behavioral Health (FBH) who also operates the NSPL for the region. FBH provides most crisis services in Spokane City and surrounding areas. FBH operates a robust array of crisis services including dedicated mobile crisis outreach. Another notable program is the Co-responder team of Spokane Police and FBH which has been nationally recognized. FBH also operates the DCR team for Spokane County. The full integration of crisis services serves Spokane City better than most regions, 15% of calls to the RCL result in a mobile crisis response which is higher than other regions due to the robust number of resources in population hub of the Spokane region.

Outside of the main population hub crisis services vary and are often reliant on DCRs and phone support due to the rural nature of those areas. In these regions local law enforcement often is the first to respond then connect someone to resources that may take days to follow up depending on availability. Internet and cell coverage are poor in many parts of the region limiting the availability of telehealth options for rural areas.

Spokane City has many facilities for care including inpatient, E&T, withdrawal management, and stabilization facilities. Recently a new stabilization facility was opened near Spokane County Jail as a diversion program. Other Stabilization facilities have struggled to keep open due to funding and low census counts. In Stevens County there is an E&T that will often take referrals a stabilization facility would take. In other areas in the region hospitals serve as crisis facilities.

Youth crisis services have been provided by youth providers, WISe teams, and adult crisis workers. Funding was provided for a youth focused mobile crisis team. A provider has been identified and they are working to hire staff. This is the region's only new investment currently.

Services in Spokane region are accessed by a person initiating treatment with a provider, a referral from a law enforcement or hospital, and from regional crisis lines. The decision on if a referral is accepted and when/who should respond is made at the provider level. There is often a dialogue between referring entity and the provider to determine the appropriateness of referral, but the decision is up to the provider.

Spokane County utilized the .02 sales tax to fund many of the crisis services. There is also a robust amount of local funds to train law enforcement on CIT and to work with co-responders.

The greatest challenges in the Spokane region are ensuring adequate access to services in the rural areas.

### Southwest

The Southwest Behavioral Health Administrative Service Organization is serviced by Beacon and includes the following counties: Clark, Skamania and Klickitat. Clark County is fifth in population in the state and includes the city of Vancouver. Skamania and Klickitat run to the East of Clark along the Columbia River and the population dwindles respectively. This region includes the traditional territory of Yakama Nation which spans into the Greater Columbia region in Yakima County.

- Beacon Behavioral Health Administrative Services Organization. Counties covered include Clark, Skamania, and Klickitat.
- RCL – Crisis Connections
- Name of NSPL in the region – Volunteers of America.
- List of crisis service providers
    - MCR Adult – Clark County – SeaMar Behavioral Health, Skamania none reported, Klickitat – Comprehensive Healthcare, primarily DCR
    - MCR Youth – Clark County – Catholic Community Services
    - DCR – Clark County – SeaMar, Skamania County – Skamania County Department of Community Health, Klickitat County – Comprehensive Healthcare
    - Co-responder teams – SeaMar co-responder team with Vancouver PD for City of Vancouver only
    - Identified Adult Facilities – Withdrawal management – 4, E & T -?
    - Identified Youth Facilities – E & T - 1

**Unique regional resources –** Southwest BH-ASO is serviced by Beacon Health Options. Beacon also services Pierce and North Central Regions.

**Unique regional gaps –** There are no inpatient services in Klickitat.

**Unique regional needs –** Beacon has received proviso funding to make the youth and family team currently in place in Clark 24/7/365. They report that Skamania has limited services, resulting in the need to go out of county or across to Oregon for care.

**Unique regional strengths –** Beacon reports that in the Southwest Region they provide up to 7 days of service when clients enter the crisis system insurance blind which is unique as this is typically only for 72 hours or 3 days. They also report in Clark that DCR/MCR services are combined while Vancouver LE directly dispatches their co-responder teams.

### Thurston/Mason

Thurston Mason Behavioral Health Administrative Service Organization covers Thurston and Mason counties and provides DCR and MCR services. They contract their own regional crisis line, Olympic Health and Recovery Services (OHRS) answered by clinical staff who also provide outreach. OHRS is also contracted with Great Rivers BH-ASO for answering calls for DCR evaluations, as OHRS DCR services are contracted to cover Thurston and Mason County as well as the five counties of Great Rivers BH-ASO which include Grays Harbor, Pacific, Wahkiakum, Cowlitz, and Lewis counties. This region includes the traditional territory of four Tribal Nations including Skokomish, Squaxin Island, Nisqually and, Chehalis confederated Tribes whose land spans across both Thurston County and Grays Harbor County.

- Thurston/Mason Behavioral Health Administrative Services Organization – Counties covered include Thurston and Mason.
- RCL – Olympic Health and Recovery Services
- Name of NSPL in the region – Volunteers of America. Dispatch and referrals go through OHRS. Youth crisis line is answered by contract by Crisis Connections who dispatches youth mobile response teams directly
- List of crisis service providers
    - MCR Adult – Olympic Health and Recovery Services
    - MCR Youth – Catholic Community Services
    - DCR – Olympic Health and Recovery Services
    - Co-responder teams – Olympia PD, Lacey PD and Thurston County Sherriff's Office - dispatched by LE
    - Identified Facilities – Adult withdrawal management – 2, E & T – 7
    - Identified Facilities – youth – E & T -1

**Unique regional resources** – Youth mobile response teams. OHRS will send most referrals up to age 20 to the youth mobile response team first. If a DCR is necessary, they can do a referral back to the DCR's. The youth provider covers both Thurston and Mason Counties in a 2-hour response time requirement.

**Unique regional gaps** – none reported

**Unique regional needs** – Some areas in North Mason create response time challenges but this is minor compared to other regions. The BH-ASO reports that adults tend to wait until it is a crisis before reaching out. They also report a culture of callers wanting a DCR first rather than MCR.

**Unique regional strengths** – In both counties there is close collaboration with law enforcement and folks in jail. TM-BHASO has partnered with law enforcement for several co-responder teams in Olympia, Lacey, and Thurston County.

Youth mobile response is delivered under the MRSS model and provides up to 77 days of in-home stabilization regardless of insurance. This is done with braided funding that is not sustainable. The youth

team also has a dedicated crisis clinician located inside the Juvenile Justice facilities in both Mason and Thurston Counties. In both counties, LE and schools refer to the youth team with consistency.

### Tribal and Urban Indian Centric Behavioral Health and Crisis System

Tribes have a longstanding history with barriers in accessing needed crisis services for their tribal members. Due to States movement towards managed care and lack of resources, crisis services as mentioned above, was supported through a county and regional system which did not provide resources to Tribal governments to fund services to members within their communities. Issues related to access to timely services, honoring of tribal court orders and clinical assessments, funding to support tribal crisis resources. The Tribes have worked with the state to advocate and develop plans to improve crisis services to tribal members and urban Native individuals across the state and to address longstanding barriers to access to care and the significant crisis and behavioral health outcomes for AI/AN individuals. AI/AN individuals and tribal members experience extensive wait times for ITA evaluations and mobile crisis teams to tribal communities and difficulties in individuals and families navigating crisis on their own. There are times when the tribe does not agree with the DCR's ITA evaluation of a tribal members.

In 2013, the Tribes, Indian Policy Advisory Committee, and the Department of Social and Health Services developed a report to the legislature that outlined the following crisis improvement recommendations to improve the Tribal Centric Crisis System. These included, timely and equitable access to crisis services for AI/AN, improved connections and ability to have designated crisis responders (formally DMHPs), notification and coordination by evaluation and treatment facilities when discharging AI/AN patients, legislation to allow tribal courts to issue ITA commitments for tribal citizens, training for non-Tribal DCRs for evaluations of AI/AN individuals, conduct feasibility study for one or more E&T facilities to serve AI/AN individuals in need of inpatient psychiatric care.

Between the years of 2016 – current date, the State has supported work to establish and maintain planning efforts to support the feasibility study for one or more E&T facilities per the recommendation of the 2013 report. The Tribes met to establish a workgroup in 2017 and have been working on realizing this plan since it's development in 2019. The plan was robust and outlined goals and activities to address crisis services for AI/AN that would provide the infrastructural support needed to create a successful culturally appropriate behavioral health crisis facility. Below are activities that have been implemented by the workgroup to date. This includes establishment of a formal Tribal Centric Behavioral Health Advisory Board (TCBHAB) to oversee these activities. Continued planning on the development of a culturally appropriate tribal inpatient behavioral health facility managed by the TCBHAB.

- Development of tribal DCRs (T-DCR), appointed by the tribe and appointed by HCA for state jurisdiction processes, that can evaluate anywhere and with anyone in the state.
- Funding support for T-DCR services.
- Legislation to enhance tribes' ability to provide crisis services to their tribal and community members including notification to tribes for ITA investigations of tribal members and AI/ANs with an Indian Health Care Provider (IHCP) as a medical home.[49]

[49] Indian Behavioral Health Act SB 6259 implementation | Washington State Health Care Authority

- Training and technical assistance to tribes and IHCPs on enhancing crisis services, including development of T-DCR tribal Codes, DCR processes and procedures/T-DCR protocols, operationalization of T-DCR, tabletop exercise for tribes.
- Training and technical assistance to non-tribal crisis providers and DCRs on working with AI/ANs and tribal communities, including reviewing and providing feedback on the DCR protocols.
- Improvements to the Tribal Crisis Coordination Protocols template and processes.
- Washington Indian BH Hub and the Native and Strong Lifeline.

In addition to the statewide Tribal/state crisis improvement projects, the 29 tribes are at different stages of implementation of crisis services. Under the self-determination act, strength and resiliency, Tribes have moved toward implementation of crisis services to provide to their tribal and community members. Several Tribes have crisis lines available either on a workday basis and 24/7 basis. Several tribes are working on establishing Tribal designated crisis responders that will conduct ITA evaluation and investigations through the State system as well as through their tribal court systems. Tribes are also exploring mobile crisis response teams and crisis facilities.

The state is working to ensure that we account for the diversity of Tribal and urban Indian organizational resources and protocols for engaging with Tribes and urban Indian organizations when serving AI/ANs in crisis and in need of behavioral health resources. Some of these efforts include, completing the State/Tribe Tribal Crisis Coordination Protocols, ensuring others working in the crisis system are aware of these protocols and the development of the Native and Strong Lifeline and the Indiana behavioral health hub.

# Crisis Stabilization Services Offered by Behavioral Health Treatment Agencies in Washington State

## Results from the 2021/2022 Behavioral HealthProvider Survey

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## Crisis Stabilization Services

The Substance Abuse and Mental Health Services Administration (SAMHSA) offers a definition and purpose of a crisis stabilization service. It is:

> *A direct service that assists with deescalating the severity of a person's level of distress and/or need for urgent care associated with a substance use or mental health disorder. Crisis stabilization Services are designed to prevent or ameliorate a behavioral health crisis and/or reduce acute symptoms of mental illness by providing continuous 24-hour observation and supervision for persons who do not require inpatient services. Short-term crisis residential stabilization services include a range of community-based resources that can meet the needs of an individual with an acute psychiatric crisis and provide a safe environment for care and recovery.*[50]

Crisis stabilization services come in a variety of forms which may include telephone services, walk-in services, mobile crisis, short-term residential treatment, 23-hour Crisis Stabilization Units, the Living Room Model, Crisis Stabilization Units and psychiatric hospitalization.[51]

## Behavioral Health Treatment Agencies and Crisis Stabilization Services

The 2021/2022 Behavioral Health Provider Survey reveals current knowledge about the crisis stabilization services offered by behavioral health treatment agencies in Washington State. The survey population, not a sample, consists of 754 Department of

Health certified, community-based mental health (MH) and substance use disorder

(SUD) treatment agencies known to provide Medicaid and publicly funded services in

Washington state. The online survey was administered through a collaboration with WSU's Social and Economic Sciences Research Center. Agency directors or administrators received a paper introduction letter by first-class mail announcing the project and providing information on how to access the online survey. The survey was available from December 2021 through April 2022. Non-respondents received email reminders and a reminder postal letter to encourage them to complete the survey and to confirm that the agency was still in operation. The survey treats each agency as a distinct unit of analysis. Agencies with multiple sites were given the option to consolidate their sites into one survey. Adjusting for consolidated sites resulted in a population size of 662 agencies. Responses were received from 231 agencies yielding a response rate of 35%.

## Scope and Type of Crisis Stabilization Services

The survey results provide a measure of the scope and type of crisis stabilization services offered by behavioral health treatment agencies. Of the 231 agencies surveyed:

- Seventy-six agencies, 35%, provide crisis stabilization services.

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[50] Taken from this review article: Saxon V, Mukherjee D, Thomas D. Behavioral health crisis stabilization centers: A new normal. Journal of Mental Health & Clinical Psychology (2018) 2(3): 17-26.
[51] Ibid.

- Among those providing crisis stabilization services, crisis outreach is the most common service offered (76%) followed by crisis telephone support (66%), crisis peer support (41%), emergency involuntary detention (37%), and crisis stabilization unit (35%).
- Nine percent offer 23-hour crisis stabilization and 3% provide the Living Room Model.
- Ten percent of the agencies specified other forms of crisis stabilization services such as: "24-hour mobile crisis team;" "assisted outpatient treatment;" "same-day appointments, regular follow-ups, peer services, case management services, medication management;" "crisis stabilization in a home-like setting (in facility);" "coordination of hospitalization, crisis interventions during business hours;" and "crisis evals, interventions, monitoring."

### Source of Referrals to Crisis Stabilization Services

Behavioral health treatment agencies receive referrals to their crisis stabilizations services from a variety of sources.

- The most commons means by which agencies receive clients in need of crisis stabilization is through self-referral, reported by 77%, followed by clients' family (76%), other behavioral health agencies/providers (67%), designated crisis responders (65%), acute care hospitals and emergency departments (62%), police departments (60%), schools (56%), mobile crisis response units (52%), physicians (52%), and 911 (38%).
- Other ways by which agencies receive referrals include: "recording prompts routed directly to crisis worker;" "Care Crisis Line is the central point for incoming crisis calls;" "our staff are dispatched by the VOA Care Crisis team;" and "VOA."

### Agency Response Following an Immediate Crisis

Behavioral health agencies provide services following a client's experience of an immediate crisis.

- Seventy-seven percent of agencies offering crisis stabilization services provide outpatient MH services.
- Agencies also report providing crisis outreach (73%), crisis telephone support (63%), MH peer service (57%), referral to substance use disorder (SUD) residential program (57%), referral to inpatient MH services (57%), same-day walk-in behavioral health services (56%), SUD intensive outpatient program (42%), mobile crisis response follow-up (41%), and SUD peer services (23%)
- Fewer than 10% offer acute detox (9%) and sub-acute detox (7%), while 3% offer sobering unit, and 1.3% provide peer-run respite centers.
- Agencies report these other responses following an immediate crisis: "refer to our crisis stabilization unit;" and "psychiatric care and medication management."

### Technology Tools Used by BH Agencies that Provide Crisis Services

The telephone is essential to a segment of agencies offering crisis stabilization services.

- Sixty-six percent of agencies providing crisis stabilization use "crisis telephone support."

Nearly 91 percent of BH agencies that provide crisis services primarily rely on an electronic health record (EHR) system for client record keeping while 9% primarily use paper.

- BH agencies report using the following health information technology or EHR system: Credible Behavioral Health (30%), Epic (22%), CareLogic (13%), Qualifacts (10%), Collective Medical (9%), and SmartCare (6%).
- Fewer that 5 percent use In Sync (4%), Netsmart (4%), Netsmart/Avatar (3%), UniteUS (3%), NextGen (3%), and Computerized Patient Record System (3%).

Behavioral health agencies use EHRs for various activities.

- Ninety percent of BH agencies use EHRs to record electronic screenings and assessments, 90% to create electronic care plans, 49% to send electronic discharge plans, 38% to send electronic referrals, and 36 percent to receive electronic referrals.
- BH agencies report these other activities for which an EHR is used: "billing, scheduling, reporting;" "communicate with clients;" "electronic intakes, crisis plans, release of information, medication management plans;" integrated care coordination within the agency;" record session progress notes, file legal paperwork, record/review crisis notes."

Behavioral health agencies use EHRs for different functions.

Seventy-three percent use EHRs for reporting and analytics, 70% for payer and revenue management, 62% to manage patient check-in activities, 57% to manage social determinants of health (SODH) information, 54% for telehealth services, 41% for pharmacy services, 39% to manage inpatient services, 33% for continuing care, 16% for dental services, and 13% for specialty services (e.g., anesthesiology, emergency, lab).

- Other functions reported by behavioral health agencies for which EHRs are used include: "all things related to crisis services/DCR function;" "crisis management;" and "e-prescribing."

Forty-six percent of behavioral health agencies offering crisis services are very willing or somewhat willing to accept an offer of a free EHR license and technical assistance to support its use, while 35% are neutral, and 19% are somewhat unwilling or not willing at all.

Seventy-eight percent of BH agencies offering crisis services are very satisfied or somewhat satisfied with their EHR system while 22% report being somewhat dissatisfied or very dissatisfied.

## Conclusions

Behavioral health treatment agencies occupy a key position in the chain of crisis stabilization and response. Over a third of the community-based, publicly funded behavioral health treatment agencies surveyed offers crisis services. The level suggests that more agencies may have to be incentivized to meet a growing need and to deliver a more diverse range of crisis-support services. More than half of the agencies offer crisis outreach and crisis telephone support, while less than half provide crisis peer support, emergency involuntary detention, and crisis stabilization unit. Fewer than 10% offer 23-hour crisis stabilization and fewer than 5% provide the Living Room Model. Most agencies receive referrals from clients themselves and from clients' families. Less than 40% receive referrals from 911. Following an immediate crisis, over two-thirds of the agencies report providing outpatient MH services, while

more than half provide referrals to inpatient SUD and MH programs, and less than half to SUD intensive outpatient services.

Behavioral health agencies that deliver crisis services rely on technology to perform specific tasks, activities, and functions. The phone remains to be an important tool in providing support during an immediate crisis and in receiving referrals from clients needing urgent care. Health information technology helps agencies to speedily obtain or share relevant patient information to provide appropriate care during a crisis. Ninety one percent of BH agencies offering crisis services use EHRs. The 9% of BH agencies that primarily use paper may present a challenge in the effective use of EHRs in crisis response. Less than a fifth of the BH agencies that provide crisis services are unwilling to accept an offer of a free license suggesting that a shift to another EHR even at no cost may not necessarily translate to an advantageous opportunity for some agencies.

## Relevant questionnaire sections

Healthcare providers are increasingly using computer applications to electronically store clinical and other service information about their clients. Known by different vendor names, or brands, these applications enable providers to create electronic health records (EHRs) of their clients. Your answers to the next questions will allow us to assess how behavioral health treatment providers in Washington State use EHRs in patient care. Your facility data will help inform policies related to the use of information technology in healthcare at the state and provider levels.

**Q17. Which of the following best describes your client record keeping system?**

1. Primarily use paper record keeping ❾ **skip to Q17a**
2. Primarily use an EHR system (***do not include billing record system***) ❾ **skip to Q18**

**Q17a. Does your agency have plans to transition to an EHR (electronic health record) or are you currently evaluating an EHR system?**

1. Have plans to transition to an EHR system
2. Currently evaluating an EHR system
3. No plans to transition to an EHR system ❼ **skip to Q17c**

**Q17b. When does your agency plan to transition to an EHR system?**

1. Within the next 6 months
2. Within the next year
3. Within the next 2 years
4. Some other timeframe (please describe): _____

**Q17c. Which of the following were or are barriers to adopting an EHR system experienced by this agency?** *(Check all that apply)*

- ☐ Finding an EHR system that meets your facility's needs
- ☐ Limited or lack of IT staff to support EHR adoption
- ☐ Cost of purchasing and maintaining an EHR system
- ☐ Loss of productivity during the transition to an EHR system
- ☐ Staff resistance to use EHR
- ☐ Privacy or security concerns
- ☐ Inadequate/lack of internet connection
- ☐ Other, specify: _____

**After answering Q17c, skip to Q19**

**Q18a**. **Please indicate the name of this facility's health information technology (HIT) or electronic health record (EHR) system.** *(Mark all that apply.*

- ☐ Credible Behavioral Health
- ☐ Epic
- ☐ Netsmart
- ☐ Netsmart/Avatar
- ☐ Cerner
- ☐ Qualifacts (including CareLogic)
- ☐ CareLogic
- ☐ Collective Medical
- ☐ Care Everywhere/CareQuality
- ☐ UniteUS
- ☐ Aunt Bertha
- ☐ NowPow
- ☐ Social Solutions
- ☐ OpenBeds/Appriss Health
- ☐ Other, specify: _____

**Q18b. Contingent on funding, the Washington State Health Care Authority plans to offer licenses for a certified electronic health record (EHR) system to be used statewide by behavioral health (BH) agencies, Tribal providers, long term care (LTC), and rural health agencies. Licenses will be made available at no charge for these providers and the offer will include training and technical assistance to support the agency's use of that EHR system.**

**How would you rate your willingness to accept this offer of a free EHR license and technical assistance to support its use**

1. Very willing
2. Somewhat willing
3. Neutral
4. Somewhat unwilling
5. Not willing at all

**Q18c. Do you use your EHR for any of the following activities?** *(Check all that apply.)*

- ☐ Send electronic referrals
- ☐ Receive electronic referrals
- ☐ Create electronic care plans
- ☐ Record electronic screenings and assessments
- ☐ Send electronic discharge plans
- ☐ Other activities, specify: _____

**Q18d. Do you use your EHR for any of the following functions?** *(Check all that apply.)*

- ☐ Manage inpatient services
- ☐ Manage patient check-in activities
- ☐ Pharmacy services
- ☐ Dental services
- ☐ Behavioral health
- ☐ Manage social determinants of health (SDOH) information
- ☐ Payer and revenue management
- ☐ Reporting and analytics
- ☐ Telehealth services
- ☐ Continuing Care (e.g., long-term care, wound care, etc.)
- ☐ Specialty services (e.g., anesthesiology, emergency, lab, etc.), specify:_____
- ☐ Other functions, specify: _____

**Q18e. Overall, how satisfied or dissatisfied are you with your EHR system?**

1. Very satisfied
2. Somewhat satisfied
3. Neither satisfied nor dissatisfied
4. Somewhat dissatisfied
5. Very dissatisfied

## Crisis Stabilization and Response

**Q19. The following questions seek to gather information about whether you provide crisis stabilization services and/or services to individuals who had been experiencing a crisis but are no longer at imminent danger.**

**Does your agency provide crisis stabilization services?**

1. Yes
2. No → **skip to Q20a**
3. Don't know → **skip to Q20a**

**Q19a. What types of crisis stabilization services does your agency provide?** *(Check all that apply.)*

- ☐ Crisis stabilization unit
- ☐ 23-hour crisis stabilization
- ☐ Crisis stabilization living-room model
- ☐ Crisis outreach
- ☐ Crisis telephone support
- ☐ Crisis peer support
- ☐ Emergency involuntary detention
- ☐ Other, please specify:_____

**Q19b. How are clients referred to your crisis stabilization services?** *(Check all that apply.)*

- ☐ Mobile crisis response units
- ☐ Designated crisis responders
- ☐ Police departments
- ☐ Acute care hospitals/emergency departments
- ☐ Physician
- ☐ Other behavioral health agencies/providers
- ☐ Schools
- ☐ Client's family
- ☐ Self-referral
- ☐ 911
- ☐ Other, please specify: _____

**Q19c. Following an immediate crisis (once the imminent danger is resolved), what types of crisis response services dores your agency provide?**

- ☐ Mobile crisis response follow-up
- ☐ Crisis outreach
- ☐ Crisis telephone support
- ☐ Outpatient mental health services
- ☐ Acute detox
- ☐ Sbu-acute detox
- ☐ Sobering unit
- ☐ SUD intensive outpatient program
- ☐ Mental Health Peer Service
- ☐ SUD Peer Services
- ☐ Peer-run respite centers
- ☐ Same day walk-in behavioral health services
- ☐ Refer patient to SUD residential program.
- ☐ Refer patient to inpatient mental health services
- ☐ Other, specify:_____

## Report citation

Rodriguez, F.I. and Miller, K.J. Crisis Stabilization Services Offered by Behavioral Health Treatment Agencies in Washington State: Results from the 2021/2022 Behavioral Health Provider Survey (Social & Economic Sciences Research Center, Washington State University Pullman, July 2022).

## Appendix G: Summary of Feedback from Roundtables

The original draft technical and operational plan was shared with Tribal governments and urban Indian health programs through a Dear Tribal Leader Letter sent in December of 2021. This letter also established the Tribal 988 subcommittee meeting. Upon meeting with tribal and urban Indian representatives quickly requested that the state establish a formal consultation for both the CRIS committee Crisis Response and Improvement Strategy and the Technical and Operations Plan. To date, HCA and DOH established five roundtables and a consultation to be conducted from May 2022 to September 2022. Below is a summary of feedback from the AIHC and the tribes during the first three roundtables.

**Feedback from the American Indian Health Commission**

| ***Concern*** | ***Applicable Section*** |
|---|---|
| Tribes and Urban Indian Health Organizations perform similar duties to BH-ASOs and should be **included in the overall analysis** of the crisis response system.<br><br>Additionally, many Tribes also have first responders and public safety officers involved in crisis response whose links with 911 and 988 need to be included in analysis and steps. | Recommend adding Indian Health Care Providers (IHCP) and Tribal First Responders to several areas,<br>• Page 10 – include brief description of local Tribal crisis lines<br>• Page 13 - Figure 3 process flow |
| Tribal and Urban Indian Health Organization programs are an under-resourced and underutilized partner in the BH crisis response system. They use a mix of funding sources and have **substantial funding needs that should be included** in the system analysis.<br><br>To assist with system interfacing and compliance, support Tribes with IT solutions, technical assistance and funding. | Include technical assistance and funding for Tribes in areas such as,<br>• Data access and permissions<br>• Cybersecurity<br>• Interoperability |
| Washington State BH crisis response system services need to have **clearly defined warm handoff process** between Tribal and Urban Indian Health Organizations and state/local systems (911, 988, Tribal Crisis Line, Indian BH Hub, IHCPs, Tribal Public Safety and Tribal First Responders).<br><br>(*Example: A case generated by a co-response or mobile crisis unit call should include steps to notify the Washington Indian Behavioral Health Hub and the applicable Indian Health Care Provider.)* | Include in process flows and planning for systems change including software system interfaces. |

| *Concern* | *Applicable Section* |
|---|---|
| Supporting IHCPs as a health home, a central coordinating entity, requires early identification of someone with tribal affiliation in the state system. Recommend intake points and processes that will identify people with tribal affiliation. | Include in process flows asks about tribal affiliation and IHCP care coordination.<br><br>Create data fields that allow for tribal affiliation tracking as an opt in process. |
| Include **Tribal Data Sovereignty** principles in planning. | Use DOH Data Sharing Agreement template language, esp. principles of data governance (collection, management, use, disclosure, and safeguards).<br><br>Page 16 – Data management subsections should reference data sovereignty principles. IHCPs should be listed as entities.<br><br>Page 20 – Add Tribes/IHCP to list of entities needing DSA |
| IHCPs with their own crisis systems will need an API/add-on module/other compatibility software solution to interface with Tribal electronic health records (EHR).<br><br>Tribes will also need funding for Tribal EHR modifications, client referral systems, and other systems to connect to regional systems and the WA Indian BH Hub. | Page 21 – Include IHCP considerations in vendor needs section.<br><br>Page 25 – add Tribes and IHCPs |
| Additional Questions:<br><br>Is Vibrant robust enough to provide the tracking desired by IHCPs, to follow the client through treatment and discharge?<br><br>If there are IHCPs that adopt more robust software, how will those systems connect? | |

*Figure 21 Feedback from the AIHC*

**Summary of feedback from Roundtables not Listed Above**

- Each Tribe is in a different place in dealing with crisis in their communities
- Need to ensure a "no wrong-door" response to crisis call and response
- The Washington Indian BH Hub is looking into the EPIC Compass Rose platform for information on IHCP and tribal services.
- Align with requirements in SB 6259 that requires that IHCPs can access the bed registry
- Law Enforcement need to be trained on de-escalation
- Providers want a robust EHR system, and to not want to have to enter multiple systems.

- Gather information from key tribal partners to identify current and future data analytics and performance metrics.
- Discussion regarding historic and current racism and stigma in the system, including implicant bias that serving the AI/AN population through IHCPs, and tribal governments are taking away from others.
- There is a need for standard contract language, to ensure coordination on behalf of AI/AN persons in crisis
- There is a need for training on Government-to-government data sharing and protections

## Appendix H: 2-1-1 Resource Directory Details

### 2-1-1

2-1-1 is the most comprehensive source of information about local resources and services in the country.[52] There are more than 200 2-1-1 agencies in the United States, each with a team of trained community specialists who assist callers access the local resources and services to address a variety of needs. In 2000, the FCC designated 2-1-1 as the 3-digit number for information and referrals to social services and other assistance. Many different types of organizations operate the 2-1-1 service, including United Way, Goodwill, Community Action Partnerships, and local crisis centers.

Nationally, 2-1-1 call centers provide callers with information and referral to variety of social services including services and supports for: crisis and emergency services, housing, food, health (including mental health and substance use), financial assistance, and transportation.

**Washington 2-1-1 (WA2-1-1) – Operations, Technical Infrastructure, and Standards**

WA2-1-1 has operated in Washington State since 2006 and is guided by Washington State RCW 43.2-1-1 WA2-1-1 is a community information and referral network that has created, uses, and maintains the most current and comprehensive database of community resources in the state with more than 32,000 records as of May 2022. The database includes mental health services and providers, but it is not a comprehensive list.

WA2-1-1 is a not-for-profit organization funded by the state legislature, United Way, and other state and national grants and contracts. In 2021, WA2-1-1 received $3 million ($1.5 million annually) in funding in the state's biennial budget.

The WA2-1-1 system is a decentralized model comprised of seven independent nonprofit organizations that operate 2-1-1 contact centers across the state under an agreement with WA2-1-1. Three of these contact centers are co-located at the NSPLs in the state: Volunteers of America (VOA), Crisis Connections (CC), and Frontier Behavioral Health (FBH). For the 2-1-1 contact centers co-located at the NSPLs, the NSPLs provide separate staff to receive and manage the incoming 2-1-1 calls and WA2-1-1 provides the technical infrastructure used by all 2-1-1 contact centers in the state.

The three NSPLs in the state do not use the WA2-1-1 technical infrastructure.

The WA2-1-1 technical infrastructure includes:

- NICE InContact as the telephony/Call Center as a Service (CCaaS) platform.
  - Should a 2-1-1 call come in and the person is in crisis, warm hand-off protocols are in place and the call taker stays on the line until the call is connected via conference call (using InContact) with the 988 line and the caller says it's okay for them to disconnect the call;
  - At this time:
    - No information is shared between WA2-1-1 and the NSPLs when a call is transferred to a crisis call taker at the NSPLs; and

[52] https://www.211.org/

- Visionlink is the platform to store all call data and support information and referral using the database of statewide community resources (created and maintained by WA2-1-1).
    - Visionlink is described as a platform that offers:
        - A wide range of pre-built, and ready-now solutions (including useful for 988);
        - Permits users to adjust, refine, and create entirely new workflows for new partners and programs using a no-code administrative suite;
        - An Application Programming Interface (API) Builder Toolkit.
        - APIs are used to support multiple types of information exchange, including information and referrals from WA2-1-1 and its partners;
        - Calls, text, chat, email, and telephony integration using Amazon Web Services (AWS); and;
        - Portals for populations, programs, and other needs.

WA2-1-1 is considering an "Active Referral" process with the 988 crisis lines that would (1) enable sharing caller records via Visionlink; and (2) support open and closed loop referrals. This type of Active Referral process would require:

- Funds to design and implement including:
    - Building a Visionlink API to capture 2-1-1 information and pushed this information into the 988 platform; and
    - Building an API that the 988 platform would create to share information with 2-1-1 regarding crisis callers in need of social service information and referrals.

Each 2-1-1 contact center in Washington State is responsible for updating the community resources in the database for their region. Currently, every resource record in the database is updated, at a minimum, once a year according to the national Alliance of Information and Referral Systems (AIRS) standards.

WA2-1-1 follows the national AIRS standards of operation and uses the AIRS adopted Taxonomy of resource data standards to organize its database records.[53]

AIRS establishes standards for information and referral services.

> "The 2-1-1 LA County Taxonomy is the North American standard for indexing and accessing human services resource databases. The Taxonomy is a hierarchical system that contains more than 9,000 fully defined terms that cover the complete range of human services."[54] The taxonomy includes concepts related to social services, mental health and substance use, and crisis services.
>
> The AIRS resource directory standards provide options for "organizing the structure of community resource databases in terms of the relationships between agency information, site information and

[53] https://211taxonomy.org/

[54] https://www.airs.org/i4a/pages/index.cfm?pageid=3386

program/service information, together with the data fields contained within each area. It also includes an API, and various payload formats for bulk data transfer."[55]

The Association of Information and Referrals Systems (AIRS) has recommended the adoption of Open Referral's Human Service Data Specification (HSDS) and API protocols[56,57] as methods of establishing interoperability among 2-1-1 resource databases and associated technologies such as EHRs."

WA2-1-1 uses the HSDS schema to host their online resource directory www.wa2-1-1.org and shares caller data analytics through 2-1-1 Counts https://wa.2-1-1counts.org. WA2-1-1 also utilizes Tableau for generating custom reports on metrics using caller data.[58]

All calls placed to 2-1-1 in Washington State are confidential and are answered by local 2-1-1 Information and Referral Specialists based on the caller's Zip Code. WA2-1-1 contact centers also provide translation services in over 240 languages.

[55] https://www.airs.org/i4a/pages/index.cfm?pageid=336

[56] https://openreferral.org/airs-recommends-open-referral-for-resource-database-interoperability/

[57] https://openreferral.github.io/api-specification/

[58] https://wa211.org/community-data/

## Appendix I: Broadband Infrastructure: Use of Telehealth, HCA and Washington State Broadband Office

As a result of the COVID-19 public health crisis, health care providers rapid transition to using telehealth to enable access to health care services. Providers used video and phone-based communication tools to engage, assess, and treat patients and clients. The CMS reported, "Approximately 34.5 million telehealth services were delivered to Medicaid and CHIP beneficiaries from March through June 2020, representing an increase of 2,632% compared to March through June 2019."[59] Insurers, including the Washington State Medicaid program, expanded coverage to cover services using audio-only and audio-visual tools.

However, the ability to access health, including behavioral health, services using telehealth was found to be limited by several factors. Surveys in Washington State[60] identified the following barriers to using telehealth for accessing behavioral health service:

- Lack of internet and insufficient internet capacity were barriers to using telehealth for behavioral health providers and persons in need of behavioral health services;
- The inability to afford internet service fees and cell phone data plans were identified as barriers to using telehealth; and
- Lack of devices (e.g., computers, laptops, cell phones) need for telehealth encounters were identified as a barrier

In addition, during information gathering activities with NSPLs, BH-ASOs, and crisis service providers the lack of internet and insufficient internet capacity were identified as barriers to using telehealth on behalf of people in crisis. During these information gathering activities, some informants also expressed an interest in using audio-visual, streaming capabilities when responding to persons in crisis.

### Health Care Authority

In an effort to increase use of telehealth, HCA provided the following supports:

- Cell Phone Program: HCA distributed approximately 6,000 smart phones (donated by cell phone companies) to Medicaid clients (including tribal members)
    - Approximately half the cell phones were distributed to agencies that serve homeless individuals
    - HCA chose two cell phone carriers, Verizon and T-Mobile, because they both have networks that provide statewide coverage, and they provided the State with the best price point for service packages

[59]Centers for Medicare and Medicaid Services. Services Delivered via Telehealth Among Medicaid & CHIP Beneficiaries During COVID-19. Accessed: January 2021. Available: www.medicaid.gov/resources-for-states/downloads/medicaid-chip-beneficiaries-COVID-19-snapshot-data-through-20200630.pdf

[60] Surveys conducted by the Behavioral Health Institute on use of telehealth for behavioral health service. The survey report can be found at: https://bhi-telehealthresource.uwmedicine.org/

    - HCA coordinated with the telephone companies to make available 400 talk minutes and unlimited data (texting and internet) per month
    - These service plans are no longer available
- Loaner Laptop Program: HCA distributed approximately 800 loaner laptops to providers (including Indian Health Care Providers and tribal members)
- The laptops were on the low-end spectrum; they worked fine for internet-based work like Zoom, but did not always support additional functional needs of providers' environments
- Zoom Licenses: HCA provided free-of-charge 2,000 Zoom licenses to providers; HCA prioritized making these licenses available to behavioral health professionals and paraprofessionals
- HCA Technical Assistance and Other Activities: HCA provided webinars to provide technical assistance and information to service providers, including behavioral health providers
- HCA supported the UW/Harborview Behavioral Health Institute (BHI), to provide Technical Assistance, Training, and Needs Assessment: The BHI engaged in several activities to support and advance the use of telehealth, particularly on behalf of behavioral health providers and the individuals they serve

### Washington State Broadband Office

In 2019, the Washington Legislature enacted Second Substitute Senate Bill 5511, establishing the Washington State Broadband Office and goals related to access and download/upload speeds for residences, businesses and communities.[61] The goal of the Washington State Broadband Office is to ensure that residents and businesses have access to affordable, reliable, redundant and scalable/future proof broadband technologies. Goals of the state of Washington under RCW 43.330.536:

- By 2024: 25/3 megabits per second (Mbps) scalable
- By 2026: 1/1 gigabit per second (Gbps) all anchor institutions
- By 2028: 150/150 Mbps all residents and businesses

The Washington State Broadband Office makes available funding and distributes information to increase access to broadband in unserved and under-served communities across the State. Funding sources include grant awards from the Federal Government[62] and state appropriations. Funds may be used for the following activities to build out the broadband infrastructure, including:[63]

- Increasing service speeds;
- Building out last mile and middle mile coverage;
- Connecting community anchor institutions;
- Extending internet service where service is lacking;
- Enhancing unreliable service;

[61] https://www.commerce.wa.gov/building-infrastructure/washington-statewide-broadband-act/

[62] For example: https://www.commerce.gov/news/press-releases/2022/02/department-commerces-ntia-awards-277m-grants-expand-broadband

[63] For definitions of key terms: https://www.commerce.wa.gov/building-infrastructure/washington-statewide-broadband-frequently-asked-questions-office/

- Creating more low-cost broadband service options;
- Making available funds to make the internet more affordable through the Affordable Connectivity Program (ACP); and
- Addressing the digital equity and inclusion needs in our communities

## Appendix J: First Responder Stakeholder Interview

07/21/2022

Adam Wasserman, William Leneweaver, Shawna Ernst

- Adam Wasserman – WA state 911 coordinator
- William (Andy) Leneweaver -- deputy state 911 coordinator – Tech expert (expertise in 911 infrastructure)
- Shawna Ernst – IT Manager Spokane Police Dept. – CAD, Dispatching, Law Enforcement Records)

To prepare for likely FCC/SAMHSA implementation/use of the 911 infrastructure, recommend gathering the following information to understand and assess the relative capabilities and costs of using the 988 vs the 911 call intake and response.

I. **Leveraging PSAPs and their infrastructure**

A. Understand the 911 infrastructure, including:

1. NextGen (NG) 911 implementation
2. ESInet
3. PSAP Operations (there are 95 originating service providers in the State of WA)
4. PSAPs are accredited
5. PSAPs use:
6. Call answering system/PBX Computer Aided Dispatch (CAD) software that supports:
    a. Call handling System
        - Call ingress – Where they are taking the call?
        - Dispatch – Who and where they are sending responders?
    b. Note taking at time of call (includes gathering some medical information)
        - Some PSAPs use PROQA to gather this information
        - Could support accessing/sharing bed availability information
7. One CAD system: Spillman Motorola
8. PSAP at the network determines:
    a. When to send/not to send someone to respond to incoming call. They don't have to send someone.
    b. They use geo-spatial mapping to identify caller location.
    c. PSAPs may retain information for longer than 24 hours (depending on how they manage their systems). In the CAD systems, the PSAPs may retain the information for longer periods of time depending on how they manage their systems. For example: In Spokane, the incident location is stored for 3 years. Specifically, if the caller is phoning in from the incident location, then the Spokane PSAP stores the caller's location for that 3-year period. PSAPs do NOT have to send/share caller location information
9. PSAP Record Retention:
    a. State Archivist at the Secretary of State establishes Record Retentions Policy
    b. Retention Policies include:
        - Records are not maintained at the network level.
        - Records are retained at the county level
        - Purging records on a routine basis

II. **Understand current NSPL and RCL call Infrastructure and processes**
   A. What is their current technology,
   B. who are the technology vendors,
   C. what is their workflow?
   D. What are the record retention policies?

III. **Specify the goal of the future state:**
   A. Ideal solution is for the current crisis line infrastructure to be "upgraded" to use the Next Generation 911 infrastructure:
      1. By so doing, the state would leverage the most recent technology and work towards a "seamless" service for Washington residents

IV. **Define what "interoperable" means: state level decision on what type of interoperability is needed**

V. Other notes:
   A. Every 911 call is triaged
   B. 911 will not transfer an active suicide call to 988 (Liability); however, calls that require DCR units (crisis) will be transferred to 988
   C. Currently – PSAP can do a "blind transfer" to a Crisis Line, bridge in an ASO, or have an ASO join and then assume the call (Soft telephone switch)
   D. There are regimented, step by step processes in place at all PSAPs.
      1. However, PSAPs have the ability to apply these processes to the circumstances of their region

VI. CPE – Call handling system

VII. 2-1-1 calls use PSAPs
   A. 2-1-1 calls are not routed with location information

VIII. Next Generation -- NG911 system using NENA i3 has been designed to be a 9xx center
   A. Intrarado is a company that provides /develops technology-enabled communication solutions
   B. Intrarado is the solution to be used by the 988 platform
   C. Intrarado does not use NG911 Nena i3

**Follow-up:**

- 911 team will share an RFP that will point to some of the interoperability capabilities with the current 911 infrastructure
- Shawna will share a proposal (with cost info) for PSAP implementation in 12 fire districts and other settings. Will include a multiplier that could be used to create a ballpark statewide estimate
- Schedule site visit to FBH/Spokane 911 PSAP in ~ Sept.
- Convene joint meeting of experts in 911 and NSPL infrastructure to:
  - Identify infrastructure needs and solutions

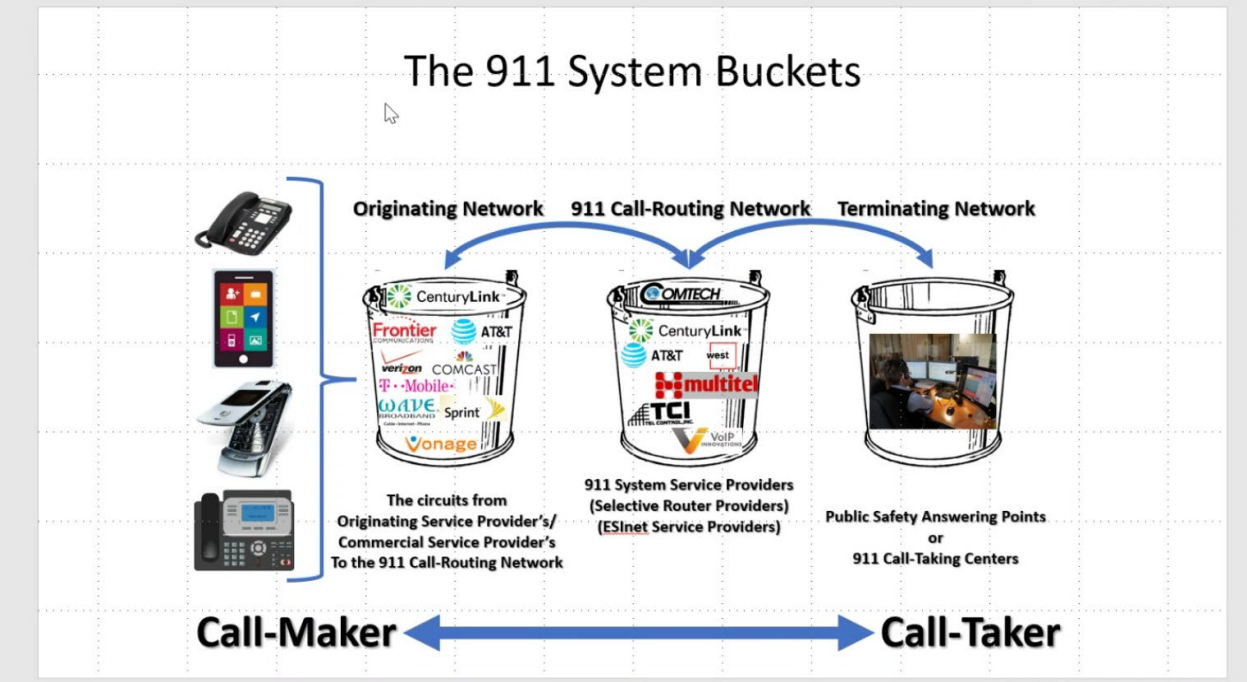


*Figure 22 The 911 System "Buckets"*

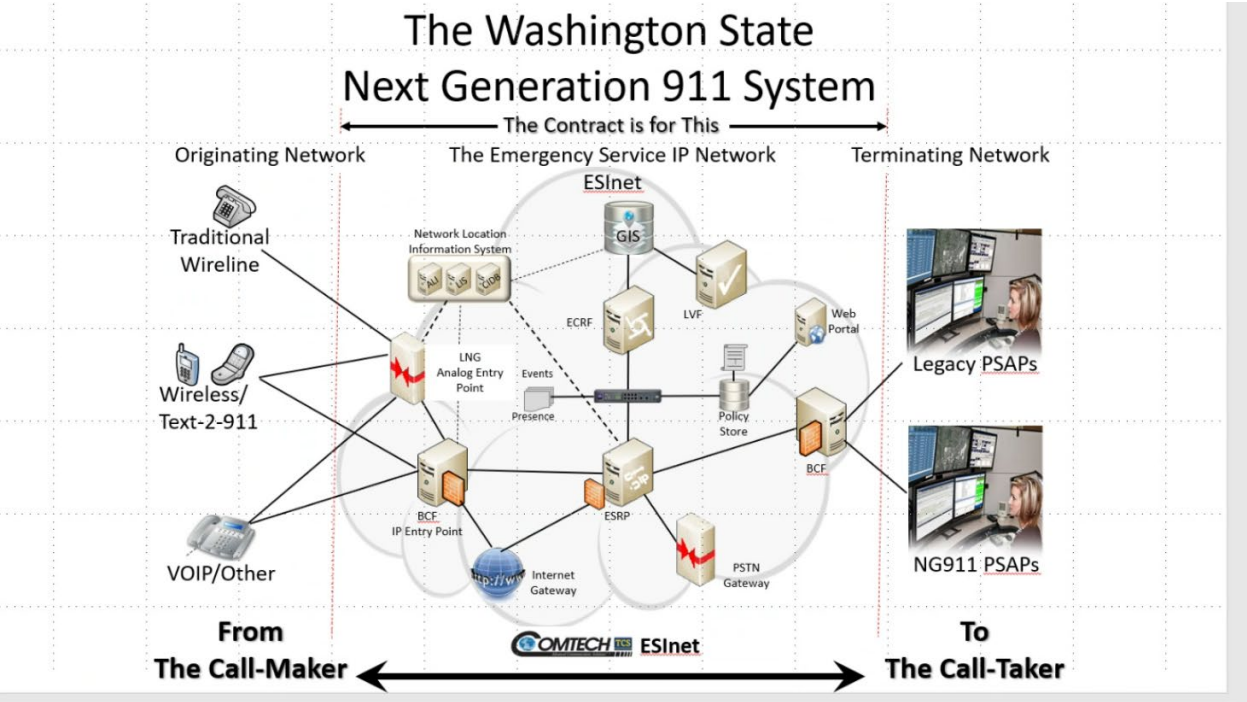


*Figure 23 Next Generation 911 System*

## Appendix K: State Summaries

### Arizona Medicaid and Crisis Technology Overview

- The AZ Medicaid program, AHCCCS, is primarily a fully capitated program (about 9% of enrollees are in an FFS program)
- AZ Medicaid MCO contracts:
  - Include requirements for: regional call centers, MCRU's, and stabilization services
  - Provide funding for:
    - Three Regional BH Authorities (RBHAs) to contract with providers and call centers
    - Four Tribal RBHAs (TRBHA)
    - TRBHA responsibilities may vary based on individual Inter Governmental Agreements (IGA)
- RHBAs are generally paid a "Block" rate for all crisis call lines and services provided to all (Medicaid and non-Medicaid) persons using braided funding (Medicaid, Block Grant, other grants) based on historic spend
- AZ has several crisis call lines:
  - NSPL
  - RBHA regional call centers
  - Tribal
  - Multiple local lines

| | NSPL | RBHA: North | RBHA: Central | RBHA: South | 22 Tribal Governments |
|---|---|---|---|---|---|
| Call Center Vendor | La Frontera and Solari | Solari | Solari | Evolve People Care | May vary based on IGA or independent lines |

*Figure 24 Arizona Vendors*

The AZ NSPL vendor, Solari, will adopt the Vibrant Unified Platform (UP).

- AHCCCS will not require RBHAs to implement the Vibrant UP
  - Effective 10/1/2022, RBHAs will:
    - Contract with a statewide Call Center vendor that meets the requirements to be an NSPL call center
      - RBHAs will do their own vendor evaluations
        - On 4/18/2022, AZ staff advise that the RBHAs agreed to contract with Solari as the Statewide RBHA call center vendor (with multiple call centers throughout the State).
      - The selected vendor must support:
        - Call Center
        - Referrals
        - Provider/Services Registry
        - GPS Capabilities
    - Continue to operate regional crisis lines and centers.
- AHCCCS is building a bed registry and potentially a closed loop referral module that will be available to call centers via the state HIE organization

- AZ wants to "own" its own bed registry out of concern about data loss should a vendor ceases to operate in the state
- AZ is working with a vendor (Contexture the State HIE) to develop a bed registry
- The Call Center vendor will be required to use the bed registry.

- Every quarter AHCCCS engages in Tribal consultation to consider how to improve practices
  - Each Tribe has its own Tribal cultural practices
- AHCCCS needs centralized statewide data for RBHAs and NSPL to track crisis call and response metrics.

**Additional Links & Information**

- New contracts starting 10/1/22: https://www.azahcccs.gov/PlansProviders/Downloads/RFPInfo/YH20/CCE_SOLICITATION.pdf
- Current titled RBHA contract: https://www.azahcccs.gov/Resources/Downloads/ContractAmendments/RBHAs/RBHA_MARICOPA_100121_AMD16_FINAL.pdf
- TRBHA IGAs: https://www.azahcccs.gov/Resources/OversightOfHealthPlans/SolicitationsAndContracts/TRBHA.html
- FAQs: https://www.azahcccs.gov/AHCCCS/Downloads/ACC/View_Crisis_System_FAQs.pdf

## Colorado Crisis Technology Overview

- State Structure
  - 1 Call Center: Rocky Mountain Crisis Partners
  - 4 Administrative service organizations (contract with mobile crisis providers etc.)
- Rocky Mountain Crisis Partners
  - State text & call line
  - NSPL line
  - Calls are triaged and can connect caller to other services such as:
    - Crisis walk in centers
    - 11 Centers (at least 1 per geographic region)
    - Mobile Crisis Providers (24/7/365): up to 1 hour response time in Urban areas and 2 hours in Rural areas
    - Also has ability to initiate health & wellness checks
- Relationship with 911
  - If the call is an active suicide / significant risk, the call center is able to initiate an immediate 911 response
  - This is initiated via telephone

- Tribal Communities
  - Tribal Community suggested that the fact that 988 is a toll-free number should be advertised and made very clear
  - There are unique needs for mobile crisis services, in some communities they are called directly.
  - Need to determine how to fund tribal specific mobile response.
- State Behavioral Health Processes
  - Tracking Follow-up Care: Required to track follow-up at 1, 2, and 5 days following an episode. Call center will also initiate follow-up at 24 hours based on severity – Columbia Suicide Assessment (answer 2 or more questions as "Yes") – evidence-based risk assessment tool used since 2017.
  - Criteria for deploying responders: Rocky Mountain has tools in place that they use – indicate when it is appropriate to send out law enforcement, safety plan establishment,
  - Tracking LRA treatment orders & MH Directives: mobile crisis providers and walk-in providers ask about advanced directives. In a mobile intervention, during an assessment, during a walk-in visit they will attempt to get that information.
    - Discussions about housing this information in the State HIE, there are also ongoing discussions about connecting the crisis center to the HIE.
    - Wait and see approach with Vibrant across the State
- Technology
  - Vibrant Unified Platform
    - Currently going to monitor Vibrant UP roll-out; specifically monitoring interoperability capabilities. Want to better understand the data ownership model and ensure our data is easily accessible to us.
  - Current System
    - Invested in current system to ensure it meets our needs; it is flexible, easy to collect additional information and modify.
    - Does not answer 988 text & chat (calls only) – may need to use 2 systems to allow for text & chat
    - Interoperability is very important; want to review usability and roll-out plans
- Solari & Zoho
  - Call Center: As part of the analysis on call volumes and staffing:
    - Recommended to shift staffing patterns to 10:1 (originally 20:1)
    - Need additional policies to support staff recruitment and retention
      - Funding was provided to work with third party vendor for recruitment and retention
      - Need in-person & remote work options
      - Crisis Line staff require a bachelors level degree
      - Supervisors require a masters level degree
      - 6-week intensive training curriculum
      - Peer line is separate but also available

- Referrals & Outpatient Scheduling: Currently a manual process (Phone, Warm hand-offs)
- Provider/Service Registry: Call center has robust resource and referral directory that they update.
  - Currently completing a gap analysis of directory.
  - Paid call center to develop the system & registry – same one Arizona uses. Found it to be very prescriptive.
  - Ladders is also a service we have where people can look up services needed. https://www.colorado.gov/ladders
- GPS Capabilities: Currently this functionality is not available; need to address before promoting 988 services
  - Need to address call routing (Priority) as 25% of Colorado residents have out of state (OOS) area codes
- Bed Registry: In the process of implementing Dimagi for Bed Registry services (www.dimagi.com)
  - Will be used for bed availability
  - Will be updated once per day
- Technology Buy-in from providers: adding to contracts with MSOs to meet requirements of bed registry use

## Georgia Crisis Technology Overview

- State Structure
  - 1 call center (GCAL) in Georgia addresses all NSPL calls
    - NSPL calls are a small percentage of overall volume (statewide)
  - GCAL answers majority of other calls through the 1-800 number
    - Caller gets an automated directory
    - GCAL provides crisis assessment, triage and is informational
    - Access to clinicians and non-clinical resources (call takers)
    - Non-clinical people answer the calls and clinical resources are used when clinically necessary
    - 24/7/365 availability
  - GCAL is part of Georgia collaborative
    - 3 different providers that come together to form the Georgia Collaborative
    - Direction of Beacon ASO – they are the lead agency. BHL & Clarence are the others.
    - One of Beacons responsibilities is maintaining providers and services available as they are credentialed. That list of credentialed services are sent via SQL to be loaded into GCAL.
    - In addition, there is a group of informal resources that are managed through BHL for crisis access teams (includes AA groups, food banks, etc.).
      - Social services requests should be directed to 2-1-1 but can provide some informal resources

    - Mobile Crisis Dispatch
        - 159 counties in GA and it is available 24/7/365 – comprised of 2 main contractors
        - When someone calls GCAL and it is determined they need a mobile crisis assessment, GCAL works with the MCRUs to dispatch. We have dispatchers on staff, and teams use GPS (Behavioral Health Link uses tool) – determine closest team to respond.
        - They use cell phones to track. MCRU teams are set-up to be 2-person teams for safety and representation. Teams are comprised of a clinician and a certified peer specialist. They use the LOCUS Assessment tool – determine next steps. Goal is to get person served in least restrictive setting.
- Relationship with 911
    - Currently developing scripts for 911 operators to help transfer calls to 988
    - During a live rescue situation there is direct line to 911 call centers in Georgia
    - If 911 needs GCAL resources, there is a direct line they can use
- State Behavioral Health Processes
    - Tracking Follow-up Care: In Georgia, the last provider that worked with the individual is responsible for the follow-up. Outside of mobile crisis, our system does not have a way to track the follow-up. More robust tracking and follow-up tools and processes are currently being worked on.
    - Metrics being tracked
        - GCAL: The length of call wait time, total number of calls, abandonment rate, dispositions (referred to mobile crisis, outpatient, etc.), etc.
        - MCUs: Average response time, # of minutes for arrival on scene, time for assessment, time for linkage, demographic data (call related to SUD, mental health, etc.; age, location), outcomes, etc.
    - Tracking LRA treatment orders & MH Directives: track 10-13's that are written by the mobile responders and also track any existing crisis plans
        - Utilize Stanley Brown for crisis assessment – the safety plan is associated with that. It is an advanced directive that gives details on who to call, what you can do, etc.
- Technology
    - Vibrant Unified Platform
        - Will not be adopting Vibrant
        - Current platform has multiple integration points – DBHDD, Medicaid office, BHL, etc. Would lose functionality by moving to another platform. Would need to run two systems to keep the integrations.
    - Current System
        - Behavioral Health Link Platform which operates the call tracking, GPS for mobile crisis dispatch, and EHR for real-time disposition tracking, outpatient scheduling, and bed inventory.
    - Call Center Platform: GCAL (Built by BHL)
    - Existing Tech/Processes: Referrals and Appointments, Live Bed Board (bed registry), Responder dispatching, standard reporting
- Current Functionality
    - Call Center: Currently have known caller and unknown caller lines.

- Known callers go to a person who doesn't have a bachelor's degree or has a bachelors but not clinically focused. These tend to not be individuals in crisis.
- Unknown calls go to a person who is trained in crisis. All NSPL calls go to unknown line.

- Referrals & Outpatient Scheduling:
  - Approximately 9 years ago, there was a requirement that all providers give open appointments to GCAL for scheduling. We still have some providers that give us appointments
  - Numerous referrals for non-urgent care.
  - If it is urgent, may send out the mobile crisis team. May incorporate 911 for active rescue.
  - Use Columbia Suicide scale to determine if a person needs an active rescue.
    - Chose assessment because it has ratings tied to it and a validity scale.
- Provider/Service Registry: One of Beacons responsibilities is maintaining providers and services available as they are credentialed. That list of credentialed services are sent via SQL to be loaded into GCAL.
- GPS Capabilities: GCAL does the mobile dispatch – GPS enabled for all responders in Georgia. Tracked on the phone.
- Bed Registry: We have a live bed board. If you are provider for crisis stabilization, we bought 10 beds from them. The crisis stabilization provider has a responsibility to place a person on the bed. Must accept patient off of bed board.
  - Aim to update within the hour, however staffing/resources challenges can increase the time
  - Majority of units are funded & contracted by GCAL.
  - Track all state funded beds through the bed boards. *There are 5 facilities that we do not fund and therefore do not track.*
- Technology Buy-in from providers: GCAL pays for the beds, but you don't get credit or paid for the beds without putting in the authorization. Only way to put in authorization, is to use the bed board. It is tied directly to their payments.
- Portal Access
  - Currently working on an ER & Jail portal for real-time disposition tracking
- EHR Integration
  - Integration between community safety boards and GCAL for registration, discharges, etc. Integration happens 3 times a day. Our safety board EMR's include NetSmart, and others. We also have integration between Beacon's DBHDD's EMR. All clinical notes, authorization data, etc.
  - Call operator has access to call records if person identifies themselves. Those call records do not go to Beacon unless there is an authorization. Operator can look up Medicaid number the person's treatment plan – in GCAL you can see treatment history through Beacon integration and can have provider contacted instead of mobile crisis team.
  - Call center to provider is only referral being tracked.

- Ideal “Perfect World” Functionality:
  - Increase dashboard availability – key to seeing what is happening live.
  - Self-reporting and customizable reporting. Standard reports: Daily call log (# of calls received), weekly average speed to answer, weekly abandonment rate, weekly hold time, weekly staffing report, monthly reports and quarterly performance reports.
  - Portals for simplified provider entry – jails, judges, EDs, etc. need a way to access the system. Want to ensure they have portal access.
  - End of authorization closes loop instead of requiring discharge.

## Illinois State Crisis Technology Overview

- CESSA – Community Emergency Services and Supports Act – Illinois law that requires 911 to coordinate with mobile mental health response services being developed by the Illinois Department of Mental Health
- State Structure
- 11 emergency services medical regions in the State, within region has resource hospitals and each resource has a medical director and has providers / responders that they work with
  - CESSA requires the regional committees to think through how to incorporate 988 into the emergency response work, including how to transfer a 988 call from 911 to 988
    - Developing scripts and processes
  - Currently if a call goes to 911 and someone is concerned about public behavior, law enforcement will respond – working towards documenting process and policy to define what is meant by a BH Crisis that does not require a police response; non-violent misdemeanor – no police, should be sending mental health resources (language referring to “if it is safe to do”) is making it harder to implement BH responders and not police, need a co-responder model
- Developing – alternative / community-based model (like Eugene, Oregon model)
- Will need to be rolled out in coordination with the 11 regions
- Legislation is very prescriptive – requires a statewide advisory committee and 11 regional committees - statewide will serve a technical support function; decision making is with the 11 regional committees / medical directors
- Currently doing the research for technology models and recommendations
- Will have some statewide processes & standards and some will be customized per region
- Virginia has a detailed plan
- Some counties in Texas and Oregon (Eugene – Cahoots model)
- 911 operator oversees the 180 PSAPS
  - PSAPS (Public Safety Answering Point) contract with private sector vendors to develop scripts and protocols
  - Organizations recognized by NENA: APCO, PowerPhone, Priority Dispatch
  - Scripts have assessments – go through risk stratification and each risk stratification coincides with the type of resources will be dispatched
  - Moving to GIS technology in phases; (geographic information systems)
  - Looking to use PSAPs to identify location of the caller

## Indiana Crisis Technology Overview

- State Structure
  - Three NSPLs (before pandemic there were five)
  - 78% answer rate – higher than the past
  - Coverage 24/7 in 89 counties
  - Are hoping to expand operations and onboard two new NSPLs to support 988
  - Building own unified platform for all of the centers - vendor to provide technology to build it and IT will oversee and implement the solution
  - None of the RCLs are currently affiliated with NSPLs
  - Goal to align with SAMHSA
  - Currently warm hand-offs but not through technology
  - No linked technology
  - Currently bed registry is not connected to NSPLs, and it is a manual process
- Tribal Communities
  - Currently engaging with Tribal communities to better understand requirements
- Technology
  - Currently there is an RFP that is out for a vendor the Indiana team will work with to build a unified platform. The new platform will be similar to what 2-1-1 system is currently on and the goal is that both 2-1-1 and 988 will be on the same platform.
    - The intent with the new platform is to address current frustrations and provide more integrated and seamless services.
      - NSPLs have provided feedback and expressed frustration with iCarol
  - Decision is still pending on whether or not Vibrant UP will be used; would like to integrate with Vibrant as much as possible.

- Resource Directory – currently using 2-1-1 and Aunt Bertha
  - There is a committee working on developing and reviewing resource information to ensure the information is correct & current.
  - Working with local system of care coordinators to document resources
  - Most resources updated annually
  - Aunt Bertha requires that resources update their own guides
- Lessons Learned (thus far):
  - Started with a very large group of stakeholders; should have streamlined more
  - Should have implemented a stronger 988 Strategy & Governance earlier in the process
  - Set a vision early and remain focused on the vision
- Follow-up:
  - Team will share their RFP as soon as they are able

## Maryland Crisis Technology Overview

**State Structure:**

- Could you give us a brief description of your provider and call center structure?
  - 988/NSPL: 8 call centers throughout Maryland. 3 of 8 handle text and chat. Started providing funding for those NSPL centers.
  - 2-1-1 press 1: Statewide crisis hotline. Of 8 NSPL centers, we have 5 centers for 2-1-1. These 5 centers double as NSPL centers. 2-1-1 & NSPL call lines handle roughly the same volume of calls. 50% go to 988 and 50% go to 2-1-1. 988 calls may not be from Maryland, but 2-1-1 calls are from Maryland.
  - NSPL centers run by independent vendors. Each are accredited. Training & education requirements meet accreditation standards. Require call takers have access to masters-level clinicians. They may pass it off to mobile crisis team or referral to a provider out of resource database.
- From our understanding, your Statewide call line is integrated with 2-1-1, how do you differentiate between regional call centers and NSPL call centers?

**Technology Platforms:**

- Do you plan on adopting Vibrant's Unified Platform, why or why not?
  - Will be up to each individual call center. A lot of the call centers also do additional work (e.g., domestic violence work) and they are using same EHR for both streams of work. This is a consideration that these organizations need to consider whether they want to switch.

We understand you use the iCarol Platform which operates the call tracking, GPS for mobile crisis dispatch, and EHR for real-time disposition tracking, outpatient scheduling, and bed inventory.

- Can you walk us through the iCarol Functionality at a high level?
  Call Center –
  Referrals and Outpatient Scheduling – They report outcome data through Vibrant.
  Provider/Services Registry – Each center has their own referral list. For 2-1-1, iCarol is used for the provider registry. Each center has the module for provider registry. They add and update resources in iCarol. We also have an organization 2-1-1 Maryland incorporated – middleman

that helps to maintain database. Shared list between all five 2-1-1 centers. We are building a public facing resource directory that we are hoping to use for public. The 2-1-1 centers select the resource they referred a caller to as it is recorded in the disposition. 2-1-1 Maryland contracted (part of United Way) to build provider registry – do not have capacity and wouldn't recommend contracting with outside agency.
GPS Capabilities –
Bed Registry – Working on bed registry in Maryland to track residential facilities. Calling in twice a day to understand availability. Working on statewide registry for appointment available.

**Implementation:**

- What considerations had to be made for tribal communities?
  - We received grant to do some specialized training – in beginning stages.
- Are you implementing tools to track real-time provider availability?
  - County specific – some call centers have a closer relationship with crisis units. Beginning stage of care traffic control tools like GPS tracking of mobile crisis.

**State BH Processes:**

- How do you track follow-up care as people transition from crisis care to non-crisis care?
  - Not tracking this level of metrics. Calls are confidential and look to maintain anonymity. 80% of calls end with talk intervention and resource information.
- Do you track LRA treatment orders & mental health advanced directives?
  - If so, how?
- For iCarol, are all centers using it?
  - All 2-1-1 press 1 centers are. Five of the eight NSPL centers use the same system. The other 3 do not use iCarol – using other vendor platform or in house system.
- The NSPL call centers provide disposition information to Vibrant but unsure how to get it back from Vibrant. No way of getting statewide NSPL center information. State did not fund the centers previously and did not have oversight into their activities.

## Michigan (MiCAL) Crisis Technology Overview

- Michigan Custom Salesforce CRM developed
  - Houses regulatory processes, used of Michigan crisis line, 988 crisis line, and after-hours crisis call coverage
  - Started with RFP process which allowed us to see other state platforms which was helpful
  - Capabilities of MiCAL system
    - 3 environments for CRM – live CRM, testing CRM (demo is in), and training CRM
    - Create New MiCAL Encounter
      - Fields: Subject, Caller Type, Primary Reason for call, Anonymous?, Caller Hang up
      - *Note that we had mandatory fields but when we check caller hangup then they are no longer required – didn't want folks to fill in fields with filler data
      - Link to person account or create a new one
      - When their person account pops up there is an Active Crisis Alert Found – identified that this person needs special support
        - Triggers, suggested plan of action, if a person is receiving ACT that has a specialty crisis care with it, etc.
        - Alerts expire after 120 days
        - Need to select that they have read the alert to proceed
      - Then fill out the details of the encounter, benefit information, Safe-T Assessment, Safety Plan, 2-1-1 Search

        - ADT doesn't display exact diagnosis – only shows minimum information necessary. Indicates physical or BH. Not commonly used functionality.
        - Safe-T assessment is mandatory for 988 calls
            - Bar indicates risk level
            - Research-based assessment that Common Ground recommended
        - Integration with 2-1-1
        - Were in discussions with OpenBeds – they mentioned they would house all the resource directory and then we are integrated with them. We will reach out to search within their database for BH services available. Eventually they will result all BH resources regardless of payer type. We are also partnering with Michigan MyCare which is rolling out the OpenBeds.
            - Didn't want to also maintain resource directory – integration seemed to be the most effective to ensure no data conflicts
        - For referral: Require our key stakeholders to fill out core crisis services that they provide
        - Consent for sharing information field in CRM – ask client if we have consent to share encounter with provider. Can also share with a provider not on the portal.
        - Can conference provider into call with client
        - Can then complete New Referral paperwork
            - Select who doing warm handoff to, communication method, etc.
            - The referral then prompts to do follow-ups. This is a follow-up task that will go to a supervisor queue and then they can assign it to someone.
    - Partner Portal
        - CRM sends email saying that you have a referral in partner portal
        - Partner logs into portal and can see the referral from the CRM
        - Click into referral to acknowledge that it has been received
        - Report goes to MiCAL on acknowledgement of referrals
        - Can pull up PDF Encounter Report to print and provide to my staff that are going to see the patient.
- Medicaid carve out state

**Discussion Questions:**

- Does Michigan use Medicaid funding?
    - Yes
    - 90-10 split for the development
- How long did it take MiCAL to be rolled out
    - RFP in Summer of 2020
    - Started building in July of 2020
    - Went live in 2021 – rolling it out statewide right now. Intend to be fully rolled out by end of Oct 2022

- Will OpenBeds be used for just the resource directory or bed tracking as well?
  - OpenBeds will be used for resource directory and bed tracking
  - 988 staff are not sending staff to psychiatric hospitals, we want them to have a face-to-face visit prior. A psychiatric hospital may not know all resources in community and do not want to encourage restrictive setting and high hospitalization rate.
  - Our 988 staff are not highly trained – doing peer support model
  - Eds will also access OpenBeds directly – helps to avoid them needing access to the CRM. Prefer them having access to OpenBeds.
- Does this Platform have mobile crisis team dispatch?
  - Salesforce can do it – Michigan currently doesn't have this functionality
- Anticipating integration will be available – Salesforce is working with Vibrant
- **New Jersey is also looking at Salesforce and Open Beds.** What is the extent of development – was this out of the box solution?
  - Used Accenture for solution development. Design process – Michigan told Accenture what they wanted for MiCAL, Accenture would lead design and demo it for Michigan. Accenture then developed and Michigan tested it. Iterative development with Accenture started in July of 2020. Accenture worked off of the Salesforce product – they are a design firm for Salesforce.
  - We talked to many firms. We have been really happy with Accenture.
- Spent a lot of time in our RFI process talking to Georgia, Colorado, etc.
- Was there an estimated cost to providers?
  - State covers the cost – no cost to providers
  - We have 3 types of licenses – type that gets into the CRM (full access), licenses for partners to access partner portal (full license if access is often, and partner portal for those only accessing once a month (pay by the number of logins)
  - Licensing is a really important thing to think through. In addition to pay for cost of licensing, you also need to manage the licensing.
  - What is managing cost?
    - Now that it is set-up, it is not a significant portion of time – couple hours per week.
    - One of the things we did, in the partner portal they send a request for the type of authorization – from the management side we just approve the request. Management of the licenses is not a huge deal
  - How many licenses do you have?
    - Common Ground (call center that operates our 988 center) also has 150+ of full license
    - State staff 60 full licenses
  - Cost?
    - Salesforce full license $2400+ per year (under $3000)
    - Not many have that full license
    - Salesforce licenses are named licenses – so all part-time or full-time staff need them
  - Maintenance cost for system also needs to be considered
  - Interaction with 911?
    - Developing best practice standard – have not gotten into the technology
    - We are also not going to have technology to actively track MCRU

- How are other states doing referral to psychiatric hospitals? This is an area where we are least likely to pursue.
  - Mary Jean (NJ) – I agree the goal for us is diversion from that system. The goal is to look for community-based alternatives. For us, the bed registry is a combination of useful and mandatory.
  - CJ (AZ) – We don't currently have a bed registry – hoping to stand one up. Our purpose to give MCRU's easy access. Our goal is to resolve as much as we can by phone, if not successful send out MCRU, and then if they determine we need higher level of care they can see who has open beds. This is a huge time consumer for us – calling around to find beds.
  - KH (MI) – That is why we want MCRUs in MI to have direct access to OpenBeds.
- 988 asks for a lot of things in parallel
  - Mary Jean (NJ) – It is a circus; we will do a phased approach. With your permission, we would love to look at your solution.
  - Michigan – we feel we have a good prioritization of what to develop.
- Was Salesforce previously providing services for your agency, prior to using it for the call center CRM?
  - Yes, we used them for other applications in the state.
- Both Accenture and Deloitte were certified in Salesforce, and we went to Accenture.
- **If there is information your technical team is interested in – reach out to Dennis Carol or Krista Hausermann**
- Reporting?
  - We haven't maximized our data reporting yet. We have dashboards that we have built out. Using them currently to help guide staff training and fields we changed to mandatory. Tracking encounters shared. Tracking # of referrals. Rate of referrals. Rate of anonymous calls.
- How did you obtain buy in, or did you require all providers to maintain/update the services and resources? Are non-Medicaid providers included in the referral listings?
  - Required providers to update it. We engaged them from the start and require them to update through the portal. For non-Medicaid providers they will come in through the OpenBeds platform. We have some providers in the CRM provider portal. They have been part of every stage of design – they come in at the demo phase and business process.
  - Do they feel that it is duplicative to have to update this system, as well as Open Beds?
    - There aren't many providers that do it. They are in it for regulatory processes as well. As we take over their after-hours on call as well, they want us to have this information. They don't love it, but they aren't complaining.
- SB: Has anyone considered the free version – Vibrant Platform or had experience with it?
  - CJ – we discussed it but unable to select the data to come so we started building our own. Hoping to be aware of future integrations.

## Oklahoma State Crisis Technology Overview

- Oklahoma Department of Mental Health and Substance Abuse Services
  - ODMHSAS has a plan for Oklahoma's Comprehensive crisis response which includes 988, mobile crisis teams, follow-up appointments, integrated technology, transportation, and adding facilities
- State Structure
  - Department of Mental Health partners closely with Health Care Authority
  - DMH holds state match for Medicaid services. Not a managed care state.
  - Directly operate 11 different facilities across the state.
  - Network of community mental health facilities –
    - 4 are state operated.
    - Also have state hospitals & residential crisis services.
  - Early adopters of CCHB model.
    - To be a CCHBC, must be responsible for crisis services in area to higher level.
    - Should have 23 urgent recovery centers across the state by end of this year.
    - Community-based crisis care, and mobile crisis care are also components under CCHB.
- There are 2 NSPL Centers
  - Tulsa
  - Oklahoma City
  - While working on the Vibrant Planning Grant key differences were noticed in how each of the NSPLs provided services. To address this, a crisis continuum plan was mapped out.
- Regional Crisis Lines
  - 5Warm Lines
  - 2-1-1
  - Tribal Crisis Lines
  - Veteran Services
- RFI to RFP Process
  - RFI was issued to gather information
  - Worked on RFI for approximately 6-9 months to ensure it captured all of our requirements
  - Drafted an RFP based on information gathered from the RFI process and as part of the RFP specifications included a large technical section: EHR Component of the Call Center, 3rd Party Billing, Outpatient Scheduling, Dispatch of MCUs etc.
- Call Center RFP
  - Awarded to a new entity that is not an existing NSPL in Oklahoma.
  - Intending to build and have system up and running in July.
  - Emphasis on connection to rest of the crisis network – including connection to warm line services. It was also important for us early on to partner with 911
  - Important to get decision criteria & partnership with 911 "right" prior to going live.
    - Need appropriate routing
- Data Management
  - Currently partner on payment of claims data
  - House prior authorization data, collect data elements at every stage of contact and every 6 months for re-authorization.
  - Also collect individual service data (type of service, level of care etc.)

    - Data sharing agreements with entities across the state:
        - Oklahoma Employment, DOC
    - Prior to implementation will review data connection protocols
    - RFP includes a detailed list of metrics
    - Information is collected and housed via a single Medicaid claims system (similar to HCA Provider One)
    - Access through website for provider specific reports
    - Outcome based payment process, some KPI's related to crisis services
        - Portion of contract is paid based on outcomes
    - Future functionality will include electronic dispatch and information sharing to allow for the crisis line to exchange clinical data.
- Technology Platforms
    - Vibrant UP not being implemented (Vibrant UP implementation timeline did not line up with 988 dates)
    - Solari was selected as the Call Center Platform
- Financial Overview
    - In Oklahoma the funding source is a combination of third-party payment sources.
        - Reimbursement for fee for services & operational budgets
        - RFP has first year initial contract of $2.8 million.
- 988 FAQs:
    - https://oklahoma.gov/content/dam/ok/en/odmhsas/documents/about/public-information/grants-and-solicitations/Call%20Center%20FAQs%2006082021%20(1).pdf
    - https://oklahoma.gov/odmhsas/treatment/comprehensive-crisis-response.html#:~:text=What%20is%20988%3F,help%20are%20happening%20every%20day.

## Oregon Crisis Technology Overview

Oregon has two 988 NSPLs. One of the Call centers covers the entire state. The other covers 2 counties.

- NWHS: Northwest Human Services
- LFL: Lines for Life

The NSPLs do not dispatch crisis responders.

County Mental Health Programs (county behavioral Health providers) employ and deliver crisis services

- The County MH System advocated to maintain responsibility for dispatching crisis services

The Oregon Rules Advisory Committee has published draft rules that require:

- If an NSPL requests that a mobile crisis team be dispatched, the County must dispatch. It is not discretionary to dispatch crisis services.

All County MH Programs also have crisis lines.

## KPIs:

**NSPLs**

- Oregon anticipates that for the 1st years after implementation of 988 that the state will employ a hybrid model where both calling the county crisis lines and the 988/ NSPLs will be supported
- Oregon is developing KPIs for the 988. Oregon will share these KPI at the end of the month. For example, the KPIs will address:
  - Who requested the dispatch?
  - Was the team dispatched? If no, why not?
  - Once the tam was dispatched, who stayed with the individual?
  - When co-responders are required, (e.g., law enforcement, EMS) were they dispatched?
- KPIs will gather information about how operational things are playing out.
- Oregon requires the 2 NSPLs in the State to develop policies and procedures, including what are the protocols for dispatching mobile crisis teams. Over the next couple of years Oregon will evaluate these policies and procedures.

**System level KPIs.** For example:

- Oregon is looking to enhance crisis services. To assess whether mobile crisis teams are set up for success:
  - Do they have resources to be successful, including do they have:
    - Out-patient providers
    - Walk-in services
  - What are their annual staff retention and recruitment rates?

Challenges:

- County MH Programs are not on the same EMR.
- Half the state is not technologically advanced
- There is significant variation in PSAP utilization and operations across the State

PSAPs in Oregon have several challenges.

- 911 calls are not linked via PSAPs.

Oregon has a workgroup with 911 PSAP representatives, including Oregon Office of Emergency Management.

- Scope: develop a Statewide 911 Roadmap for partnering entities.
- Landscape analysis across PSAPs found:
  - Great variation across PSAPs. For example:
    - Portland PSAPs seems to be better -- e.g., they have protocols for coordinating the BH crisis line
      - Oregon may scale up the Portland practices statewide

Next Steps:

- Do a lot of education with 911 PSAPs including:
  - Addressing liability and building confidence that when a call is transferred from 911 to 988 that someone will answer
  - 911 needs to know:
    - What resources are available
    - MH 1st Aide
    - Ability to share telephony technology with 988
      - For example: the 911 in LA County shares the telephony system with 988 to ensure seamless transfer of calls

Oregon has the Department of Public Safety and Training that provides public safety training for Law Enforcement

Oregon is following the protocols from the American Association of Suicidality (AAS) https://suicidology.org/

- NSPLs are required to be certified/accredited by the AAS

**Oregon shared the draft NSPL contracts which for example makes contingent** 30% of funds on submitting policies and procedures for:

- A plan to provide text and chat services. This plan must include a date determined by the contractor that is feasible to implement text and chat services and be approved by OHA.
- Policies and procedures for ensuring culturally, linguistically, and developmentally appropriate services.
- Policies and procedures with each County Mental Health Programs to dispatch mobile crisis and Mobile Crisis Teams
- Policies and procedures to warm transfer callers to non-crisis and nonemergency resources; Youthline; Alcohol & Drug line; Veteran's Crisis Line; and the Oregon Behavioral Health Access System call lines.
- Policies and procedures for transfer of calls to and from 911.

**Draft contracts for Oregon 988 call centers: Open for public comment June 13-20, 2022.**

- Lines for Life https://oregon.gov/oha/HSD/AMH/docs/Draft-988-Call-Center-contract-LFLpdf
- Northwest Human Services https://oregon.gov/oha/HSD/AMH/docs/Draft-988-Call-Center-contract-NWHS.pdf

The draft contracts include requirements related to:

- Data Requirements including data to be collected regarding:
  - Individuals and families in crisis
  - Data mobile crisis responders are required to collect
  - SOGI regarding type of DEI categories for which data is to be collected

A consultant provided a useful starter list of data to be collected.

Oregon will share its landscape assessment/analysis of 911/988

Oregon is looking for a system that can be implemented statewide.

Oregon has had discussions with:

- BHL
- Solari
- AWS

Oregon has spoken with:

- AZ
- GA

Oregon will be implementing a soft rollout of 988.

https://namior.org/may-public-policy-update/

## Appendix L: Vendor Descriptions & Categorization

| VENDOR | DESCRIPTION | DOMAIN |
|---|---|---|
| Vibrant Up | VibrantUP provides call, text, chat, and online mental health services by way of 20 different national and local hotlines set up. Notably, they have they the National Suicide Prevention Lifeline which provides 24/7 support. It is a national network of local crisis centers in the United States launched by the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) in January 2005. | CALL CENTER AS A SERVICE (CCAAS) / TELEPHONY |
| Nice CXOne | Nice CxOne, recognized by Gartner as Magic Quadrant Leader for Call Center as a Service (CCaaS) uses a cloud platform that can be customized to meet customer/user needs. There are multiple digital entry points such as mobile, web and application, uses AI to guide users through a journey and has digital queues to prepare call center agents. It is a smart and scalable platform that works well with different layers of certified security including HIPPA. | CALL CENTER AS A SERVICE (CCAAS) / TELEPHONY |

| VENDOR | DESCRIPTION | DOMAIN |
|---|---|---|
| Cisco | Cisco is a widely known technology conglomerate that houses multiple IT solutions and platforms. It provides a cloud solution for new or current standing contact centers with the ability of moving already existing ones onto their cloud services. Cisco solution revolves mostly around work from home and remote agent capabilities as it leverages WebEx. The City of Buffalo has also been using this solution among their ministries with success. | CALL CENTER AS A SERVICE (CCAAS) / TELEPHONY |
| MiTel | MiTel is a telecommunications company that launched a CCaaS solution in 2018 to provide a cloud enabled contact center. This contact center solution provides analytics, omnichannel capabilities and simple set up. The MiTel solution is an over the shelf software that does not require any equipment for deployment, it works with any call control platform and can easily integrate with a range of third-party CRM applications. It also supports remote workers, an entire virtual workforce including administrative staff. | CALL CENTER AS A SERVICE (CCAAS) / TELEPHONY |
| Genesys | Genesys is a software company that focuses mainly on enterprise call center solutions. Genesys offers personalized experiences through multiple channels and devices and includes a comprehensive stack of capabilities in one single solution, leaving disparate tools behind. This solution also provides consistency in accessibility by using email, chatbots and social media. This allows for convenience 24/7 through chatbots that are also able to escalate complex issues to live agents. | CRM/CONTACT MANAGEMENT SOFTWARE |
| Salesforce | Salesforce is a cloud-based software company that provides a customer relationship platform with multiple categories and capabilities focused on sales, customer service, marketing, and application development. Salesforce has entered the CCaaS arena by providing a Service Cloud Voice solution. It allows integration with existing contact center solutions to elevate the voice experience through digital channels, centralized interface and AI powered recommendations. | CRM/CONTACT MANAGEMENT SOFTWARE |

| VENDOR | DESCRIPTION | DOMAIN |
|---|---|---|
| ABHS Salesforce<br>  | Since the Federal Communications Commission (FCC) mandated that states adopt 988 as the national number for suicide and mental health, Accenture has spearheaded a solution, Accenture Behavioral Health Solution (ABHS) Salesforce. ABHS facilitates omnichannel communication between state agencies, mental health providers and individuals who need help. It provides omnichannel engagement by phone, text and chat, a command center platform and interoperability with any external systems. |  <br>CRM/CONTACT MANAGEMENT SOFTWARE |
| iCarol<br>  | iCarol is a software focused on helping a range of people and organizations with a focus on helplines, charities, non-profits, crisis centers and other community programs. iCarol was one of the first commercially available subscription software is built specifically for crisis, helplines, and referral systems. Their solutions have served school districts, healthcare public sectors and governments alike. Being a web-based system, iCarol can provide service required by IT departments at one monthly subscription price, it is easily managed and kept up to date. |  <br>CRM/CONTACT MANAGEMENT SOFTWARE |
| BH Link<br>  | Behavioral Health Link is a platform providing behavioral health services by way of call center crisis hubs, 24/7 GPS enabled mobile services, crisis now software solutions and more. Beginning in 2006 through a collaboration with Georgia Department of Behavioral Health and Development Disabilities. It was the first time that individuals anywhere in Georgia could call one toll free number for crisis care. It comes in forms of a call center platform and a mobile app for individuals. |  <br>CRM/CONTACT MANAGEMENT SOFTWARE |

| VENDOR | DESCRIPTION | DOMAIN |
|---|---|---|
| Collective Medical | Collective Medical is a PointClickCare company that helps care teams collaborate and support vulnerable populations whose needs may not be met in any single existing department. It connects members from each care team on one collaborative platform which allows for better patient outcomes, especially in behavioral and mental health. Collective Medicals primary focus is the EMR platform with an emphasis on ED and referrals. |  CRM/CONTACT MANAGEMENT SOFTWARE |
| NetSmart | Netsmart is an organization with numerous technology solutions fit for multiple sectors. The EHR is it can cater to multiple specialties, the main one being myAvatar that focuses on behavioral health. It offers a recovery focused suite of further solutions and plug ins to manage real time analytics and manage call center requirements and more. |  EMR/EHR |
| Epic | Epic is a known name for health solutions and technology, most known as EHR. The EHR is unique in the sense that it has contact center integration capabilities. It brings EHRS together with contact centers to provide a better experience and quick responses. The system is easily scalable and encompasses call, text, and appointment/referral features. |  EMR/EHR |
| CareLogic | CareLogic is an EHR platform created by Qualifacts that is easy to use, simple to schedule appointments and improves service in behavioral health clinics. It is highly configurable with a robust suite of clinical, administrative and customer capabilities, including scheduling, planning and engagement. |  EMR/EHR |

| VENDOR | DESCRIPTION | DOMAIN |
|---|---|---|
| Solari (Co-Centrix) | Solari is a Call Center as a Platform and an EHR provider. They offer customized dashboards and forms, and CRNexus can also integrate with HIEs. | EMR/EHR |
| OpenBeds | OpenBeds is a provider facing behavioral health solution for states and governments. It is created by Bamboo Health and provides real time bed inventory, easy referral, reporting on usage patterns and integration with other data and applications. It can provide better access to social services, is compliant with HIPPA and ability to scale. | SERVICE TOOLS & REGISTRIES |
| UniteUs | UniteUs is platform that caters to many needs through multiple solutions, it provides both in person care coordination solutions and remote. The organization works hand in hand with communities to provide solutions among community needs, enrollment services, clients, measuring impact and social care. It is built on the following pillars, protect data, integrate systems and evaluate impact. | SERVICE TOOLS & REGISTRIES |

*Figure25 Vendor Description & Categorization*

## Appendix M: Vendor Discussion Notes

### Accenture Behavioral Health Solution (ABHS)

Demo Date: March 10, 2022

ABHS Attendees:
Teri Lewis, Health & Human Services Managing Director – ABHS
Pawel Walczuk, BH Practice Lead – ABHS
Michelle Adams, PH Topic Advisory – ABHS
Nicholas Vree, Technical Lead – ABHS

## Accenture Behavioral Health Solution

**With ABHS States operate their own platform —facilitating coordination across 911, 211, local providers and mobile crisis units resulting in a complete continuum of care**

| Core Capabilities | Accenture Behavioral Health Solution |
|---|---|
| **CONFIGURATION & CONTROL** | |
| State designed and managed | ✓ |
| Federally designed and managed (no direct state control/input on system changes) | |
| **CALL CENTER INTAKE** | |
| Call | ✓ |
| Chat | ✓ |
| Text | ✓ |
| National Suicide Prevention Line (NSPL) support | ✓ |
| Additional warm lines and non-NSPL lines support | ✓ |
| Crisis alerts | ✓ |
| Automated follow-up | |
| Intake volume forecasting | |
| **REFERRALS & APPOINTMENTS** | |
| Real-time provider referral and access handoff | ✓ |
| Direct provider appointment scheduling | ✓ |
| Provider-to-provider referral tracking | ✓ |
| **PROVIDER PORTAL & PROVIDER REGISTRY** | |
| Integration capability for licensing/certification | ✓ |
| Integration with 211 / 911 / Mobile Crisis Response Units | ✓ |
| Visibility to prior records and/or case notes to inform treatment | ✓ |
| Interoperability across providers, enabling direct handoff to local providers | ✓ |
| **BED REGISTRY & GPS DISPATCHING** | |
| GPS available for dispatching and locating resources | ✓ |
| Bed registry with twice-daily live updates to real-time information | ✓ |
| **ANALYTICS & REPORTING** | |
| National | |
| State | ✓ |
| Data-driven case management | ✓ |
| Reports & dashboards | ✓ |



*Figure 26 Accenture Core Capabilities*

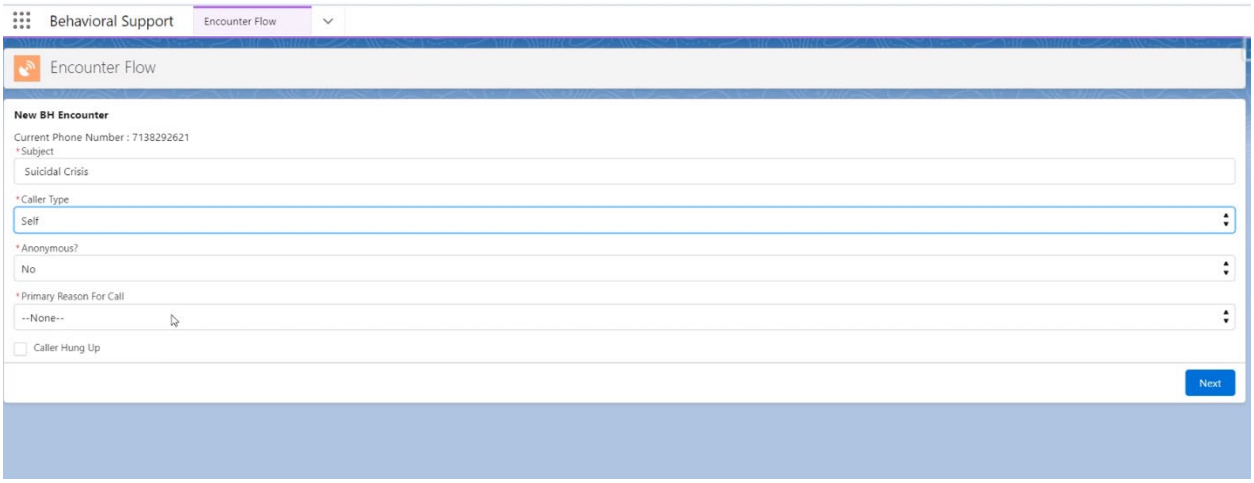


*Figure 27 Accenture Encounter Flow Start Screen*

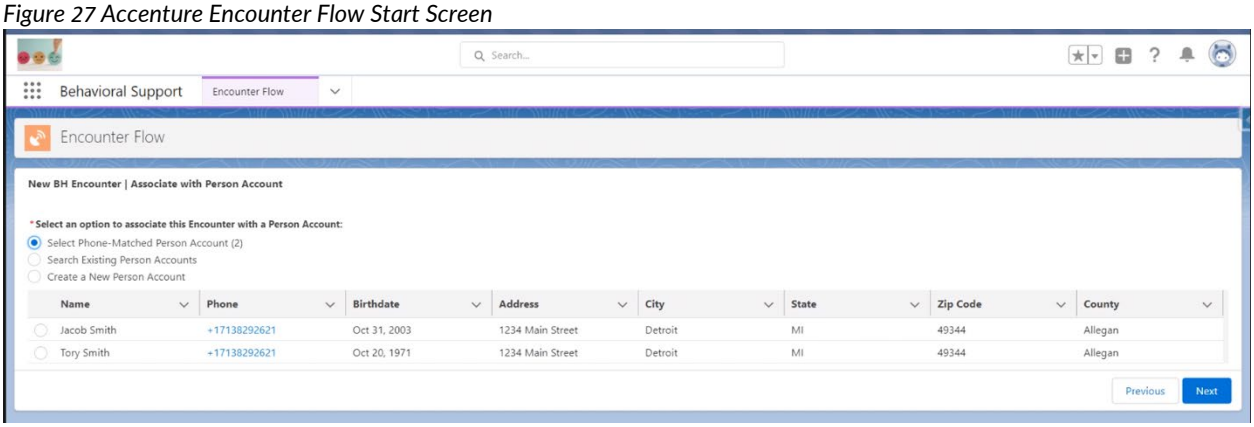

*Figure 28 Accenture Encounter Flow*

- Also, a warm-line hand-off can be noted here.
- The appropriate person account is selected. Mother has also called on his behalf.

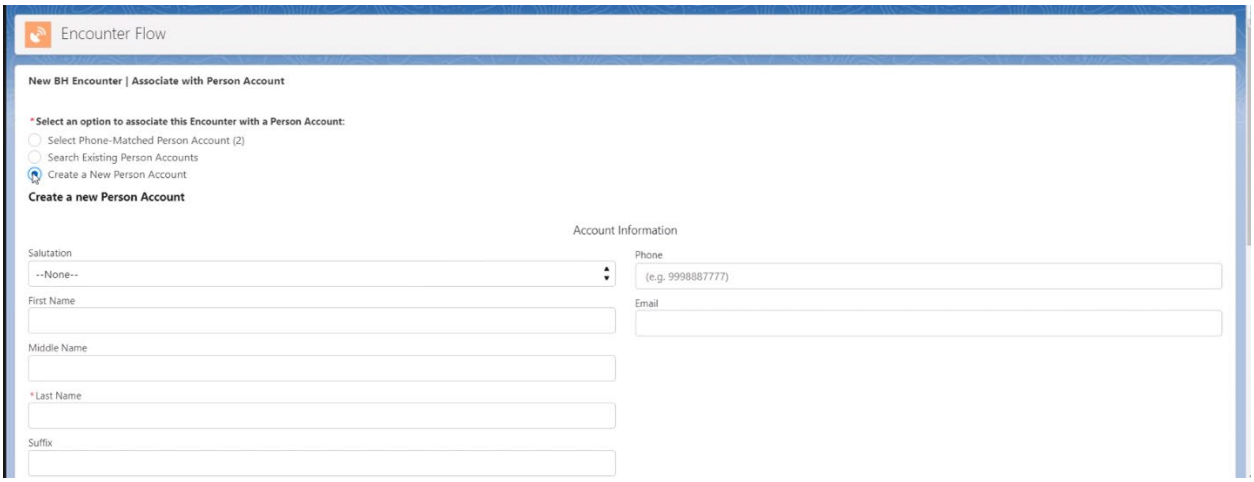


*Figure 29 Accenture Encounter Flow New Patient Account Screen*

- A new person account can be created if an entry for the person does not yet exist.

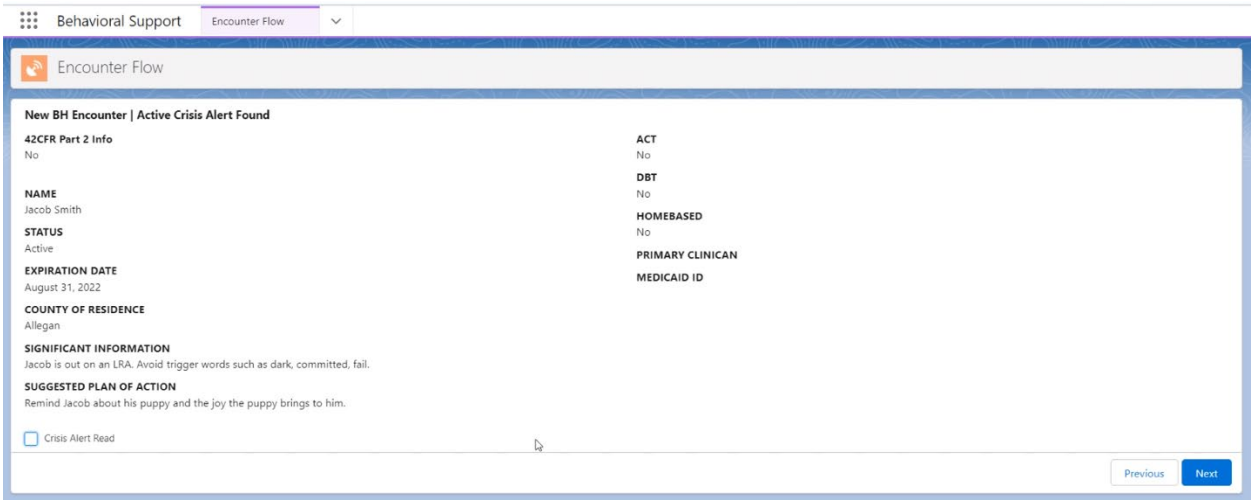


*Figure 30 Accenture Encounter Flow*

- Can also see if person is out on an LRA, detailed information, etc.

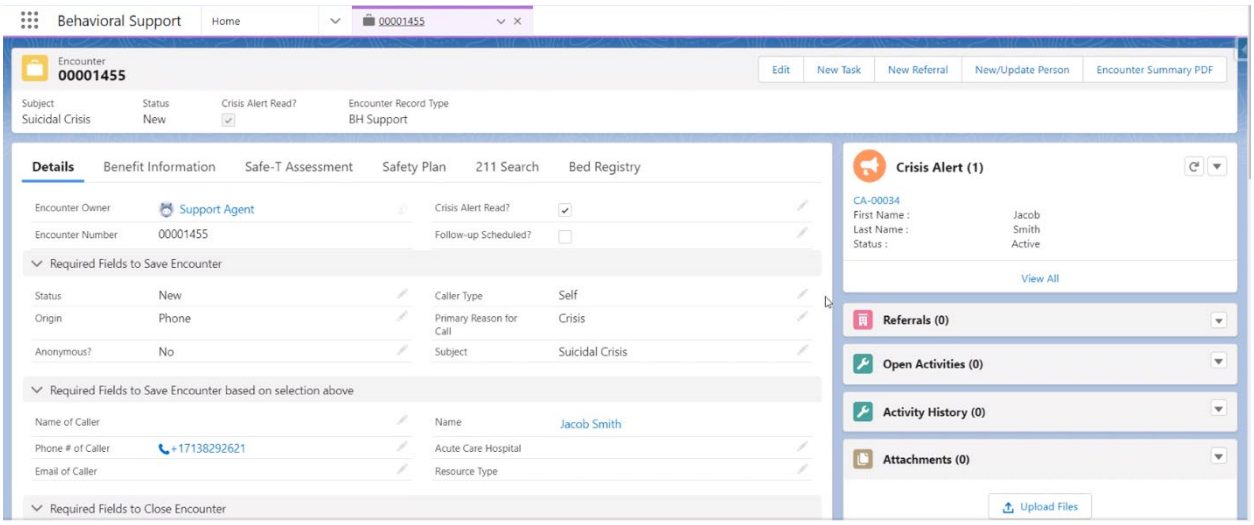


*Figure 31 Accenture Encounters/Details Screen*

- Encounters/details page
- Additional notes on the call can be taken

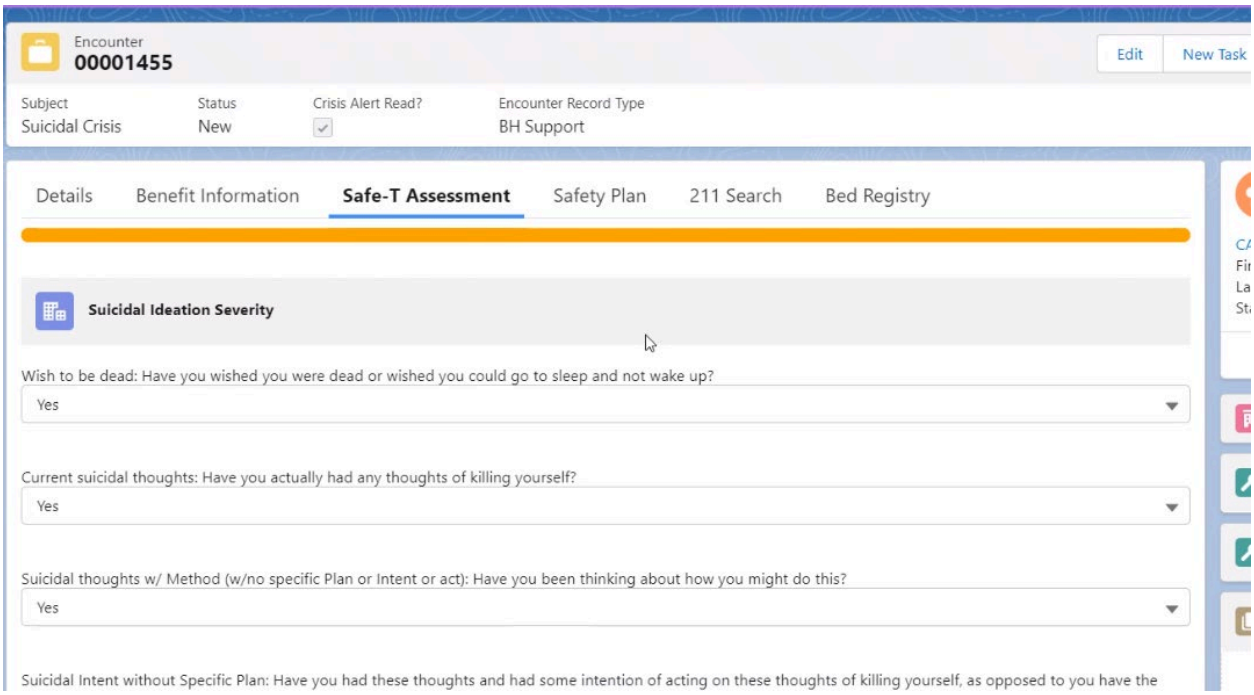


*Figure 32 Accenture Safe-T Assessment Screen*

- Can perform safety assessment via the tabs at the top.
- A safety plan can be entered

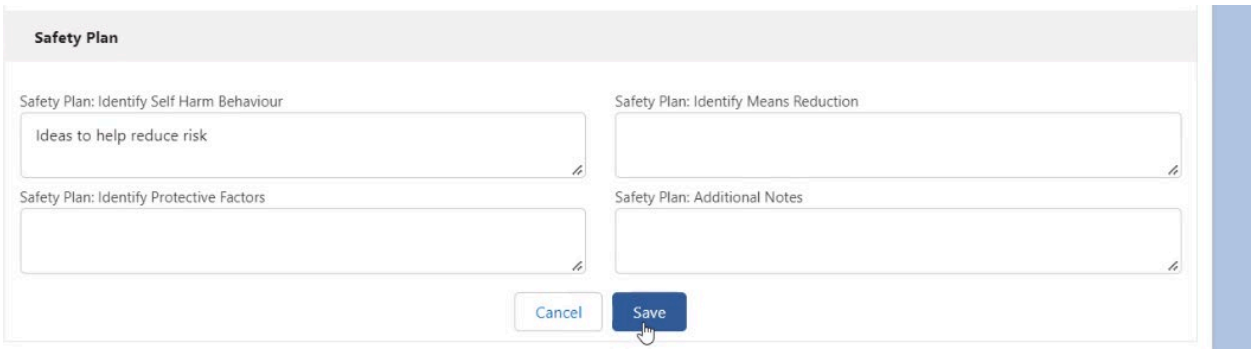


*Figure 33 Accenture Safety Plan Screen*

- The 2-1-1 tab can be searched for resources and to copy or correct information

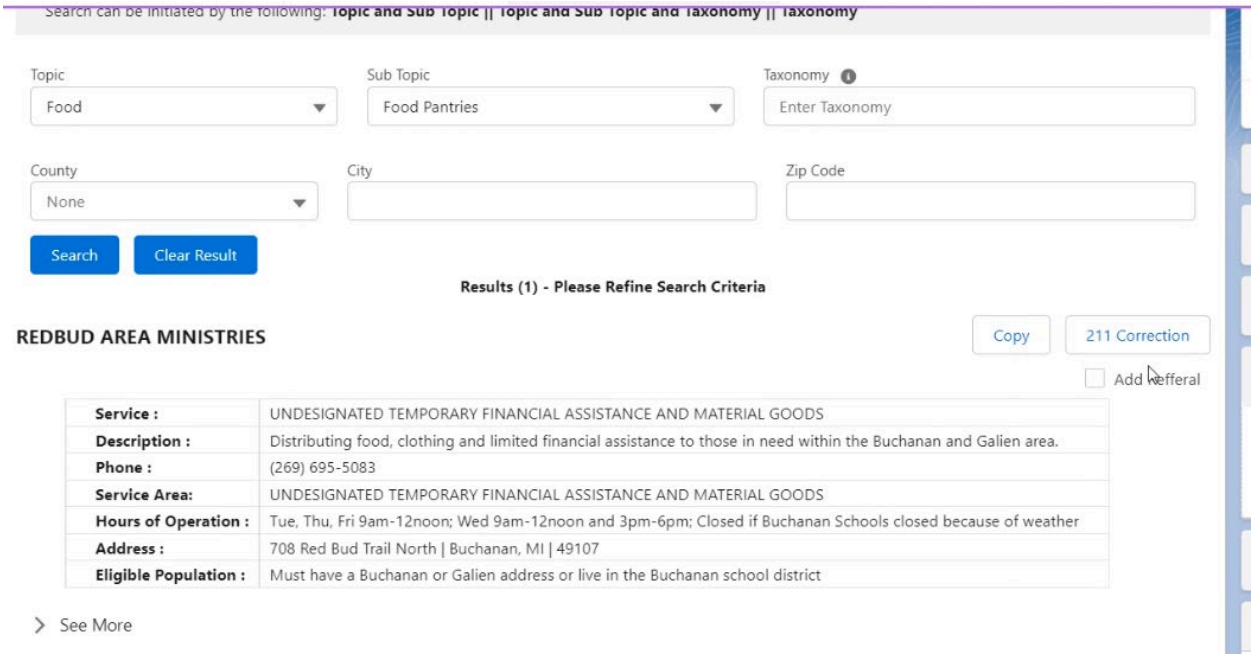


*Figure 34 Accenture Services Search Screen*

- Providers update bed availability manually

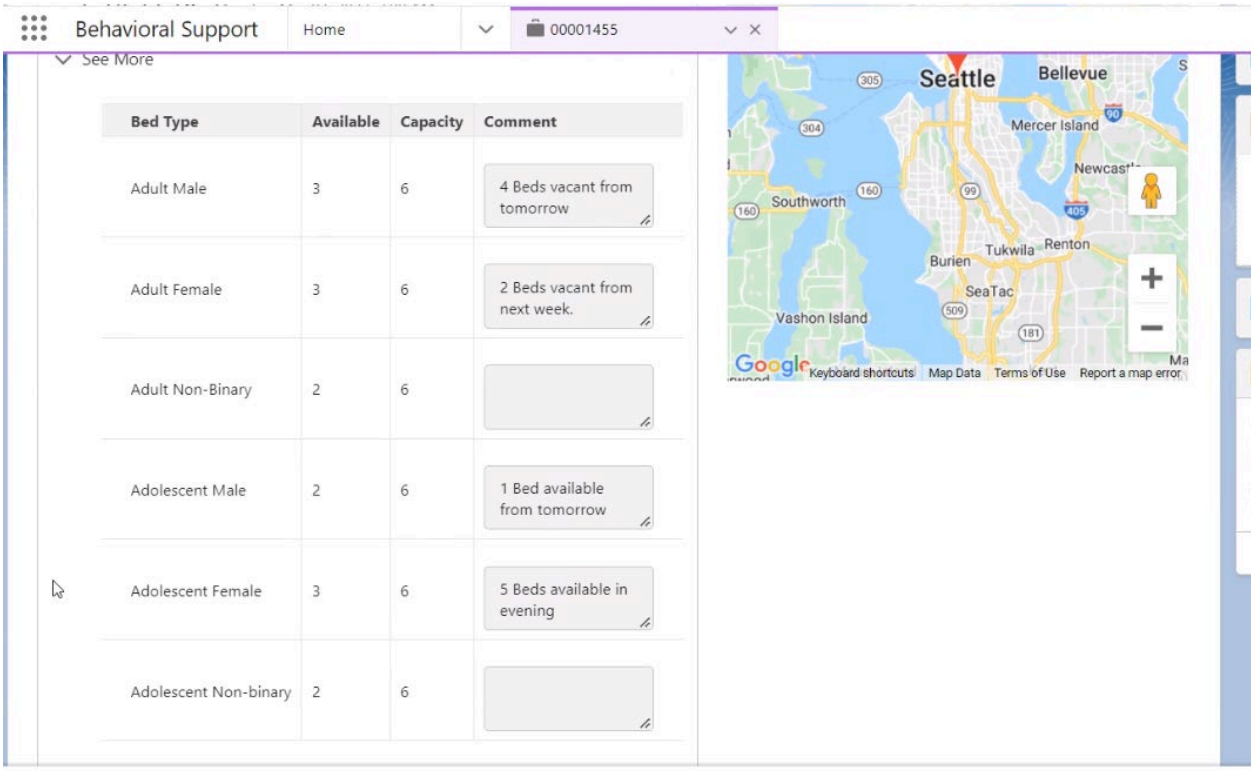


*Figure 35 Accenture Provider Search Screen*

- Provider Search
    - Select & search for various service types

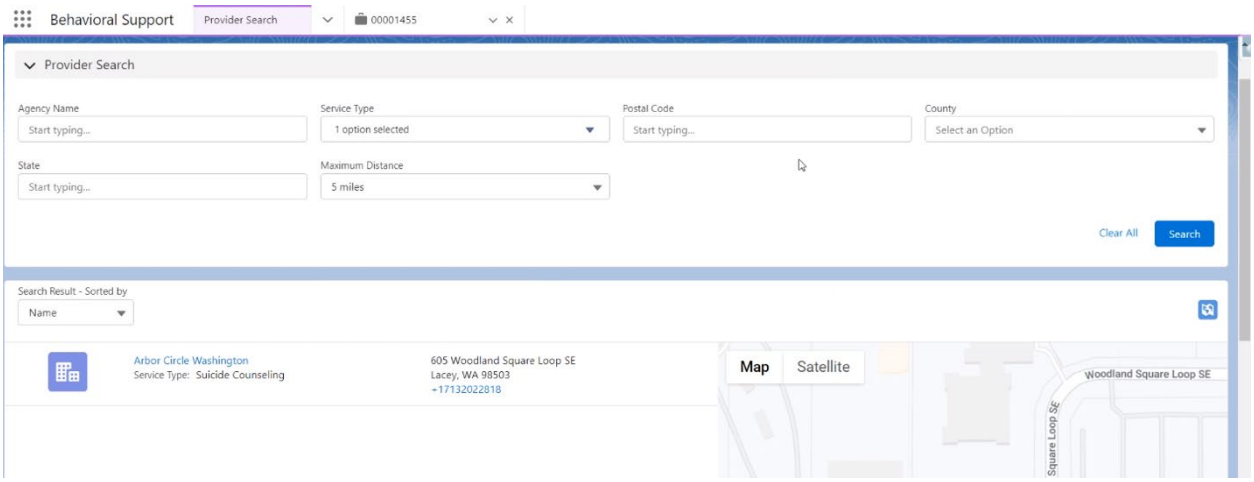


*Figure 36 Accenture Provider Search Screen*

- Providers may also have a “click to call” ability – can also conference them into our call

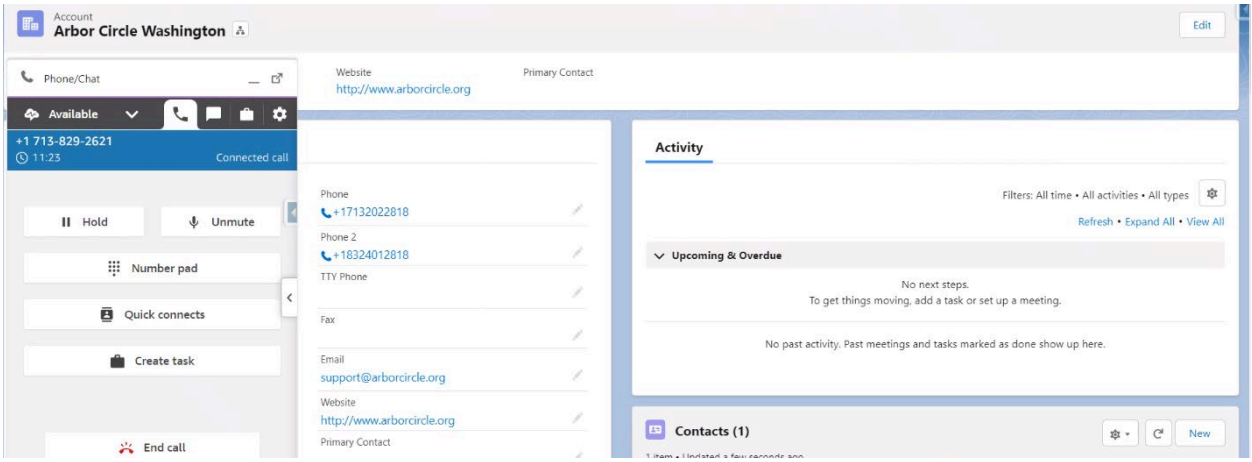


*Figure 37 Accenture Provider Screen Showing Click to Call*

- Can create a referral – and add follow-up to the queue.
    - This follow-up will be added to the supervisor queue and the supervisor can then assign into another operator the following day.
    - Also looking to have an automated follow-up text.

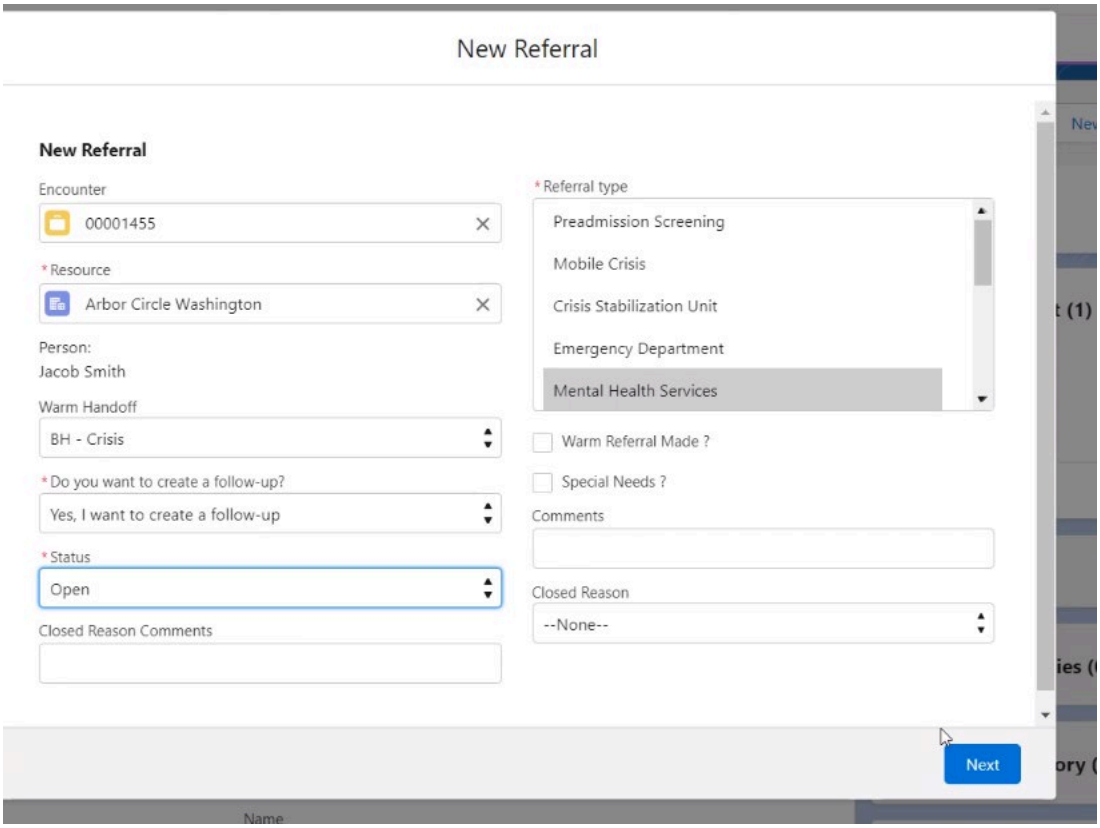


*Figure 38 Accenture Provider New Referral Screen*

- Dashboard view:
    - Very configurable

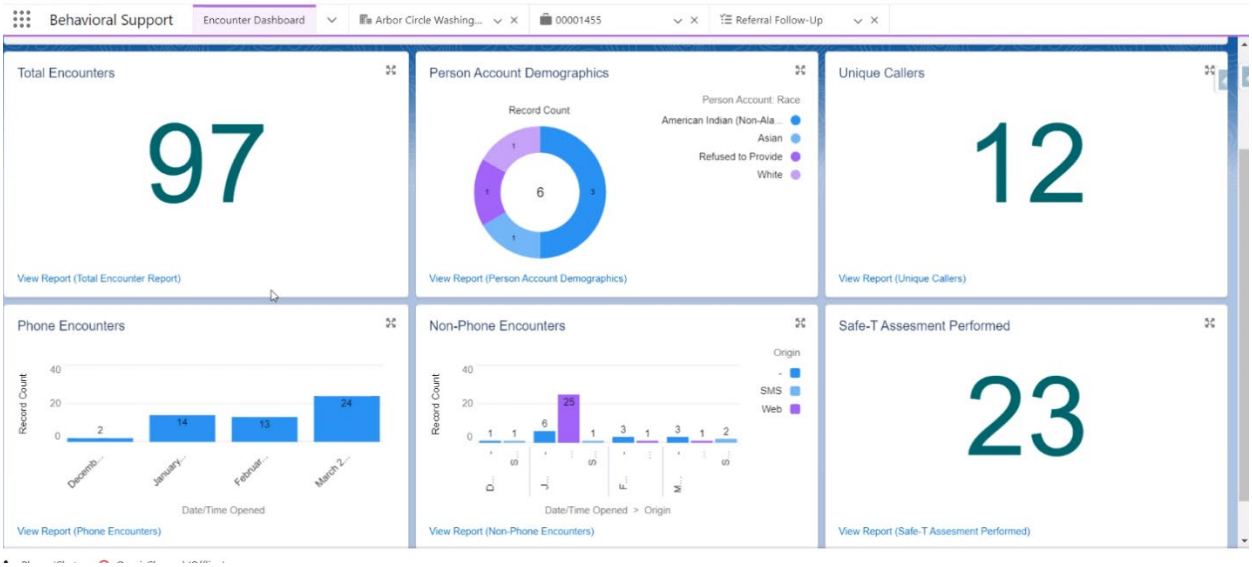


*Figure 39 Accenture Provider Dashboard*

- Provider portal view
  - Need to update manually
  - Can also see the reports on encounters
  - How can a provider see this information?
    - The provider logs into the portal to see information. There are a several ways to do it, APIs are possible, and integrations are possible with provider EHRs. Work closely with the systems the providers are using if that level of information is desired.
    - Is that considered a critical component at this time?
      - Integration to the extent possible is required by legislation. The intent is to make all the systems that need to interact interoperable.
      - It is possible, we can easily expose the API. Technically it is feasible, the burden would then fall on the providers to integrate. If you do not want the burden to fall on the providers, then the integration would need to be done for them. If it is prioritized, it can be done.
    - One of the large pieces is integrations.
      - MiCAL is one of the most integrated systems in Michigan. It depends on the needs of the user. User might just need to login and see only a level of information, another user might need more information, interaction, and therefore integration. Platform is extremely flexible, put priorities of interoperability on the roadmap.
  - Permissions – is this role-based permissions?
    - Yes, can set by role or profile type.
- There was a risk assessment performed in the demo for Jacob – what was the source of the Safe-T Assessment questions?
  - We worked with Michigan providers to establish questions and followed SAMSHA guidelines. These can be configured.
  - Peer warm-line questions also may be very different based on their flow.

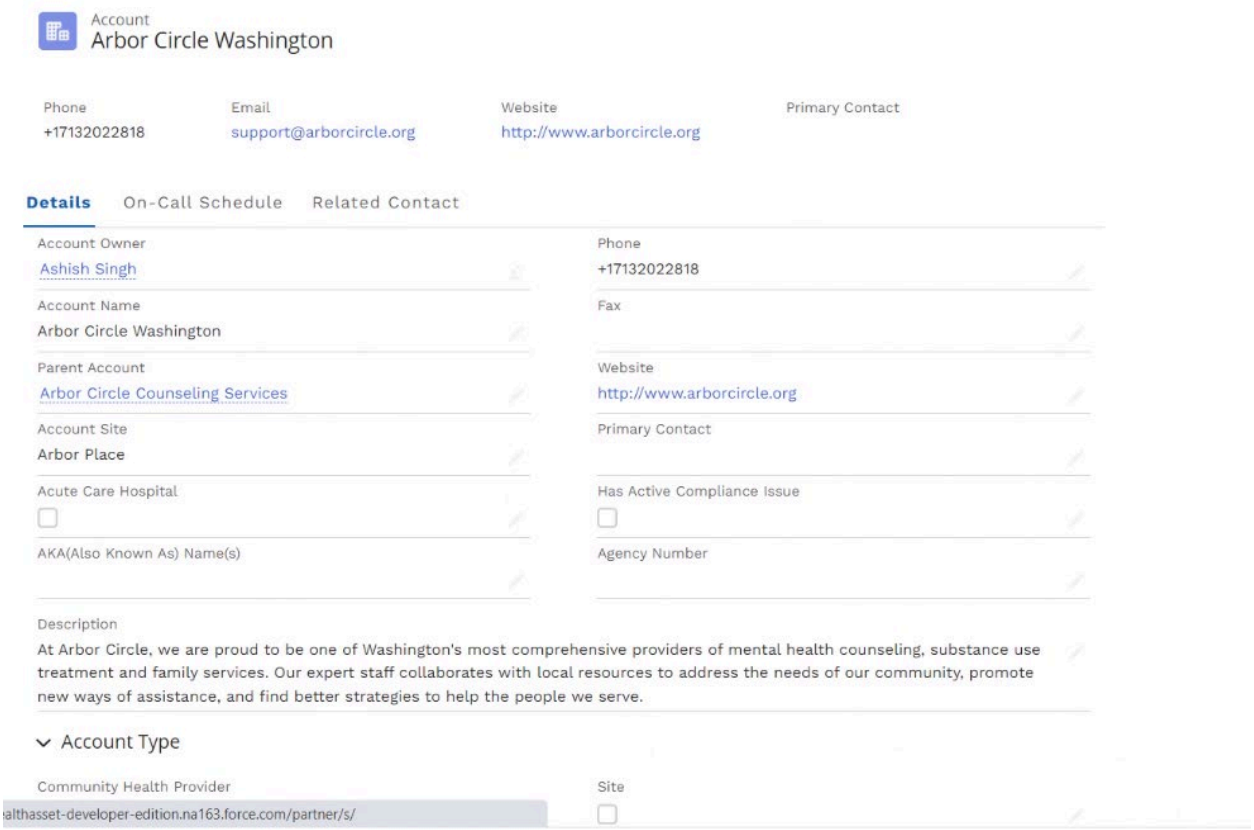


*Figure 40 Accenture Provider Portal View*

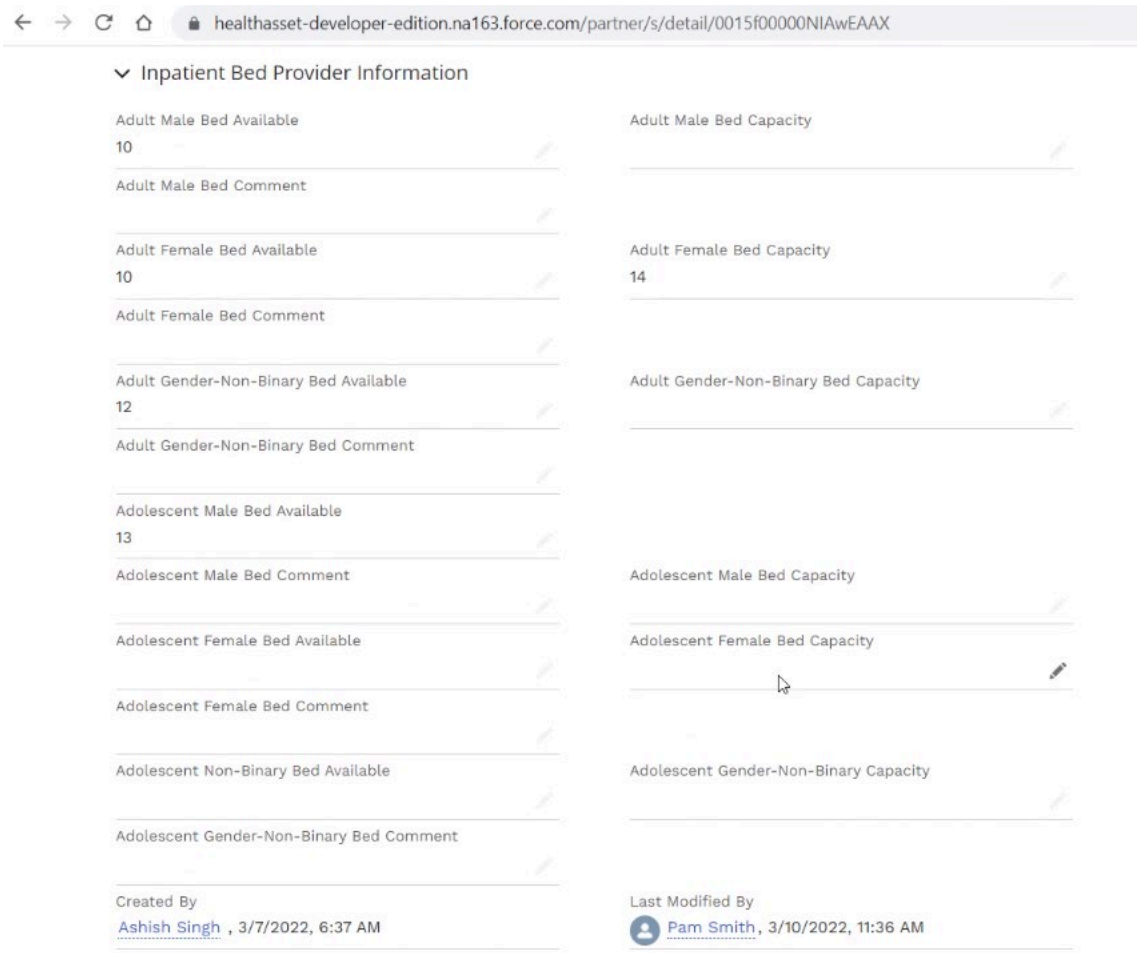


*Figure 41 Accenture Inpatient Provider Bed Count Screen*

Can MiCAL accommodate different call centers using the same system?

- Michigan also wanted to have all of their warm lines on the same platform. The warm lines are using the same platform, they have a completely different access model, but we have expanded the functionality to them. I would say about 50% of the calls in Michigan are handled by warm lines in Washington. Need to decide as a state - do you want to own the platform and bring them onto it? Or do you want to integrate with them at a different capacity? Michigan decided on the first – they have the same platform. You need to Figure out what works best for provider-to-provider referrals?
- It is completely configurable – from a platform capability it is possible.

## Behavioral Health Link

Demo Date: May 16, 2022

- BH Link is a fully integrated crisis now solution – web-based platform (SaaS)
- Active in Georgia
- Partnered with Netsmart in Virginia
- Active in a few counties in Maryland

- Currently working on 988 readiness – updates and new iterations of the platform
- BH Link is Accredited by:
  - URAC
  - American association of Suicidology
  - CARF
  - ICH – International Council for Helplines
- Bed Registry is currently updated twice a day – this integration will be upgraded, and the goal is to be more "real time"
- Offers:
  - Call Center Hub Capabilities
  - Crisis Services
  - Reporting & Analytics
- "Care Traffic Control" model
  - Call Center Hub connected to: Bed Registry, Service Provider Gateway – Dashboards – Referrals and Follow-up – Mobile Dispatching & Monitoring – 24x7 outpatient scheduling
  - GPS enabled mobile dispatch
  - Screening – suicide and risk

Summary

- **Functional Requirement Analysis**: BH Link meets all of the functional requirements we have defined; it also integrates with other vendors and registries / service tools if needed to align with the "system of systems" approach

## Care Connect Washington

Demo Date: June 2, 2022

Attendees:
Jeremy Rolfer – UnCommon Solutions
Sarah Stacy – UnCommon Solutions

*Note: UnCommon Solutions is a consulting firm that is working with DOH on the Care Connect Washington initiative*

Background of Care Connect Washington

- Statewide infrastructure to address individual and family needs – originally established for Covid19 Response
- Built upon existing systems
- Focus on community-based care coordination & workforce
- Resource directory is a key infrastructure component
- Technology: HealthBridge is the resource directory application (this technology has been adopted by many ACH's)
- Facilitates the immediate services & coordination with local resource agencies via community-based care coordinator

Need its fulfilling

- Community based workforce needs access to reliable directory

Current Footprint in WA

- DSHS-CLC: Community Living Connections
- WA2-1-1
- Crisis Connections
- WithinReach

Washington Resource Data Collaborative (WRDC)

- Facilitated the formation of the WRDC
- Focuses on solutions and long-term needs

Health services data standard

- Open source, with different classifications on how resource data can be exchanged (AIRS taxonomy) – supports API builds to know that all data being shared is the same – different directories can "speak" to each other – https://docs.openreferral.org/en/latest/hsds/
- Interoperability & Data exchange is critical – "no wrong door" – how to connect resources to a call center

How is the data being updated?

- DOH has data sharing agreements MOU's – each of the organizations will be responsible (based on their standards) for updating their own data
    - Once a centralized directory is established, organizations that own or have stewardship over the data in the directory will be tasked with its updating
- Governance has yet to be determined (Federated vs. Utility Model)

Current Functionality & Timelines/Next Steps

- CCWA is ingesting data from 2-1-1 and Within Reach – and currently there is a data comparison task that is being completed (all data will go through a data scrub/validation)
- Within six months all partners should be ingesting data

Summary

- Would be beneficial to meet with UniteUS in the future, there is potential to integrate as they provide a lot of registry integrations and currently working on standardizing the data that is being ingested so all data is consistent and meets data requirements (currently working on a data comparison)

## Collective Medical

Demo Date: May 31, 2022

Attendees:
Aubree Booth – Collective Medical
Bonnie Smith – Collective Medical
Ian Bruce – Collective Medical
Janet Devlin – Collective Medical
Charles DeElena, Compliance Office, PM Lead – NS BH-ASO

**Purpose: Discuss the Collective Medical & NS BH-ASO Pilot on Crisis Response**

How is Collective Medical being used, and what is the provider experience thus far?

- Intention behind pilot: goal for NS was to get better information and access to information to the crisis responders at the time of a crisis (outreach, crisis line VOA)
- crisis plan information – get access when responders need it
- Currently is the Initial phase – training next week for VOA , crisis line to go first,
  - 1-2 months later roll-out to crisis outreach team
- Care Guidelines & Care History can add the crisis plan as an attachment or paste into Care Guidelines or History
- Use Case: to make crisis plan information available and viewable to crisis response teams
- Barrier: will be the actual input of the information – heavy reliance on outpatient providers sharing the information (crisis plans) – have put agreements in place with MCO to allow for access (ED Access, Current Provider Status)
- Providers that have implemented CM are participating in sharing sessions between providers to address questions and concerns in a peer-to-peer environment
- This implementation model supports the teams in enabling patient look up functionality – helping to leverage what information is currently available – provide response teams more insight into the patient
  - Framework is patient search based, has opportunity for input as well
- VOA – supporting as the RCL (not the NSPL role)
- What is the data source for the information?
  - Information is coming through an ADT feed of a current member or CCDs sourced through an HIE local to a state, repository etc., in Washington all ADTs from Oregon, Idaho etc.
- Timeline of Pilot: VOA first, 1-2 months of use etc. then roll-out to responders (2-6 months later)
- NS-BH-ASO & Collective Medical built use cases, and built the flow of information – working with MCOs to supply eligibility information for members to Collective Med – provides eligibility files –
- Is there DSA template between MCO's & VOA?
  - Data sharing agreement BH-ASO will manage which RCL gets access to the data -

## ILRS – Integrated Licenses Regulatory System

Discussion Date: June 14, 2022

Attendee:
Mina Moghaddami, Epidemiologist – DOH- ILRS

**ILRS – Integrated Licensing and Regulatory System**

- Licenses every health care provider in the state
- Licenses certain types of facilities, such as BH hospitals, psych hospitals, acute care provider, substance use disorder care, etc.
- For providers – track everything for the life span of their career (credentials) – track education, have they met the requirements to practice in Washington State; continuing education, renew credentials yearly (on their birthday)
- Built strictly to credential (not a surveillance system)
- Very limited demographic type of data
- **Address: is only a mailing address – not guaranteed to be a home or practice location**
- **ILRS – being phased out, new system being developed HELMS:**
  - Estimated to be done by end of 2023 (not official)
- All data to be migrated from ILRS to HELMS
- Demographic data improvement project before migrating to HELMS
  - Better data on providers' location of practice and services offered is needed
- Providers may practice/provide services at multiple locations – the goal is to capture ALL practice locations.
  - Being piloted with osteopaths first (survey to capture demographic information)
- Survey system was built in ADOBE
- Goal for HELMS is to require a survey response before credentials/licenses are issued
- Current linkage between ILRS and Provider One – could provide some practice location information for MEDICAID population – Provider One collects at a facility level and then ask the facility or group to answer where the providers work
- July 1 BH Green book – BH facilities, locations and all of the services that are offered, published yearly on DOHwebsite
  - Planning to update quarterly

**Summary**

- In its current state a link to the ILRS registry will not meet 988 requirements, however in the future once the new system is place, it will be important to re-evaluate.
  - If there is more practice specific, location data and demographics then there is potential to link to the new registry for Provider specific details (i.e., for referrals)

## NICE InContact (CxOne)

Demo Date: May 19, 2022

Attendees:
David Patnode
Tracey Dodd
Michael Hampton

- NICE InContact is a CCaaS (Call Center as a Service) solution (cloud platform)
  - FedRAMP ATO – multilayer security
  - Compliant w/ PCI Level I/II, SOC II, HIPAA, TCPA, GDPR, Cyber Essentials & IRAP
- Has the ability to route calls into a CRM or stand alone.
- Data is captured and transferred but never stored in NICE InContact.
- Multiple call centers with different staff skills and priority routing are supported as well as a variety of quality assurance, training, and reporting features.
- Contact Center as a Service platform
- Omnichannel messaging
- Cloud based to support current workforce shortages
- Ability to introduce AI (new features) – work well for chatbots
- Overall leader in SPARK Matrix
- Experience in building cloud contact center solutions for healthcare
- HIPAA compliant
- FedRAMP
- Milwaukee 2-1-1 CCaaS Platform
- Used by NSPL in Washington State (Crisis Connections)

Summary

- Functional Requirements Analysis: NICE inContact meets the requirements for a CCaaS platform and has the ability to integrate with other vendors to support a system of systems approach, it is currently used as the CCaaS platform by Crisis Connections (NSPL)

## OpenBeds

Demo Date: April 11, 2022

Attendees:
Bob Chouinard – VP of Business Development
Vatsala Kapur – VP Government Affairs
Nishi Rawat – Chief Clinical Officer
Emily Hunter, PM (working with Beacon) – Bamboo Health
Gina Gibson, 988 Implementation/Operations – Bamboo Health

**Background:**

- Appriss Health is part of Bamboo Health
- 12 (going on 14) States
- NetSmart – EHR vendor for King County – OpenBeds is the partner of choice for bed tracking

- Is NetSmart interoperable with OpenBeds?
  - Currently working on an integration that is the planning phase

Technology Platform:

- Do you plan on integrating with Vibrant's Unified Platform, why or why not?
  - Working on Integrations with the Vibrant vendors
  - A lot of states also use iCarol and are working on those integrations
  - New integration with Epic – currently building with Cerner (FHIR integration referral)
  - Working on automating bed availability – anticipate having it done in Nebraska in 5-6 months.
  - Is the integration with Epic require additions?
    - This is done via the Epic ADT
- How do you support "real-time" bed inventory, is it a manual process or an integration via an API?
  - At present, it is "manual entry," it is near real-time. Automating this is a priority – we are working on populating data from the ADT and then having a human with the ability to update it.
    - The way they keep this up to date – the receiving provider can update information (via a partner portal).
  - Provider populates information
    - OpenBeds to a quarterly sweep to ensure data is up to date.
    - They have a public facing (Treatment Connection) and clinician referral view.
    - In terms of 2-1-1 & social services – how is that directory maintained?
      - We have recovery support services listed. You can make a referral to 2-1-1 through this system.
- Can you walk us through your current or future functionality as a high level?
  - Referrals and Outpatient Scheduling – approach is to have everyone working off the same system.
    - SD: A lot of these providers already have their own systems– how do you handle that?
    - NR: Absolutely, this can mean double data entry. In New Hampshire, treatment providers are identifying appointments for emergency. The best way to do this is for us to integrate but the problem is some are not using technology, some have systems, etc. We can integrate with larger EMRs – Cerner, Epic, Netsmart.
- Can Tribal Affiliation be included?
  - Yes, we could add that to the intake form.

**Demo:**

Intake form

Can transfer:

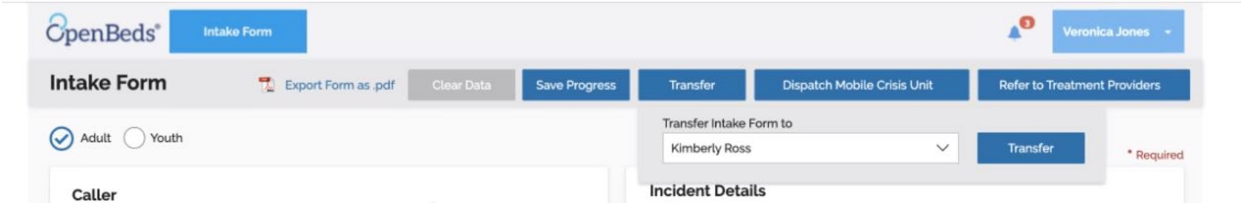


*Figure 42 OpenBeds Intake Form*

Refer to outpatient care:

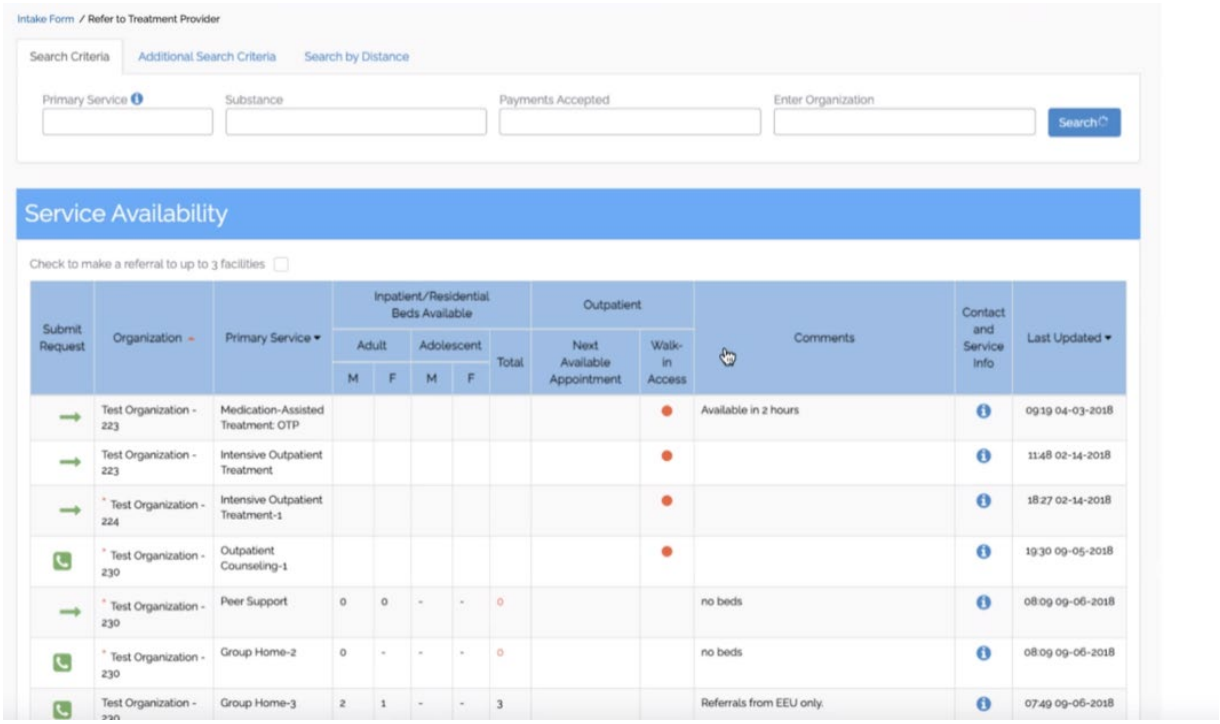


*Figure 43 OpenBeds Provider Service Availability Screen*

Mobile Crisis team dispatch (GPS location of browser – not phone tracker):

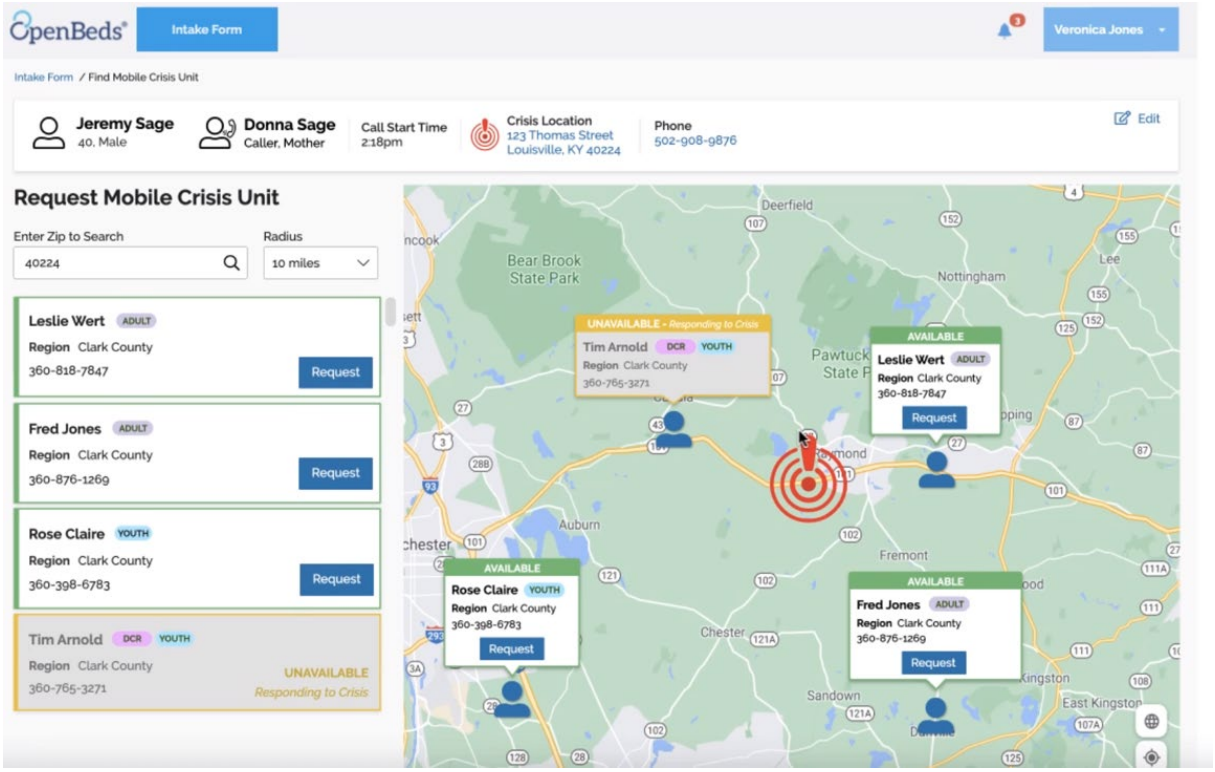


*Figure 44 OpenBeds Mobile Crisis Team Dispatch Screen*

From the MCRU team perspective:

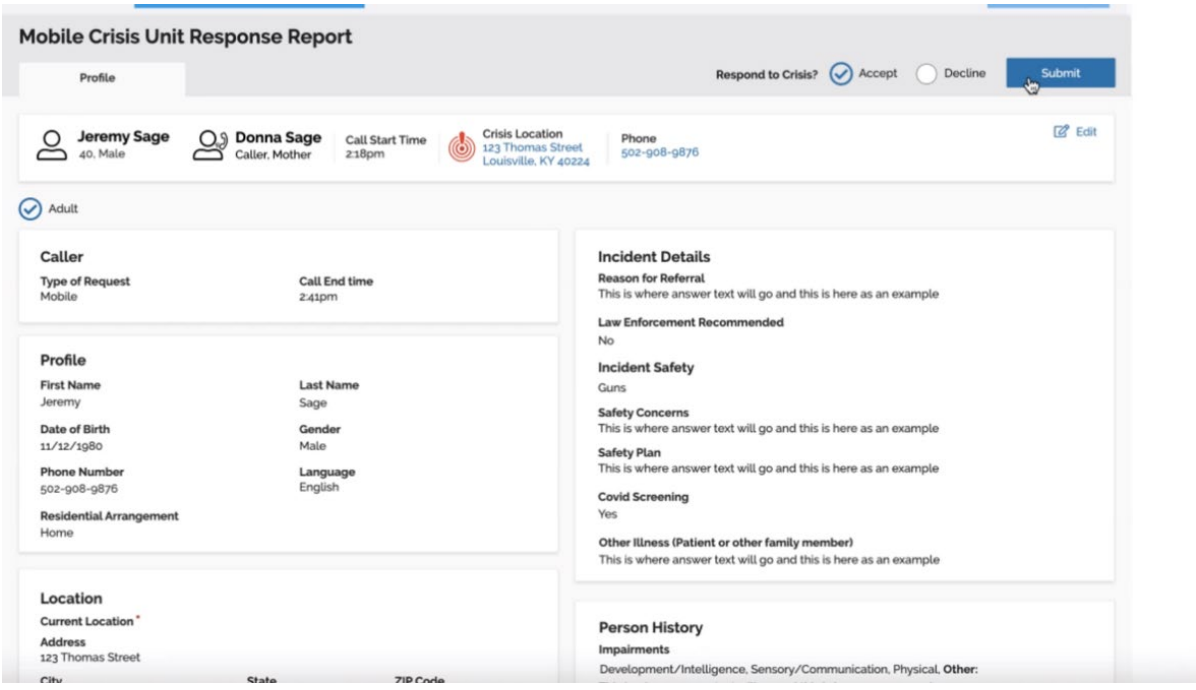


*Figure 45 OpenBeds MCRU Report Screen*

Can then indicate if you are available after:

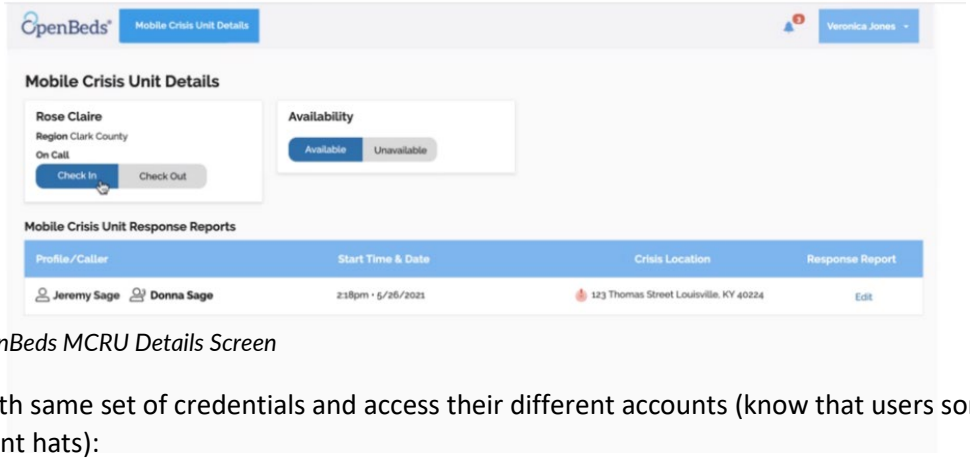


*Figure 46 OpenBeds MCRU Details Screen*

Can login with same set of credentials and access their different accounts (know that users sometimes wear different hats):

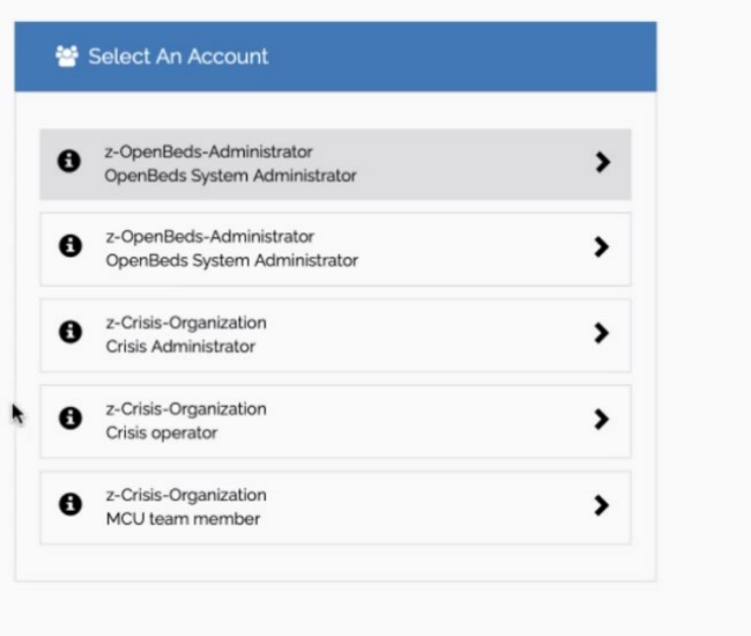


*Figure 47 OpenBeds Provider Account Access Screen*

Can see intake history:

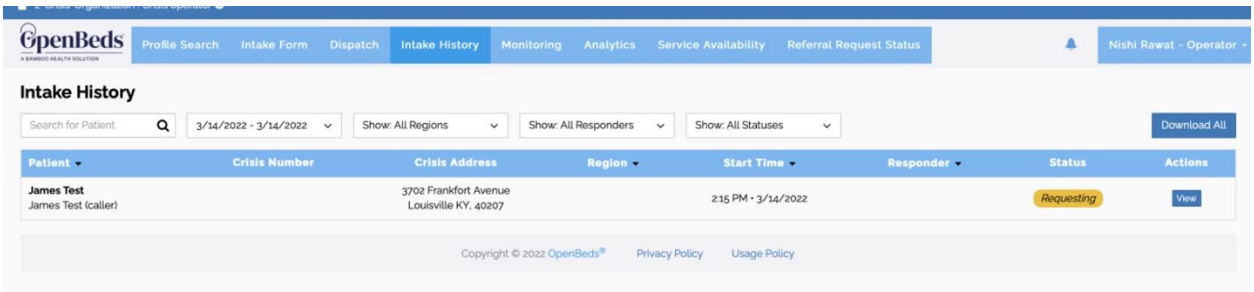


*Figure 48 OpenBeds Intake History Screen*

Can also view MCRU availability via list view:

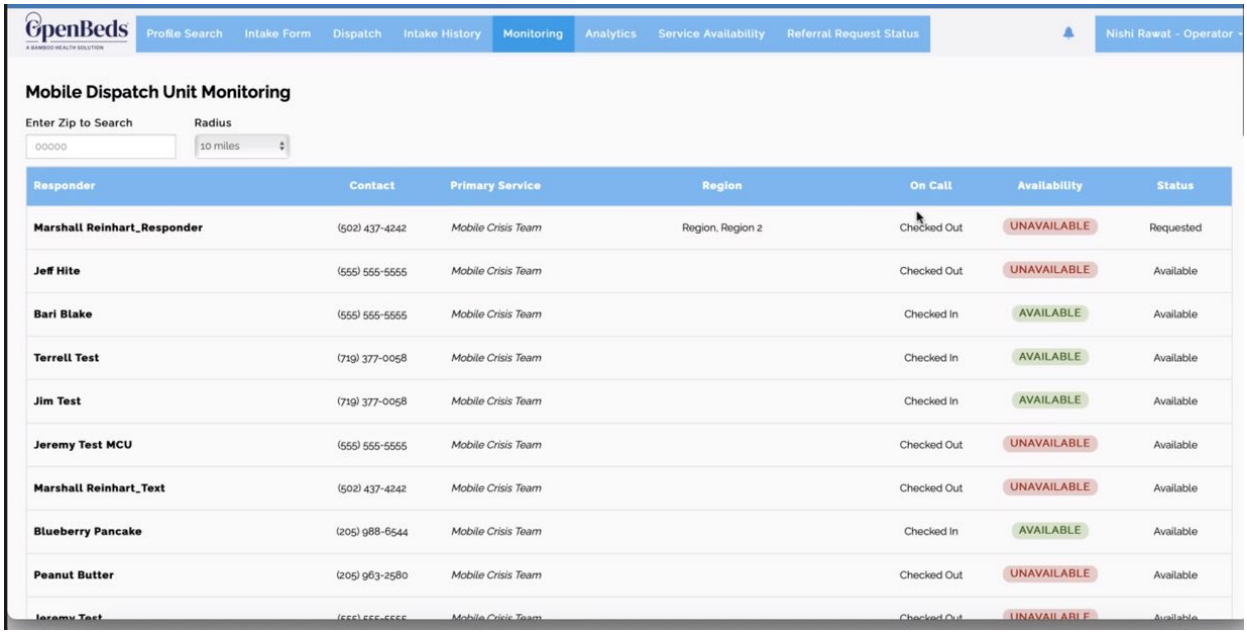


*Figure 49 OpenBeds MCRU Availability List View Screen*

- Users able to select specific account they want to log in with "Multi account mechanism"
- Currently pursuing an integration with Vibrants Genesis system
- Intake forms are customizable – some customizations can be done as a system admin, some of you will need to work with the OpenBeds
    - Adult & Youth intake forms
- If caller has called before – then information in the intake form is auto populated
- If there is a CRM integration, then information can be auto populated
- Can be referred for treatment, transferred to a clinician, or a mobile crisis team can be dispatched
- Source of information can be customized – Mobile team enters the disposition, and the options within the list can be customized ("Final Disposition of Consumer" – these are generic options) – if you select Hospital, then go back and select hospital – and the list of hospitals can be updated with a system admin account - state will identify the hospitals/crisis centers and OpenBeds works with the identified sites to train and implement on their end (no fee contracts)
- Bed tracking / referral implemented in approx. 14 states and some of these states are adding on crisis management
- Mobile responder can update and submit reports
- Service availability / bed availability – will work with state to configure how often the bed availability is updated along with appointment availability
- EHR integrated with Epic – can pull information when working on a referral (FHIR integration with Epic)
- SSO – available
- FHIR – working on for Cerner, have it for Epic
- Create docs from EHR into PDF – have it for Epic

- Working on dedicated integration for NetSmart – just kicking off / NetSmart FHIR API for bed availability
- ADT – will be complete in 4-5 months
- Currently working API enabling the core functionality for OpenBeds to send data back into EHRs
- GPS location is manually entered, does not rely on the caller's phone number
  - 988 currently does not have geo-tracking
  - What if a caller has a VPN or is on a mobile device? – work through this on a case-by-case basis
- As of 30th live with Crisis Connections and SeaMAR – using crisis module
  - Clark County – Using crisis management
  - Pierce County – Using bed capacity and referral system
  - No one has implemented SSO
  - 4-6 months for implementation and customizations

## Salesforce

Demo Date: May 3, 2022

Attendees:
Ben Mead, Account Executive – Salesforce
Nicholas Kartalian, Business Development Representative – Salesforce
Angela Tomczick, Solution Engineer – Salesforce
Dina Shuqom, Director, Digital Strategy – Salesforce
Christen Quinn, Director, Digital Strategy – Salesforce
Ben Ault, Senior Director, Solution Engineering – Salesforce

- Salesforce team provided an overview of their understanding of 988 Requirements and Washington State
  - Discussion of House Bill 1477
  - Understanding of Washington's 988 implementation plan to enhance behavioral health crisis response and suicide prevention services
- Discussion on 988 efforts across the US
- Salesforce can provide a comprehensive solution for 988 & BH Care Coordination
  - Crisis center response
  - Community engagement
  - Coordinated care support
  - Integrated Service Delivery (Integration with source solutions such as EHRs and Telephony
    - Bed Registry
  - Tracking & Reporting
- Salesforce Demo
  - Offer scalable crisis support
    - Air Traffic control model – as calls come in, counselor can route calls as needed
    - Air Traffic Response Management – real time monitoring with centralized "command center"
  - Standard API connections to systems outside of the SF cloud
    - Platform is open and allows for API integrations

        - Use MuleSoft for integrations (middleware) – (HCA uses MuleSoft as well)
    - Are able to provide hosting and integration solutions by working with a system integrator.
        - Salesforce would provide the licenses and the systems integrator manages the implementation and integrations
        - Would work with the team to define scope and roll-out in a modular/phased approach
    - Able to provide integration with the unified platform at a national level
- Salesforce team shared the PPT slides with the team for additional resource / reference material.

**Summary**

**Functional Requirements Analysis:** The Salesforce platform supports our functional requirements through their CRM, Health Cloud and their ability to integrate via MuleSoft; they also support a wide variety of telephony/CTI Integrations (CTI = Computer Telephony Integrations)

**Note:** Although Salesforce supports the functional requirements, it needs to be noted that they will work with a Systems Integrator to provide all of the required functionality, this is not an "out of the box" solution and will require customization and work with multiple vendors. Cost **might** be higher.

## Solari (CoCentrix)

Demo Date: June 23, 2022

Solari Attendees:
Andrew Erwin, COO – Solari (Andrew.Erwin@solari-inc.org)
Mark Griffiths, CIO – Solari (mark.griffiths@solari-inc.org)
Julie Shockley, Director, PM & HR Development – Solari (Julie.Shockley@solari-inc.org)

- Solari is providing 988 services for Arizona, they have recently been awarded a contract with Oklahoma
- System in Arizona was built out to what the states are envisioning now for 988
    - Hi-tech ACD phone system
    - Mobile response capabilities
    - In-patient facility access
    - Solari- manages how system receives and processes calls/individuals
    - Highest call volume in the US
    - Marketing for all BH crisis not just Suicidal caller
    - Calls answered under 9 seconds
    - Less than 35 seconds to get to a specialist
    - Abandonment rate less than 1% (dashboard available on public website and updated daily)
- To deal with high volume, data quality and coordination Solari linked in their EHR
    - CoCentrix EHR – customized EHR for Behavioral Health linked to Solari's CM
- Ability to pull up caller information if they have been saved, can keep anonymous (Unknown Caller) as well
- Telephony Integrations: built a telephony integration so their phone system works with their EHR, can work with any telephony system that can send this info (API)

- Data points available for Medicaid reporting (Fund Sources & Payer) – automated process to pull these data points
    - Automating the process has cut down on the denials / billing etc.
- Client ID in CoCentrix is like having an MRN (Patient Identifier)
- CoCentrix Medical Record / EHR is an ONC certified system
- Accessible for remote workers as well
- Multiple window integration – call takers have multiple screens – CCaaS/Telephony system on one screen, EHR on another
- This system flows better than other systems because it does not dictate like a script for call takers
- Can initiate dispatch from the EHR – info gets sent to dispatch management system
- DMS (Dispatch Management) – 3 elements, hardware devices located in mobile units, device sends a signal every 2 minutes showing their location (GPS) – tablet receives notifications via App – app used to update arrival and when completed etc. (this changes their status in the DMS as well)
- Map is similar to Google Maps with different views available etc. while tracking the mobile unit
    - Can manage dispatch and coordination with fire & police, in a different system – will be built and completed and in use by January
- Rural units have a portal they can access if they don't have the integration in place
- Responders have different systems they use (they are a different entity) – can share data with them if they are able to ingest standardized data (based on regulations): Clinical and Software teams worked together to ensure correct data was available
    - Responders can push back because at times it will cost them money to integrate etc.
- Bed Management – working with NextGen, NetSmart etc.
    - Building a crisis data repository in Arizona
    - Currently do not have access to bed availability
    - Creating data sets for recliners and inpatient beds
    - Complex build – data set will be available in about a year
    - Do not integrate with OpenBeds
    - Want API integration with real time data
    - Try to coordinate with providers EHR vendor as much as possible
- In Arizona, Solari is 2-1-1 – largest nationwide
    - Information in 2-1-1 DB is updated quarterly
    - Team dedicated to coordinating/completing updates
- Central HIE in Arizona – Solari uses HIE to pull in data, re: bed availability *etc.*, available resources
- Working on packaging product as Software as a service
- Utah – Solari is not taking calls for the Utah statewide crisis line, but they're using CoCentrix
- Oklahoma – go-live July 1
- Missouri – helping with prep / pre-planning prior to going live
- Manage a homeless DB / homeless management information system
    - In Central Arizona and outlying counties (everywhere but Tucson)

**Summary**

- Currently have a telephony system and integrations available to make the call taking process simpler (however it is multi-screen so not a full seamless integration)
- Working on Bed Registry integration – did not like the OpenBeds model because Solari would like real-time data
- Willing to work with Provider EHRs and State HIEs to integrate where it makes sense
- Working towards proving an all-encompassing Software Package to address facets of BH not just 988
- Their integration standards are unclear (e.g., FHIR or not)
- Consider themselves a leader in this space (Crisis Care / 988)

## Unite Us

Demo Date: June 22, 2022

UniteUS Attendees:
Scott Yeung, Sales – UniteUs
Julie Distel, Training/Workflow – UniteUs
Read Holman, Policy Director – UniteUs
Molly Harris, VP Compliance – UniteUs
Anna Becker, Customer Success – UniteUs
Natalie Mueller, Sr. Policy Manager (BH & 988) – UniteUs

- UniteUs: supports close loop referrals, (referral platform), Care Coordination (no wrong door approach), work with a lot of Non-Profits
- Active networks across Washington State – CBO networks providing services
- Referrals by service type such as: Individual & Family Support, Mental / Behavioral Health, Social Enrichment, Benefits Navigation, Housing & Shelter, Substance Use etc.
- Partners paying for licenses in Washington State: are traditionally funders (MultiCare, WestCare, Optum, etc.)
    - Funding the building of the network
    - Organization types that are paying, Health Systems, Health Plans & Government Agencies
    - Umbrella contracts
- CBO (Community Based Organizations) are brought on at no charge (they will generally fit into an existing contract (Umbrella Contracts)
- Licensing – Types & Costs: types of licenses vary based on who the users are and how it is being rolled out (care delivery: nurses, social workers etc.), discharge planners, small clinics may have clinicians, community-based resources, care coordinators etc. available to anyone who is at a point of intervention (web based); Cost: different models based on the organizations and scale – with health systems purchase on a per license fee (25-50 licenses); Medicaid Plans / State agencies – umbrella contracts, buy licenses on behalf of all of the entities within the organization. Network access model, unlimited licenses

**Demo of Unite US Referral Platform (Unite Washington):**

- Log in as care manager at a Mental Health Center (Sensitive Organization)
- Role based access within the platform
- EMPI is built in to avoid duplication
- **Does the platform currently integrate with any EHR or CRM out of the box?**
  - SMART on FHIR integration offering with Epic, Cerner, eClinicalWorks and OCHIN Epic
  - Level of integration varies from technical perspective and client workflow/needs etc. lowest level of integration via SSO to remove the log-in step (so agents don't have to log into Unite US and a CRM) – deeper integrations are possible to meet client needs
- Consent – can be captured multiple ways (on screen consent, read out to client, digital consent, paper and verbal)
- Dashboards – can send row level data in raw form (all Tableau based)
  - Most robust is a direct link to the client (data feed goes directly to repository)
  - Ability to provide raw data to organizations so they can customize analysis
  - Data can be exported as well (case data)
  - Comply with CRF 42
  - Reporting metrics, legislative requests: HCA will need the ability to access data to review and provide metrics

**Summary**

- UniteUs has a significant footprint in Washington State
- Ability to integrate with different platforms (other service registries to access information, EMR/EHR integration is also possible and currently exists)
- Licensing models can support different scenarios
- Social Needs Score (SNS) was recently recognized by CMS as an acceptable data set to consider in MA star rating and risk adjustment

## Visionlink

Demo Date: June 1, 2022

Attendees:
Douglas Zimmerman – Visionlink
Lisa Hrivnak – Visionlink

**Background**

Visionlink is the platform used by Washington 2-1-1. WA2-1-1 suggested that it might be beneficial for HCA team to meet with the Visionlink team to learn about the platform and its capabilities.

- System of Systems approach – community information exchange
- Provide the technical platform for WA2-1-1 – provide tools that call specialists use and also tools for the resource managers
- Exchange information with other customers like – Crisis Connections

- Integration with CCS pathways
- Integrate resource records
- Visionlink platform – is an architected toolkit – designed for many different projects
- Essentially a CIE platform -multi partner / multi language
- The tool is versatile and is deployed in many different ways
- Community operating system
- Using AWS
    - Would be deployed from discreet AWS and HIPPA compliant instance
- Other customers: Red-cross, state governments, Athena, UnitedWay
- Bi-directional sharing /exchange - each portal or sharing entity can set their own sharing parameters /client consent / data sharing agreements between partners
- Pre-built systems can be customized
- MCU search capabilities – currently being used by crisis connections
- Contract with Epic – prebuilt integration for data to flow into Healthy Planet
- Can share client, resource data between different systems
- API system allows system to be highly configurable
- Bed Registry Data source – facilities update from an app on their smartphones / system send out reminders and asks for bed counts
- Assessment Builder - can build custom assessments (suicide prevention) – data fields can be linked to HIT codes –
- Public facing forms, follow-up forms, automated follow-ups
- Control over triggers to ensure the forms are populated with the information you need – depending on the answer the next question will be generated etc.
- Integration APIs:
    - Is there a cost for engaging with engineers? Yes, covered through Professional Services
    - Solution Engineers – build screens/forms etc. for customers if needed (VL provides training on how to build the forms and APIs as needed) some customers build on their own, some request VL to do the entire build – can be mixed as well
    - FHIR – solutions engineers – charge hourly rates through a task order process
- **Integrate Twilio for texting, chat – complying with HIPPA, integrate with NICE for telephony, Ring Central - prebuilt integrations**
- Can this be a modular solution? For instance, implement bed reg and not closed loop?
    - Can tweak the existing pre-built solutions or can start from a blank system and build field/module by module
- Support the workflow outlined in the draft 988 report

<u>Summary</u>

- Visionlink seems to be highly customizable and has a footprint in different sectors / multi- use platform due to its configurability
- Pro: Already integrated with and used by WA2-1-1
- Need to better understand how scalable the platform can be and the actual costs, because there will be a lot of customization needed

## Washington 2-1-1

Discussion Date: May 17, 2022

Attendee:
Tim Sullivan – WA2-1-1

Follow-up Discussion Date: May 26, 2022

Attendees:
Wanda Oliver, Communications Coordinator – WA2-1-1
Hannah Newton, Resource center manager, statewide coordinator for WA2-1-1
Tim Sullivan, State Director WA2-1-1

May 17, 2022, Discussion

- 2-1-1 is a national service, goal is to connect callers to social services
- Live in Washington since 2006
- United Way funded, also receive grants
  - $1.5M received from Washington State
- There are approximately 250 2-1-1 call centers across the United States
- De-centralized model
- In Washington there are 7 call centers
  - Three of these are the NSPLs in the State (VOA, Crisis Connections, FBH)
  - 2-1-1 provides the infrastructure to the call centers and the NSPLs provide the staffing etc.
  - System is shared and seamless, calls stay within the state
  - Cloud based system that allows for remote staff
  - Using Nice InContact as the Telephony/CCaaS platform
  - Visionlink platform
  - Resources managed via Community O/S
    - Regions within the state manage their own resources
- Suggested standards that 988 should adopt:
  - AIRS - Alliance of Information and Referral Systems
  - www.airs.org
  - $6000 to get certified – involves intensive training and review
- VisionLink's API builder allows to easily share and connect data (easy data sharing)
- Work with Care Connect Washington
  - Washington Data Collaborative

From Tim: WA2-1-1 had contracted with the University of Washington Departments of Family Medicine & Psychiatry and Behavioral Sciences through a DOH grant to provide resource data to the www.waportal.org back in 2018-2019.

**Information from Visionlink:**

WA2-1-1's use of the Visionlink platform offers strategic capacities that could be of great use, while using monetary resources efficiently.

1) We offer a *no-code administrative suite*, so that our customers such as Washington 2-1-1, can adjust, refine, and create entirely new workflows for new partners and programs. Plus, we also offer a wide range of pre-built, and ready-now solutions useful to 988.

2) Plus an *API Builder Toolkit* with customer-facing wizards to create API endpoints on the fly. Or, for more complex data exchange needs, our engineers can help. With this builder, we move more than 30 billion fields of data every month (such as WA2-1-1's resource and community service listings).

3) We support *text, chat, email, and telephony integrations, are mobile responsive, multi-lingual*, and deploy from Amazon Web Services for tremendous scale, stability, and regulatory compliance. We also offer portals for specific populations, programs, locations and other needs.

4) Finally, true *coordinated care capacities*, so that agencies can work with one another, all on one Visionlink platform to serve the same or different clients—**and** by using our API infrastructure to connect with other third-party systems. Whether on platform, or connections between systems—the point is system building to leverage and coordinate client assistance.

**May 26, 2022, Discussion**

- HCA: example workflow would be that the call-taker would be able to access the 2-1-1 resource directory and search for housing information
- 2-1-1 currently has some mental health resources in the directory, this can be updated if 988 needs to access this information, additional resources can also be added
- Currently Crisis Line does not use 2-1-1
- FBH, VOA, Crisis Connections – they have separate 2-1-1 and Crisis lines, each program is using different technology
    - This is considered not-integrated, ideally you would want an integrated system, so data is used more often (easier to access if its integrated)
    - If someone calls an NSPL, in most situations the call is for support and there is no immediate risk; however, the NSPLs currently
- 2-1-1 is currently using Visionlink and NICE inContact
- 2-1-1 call comes in, can manage queue, and direct call to appropriate line – all data for the call is stored in Visionlink, crisis calls are transferred out because they are not 24/7 and crisis calls are kept separate
- Warm hand-off protocols in place and call taker stays on the line until the call is connected via conference call (inContact) and 2-1-1 call taker stays on the line until the caller says it's okay for them to disconnect the call
- What information is shared when you transfer the call to a crisis call taker? – Currently we are just setting up Active Referral with crisis lines, if we are able to have a shared record via Visionlink then we can do open and closed loop referrals. "Wrap-around model" Social & Crisis needs
    - To have an MOU with a crisis line to do this – this is potential workflow – Active Referral partnership would be needed – need to consider costs, resources etc.
    - Active referral – with SHIBA – email provides secure link to Visionlink so they can access information that is collected
        - SHIBA – Medicare

        - 2-1-1 takes initial call and addresses basic questions “first line support” model, and if needed transfer to SHIBA if the caller has specific questions
    - Potential Future Workflow: Visionlink to build API and then info pushed to 988 and then 988 to decide how to integrate
        - If outside of 988 software, then work with 2-1-1 website developer – he can build search criteria *etc.*
- AIRS LA taxonomy is used to categorize
- Tabelau for generating reports
- Corrections to records: AIRS standards are followed
- Link to website with caller data and metrics: https://wa2-1-1.org/community-data/
- DB updated once a year, and high demand resources more often or as needed
- Privacy and Patient info in VL: 2 instances, HIPPA compliant DB and non-compliant DB
- MOU – memorandum of understanding
- Connection between WA2-1-1 also operated DOHCovid hotline
    - Care Connect Hotline – directs calls to Covid Hotline (2-1-1)
- Plan is to build an API and agents enter caller info and that info sent in real-time into CCS Pathways
- API with CCS Pathways for resource database – information is integrated into their client software so when they make referrals the information all stays within their own software at CCS
    - Care Coordination Platform (CCS) – Health bridge is their resource directory
- Taxonomy Link - 2-1-1taxonomy.org
    - “Living” taxonomy and is updated regularly to reflect changes and new information
- https://thegravityproject.net/
- AIRS Taxonomy committee information / user group etc.
- https://www.airs.org/

Summary

- 2-1-1 core to the 988 effort, majority of the resource and search capabilities are already built out
- If integrating with the 988 system, consider minimizing the search fields to what is most relevant in a 988 call situation; if we integrate the entire system there is risk of losing functionality
- Need to learn more about Visionlink and their API builder
- Recommend 2-1-1 resources + BH services from providers and this would cover 90% of 988 referral needs

## Appendix N: Functional Requirements

### Summary Table

| Functional Requirements | Call Center as a Service (CCaaS) / Telephony | | Call Routing | CRM / Contact Management Software | | | | EMR/EHR | | Service Tools & Registries | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Call Center Platform: Create, Assign & Track(follow-up) | Vibrant UP | NICE CXOne | 911 | Salesforce | Accenture Behavioral Health System (ABHS) | iCarol | Behavioral Health Link (BH Link) | NetSmart | Solari | WA211 | OpenBeds | UniteUS | Care Connect WA |
| Encounter Intake (Call/SMS/Chat) | ✓ | | | With Integrator | ✓ | ✓ | ✓ | ✓ | ✓ | | Phone Only | | |
| Telephony/IVR/CTI Integration | ✓ | | | With Integrator | ✓ | ✓ | ✓ | ✓ | ✓ | | Work-In-Progress | | |
| Intake Extensibility | X | | | With Integrator | ✓ | | ✓ | ✓ | ✓ | | ✓ | | |
| *InState Routing (Note: need to consider other requirements supported by NENA i3 /911) | | ✓ | ✓ | N/A | N/A | N/A | N/A | N/A | N/A | | | | |
| GPS/i.e.Geolocation) location of caller | | ✓ | | N/A | N/A | N/A | N/A | N/A | N/A | | | | |
| *Crisis Alerts | | | | With Integrator | ✓ | ✓ | ✓ | ✓ | | | | | |
| Suicide Risk Assessment | ✓ | | | With Integrator | ✓ | ✓ | ✓ | ✓ | ✓ | | Clinical Assessment | | |
| Safety Plan | ✓ | | | With Integrator | ✓ | ✓ | ✓ | ✓ | ✓ | | X | | |
| Follow-up Queue | ✓ | | | With Integrator | ✓ | ✓ | ✓ | ✓ | | | X | | |
| Crisis Referrals | ✓ | | | With Integrator | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | | |
| Provider Portal | X | | | With Integrator | ✓ | ✓ | ✓ | ✓ | | | ✓ | | |
| Provider Integration | Send Only | | | With Integrator | ✓ | ✓ | ✓ | ✓ | | | Work-In-Progress | | |

| Functional Requirements | Call Center as a Service (CCaaS) / Telephony | | Call Routing | CRM / Contact Management Software | | | | EMR/EHR | | Service Tools & Registries | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Call Center Platform: Create, Assign & Track(follow-up) | **Vibrant UP** | **NICE CXOne** | **911** | **Salesforce** | **Accenture Behavioral Health System (ABHS)** | **iCarol** | **Behavioral Health Link (BH Link)** | **NetSmart** | **Solari** | **WA211** | **OpenBeds** | **UniteUS** | **Care Connect WA** |
| Interoperable With Existing Systems | X | | | With Integrator | ✓ | ✓ | ✓ | ✓ | | | Work-In-Progress | | |
| Responder Dispatching: Search, Dispatch & Track | | | | | | | | | | | | | |
| GPS/i.e.Geolocation: Responder Tracking (e.g., DCR and MCRU) | X | | | With Integrator | ✓ | Yes (GPS is available through integration as a separate module) | ✓ | ✓ | ✓ | | ✓ | | |
| Dispatch Coordination | ✓ | | | With Integrator | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | | |
| Resource Map | Need more info | | | With Integrator | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | | |
| Provider Portal | X | | | With Integrator | ✓ | ✓ | ✓ | ✓ | | | ✓ | | |
| Provider Integration | Send Only | | | With Integrator | ✓ | ✓ | ✓ | ✓ | | | Work-In-Progress | | |
| Interoperable With Existing Systems | X | | | With Integrator | ✓ | ✓ | ✓ | ✓ | | | Work-In-Progress | | |
| Referrals and Appointments: Search, Create, Assign & Track | | | | | | | | | | | | | |
| Next-Day Appointments | Track Only | | | With Integrator | ✓ | | ✓ | ✓ | | | Track Only | | |
| Open loop referrals (includes health and social services) | ✓ | | | With Integrator | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | |
| Closed Loop Referrals (includes health and social services) | X | | | With Integrator | ✓ | | ✓ | ✓ | | ✓ | ✓ | ✓ | |

| Functional Requirements | Call Center as a Service (CCaaS) / Telephony | | Call Routing | CRM / Contact Management Software | | | | EMR/EHR | | Service Tools & Registries | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Call Center Platform: Create, Assign & Track(follow-up) | **Vibrant UP** | **NICE CXOne** | **911** | **Salesforce** | **Accenture Behavioral Health System (ABHS)** | **iCarol** | **Behavioral Health Link (BH Link)** | **NetSmart** | **Solari** | **WA211** | **OpenBeds** | **UniteUS** | **Care Connect WA** |
| Provider-to-Provider Referrals (limited to referrals to and from any type of health/behavioral health provider) | X | | | With Integrator | ✓ | | ✓ | ✓ | | | ✓ | ✓ | |
| Resource Directory | Integration only | | | With Integrator | ✓ | | ✓ | ✓ | | ✓ | ✓ | ✓ | |
| Provider Portal | X | | | With Integrator | ✓ | ✓ | ✓ | ✓ | | | ✓ | ✓ | |
| Provider Integration | Send Only | | | With Integrator | ✓ | ✓ | ✓ | ✓ | | | Work-In-Progress | ✓ | |
| Interoperable With Existing Systems | X | | | With Integrator | ✓ | ✓ | ✓ | ✓ | | With VisionLink API | Work-In-Progress | Needs to be built | |
| Bed Registry: Search, Schedule & Report | | | | | | | | | | | | | |
| Bed Availability | X | | | With Integrator | ✓ | | ✓ | ✓ | | | ✓ | | ✓ |
| Bed Metrics/Data | X | | | With Integrator | ✓ | | ✓ | ✓ | | | ✓ | | ✓ |
| Provider Portal | X | | | With Integrator | ✓ | ✓ | ✓ | ✓ | | | ✓ | | ✓ |
| Provider Integration | Send Only | | | With Integrator | ✓ | ✓ | ✓ | ✓ | | | Work-In-Progress | | |
| Interoperable With Existing Systems | X | | | With Integrator | ✓ | ✓ | ✓ | ✓ | | | Work-In-Progress | | |
| Reporting: Create, Customize & Share | | | | | | | | | | | | | |
| Standard Reports | ✓ | | | With Integrator | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | | |
| Custom Reports | X | | | With Integrator | ✓ | ✓ | ✓ | ✓ | ✓ | | Limited | | |

| Functional Requirements | Call Center as a Service (CCaaS) / Telephony | | Call Routing | CRM / Contact Management Software | | | | EMR/EHR | | Service Tools & Registries | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Call Center Platform: Create, Assign & Track(follow-up) | **Vibrant UP** | **NICE CXOne** | **911** | **Salesforce** | **Accenture Behavioral Health System (ABHS)** | **iCarol** | **Behavioral Health Link (BH Link)** | **NetSmart** | **Solari** | **WA211** | **OpenBeds** | **UniteUS** | **Care Connect WA** |
| Dashboards | ✓ | | | With Integrator | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | | |
| Survey | | | | With Integrator | ✓ | | ✓ | ✓ | | | | | |
| Provider Portal | X | | | With Integrator | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | | |
| Provider Integration | Send Only | | | With Integrator | ✓ | ✓ | ✓ | ✓ | ✓ | | Work-In-Progress | | |
| Interoperable With Existing Systems | | | | With Integrator | ✓ | ✓ | ✓ | ✓ | ✓ | | Work-In-Progress | | |
| **Recommended Functionality** | | | | | | | | | | | | | |
| *Functional Requirements to be available for Regional Crisis Lines (in addition to NSPLs) | X | | | With Integrator | ✓ | | ✓ | ✓ | ✓ | | ✓ | | |
| *Services Registry (information on services provided) | | | | With Integrator | ✓ | | ✓ | ✓ | ✓ | | | | |
| *Level of Care Assessments | | | | With Integrator | ✓ | | ✓ | ✓ | | | | | |
| *Public Facing Website (i.e., for (i) provider resource directory, (ii) social service resource directory, and (iii) bed registry) | | | | With Integrator | ✓ | | ✓ | ✓ | | | | | |

*Figure 50 Functional Requirements Summary Table*

## Call Center Platform Requirements: Details

| | Platform | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Call Center as a Service (CCaaS) / Telephony | | CRM / Contact Management Software | | | | EMR/EHR | | | | |
| | Platform | | | | | | | | | | |
| **Call Center Platform: Create, Assign & Track (follow-up)** | Vibrant UP | NICE CXOne | Salesforce | Accenture Behavioral Health System (ABHS) | iCarol | Behavioral Health Link (BH Link) | NetSmart | Epic | Care Logic | Solari | OpenBeds |
| **Encounter Intake (Call/SMS/Chat):** Ability to record information from callers via various channels on an Encounter intake form. | Yes | | With Integrator | Yes | | Yes | Yes | | | Yes | Yes |
| Receive Call | | | With Integrator | Yes | | | | | | | Yes |
| Receive SMS | | | With Integrator | Yes | | | | | | | |
| Receive Chat | | | With Integrator | Yes | | | | | | | |
| Create Encounter | | | With Integrator | Yes | | | | | | | Yes |
| Track Encounter | | | With Integrator | Yes | | | | | | | |
| **Telephony/IVR/CTI Integration:** Ability to receive and place calls while logged into the platform without having to have a separate window or tab open. Can import data to platform such as Caller ID, DNIS, and ANI. | Yes | | With Integrator | Yes | | Yes | Yes | | | Yes | |
| Ingest/import caller ID/phone number | | | With Integrator | Yes | | | | | | | |
| Able to dial out | | | With Integrator | Yes | | | | | | | |
| Associate caller ID with past calls to help identify frequent callers | | | With Integrator | Yes | | | | | | | |
| *Customizable once integration is in place | | | With Integrator | Yes | | | | | | | |
| **Intake Extensibility:** The platform must have the ability to adapt to future communication methods and intake information using those methods. | No | | With Integrator | Yes | | Yes | Yes | | | | |
| Encounter intake form easily configurable to future needs | | | With Integrator | Yes | | | | | | | |
| ***Instate Routing Requirements (note: need to consider other requirements supported by NENA i3 /911)** | | Yes | N/A | N/A | | N/A | N/A | | | | |
| Leverage 911 standards to enable instate call routing | | Yes | N/A | N/A | | N/A | N/A | | | | |
| GPS location of caller | | Yes | N/A | N/A | | N/A | N/A | | | | |
| **Person Account History: Create, Maintain & Use Pt. History:** The platform must be able to associate Person Accounts (unless anonymous) to multiple Encounters, Referrals, and Alerts. | Yes | | With Integrator | Yes | | Yes | Yes | | | Yes | Yes |
| Create & link all encounters for caller | | | With Integrator | Yes | | Yes | Yes | | | | Yes |
| Maintain/View all encounters, referrals etc. that are linked to the caller | | | With Integrator | Yes | | Yes | Yes | | | | Yes |
| **LRA/Mental Health Directive Alerts:** The platform must have the ability to display alerts related to LRAs and Mental Health Directives associated with the caller. | | | With Integrator | Yes | | Yes | Yes | | | | |
| Interface with court system | | | With Integrator | Yes | | | | | | | |
| Ingest/display Mental Health Directive | | | With Integrator | Yes | | | | | | | |
| Ingest/display LRA | | | With Integrator | Yes | | | | | | | |
| Customizable for WA LRA | | | With Integrator | Yes | | | | | | | |
| Customizable for WA standard MHAD template | | | With Integrator | Yes | | | | | | | |
| **Crisis Alert:** | | | With Integrator | Yes | | Yes | Yes | | | | |
| Create crisis alert | | | With Integrator | Yes | | | | | | | |
| Share crisis alert | | | With Integrator | Yes | | | | | | | |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Suicide Risk Assessment:** The platform must have a suicide risk assessment that follows the NSPL guidelines such as the Columbia Assessment. | Yes | | With Integrator | Yes | | Yes | Yes | | | Yes | | |
| Display assessment | | | With Integrator | Yes | | | | | | | | |
| Complete assessment | | | With Integrator | Yes | | | | | | | | |
| Calculate results | | | With Integrator | Yes | | | | | | | | |
| *Support Columbia Assessment | | | With Integrator | Yes | | | | | | | | |
| **Safety Plan:** The platform must be able to create a safety plan to identify protective factors and mitigate risks. | Yes | | With Integrator | Yes | | Yes | Yes | | | Yes | | |
| Safety Plan - Create | | | With Integrator | Yes | | | | | | | | |
| Safety Plan - Receive | | | With Integrator | Yes | | | | | | | | |
| Safety Plan - Update | | | With Integrator | Yes | | | | | | | | |
| Safety Plan - Display | | | With Integrator | Yes | | | | | | | | |
| Send Safety plan to referring provider | | | With Integrator | Yes | | | | | | | | |
| Link safety plan back to the encounter | | | With Integrator | Yes | | | | | | | | |
| **Follow-up Queue: Create, Assign & Track**: The platform must have Follow-Up management to create, track, and assign follow-ups when needed. | Yes | | With Integrator | Yes | | Yes | Yes | | | | | |
| Create follow-up tasks | | | With Integrator | Yes | | | | | | | | |
| Assign follow-up tasks | | | With Integrator | Yes | | | | | | | | |
| Track follow-up progress | | | With Integrator | Yes | | | | | | | | |
| **Referrals:** The platform must have Referral management to search, create, and track referrals when needed. | Yes | | With Integrator | Yes | | Yes | Yes | | | | | Yes |
| Search for appropriate referral resource | | | With Integrator | Yes | | | | | | | | Yes |
| Create the referral | | | With Integrator | Yes | | | | | | | | Yes |
| Assign referral | | | With Integrator | Yes | | | | | | | | Yes |

*Figure 51 Call Center Platform Requirements: Details*

## Bed Registry Requirements: Details

| | CRM / Contact Management Software | | | | Service Tools & Registries | |
|---|---|---|---|---|---|---|
| | Salesforce | Accenture Behavioral Health System (ABHS) | iCarol | Behavioral Health Link (BH Link) | OpenBeds | WACares |
| **Bed Availability:** The platform must have the ability to show and make referrals to open beds**.** | With Integrator | Yes | Yes | Yes | Yes | Yes |
| Supports manual population of number of available beds | With Integrator | Yes | | | Yes | |
| Supports electronic population of number of available beds | With Integrator | Yes | | | Yes | |
| Supports manual population of characteristics (male, female, level of care etc.) of available beds | With Integrator | Yes | | | Yes | |
| Supports electronic population of characteristics of available beds | With Integrator | Yes | | | Yes | |
| Supports user defined update schedule of bed registry information (e.g., at a minimum of 3 times per day) | With Integrator | Yes | | | Yes | |
| **Bed Metrics/Data:** The platform must be able to collect bed metrics. | With Integrator | Yes | Yes | Yes | Yes | Yes |
| Capture & Report Metrics such as bed usage, how long was the bed free, which beds are used the most? | With Integrator | Yes | | | Yes | |
| More specific metrics will align with business needs & requirements | With Integrator | Yes | | | Yes | |
| **Provider Portal: Create, Exchange, Use, Ingest, Share** | With Integrator | Yes | Yes | Yes | Yes | Yes |
| Search portal for required provider type | With Integrator | Yes | | | Yes | |
| Create Request | With Integrator | Yes | | | Yes | |
| Exchange (ingest & share) information | With Integrator | Yes | | | Yes | |

| | CRM / Contact Management Software | | | | Service Tools & Registries | |
|---|---|---|---|---|---|---|
| Account Management | With Integrator | Yes | | | Yes | |
| **Provider Integration: Create, Exchange, Use, Ingest, Share** | With Integrator | Yes | Yes | Yes | Yes | Yes |
| Search portal for required provider type | With Integrator | Yes | | | Yes | |
| Create Request | With Integrator | Yes | | | Yes | |
| Exchange (ingest & share) information | With Integrator | Yes | | | Yes | |
| **Interoperable With Existing Systems** | With Integrator | Yes | Yes | Yes | Yes | Yes |
| Architecture (e.g., REST/JSON architecture, i3 (NENA NG 911 System Architecture)) | With Integrator | Yes | | | Yes | |
| Exchange Standards (e.g., HL7 FHIR, CCDA) | With Integrator | Yes | | | Yes | |
| Content Standards (e.g., LOINC, SCT, CPT) | With Integrator | Yes | | | Yes | |
| 911 Standards (e.g., NENA I3 Standards) | With Integrator | Yes | | | Yes | |
| **Recommended Functionality** | | | | | | |
| Public Facing Website | With Integrator | Yes | | | | |

*Figure 52 Bed Registry Requirements: Details*

## Responder Dispatching Requirements: Details

| | Platform | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | **Call Center as a Service (CCaaS) / Telephony** | **CRM / Contact Management Software** | | | | **EMR/EHR** | | **Service Tools & Registries** |
| | Vibrant UP | Salesforce | Accenture BehavioralHealth System (ABHS) | iCarol | Behavioral Health Link (BH Link) | NetSmart | Solari | OpenBeds |
| **GPS Mobile Crisis Unit/DCR Tracking:** The platformmust have the ability to track MCU's & DCRs in real-time using GPS technology. | | With Integrator | Yes | Yes | Yes | Yes | Yes | Yes |
| Search for closest unit | | With Integrator | Yes | | | | | |
| Track & Display on map w/ ETA | | With Integrator | Yes | | | | | |
| Ability to track responder location via GPS | | With Integrator | Yes | | | | | |
| **Dispatch Coordination:** The platform must be ableto dispatch MCUs & DCRs, and coordinate with outside agencies (such as, Law Enforcement, Ambulance etc.) if needed. | Yes | With Integrator | Yes | Yes | Yes | Yes | Yes | Yes |
| Dispatch - Coordinate with MCUs & DCRs | | With Integrator | Yes | | | | | |
| Electronic Process (for example an app or via laptop messaging etc.) | | With Integrator | Yes | | | | | |
| Ability to track first responders | | With Integrator | Yes | | | | | |
| **Resource Map:** The platform must have a resource map that can be used by MCUs/ DCRs and Dispatch/Call Centers (for instance display a map with directions to support routing to nearest service locations i.e., hospital, care center etc.) | | With Integrator | Yes | | | | Yes | |
| Track -ETA displayed on Map | | With Integrator | Yes | | | | | |
| **Provider Portal: Create, Exchange, Use, Ingest, Share** | | With Integrator | Yes | Yes | Yes | Yes | | Yes |
| Search portal for required provider type | | With Integrator | Yes | | | | | |
| Create Request | | With Integrator | Yes | | | | | |
| Exchange (ingest & share) information | | With Integrator | Yes | | | | | |
| Account Management | | With Integrator | Yes | | | | | |
| **Provider Integration: Create, Exchange, Use, Ingest, Share** | | With Integrator | Yes | Yes | Yes | Yes | | Yes |
| Search portal for required provider type | | With Integrator | Yes | | | | | |
| Create Request | | With Integrator | Yes | | | | | |
| Exchange (ingest & share) information | | With Integrator | Yes | | | | | |
| **Interoperable With Existing Systems** | | With Integrator | Yes | Yes | Yes | Yes | | Yes |

*Figure 53 Dispatching Requirements: Details*

## Referrals and Appointments Requirements: Details

| | Platform | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | **Call Center as a Service (CCaaS) /Telephony** | **CRM / Contact Management Software** | | | | **EMR/EHR** | **Service Tools & Registries** | | |
| | Vibrant UP | Salesforce | AccentureBehavioral Health System (ABHS) | iCarol | BehavioralHealth Link(BH Link) | NetSmart | 211 | OpenBeds | UniteUS |
| **Next-Day Appointments:** The platform must have the ability to create, assign, and track appointments | Track Only | With Integrator | Yes | No | Yes | Yes | | Track Only | |
| Search for appropriate referral resource (be able to search for resources that are prioritized by the agency) | | With Integrator | Yes | | | | | | |
| Create the referral | | With Integrator | Yes | | | | | | |
| Assign referral | | With Integrator | Yes | | | | | | |
| Track Progress | | With Integrator | Yes | | | | | | |
| **Open Loop Referrals:** | Yes | With Integrator | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| Search for appropriate referral resource | | With Integrator | Yes | | | | | | |
| Create the referral | | With Integrator | Yes | | | | | | |
| Send referral | | With Integrator | Yes | | | | | | |
| Assign referral | | With Integrator | Yes | | | | | | |
| ***Closed Loop Referrals:** The platform must have the ability to close the loop on referrals and track the outcome. | | With Integrator | Yes | No | Yes | Yes | Yes | Yes | Yes |
| Search for appropriate referral resource | | With Integrator | Yes | | | | | | |
| Create the referral | | With Integrator | Yes | | | | | | |
| Send referral | | With Integrator | Yes | | | | | | |
| Assign referral | | With Integrator | Yes | | | | | | |
| Receive encounter report/results (Close loop) | | With Integrator | Yes | | | | | | |
| ***Provider-to-Provider Referrals:** The platform must have the abilityto search, assign, and track provider-to-provider referrals. **(Compliance w/ 42 CFR Part 2)** | | With Integrator | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| Search for appropriate referral | | With Integrator | Yes | | | | | | |
| Create the referral | | With Integrator | Yes | | | | | | |
| Assign referral | | With Integrator | Yes | | | | | | |
| Track Progress (Close loop) | | With Integrator | Yes | | | | | | |
| **Resource Directory:** The platform must have the ability to search multiple resource directories. | Integration only | With Integrator | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| Search for resource from multiple directories | | With Integrator | Yes | | | | | | |
| Display available Resource from multiple directories | | With Integrator | Yes | | | | | | |

| | Platform | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | **Call Center as a Service (CCaaS) /Telephony** | **CRM / Contact Management Software** | | | | **EMR/EHR** | **Service Tools & Registries** | | |
| | Vibrant UP | Salesforce | AccentureBehavioral Health System (ABHS) | iCarol | BehavioralHealth Link(BH Link) | NetSmart | 211 | OpenBeds | UniteUS |
| **Provider Portal: Create, Exchange, Use, Ingest, Share** | Send Only | With Integrator | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| Search portal for required provider type | | With Integrator | Yes | | | | | | |
| Create Request | | With Integrator | Yes | | | | | | |
| Exchange (ingest & share) information | | With Integrator | Yes | | | | | | |
| Account Management | | With Integrator | Yes | | | | | | |

*Figure 54 Referrals & Appointments Requirements: Details*

## Reporting Requirements: Details

| | Platform | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | **Call Center as a Service** | **CRM / Contact Management Software** | | | | **EMR/EHR** | | **Service Tools & Registries** |
| | Vibrant UP | Salesforce | AccentureBehavioral Health System (ABHS) | iCarol | Behavioral Health Link (BH Link) | NetSmart | Solari (Co-Centrix) | OpenBeds |
| **Standard Reports:** The platform must have standard reports. | Yes | With Integrator | Yes | Yes | Yes | Yes | Yes | Yes |
| Create / Generate reports (out of the box) | | With Integrator | Yes | | | | | |
| Share reports (integrated/email etc.) | | With Integrator | Yes | | | | | |
| **Custom Reports:** The platform must provide a reporting solution that can be used for deeper analysis of trends that can be customized by end-users. | | With Integrator | Yes | Yes | Yes | Yes | Yes | Yes |
| Customize report criteria / data | | With Integrator | Yes | | | | | |
| **Dashboards:** The platform must have Dashboards for a quick visibility into key metrics. | Yes | With Integrator | Yes | Yes | Yes | Yes | Yes | Yes |
| Create & Share Dashboards | | With Integrator | Yes | | | | | |
| **Provider Portal: Create, Exchange, Use, Ingest, Share** | | With Integrator | Yes | Yes | Yes | Yes | Yes | Yes |
| Search portal for required provider type | | With Integrator | Yes | | | | | |
| Create Request | | With Integrator | Yes | | | | | |
| Exchange (ingest & share) information | | With Integrator | Yes | | | | | |
| Account Management | | With Integrator | Yes | | | | | |
| **Provider Integration: Create, Exchange, Use, Ingest, Share** | | With Integrator | Yes | Yes | Yes | Yes | Yes | Yes |
| Search portal for required provider type | | With Integrator | Yes | | | | | |
| Create Request | | With Integrator | Yes | | | | | |
| Exchange (ingest & share) information | | With Integrator | Yes | | | | | |
| **Interoperable With Existing Systems** | | With Integrator | Yes | Yes | Yes | Yes | Yes | Yes |
| Architecture (e.g., REST/JSON architecture, i3 (NENA NG 911 System Architecture)) | | With Integrator | Yes | | | | | |
| Exchange Standards (e.g., HL7 FHIR, CCDA) | | With Integrator | Yes | | | | | |
| Content Standards (e.g., LOINC, SCT, CPT) | | With Integrator | Yes | | | | | |
| 911 Standards (e.g., NENA I3 Standards) | | With Integrator | Yes | | | | | |

*Figure 55 Referrals & Appointments Requirements: Details*

## Appendix O: Crosswalk of Functional Requirements and House Bill 1477

### Call Center Platform Requirements Crosswalk

| Functional Requirement Description | Section | Exact Reference | Requirement Type | Functional Area |
|---|---|---|---|---|
| The System must display information about any less restrictive alternative treatment orders or mental health advance directives related to the person | 102 | 102 (6) (A) | Functional | Call Center Platform |
| LRA | | | | |
| Mental Health Directives | | | | |
| The System must have the means to track the outcome of the 988 call to enable appropriate follow up, cross-system coordination, and accountability, including any immediate services dispatched and reports generated from the encounter. | 102 | 102 (6) (c) | Functional | Call Center Platform |
| Closed Loop Referrals | | | | |
| Follow-Ups | | | | |
| Interoperability | | | | |
| Encounters | | | | |
| Reports | | | | |
| The System must have the means to track the outcome of the 988 call to enable appropriate follow up, cross-system coordination, and accountability, including the validation of a safety plan established for the caller in accordance with best practices. | 102 | 102 (6) (c) | Functional | Call Center Platform |
| Closed Loop Referrals | | | | |
| Follow-Ups | | | | |
| Interoperability | | | | |
| Safety Plan | | | | |

| Functional Requirement Description | Section | Exact Reference | Requirement Type | Functional Area |
|---|---|---|---|---|
| The System must have the means to track the outcome of the 988 call including the next steps for the caller to follow in transition to noncrisis follow-up care, including a next-day appointment for callers experiencing urgent, symptomatic behavioral health care needs | 102 | 102 (6) (c) | Functional | Call Center Platform |
| Closed Loop Referrals | | | | |
| Follow-Ups | | | | |
| Interoperability | | | | |
| Next-Day Appointment | | | | |
| The System must have 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 | 102 | 102 (6) (e) | Functional | Call Center Platform |
| Provider Search | | | | |
| Services | | | | |
| Person Account History | | | | |
| Crisis Call Center Hubs shall provide crisis intervention services, triage, care coordination, referrals, and connections to individuals contacting the 988-crisis hotline from any jurisdiction within Washington | 102 | 102(4) | Functional | Call Center Platform |
| Level of Care | | | | |
| MCU | | | | |
| Referrals | | | | |
| Provider Search | | | | |
| Services | | | | |
| The System 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 | 102 | 102 (5) (a) | Functional | Call Center Platform |
| Encounter Intake (Call/SMS/Chat) | | | | |

| Functional Requirement Description | Section | Exact Reference | Requirement Type | Functional Area |
|---|---|---|---|---|
| Intake Extensibility | | | | |
| The System must be interoperable across crisis and emergency response systems **used throughout the state**, state, **such as 911 systems**, emergency medical services systems, and other nonbehavioral health crisis services, for use in crisis call center hubs | 102 | 102 (5) (a) | Functional | Call Center Platform |
| Interoperable with existing systems | | | | |

*Figure 56 Call Center Platform Requirements Crosswalk*

## Bed Registry Requirements Crosswalk

| Functional Requirement Description | Section | Exact Reference | Requirement Type | Functional Area | Supported Business Process | Applicable/Dependent Systems |
|---|---|---|---|---|---|---|
| The System must provide access to real-time bed availability information for all behavioral health bed types | 102 | 102 (6) (a) (i) | Functional | Bed Registry | Functional | Bed Registry |
| Bed Availability | | | | | | |
| Bed Metrics/Data | | | | | | |
| The System will allow relevant parties to report, maintain, and update inpatient and residential bed and outpatient service availability in real time to correspond with the crisis call center system platform or behavioral health integrated client referral | 103 | 103 (6) (e) | Functional | Bed Registry | Functional | Bed Registry |
| Bed Availability | | | | | | |
| Bed Metrics/Data | | | | | | |
| Provider Portal | | | | | | |
| Provider Integration | | | | | | |

*Figure 57 Bed Registry Requirements Crosswalk*

## Responder Dispatching Requirements Crosswalk

| Functional Requirement Description | Section | Exact Reference | Requirement Type | Functional Area |
|---|---|---|---|---|
| The System must provide access to information necessary to enable the crisis call center hub to actively collaborate with emergency departments, primary care providers and behavioral health providers within managed care organizations, behavioral health administrative services organizations, and other health care payers | 102 | 102 (6) (B) | Functional | Dispatch Responders |
| Dispatch Coordination | | | | |
| Resource Map | | | | |
| The System must be able 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 noncrisis care | 102 | 103 (6) (B) | Functional | Dispatch Responders |
| Follow-Ups | | | | |
| Safety Plan | | | | |
| The System must have the 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 | 102 | 102 (6) (b) | Functional | Dispatch Responders |
| Dispatch Coordination | | | | |
| Resource Map | | | | |
| The System must track local response through global positioning technology | 102 | 103 (6) (b) | Functional | Dispatch Responders |
| GPS Mobile Crisis Unit Tracking | | | | |

*Figure 58 Responder Dispatching Requirements Crosswalk*

## Referrals and Appointments Crosswalk

| Functional Requirement Description | Section | Exact Reference | Requirement Type | Functional Area |
|---|---|---|---|---|
| The System must have behavioral health integrated client referral system capable of providing system coordination information to crisis call center hubs and the other entities involved in behavioral health care | 102 | 102 (5) (b) | Functional | Referrals and Appointments |
| Open Loop Referrals | | | | |
| Closed Loop Referrals | | | | |
| The System Must provide access to Real-time information relevant to the coordination of behavioral health crisis response and suicide prevention services for a person | 102 | 102 (6) (a) (ii) | Functional | Referrals and Appointments |
| Person Account History | | | | |
| Dispatch Coordination | | | | |
| Suicide Risk Assessment | | | | |
| Safety Plan | | | | |
| Resource Directory | | | | |
| Referral | | | | |
| Follow Ups | | | | |
| The System must have the means to facilitate actions to verify and document whether the person's transition to follow up noncrisis 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. | 102 | 102 (6) (d) | Functional | Referrals and Appointments |
| Follow Ups | | | | |
| Encounters | | | | |
| Person Account History | | | | |
| Referrals | | | | |

*Figure 59 Referrals & Appointments Crosswalk*

## Reporting Requirements Crosswalk

| Functional Requirement Description | Section | Exact Reference | Requirement Type | Functional Area |
|---|---|---|---|---|
| The System must have a means to provide an annual report regarding the usage of the 988-crisis hotline, call outcomes, and the provision of crisis services inclusive of mobile rapid response crisis teams and crisis stabilization services. | 105 | 105 (1) | Functional | Reporting |
| Custom Reports | | | | |
| Standard Reports | | | | |
| Surveys | | | | |
| Dashboards | | | | |

*Figure 60 Reporting Requirements Crosswalk*

## Appendix P: Vibrant Unified Platform: Functional Requirements and Timeline

Since 2005, Vibrant Emotional Health (referred to as Vibrant) has been the administrator of the NSPL network. There are 190 NSPL centers across the county. In 2020, Vibrant recommended that the NSPLs adopt a shared technology platform that would support.[64]

- Multi-channel crisis communication (i.e., phone, text, chat)
- Equitable and efficient connection to counselors across all channels and services
- For populations
- Seamless coordination with local crisis response services for individuals requiring urgent care
- Follow-up and community resource linkages for persons needing continuing support after contacting 988
- Interoperability across channels (i.e., transfers between modalities such as calls, chats and texts, warm transfers, *etc.*) and between services (e.g., connections to follow-up care, mobile crisis teams, 911 linkages, crisis/emergency receiving facilities)
- Unify provider data collection and reporting to effectively, efficiently and continuously monitor (across all channels) that consumer crisis needs are measured across all communities across the country
- All counselors responding to 988 contacts have access to the same training, resources, and announcements

In July 2022, Vibrant shared three spreadsheets[65] identifying the functional requirements that the Unified Platform (UP) is expected to support and whether these requirements are targeted for Release 1, 2, or some other future date. On July 14, 2022, Vibrant Emotional Health indicated that it "is working on a comprehensive timeline, but our initial plans are for R1 to be deployed in late October as a pilot with voice only (no chat/text), and R2 (added functionality – chat/text TBD) to be deployed tentatively in January 2023."[66]

The table below provides a high-level summary of the functional requirements in E2SHB 1477 and the requirements that the Vibrant UP is expected to support and when. It is very important to note the spreadsheets that Vibrant shared are:

- Working documents and thus subject to change
- Do not represent a final set of functional requirements for the NSPL crisis call centers
- Include functionalities that are not intended for the NSPLs

[64] https://www.hca.wa.gov/assets/program/unified-platform-public-final-press-release.pdf

[65] DRAFT LifeLine Core Fields v0.7; DRAFT User Profile Matrix – LifeLine; and DRAFT Vibrant User Stories_Requirements for Salesforce presented by Coastal Cloud

[66] July 14, 2014, Email communication with Vibrant Emotional Health to HCA and DOH staff.

- Challenging to interpret (upon review of an earlier version of the table below Vibrant remarked that it saw "no significant errors or issues" but "the definition of a particular functional requirement may differ."[67]

HCA and DOH analysis:

- Reviewed and cross-referenced the requirements related specifically to LifeLine functionality in the Vibrant LifeLine Core Fields spreadsheet. The LifeLine spreadsheet includes several categories of information (e.g., demographics, suicidal/homicidal ideation, safety plan, crisis plan)
- Reviewed the Vibrant spreadsheet "User Stories_Requirements for Salesforce presented by Coastal Cloud." The Coastal Cloud (CC) workbook includes content related to Lifeline users and referenced content in the Lifeline spreadsheet; and was, thus, the primary source of information for the table below
- Makes assumptions about the Vibrant UP functionality based on descriptions in the spreadsheets (e.g., the description that the Lifeline will include "location" is assumed to support the functionality of a "resource map")
- Includes notes that reference requirements in the CC spreadsheet that led to the conclusion that a particular functional requirement would be supported by the Vibrant UP. These notes are included for requirements that were particularly unclear in the Vibrant spreadsheets

| WA State Functional Requirement | Vibrant UP | | | | | |
|---|---|---|---|---|---|---|
| | Included in | | | Currently Not in Vibrant | Not enough Information | Notes: Rows in Coastal Cloud (CC) Spreadsheet |
| | R1 | R2 | Future | | | |
| **Call Center Platform: Create, Assign & Track(follow-up)** | | | | | | |
| Encounter Intake (Call/SMS/Chat) | ✓ | ✓ | | | | R1: Call-only<br>R2: SMS/Chat |
| Telephony/IVR/CTI Integration | ✓ | | | | | |
| Intake Extensibility | ✓ | | | | | |
| *Instate Routing (Note: need to consider other requirements supported by NENA i3 /911) | | | ✓ | | | |
| GPS/i.e.Geolocation location of caller | | | ✓ | | | |
| *Crisis Alerts | | | ✓ | | | |
| Least Restrictive Alternative (LRA) | | | | | | |
| Mental Health Advance Directives | | | | | | |

[67] We shared an earlier draft of the table below with Vibrant. In a July 20, 2022, email Vibrant remarked that it saw "no significant errors or issues. My caveat would be that the definition of a particular functional requirement may differ; as they say, the devil is in the details. At this point, I would not have any specific updates."

| WA State Functional Requirement | Vibrant UP | | | | | |
|---|---|---|---|---|---|---|
| | Included in | | | Currently Not in Vibrant | Not enough Information | Notes: Rows in Coastal Cloud (CC) Spreadsheet |
| | R1 | R2 | Future | | | |
| Suicide Risk Assessment | ✓ | | | | | |
| Safety / Crisis Plan | ✓ | | | | | |
| Follow-up Queue | ✓ | | | | | |
| Crisis Referrals | ✓ | | | | | See Notes: 1, 7 |
| Provider Portal | | | | | ✓ | |
| Provider Integration | | | | | ✓ | |
| Interoperable With Existing Systems | ✓ potential | | | | | See Note: 6 |
| **Responder Dispatching: Search, Dispatch & Track** | | | | | | |
| GPS/i.e.Geolocation Responder Tracking (e.g., DCR and MCRU) | | | ✓ | | | |
| Dispatch Coordination | | | ✓ | | | |
| Resource Map | ✓ | | | | | See Notes: 2, 8 |
| Provider Portal | | | | | ✓ | |
| Provider Integration | | | | | ✓ | |
| Interoperable With Existing Systems | ✓ potential | | | | | See Note: 6 |
| **Referrals and Appointments: Search, Create, Assign & Track** | | | | | | |
| Next-Day Appointments | | | Track & Remind Only | | | |
| Open loop referrals (i.e., referrals that are initiated to health and/or social services) | Note 13 | | | | | See Notes: 2, 8 |
| Closed Loop Referrals (includes health and social services) | | | | | Dependent on Provider Integration | |
| Provider-to-Provider Referrals (i.e., referrals to and from any type of health/ behavioral health provider) | | | | | Dependent on Provider Integration | |
| Resource Directory (provider and social services) | ✓ | | | | | See Notes: 3, 9 |
| Provider Portal | | | | | ✓ | |
| Provider Integration | | | | | ✓ | |
| Interoperable With Existing Systems | ✓ potential | | | | | See Note: 6 |
| **Bed Registry: Search, Schedule & Report** | | | | | | |
| Bed Availability | | | ✓ | | | See Note: 10 |
| Bed Metrics/Data | | | ✓ | | | See Notes: 4, 10 |

| WA State Functional Requirement | Vibrant UP | | | | | |
|---|---|---|---|---|---|---|
| | Included in | | | Currently Not in Vibrant | Not enough Information | Notes: Rows in Coastal Cloud (CC) Spreadsheet |
| | R1 | R2 | Future | | | |
| Provider Portal | | | | | ✓ | |
| Provider Integration | | | | | ✓ | |
| Interoperable With Existing Systems | | | ✓ | | | See Note: 6 |
| **Reporting: Create, Customize & Share** | | | | | | |
| Standard Reports | ✓ | | | | | |
| Custom Reports | ✓ | | | | | |
| Dashboards | ✓ | | | | | |
| Survey | ✓ | | | | | |
| Provider Portal | | | | | ✓ | |
| Provider Integration | | | | | ✓ | |
| Interoperable With Existing Systems | ✓ potential | | | | | See Note: 6 |
| **Electronic Health Records** | | | | | | |
| EHRs | | | | | ✓ | |
| EHRaaS | | | | | ✓ | |
| Provider Integration | | | | | ✓ | |
| Interoperable with Existing Systems | | | | | | See Note 6 |
| **Recommended Additional Functionality** | | | | | | |
| *Functional Requirements to be available for Regional Crisis Lines (in addition to NSPLs) | | | | | ✓ | |
| *Services Registry (information on services provided) | | | | | ✓ | |
| *Level of Care Assessments | | | | | ✓ | See Note: 11 |
| *Public Facing Website (i.e., for (i) provider resource directory, (ii) social service resource directory, and (iii) bed registry | | | | ✓ | | |
| Support to Tribal Governments and IHCPs | | | | | | |

**Notes:**

1. CC Salesforce Release 1 Only Worksheet: Rows 24 & 25 Column L, user is System & Lifeline (Column J)
2. CC Salesforce Release 1 Only Worksheet: Row 17, Column L, Users (Column J): Counselor (Crisis, Peer, etc.), Supervisors, Team Leads, Lifeline
3. CC Salesforce Release 1 Only Worksheet: Rows 24, Column K & Column J – System & Lifeline
4. Worksheet CC Salesforce Overall Requirements Row 47 Column K & User – System in Column J
5. CC Salesforce Overall Requirements Worksheet Column K Row 16
6. Salesforce platform is capable of interoperability; implementation will vary by integrator, content, and priorities.
7. Counselors can identify potential referral sources that match contacts' needs
8. Referral resources can be reviewed (for relevancy, location, availability, etc.) recommended, and included in call reports
9. Ability to compile a resource database that is filterable and includes keyword search. Filters include, but are not limited to: Zip code, insurance, in/out-patient, Spanish speaking.
10. Ability to include in resource database intake status/provider availability
11. Ability to include 3 required prompt questions of which answers can be related to specific secondary assessments
12. Resource Information to all Contacts, such as: 1. SAMHSA (https://www.samhsa.gov/)
13. Will include fields to assist with tracking referrals made. Stronger integration to other entities is out of scope.

*Figure 61 WA functional requirements*

## Vibrant In-Scope and Timelines

Assuming (i) pilot implementation happens by the timeline suggested by Vibrant and (ii) our assumptions regarding the Vibrant UP functionality are accurate, the following functionalities would be implemented on a piloted basis in the Vibrant UP R1 (October 2022):

| **Vibrant Pilot Implementation (projected to begin in October 2022) (R1)) for calls-only could support the following functionality either in or related to in E2SHB 1477** | |
|---|---|
| **Functional Requirement expected to be implemented in R1** | **Notes** |
| **Call Center Platform: Create, Assign & Track (follow-up):**<br>• Encounter Intake (Call-only)<br>• Telephony/IVR/CTI Integration<br>• Intake Extensibility<br>• Suicide Risk Assessment<br>• Safety / Crisis Plan<br>• Follow-up Queue<br>• Interoperable With Existing Systems | • Interoperability for all WA State requirements is dependent on Vibrant requirements that have not yet been specified)<br>• R1 will NOT include SMS/Chat |
| **Responder Dispatching: Search, Dispatch & Track:**<br>• Resource Map<br>• Interoperable With Existing Systems | • Interoperability for all WA State requirements is dependent on Vibrant requirements that have not yet been specified |

| Vibrant Pilot Implementation (projected to begin in October 2022) (R1)) for calls-only could support the following functionality either in or related to in E2SHB 1477 | |
|---|---|
| **Functional Requirement expected to be implemented in R1** | **Notes** |
| **Referrals and Appointments: Search, Create, Assign & Track**<br>• Open loop referrals (i.e., referrals that are initiated to health and/or social services)<br>• Track Crisis Referrals (Field to assist with tracking (i.e., counting) referrals)<br>• Resource Directory (provider and social services)<br>• Interoperable With Existing Systems | • R1 includes a field to assist with tracking referrals made (stronger integration to other entities is out of scope).<br>• Its unclear whether/when the Vibrant functional requirements will include links to local resource directories (e.g., WA2-1-1)<br>• Interoperability for all WA State requirements is dependent on Vibrant requirements that have not yet been specified |
| **Reporting: Create, Customize & Share**<br>• Standard Reports<br>• Custom Reports<br>• Dashboards<br>• Survey<br>• Interoperable With Existing Systems | • Interoperability for all WA State requirements is dependent on Vibrant requirements that have not yet been specified |

*Figure 62 Vibrant Scope and Timeline*

## Vibrant Out-of-Scope

Notably, the Vibrant timeline does not specify:

- When widespread/national implementation of functionality is expected (i.e., moving beyond the pilot phase of implementation)
- A date for R2, and therefore no date for implementing text/chat capabilities

In addition, as implied in the paragraph below, on-going conversations between Vibrant, the FCC and carriers suggests that, at this time, it is not possible for Vibrant to establish requirements or timelines for functional requirements related to:

- In-state call routing
- Use of GPS/geolocation to identify the location of caller and/or tracking the location of the responder (e.g., DCR and MCRU)

Vibrant Emotional Health reports having a "close relationship to Intrado who support a portion of the current 911 infrastructure and offer a PSAP lookup tool to Lifeline counselors which pulls from a database maintained by Intrado. We are actively seeking a more robust integration with 911 centers, and the ability to more effectively dispatch for emergencies. Part of this effort involves discussions with the carriers and the FCC on geolocation and the permission required to utilize more accurate information."[68]

As depicted in the table, based on the information received from Vibrant, the following functional requirements specified in E2SHB 1477 appear to be out-of-scope for Vibrant and thus, there are no timelines specified by Vibrant for these requirements.

[68] July 14 email communication between Vibrant Emotional Health and staff at the HCA and DOH.

| WA State Functional Requirement that are not addressed by Vibrant and have NO implementation timeline | Vibrant UP: Comments/Note |
|---|---|
| **Call Center Platform: Create, Assign & Track(follow-up):**<br>• Crisis Alerts<br>• Least Restrictive Alternative (LRA)<br>• Mental Health Advance Directives<br>• Provider Integration (e.g., integration with provider EMRs/EHRs) | • At some future point (date unspecified) Vibrant UP will include crisis alerts.<br>• Vibrant Emotional Health says that it will address text and chat but has not provided a timeline for doing so. |
| **Responder Dispatching: Search, Dispatch & Track:**<br>• Dispatch Coordination<br>• Provider Portal<br>• Provider Integration (e.g., integration with provider EMRs/EHRs) | |
| **Use of GPS/geolocation**:<br>• In-state call routing<br>• Location of callers and responders | Federal-level decision may permit this |
| **Referrals and Appointments: Search, Create, Assign & Track**<br>• Next-Day Appointments<br>• Closed Loop Referrals (includes health and social services)<br>• Provider-to-Provider Referrals (i.e., referrals to and from any type of health/behavioral health provider): stronger integration to other entities is out of scope<br>• Provider Portal<br>• Provider Integration | At some future point (date unspecified) Vibrant UP will include:<br>• "Track & Remind Only" for next day appointments<br>• Only includes field to assist with tracking referrals made (stronger integration to other entities is out of scope). |
| **Bed Registry: Search, Schedule & Report**<br>• Bed Availability<br>• Bed Metrics/Data<br>• Provider Portal<br>• Provider Integration<br>• Interoperable With Existing Systems | At some future point (date unspecified) Vibrant UP will include:<br>• Bed Availability<br>• Bed Metrics/Data<br>• Interoperable With Existing Systems<br>• (Note: Interoperability for all WA State requirements is dependent on Vibrant requirements that have not yet been specified) |
| **Reporting: Create, Customize & Share**<br>• Provider Portal<br>• Provider Integration | |
| **Recommended Additional Functionality**<br>• Level of Care (LOC) Assessments<br>• Public Facing Website (i.e., for (i) provider resource directory, (ii) social service resource directory, and (iii) bed registry<br>• Functional Requirements to be available for Regional Crisis Lines (in addition to NSPLs)<br>• Services Registry (information on services provided) | • The Vibrant UP functional requirements include links to certain resources (e.g., SAMHSA)<br>• Its unclear whether/when the Vibrant functional requirements will include links to local resource directories (e.g., WA2-1-1)<br>• It is unclear whether the Vibrant assessment requirements include LOC assessments |

*Figure 63 Vibrant Requirement Gap*

## Summary of Vibrant UP Functionality

Based upon an analysis of the preceding information (including the assumption that were made regarding the Vibrant functional requirements) and the requirements in E2SHB 1477, the table below summarizes what the Vibrant UP could potentially support (at some point) and what this platform is not expected to support.[69]

| WA State Functional Requirement | Vibrant UP could support | Vibrant UP may NOT support |
|---|---|---|
| **Call Center Platform: Create, Assign & Track (follow-up)** | • Encounter Intake (Call/SMS/Chat) However, no timeline is provided for text and chat.<br>• Telephony/ Interactive Voice Response (IVR) and Computer Telephony Integration (CTI) Integration<br>• Intake Extensibility<br>• Suicide Risk Assessment<br>• Safety / Crisis Plan<br>• Follow-up Queue<br>• Interoperable With Existing Systems | • Crisis Alerts<br>• Least Restrictive Alternative (LRA)<br>• Mental Health Advance Directives<br>• Provider Integration (e.g., integration with provider EMRs/EHRs) |
| **Responder Dispatching: Search, Dispatch & Track** | • Resource Map<br>• Interoperable With Existing Systems Note: Interoperability for all WA State requirements is dependent on Vibrant requirements that have not yet been specified | • Dispatch Coordination<br>• Provider Portal<br>• Provider Integration (e.g., integration with provider EMRs/EHRs) |
| • In-state call routing; and<br>• Use of GPS/geolocation (of callers and responders) | | • Note: Federal decision making needed to integrate geolocation functionality into Vibrant UP |
| **Referrals and Appointments: Search, Create, Assign & Track** | • Track & Remind Only for next day appointments<br>• Field to assist with tracking referrals made<br>• Resource Directory (provider and social services)<br>• Interoperable With Existing Systems | • Provider-to-Provider Referrals (i.e., referrals to and from any type of health/behavioral health provider)<br>• Stronger integration to other entities is out of scope<br>• Closed Loop Referrals (includes referrals to health and social services)<br>• Its unclear whether/when the Vibrant functional requirements will include links to local provider and social resource directories<br>• Provider Portal<br>• Provider Integration |

[69] The reader is reminded to keep in mind the caveat that regarding the Vibrant UP functionalities.

| WA State Functional Requirement | Vibrant UP could support | Vibrant UP may NOT support |
|---|---|---|
| **Bed Registry: Search, Schedule & Report** | • Bed Availability<br>• Bed Metrics/Data<br>• Interoperable With Existing Systems<br><br>Note: Interoperability for all WA State requirements is dependent on Vibrant requirements that have not yet been specified | • Provider Portal<br>• Provider Integration |
| **Reporting: Create, Customize & Share** | • Standard Reports<br>• Custom Reports<br>• Dashboards<br>• Survey<br>• Potential Interoperability with Existing Systems<br><br>Note: Interoperability for all WA State requirements is dependent on Vibrant requirements that have not yet been specified | • Provider Portal<br>• Provider Integration |
| **Recommended Functionality** | | • Level of Care Assessments<br>• Services Registry (information on services provided)<br>• Public Facing Website (i.e., for (i) provider resource directory, (ii) social service resource directory, and (iii) bed registry<br>• Functional Requirements to be available for Regional Crisis Lines (in addition to NSPLs) |

*Figure 64 Vibrant Requirements Support*

## Appendix Q: Crisis Documents for Exchange

E2SHB 1477 Section 102 requires that HCA and DOH coordinate to develop the technology and platforms necessary to manage and operate the behavioral health crisis response and suicide prevention system, including technologies for "a behavioral health integrated client referral system capable of providing system coordination information to crisis call center hubs and the other entities involved in behavioral health care." E2SHB 1477 requires, in part, that needed technology is interoperable and provides access to:

- Information about any less restrictive alternative treatment orders or mental health advance directives
- Safety plans and next steps for individuals as they transition to follow-up noncrisis care
- Suicide and other behavioral health crisis assessments

In addition, during the course of interviews with NSPLs and others, HCA and DOH were informed that crisis plans also need to be created and shared.

There is general agreement about the type of information these different document types should include. However, at present in Washington State there is no agreement on which document template or assessment instrument should be used.

The following table provides information about these different document types, including some of the available templates.

| Document | Content |
|---|---|
| Safety Plan | Safety plan is a tool to help someone navigate suicidal feelings and urges.[70]<br><br>Safety and Crisis Planning[71]<br><br>A plan that:[72]<br><br>• Includes strategies and tactics for managing risk, including tactics for monitoring the individual and identifying warning signs, client supervision, treatment options and victim safety planning.<br>• Identifies who will implement each aspect of the plan and<br>• Addresses any issues about adhering to confidentiality regulations.<br><br>A safety plan is a prioritized list of coping strategies and sources of support. It can help you to identify what leads to your thoughts of suicide, and how to feel better when you are having these thoughts.[73] |

[70] https://www.samaritans.org/how-we-can-help/if-youre-worried-about-someone-else/supporting-someone-suicidal-thoughts/creating-safety-plan/

[71] https://zerosuicide.edc.org/toolkit-taxonomy/safety-and-crisis-planning

[72] https://www.thenationalcouncil.org/event/safety-planning-for-danger-to-others-its-very-different-than-suicide-safety-planning-2/

[73] https://nycwell.cityofnewyork.us/en/crisis-services/safety-plan/

| Document | Content |
|---|---|
| | A safety plan: A brief intervention to help those experiencing self-harm and suicidal thoughts with a concrete way to mitigate risk and increase safety. Link provides a template.[74]<br><br>Suicide safety plans for veterans,[75] includes a template.<br><br>Vibrant has a crisis safety plan template. |
| Crisis Plan | Crisis plan is a document to let your support system and providers know how to assist you if you are undergoing a time when you need additional support or need them to take action on your behalf.<br><br>Crisis plan: resources:[76, 77] Includes a crisis plan template.<br><br>Frontier Behavioral Health has a person-centered crisis plan |
| Mental Health Advance Directive (MHADs) | MHADs sometimes referred to as Psychiatric Advance Directives. A written document that describes how you want your mental health care to be given if in the future you are judged unable to tell your care provider those decisions for yourself.<br><br>Mental Health Advance Directive template[78]<br><br>HCA Mental Health Advance Directive Webpage[79]<br><br>Chapter 71.32 RCW: Mental Health Advance Directives[80] |
| Less restrictive order/alternative (LRO/LRA) | An LRO/LRA is a court order that gives conditions that must be met for an individual to leave the hospital. Individuals with LROs/LRAs must follow the condition of the court order or they may be detained and returned to a hospital setting.[81]<br><br>LRA is outpatient treatment provided to an individual who meets criteria for commitment but is not residing in a facility providing inpatient treatment. If the court finds that the individual meets the criteria for commitment, the court can either authorize commitment of the individual for inpatient treatment or for a less restrictive alternative treatment. Release under a less restrictive alternative is subject to conditions set by the court. |

[74] https://suicidesafetyplan.com/forms/

[75] https://starttheconversation.veteranscrisisline.net/pdf/what-is-a-safety-plan/

[76] https://psychcentral.com/health/creating-a-mental-health-crisis-plan#whats-a-crisis-plan

[77] https://www.nami.org/Your-Journey/Family-Members-and-Caregivers/Being-Prepared-for-a-Crisis

[78] https://www.washingtonlawhelp.org/resource/mental-health-advance-directives

[79] https://www.hca.wa.gov/health-care-services-supports/behavioral-health-recovery/mental-health-advance-directives

[80] https://app.leg.wa.gov/rcw/default.aspx?cite=71.32

[81] What is a Less Restrictive Alternative (LRA)?

| Document | Content |
|---|---|
| Suicide Assessment | In early 2022, information was gathered from MCO/BH-ASOs regarding the three to five most frequently used assessments/screeners instruments in behavioral health (mental health and/or substance use disorder), including crisis assessment/screener instruments. The most frequently used suicide assessment was identified as the Columbia Suicide Severity Rating Scale (C-SSRS).<br><br>Information about the C-SSRS:<br>• Three versions[82]<br>• CMS one pager[83] |
| Tribal Crisis Coordination Protocols | This is a government-to-government plan that HCA develops with each Tribe that outlines the protocols for non-Tribal DCRs providing ITA and crisis services on tribal reservation lands. This information will be stored with the Indian BH Hub and HCA. However, crisis workers should be aware and be able to access these plans so that they can appropriately follow protocols for tribal members. |

*Figure 65 Document Types*

These electronic documents could be:

- Created by or with the individual (as appropriate)
- Shared with family members/significant others
- Shared with clinicians
- Accessed in real-time by emergency responders

Electronic and interoperable information enables information to be cost-effectively and efficiently created, accessed, and shared. To do so, content in documents needs to be standardized and made interoperable.

Consensus would need to be reached to standardize the content to be included for the document types listed in the table above.

Health IT standards are available to make needed content interoperable so that information can be electronically shared, accessed, and re-used by individuals who may experience crises and their family members/significant other, clinicians, and emergency responders. The standards that could be used include:

- Content standards (e.g., LOINC, SNOMED CT, ICD-10); and
- Exchange standards (e.g., HL7 Clinical Document Architecture (CDA), Fast Health Interoperability Resources (FHIR))

In addition, technology resources are available / could be developed to make available these documents at the time of crisis (e.g., use of EMRs/EHRs, repositories, web-based tools, QR codes, smart cards).

[82] https://zerosuicide.edc.org/resources/resource-database/columbia-suicide-severity-rating-scale-c-ssrs

[83] https://www.cms.gov/files/document/cssrs-screen-version-instrument.pdf

Prior to using standardized and interoperable documents, protypes will need to be tested and documents will need to be piloted. Finally, interoperable documents will need to be integrated into the NSPL call center platform and tools used by crisis responders.

## Appendix R: Standards Details

### Technical and Interoperability

**Health Level 7 (HL7):** HL7 standards are healthcare-specific formatted messages that support a variety of system integrations and interoperability—and enable EHRs to communicate with a variety of systems that operate outside the EHR. These standards focus on the application layer, which is "layer 7" in the OSI model. The HL7 standards are produced by Health Level Seven International, an international standards organization, and are adopted by other standards issuing bodies such as American National Standards Institute and International Organization for Standardization. (https://www.hl7.org) This standard is used by many health care organizations and systems, including EHRs.

**Fast Healthcare Interoperability Resources (FHIR):** Also known as HL7 FHIR, was created by the Health Level Seven International (HL7) International and also adopted by other standards organizations. This standard defines how healthcare information can be exchanged between different computer systems regardless of how it is stored including an API for exchanging electronic health records (EHR). FHIR builds on previous data format standards from HL7, except it is easier to implement because it uses a modern web-based suite of API technology, including a HTTP-based RESTful protocol, and a choice of JSON, XML or RDF for data representation. The goal of FHIR is to facilitate interoperability between legacy health care systems, making it easier to provide health care information to health care providers and individuals on a wide variety of devices from computers to tablets to cell phones, and to allow third-party application developers to provide medical applications which can be easily integrated into existing systems. (https://fhir.org) This standard is used by many health care organizations and systems, including EHRs.

**National Emergency Number Association (NENA) i3:** This Standard provides the detailed functional and interface specifications for a post-transition IP (Internet Protocol)-based multimedia Communications system, including the Core Services and legacy gateways necessary to support delivery of emergency calls via an IP-based Emergency Services IP network i3 refers to the NG911 system architecture defined by NENA, which standardizes the structure and design of Functional Elements making up the set of software services, databases, network elements and interfaces needed to process multi-media emergency calls and data for Next Generation 911 (NG911). The i3 solution supports end-to-end IP connectivity; gateways are used to accommodate legacy wireline and wireless originating networks that are non-IP as well as legacy Public Safety Answering Points (PSAPs) that interconnect to the i3 solution architecture. NENA i3 introduces the concept of an Emergency Services IP network (ESInet), which is designed as an IP-based inter-network (network of networks) that can be shared by all public safety agencies that may be involved in any emergency and a set of core services that process 911 calls1 on that network (NGCS – NG911 Core Services). The i3 PSAP is capable of receiving IP-based signaling and media for delivery of emergency calls conformant to the i3 Standard. (https://www.nena.org) This standard is used by 911 related organizations and systems.

**United States Core Data for Interoperability (USCDI)**: (https://www.healthit.gov/isa/united-states-core-data-interoperability-uscdi) USCDI is standardized set of health data classes and constituent data elements for nationwide, interoperable health information exchange. This standard is used by systems used by many health care organizations, including in EHRs.

## Content and Clinical

**Alliance of Information and Referral Systems (AIRS):** AIRS defines professional organization whose mission is to unite and serve the field and to advance the profession of information and referral (I&R) as a vital means of bringing people and services together. AIRS has developed national quality standards and methods of evaluating information and referral services. The purpose of the 27 AIRS Standards is to establish reference points that define expected practices within the field of I&R that can be used to measure the extent to which individual organizations follow those requirements. AIRS Standards provide essential guidelines that can be used to develop an I&R program to meet the needs of communities. (https://www.airs.org) This standard is used by 2-1-1 and other organizations providing I&R services.

**Logical Observation Identifiers Names and Codes (LOINC):** This standard is a laboratory and clinical terminology standard that is important for laboratory test orders and results and is one of a suite of designated standards for use in U.S. Federal Government systems for the electronic exchange of clinical health information. LOINC is used to identify data and move it seamlessly between systems. It was created and is maintained by the Regenstrief Institute, a US nonprofit medical research organization. LOINC was created in response to the demand for an electronic database for clinical care and management and is publicly available at no cost. Several standards, such as IHE or HL7, use LOINC to electronically transfer results from different reporting systems to the appropriate healthcare network. (https://loinc.org) This standard is used by many health care organizations and systems, including EHRs.

**Systematized Nomenclature of Medicine – Clinical Terms (SNOMED CT):** This is a standardized, multilingual vocabulary of clinical terminology that is used by physicians and other health care providers for the electronic exchange of clinical health information. According to the International Health Terminology Standards Development Organization (IHTSDO), which distributes the standard, SNOMED CT currently contains more than 300,000 medical concepts, divided into hierarchies as diverse as body structure, clinical findings, geographic location, and pharmaceutical/biological product. Each concept is represented by an individual number and several concepts can be used simultaneously to describe a complex condition. (https://www.snomed.org) This standard is used by many health care organizations and systems, including EHRs.

**Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR):** This is the handbook most widely used by clinicians and psychiatrists in the United States to diagnose psychiatric illnesses. Published by the American Psychiatric Association (APA), the DSM covers all categories of mental health disorders for both adults and children. It contains descriptions, symptoms, and other criteria necessary for diagnosing mental health disorders. It also contains statistics concerning who is most affected by different types of illnesses, the typical age of onset, the development and course of the disorders, risks and prognostic factors, and other related diagnostic issues. Just as with medical conditions, certain government agencies and many insurance carriers require a specific diagnosis to approve payment for support or treatment of mental health conditions. Therefore, in addition to being used for psychiatric diagnosis and treatment recommendations, mental health professionals also use the DSM to classify patients for billing purposes. (https://www.psychiatry.org/psychiatrists/practice/dsm/dsm-5) This standard is used by many health care organizations and systems specifically in the area of behavioral health.

**International Classification of Diseases (ICD):** Published by the World Health Organization (WHO), the International Classification of Diseases (ICD) contains codes for diseases, signs and symptoms, abnormal

findings, complaints, social circumstances, and external causes of injury or diseases which includes symptom codes for suicidal behavior. While WHO manages and publishes the base version of the ICD, several states and governmental organizations have modified to meet their needs. The National Center for Health Statistics (NCHS) and the Centers for Medicare and Medicaid Services (CMS) are the U.S. governmental agencies responsible for overseeing all changes and modifications to the ICD versions. (https://www.who.int/standards/classifications/classification-of-diseases) (https://www.cms.gov/Medicare/Coding/ICD10) This standard is used by many health care organizations and systems specifically in the area of behavioral health.

**Current Procedural Terminology (CPT):** Current Procedural Terminology (CPT) is a medical code set that is used to report medical, surgical, and diagnostic procedures and services to entities such as physicians, health insurance companies and accreditation organizations. (https://www.ama-assn.org/practice-management/cpt) This standard is used by many health care organizations and systems, including EHRs.

**Healthcare Common Procedure Coding System (HCPCS):** HCPCS is a collection of standardized codes that represent medical procedures, supplies, products, and services. The codes are used to facilitate the processing of health insurance claims by Medicare and other insurers. HCPCS is divided into two subsystems, Level I and Level II. Level I is comprised of Current Procedural Terminology® codes (HCPT). HCPT codes consist of five numeric digits. Level II HCPCS codes identify products, supplies, and services not included in CPT. Level II codes consist of a letter followed by four numeric digits. Current Dental Terminology codes are included in the Level II codes as HCDT. (https://www.cms.gov/medicare/coding/medhcpcsgeninfo) This standard is used by many health care organizations and systems, including EHRs.

### Information about interoperability technology

Application programming interface (API) is the technology that will be used for integration and interoperability between systems in this 1477 system architecture and the primary technology for the interoperability platform. Where possible the state will use well known and common programming languages and industry accepted protocols and architecture styles. Exceptions to these principals may be allowed within in reason, when the system may need to interface with legacy systems that may exist with the provider. The state systems will require vendors to use common technical and content standards listed.

An API is designed to expose certain aspects of an application's business logic on a server, and SOAP uses a service interface to do this while REST uses Uniform Resource Identifier (URIs). While SOAP APIs are designed after the functions that the API exposes, REST APIs are designed after the data. API architectures, it's common to compare SOAP vs. REST, two of the most common API paradigms. Although the two are often compared they're inherently different technologies because SOAP is a protocol, and REST is an architectural style. A REST API can utilize the SOAP protocol, just like it can use HTTP. REST APIs are based on URIs (Uniform Resource Identifier, of which a URL is a specific type) and the HTTP protocol and can use JSON for a data format, which is browser compatible. REST is optimized for the web and can use JSON as its data format making it compatible with browsers. When a client request is made via a RESTful API, it transfers a representation of the state of the resource to the requester or endpoint. This information, or representation, is delivered in one of several formats via HTTP: JSON (Javascript Object Notation), HTML, XLT, Python, PHP, or plain text. JSON is the most generally popular file format to use because, despite its name, it's language-agnostic, as well as readable

by both humans and machines. REST is known for excellent performance and scalability, but like any technology, it has its disadvantages that could slow down the app. That's why languages like GraphQL have come along to address problems even REST can't solve.

Fast Healthcare Interoperability Resources (FHIR) is a standard that describes data formats and elements as well as an API for exchanging health care data. The FHIR format is highly regarded as the future of healthcare formatting as it continues to overtake older standards such as Health Level Seven International (HL7). For coding purposes, it looks fairly similar to another popular format, JSON, as both use objects like JavaScript. Because FHIR looks so similar to JSON, it can be easily converted if needed, unlike HL7 which would require more complex conversions.

The Center for Medicare and Medicaid Services (CMS) has issued a rule requiring some government-funded plans, such as Medicaid and Qualified Health Plan payers, to build their APIs using FHIR to improve access and cut prior authorization turnaround times. Because healthcare technology is often dealing with very sensitive, private information, enhanced security measures are necessary. Many parties could be connecting to a healthcare API, so no compromises can be made with regards to security. The systems needed to meet E2SHB1477 contain patient data and are required to comply with HIPAA regulations and in some cases 42 CFR Part 2. The state must comply with building APIs using FHIR as well as ensure all security precautions are met. The state has made investments in Universal API management (UAPIM) specifically Mulesoft which enables organizations to work with any API regardless of its origin or protocol. Many of the vendors interviewed are planning to have APIs within their native systems or have recognized this need and starting to build APIs in their systems to facilitate easier integration to other systems as well as the state's planned EHRaaS using Epic. This functionality was not demonstrated and only discussed during the discovery stage because this function is not complete in many of the systems explored. Along with interoperability using standards, these systems will need to be interoperable with other systems such as 911 or 2-1-1 that use other standards. These interoperability needs will be determined as the architecture and vendors are defined.

## Appendix S: Proposed User Roles

| Role | Description | Some Possible Permissions & Data Access |
|---|---|---|
| System Administrator | Each separate system will have administrators defined separately:<br>Role applied to users requiring full access to analytics, reporting, users, quality assurance portals, etc. (i.e., NSPL Crisis Call Hub administrator/supervisor)<br>Integrated Referral System will have different administrators with the same types of permissions.<br>Integrated Referral System will have different administrators with the same types of permissions. | • Full control of reporting & analytics<br>• User management access (add/delete users, assign any role or data restriction).<br>• Ability to grant administrator permissions to users<br>• 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<br>• Access to upload/amend provider service data<br>• Ability to send, receive and respond to referrals |
| DCR | Role applied to Designated Crisis Responders | • Access to active response data<br>• Access to upload encounter notes/reports |
| MCRU | Role applied to Mobile Crisis Response Units | • Access to active response data<br>• 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<br>• Ability to send, receive and respond to referrals |
| Tribal Governments | Role applied to both tribal governments as governments and providers for their IHCPs | • Different levels need to be established within the Tribal government that reflects the DSA |

*Figure 66 Proposed User Roles*

## Appendix T: Procurement Approach

For the procurement process to be successful, DOH and HCA must:

- Identify what needs to be procured:
  - What type vendors are needed to meet the functional and technical requirements as part of a system-of-systems design?
  - Is there a need to procure services? Are implementation resources / consultants needed to lead or support the project?
  - Is there a need for any custom software or interface development?
  - Is there any new technology that is needed or upgrades to the infrastructure, for instances, cloud vendor, integration engines etc.
- Identify who will be involved in the procurement process: The joint HCA and DOH teams will be included as will the NSPL workgroups(s). Tribal governments, IHCPs, regional health and other partners may also want to participate.
- Identify the procurement lead: Will this be a DOH Procurement or HCA? Who will be involved in the procurement process? Who will own the resulting contracts? Are their legislative reviews and approvals that need to be taken into consideration?

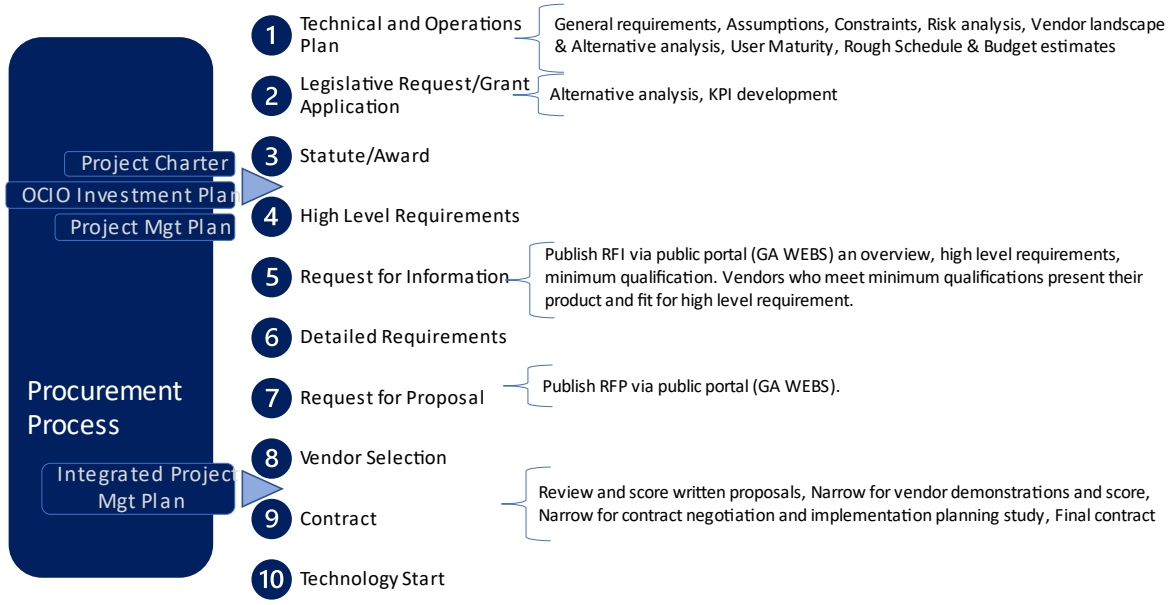


*Figure 67 Procurement Process*

The Agencies will follow WA state best practices and standards. Examples of the standard RFI, RFP and contract templates are available from the agencies.

## Appendix U: Project Management Approach

### Project Governance

The Technology details of E2SHB 1477 is a partnership of HCA and DOH, whose goal is to support the technology needed in the NSPLs and the data and technical handoffs from NSPL Hubs to regional or escalated care. The technology solution(s) will be unified technology requirement for all WA based NSPLs. In addition, it is hoped that regional behavioral health partners, managed by HCA, can also benefit from the chosen technology.

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*The department and authority must coordinate to develop the technology and platforms necessary to manage and operate the behavioral health crisis response and suicide prevention system.*

---

**Lead Agency for Technology**: The law details that DOH is lead in developing the call center technology for the NSPLs Call center and that HCA is the lead in developing the referral and interoperability technology.

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*This platform…shall be developed by the department (DOH) and must include the capacity to receive crisis assistance 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; and*

*A behavioral health integrated client referral system capable of providing system coordination information to crisis call center hubs and the other entities involved in behavioral health care. This system shall be developed by the authority (HCA).*

---

**Agency Coordination**: The Project governance must partner HCA's technology division, HCA's regional health division, DOH NSPLs, the CRIS committee, and supporting agencies. To ensure agency unity, the bill created a position in the Governor's office for a 988 Hotline & Behavioral Health Crisis System Coordinator.

**Product Lifecycle Ownership and User group**: Success of the chosen technology requires deep involvement of the eventual end users of the technology in the NSPLs and product ownership at DOH for the initial technology build and the ongoing enhancement and lifecycle support that will be needed. As such, DOH is working with NSPLs to organize user groups with focus on NSPL hub workflow and handoffs to other behavioral health partners to detail for the vendor(s) the detailed requirements for the technology tools needed to support their operations and data and reporting requirements.

*The department (DOH) shall designate crisis call center hubs by July 1, 2024. The crisis call center hubs shall provide crisis intervention services, triage, care coordination, referrals, and connections to individuals contacting the 988 crisis hotline from any jurisdiction within Washington 24 hours a day, seven days a week, using the system platform developed under subsection (5) of this section.*

The resulting draft project organization is written to support communications and decision-making.

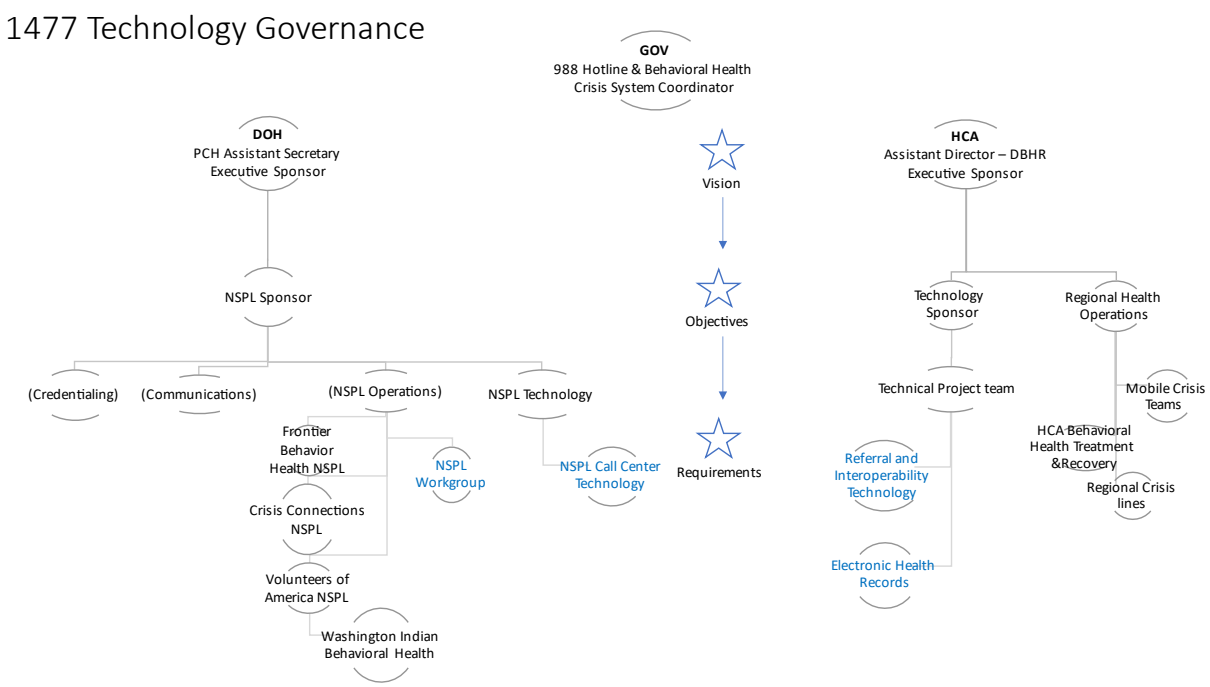


*Figure 68 Draft Technology Governance Chart*

## Formal Methodology

**Project Management**: HCA and DOH both subscribe to a combination of Project Management Body of Knowledge (PMBOK) and industry project management best practices. Formalized processes for work plan development, resource management, scope management, contract management, change requests, risk management, and issue management are documented, followed, and well exercised over the history of both agencies' projects.

**Solution Delivery Standards**: HCA and DOH both subscribe to standards for Solution Design including architecture, requirements, code development, testing, training, platform and network. These formal processes will be detailed as part of project planning and employed throughout. The configuration methodology employed with vendors is typically negotiated, and in some cases prescribed by, the software vendor.

To support project management and solution delivery practices, the project will employ external quality assurance and Independent Verification & Validation (IV&V) as oversight and assistance in confirming the project is using best practices.

## Timeline and Phased Approach

The draft timeline below proposes a schedule to meet the legislative deadlines outlined in the bill. The combined teams feel this is a very aggressive schedule for the complexity of this technical solution. The Call Center software proposal and selection must consider the full suite of requirements wholistically for which multiple vendors, will be selected to deliver each segment. This timeline will be more accurate following the Request for Information and the schedule fully negotiated as part of the RFP and resulting contract(s). It is expected that the timeline will reflect a phased or gated deliverable schedule and corresponding deliverable expectations will detail the approving authorities for each deliverable.

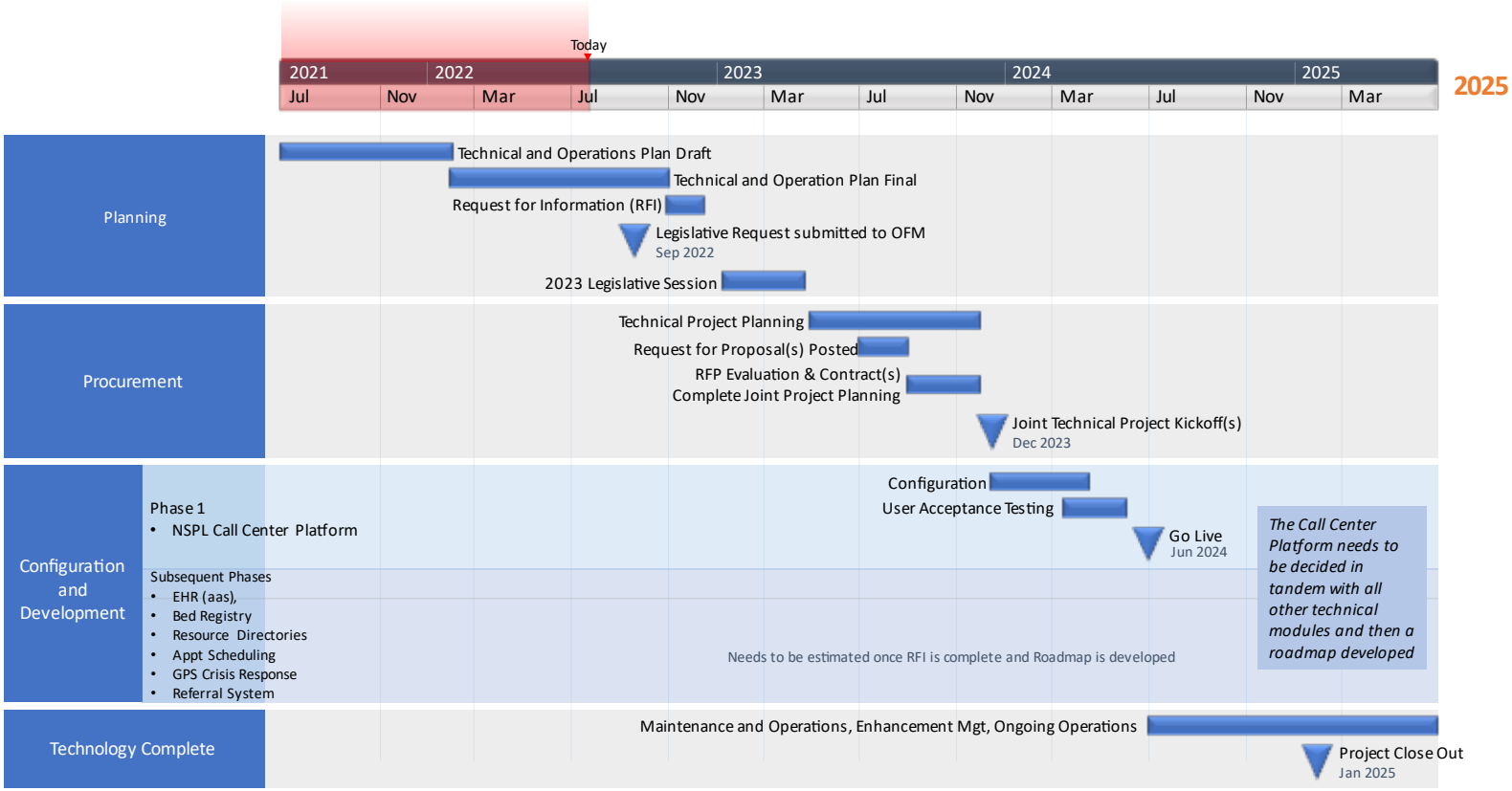


*Figure 69 Draft timeline*

To mitigate the complexity risk, the team recommends a phased implementation approach. The Call Center Platform is the core for which the remaining functionality must interface with. The draft timeline considers a multiple phased approach. Furthermore, a Milestone/Gate strategy should be applied. As part of the project planning exercise, and as part of vendor negotiations, the contractual key milestones and project gates will be explicit to ensure all tasks are completed prior to moving to the next phase of the project.

| PHASE | ACTIVITIES |
|---|---|
| **Phase 1** | Call Center Platform should be live for MVP (minimum viable product). |
| **Subsequent Phases** | Selected lead vendor, in collaboration with and in agreement by HCA and DOH, will integrations should be the focus of future phases (e.g., referral system, EHRs, bed registry, additional resource directories, appointment scheduling, crisis reporting, GPS). |

*Figure 70 Phased Implementation*

## Implementation Risk Planning

### Risk Analysis

The 988 project faces several risks that stem from both internal and external factors. The implementation plan can work to mitigate these risks to varying degrees. There are risks that relate to technological and data environments, organization structure and decision making that may be needed to align in new ways to support new business processes and risks related to funding. The list of risks below is only a preliminary risk analysis.

There are a number of high-risk issues facing the project and therefore a considerable risk allowance of 25-30% contingency has been included in the budget model. Most risks have the potential to impact the rate of implementation thereby delaying benefits and impacting project costs rather than posing risks to persons safety.

### Project Risk Register

| RISK | LIKELIHOOD | IMPACT | RISK LEVEL |
|---|---|---|---|
| **Scope Creep** | Likely 4 | Significant 3 | High 12 |
| **Dependency on Consolidation of Systems** | Likely 4 | Significant 3 | High 12 |
| **Dependency on Transformation Projects** | Likely 4 | Significant 3 | High 12 |

| | | | |
|---|---|---|---|
| **Inadequate Funding** | Possible 3 | Significant 3 | Moderate 9 |
| **Lack of Enabling Structures & Policy** | Possible 3 | Significant 3 | Moderate 9 |
| **Lack of Stakeholder Support** | Unlikely 2 | Major 4 | Moderate 8 |

*Figure 71 Project Risk Register*

## Appendix V: Technology Stakeholders and Partners

The activities for 988 go live and for E2SHB 1477 engage a substantial list of Tribal Partners and Stakeholders. This work crosses many state and federal agencies, behavioral health services and providers, related legislation, and direct involvement from our legislators and the community.

The technology solution as detailed in this plan, is the tool to coordinate services provided and the handoffs between entities. Therefore, many of the partners identified in E2SHB 1477 are impacted by the technology decisions. They can be categorized as:

- Users of the technology: Staff and behavioral health partners who will be the end users of the systems and data
- Vendors who supply the technology and all support services for vendor management
- Key populations benefit from the technology

---

*"Provide higher quality support for people experiencing behavioral health crises through investment in new technology to create a crisis call center hub system to triage calls and link individuals to follow-up care"*

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- Advising and authorizing partners: Agency and oversite entities defines in the bill and approvers of this technology plan and subsequent technology acquisitions
- Stewards of the technology: Primarily Health Care Authority and Department of Health however some components may be held by other agencies or federal partners

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*"The department and authority must coordinate to develop the technology and platforms necessary to manage and operate the behavioral health crisis response and suicide prevention system."*

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- Funding stakeholders: Sources who will fund the technology platforms in their inception and ongoing

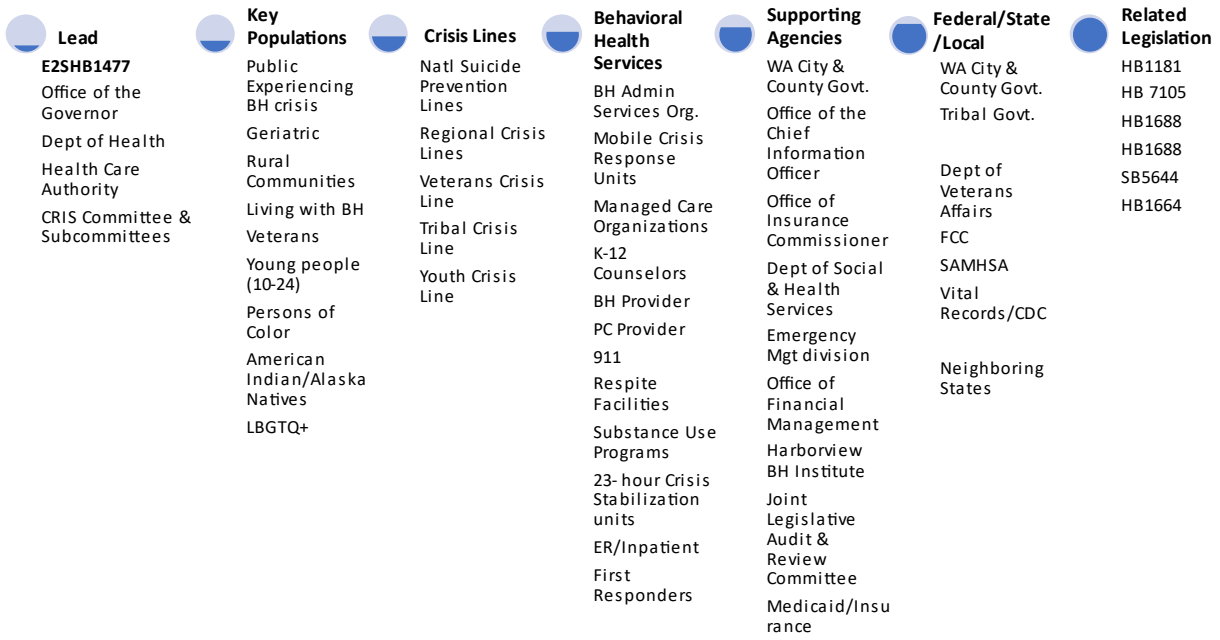


*Figure 72 Stakeholders*

**Users of the Technology:**

NSPLs: NSPLs are the primary users of the systems as key stakeholders. The tools selected directly support their work and all handoffs to other behavioral health services such as regional BH-ASOs.

BH-ASOs: BH-ASOs may also use the selected technology as their primary system. Alternatively, they may use only the interoperability tools to receive information needed for client handoff.

Interoperable group (transfer services): When a client is transferred from a call center to another entity such as a mobile health provider, this group is expected to use the interoperability tools to receive information needed for client handoff.

**Vendors who supply the technology and all support service s for Vendor Management**

This Technology and Operations Plan details the vendor landscape to supply the needed technology component. The selected solution may use one or many vendors. The state procurement and contracting standards prescribe the steps in acquiring and ongoing partnering with the selected vendor(s).

Vibrant is a vendor procured by SAMHSA to build and manage the call center software that is currently used in the three NSPLs. Vibrant is both a stakeholder as a vendor and also a stakeholder as a current technology partner.

**Public who benefits from the technology: Key Populations**

The public who uses 988 and all supporting services benefit from the behavioral Health infrastructure and selected technology and tools to support that infrastructure. A goal of the technology solution is to

aid in service delivery and transition to additional services if needed so a representative can attend to the caller.

E2SHB 1477 summarizes the technology goals as:

> *"Provide higher quality support for people experiencing behavioral health crises through investment in new technology to create a crisis call center hub system to triage calls and link individuals to follow-up care"*

In addition, there are key populations with technical services that are unique to their demographic such as veterans, youth, tribal etc. There are unique services available to these groups and the technology solution needs to support available options.

**Advising and Authorizing Partners**

This Technology and Operations Plan has a broad list of reviewers which will aid in the adoption of the plan and eventual support of the technology funding required.

The Technology and Operations plan *reviewers* are:

- Governor
- Office of Financial Management (OFM)
- Steering Committee of the Crisis Response Improvement Strategy committee
- Fiscal committees of the legislature, which shall include:
    - Senate ways and means committee chair
    - House of representatives appropriations committee chair
    - Senate Environment, Energy and Technology committee chair
    - Senate Behavioral Health subcommittee chair
    - House of Representatives health care and wellness committee chair

It is likely that additional plan reviewers will be identified throughout this discovery phase.

The Technology and Operations plan approvers are:

- Office of the Chief Information Officer
- Director of Office of Financial Management
- Steering Committee of the Crisis Response Improvement Strategy committee which shall consider any feedback received from:
    - Senate ways and means committee chair
    - House of representatives appropriations committee chair
    - Senate Environment, Energy and Technology committee chair
    - Senate Behavioral Health subcommittee chair
    - House of Representatives health care and wellness committee chair

**Stewards of the Technology**

The bill details Department of Health and Health Care Authority as the technology stewards. HCA will lead the technology solutions that it will manage and is responsible for ensuring interoperability across all tools/systems implemented in for E2SHB 1477. DOH will lead the technology solutions it will manage. For solutions that are used jointly by HCA and DOH programs, leadership and management of these tools will be determined.

**Funding Stakeholders**

Multiple funding sources will be needed to support the implementation of the technology systems and platforms required under E2SHB 1477. Some of the possible funding sources include Medicaid, state appropriations, state tax, grants, and commercial insurance carriers. Work is needed to identify and braid funding sources.

# Glossary

**Accountable Community of Health (ACHs):** Accountable Communities for Health (ACHs) are collaborative partnerships spanning health, public health, and social services that seek to improve the health of individuals and communities by addressing social determinants of health such as housing, food security, employment, and transportation.

**Active Rescue:** When a person presents imminent danger to self or others. Examples may be person has a weapon and is actively threating self or others, is physically in a dangerous location such as on a bridge or in traffic and presents a risk to self or public safety.

**Adult Family Homes (AFH):** These are residential homes licenses to care for up to 6 non-related residents.

**American Indian & Alaska Native (AI/AN)** persons**:** American Indian & Alaska Native peoples

**American Indian Health Commission (AIHC):** AIHC is a tribally driven non-profit organization with a mission of improving health outcomes for American Indians and Alaska Natives (AI/AN) through a health policy focus at the Washington State level.

**Application Programming Interface (API):** API stands for "application programming interface." An API is essentially a set of rules that dictate how two machines talk to each other

**Attorney General's Office (AGO):** Advises the Governor, members of the Legislature, other state officers, and county prosecutors on legal issues; and represents the State of Washington before the Supreme Court, the Court of Appeals, and trial courts in all the cases involving the state's interest and defends in court state officers or employees ethically acting in their official capacities.

**BH-ASOs:** Behavioral Health Administrative Service Organization.

**Call Center as a Service (CCaaS):** Call center as a service (CCaaS) is a cloud-based application that enables customer service organizations to manage multichannel customer interactions holistically (using self- and assisted-service) from both customer experience and an employee experience perspective.

**Caregiver** – can mean any parent or adult referring a youth for mobile crisis response, a foster parent with a foster child in their care or a social worker with the Department of Children Youth and Families who represents any youth in state custody.

**Child Protective Services (CPS)**: under the DCYF umbrella, commonly known as "child welfare" and investigates reports of child abuse or neglect.

**Closed Loop Referral**: A bi-directional electronic, interoperable referral workflow that enables (i) a sending provider to create and send a referral to a receiving provider; (ii) the receiving provider to accept or decline the referral; and (iii) the receiving provider to create and send a report to the sending provider regarding the outcome of the referral, including next steps beyond the referral itself.

**Community-Based Organizations (CBOs):** Non-profit, non-governmental, or charitable organizations that represent community needs and work to help them.

**Consolidated Clinical Document Architecture (CCDA):** The HL7 Consolidated Clinical Document Architecture (C-CDA) is an XML-based markup standard which provides a library of CDA formatted documents.

**Coordinated Care Platform (CCP):** CoCentrix Coordinated Care Platform – EHR designed by Solari.

**Crisis Connections:** Crisis Connections, formerly known as Crisis Clinic, is home to five programs focused on serving the emotional and physical needs of individuals across Washington State.

**Crisis Response Improve Strategy (CRIS):** Established in E2SHB 1477, Crisis Response Improvement Strategy (CRIS) Committee and Steering Committee will develop recommendations to support implementation of the national 988 suicide prevention hotline and the statewide improvement of behavioral health crisis response and suicide prevention services.

**Crisis Stabilization Facility Services:** Stabilization services are provided following initial contact and de-escalation with an individual in crisis. These services can be provided in the home, the community or a facility. Crisis stabilization facilities provide short-term (under 24 hours) observation and crisis stabilization services in a home-like, non-hospital environment. These services are meant to further stabilize the person experiencing the crisis, support them in returning to a non-crisis state and help prevent future crises.

**Customer Relationship Management (CRM):** A technology for managing all a company's relationships and interactions with customers and potential customers. The goal is to: Improve business relationships. A CRM system helps companies stay connected to customers, streamline processes, and improve profitability.

**Department of Children, Youth and Families (DCYF):** The Washington State agency that has custodial authority of youth in state custody, CPS is under DCYF authority.

**Department of Health (DOH):** A Washington State agency that works with others to protect and improve the health of all people in Washington state. DOH programs and services help prevent illness and injury, promote healthy places to live and work, provide information to help people make good health decisions and ensure our state is prepared for emergencies.

**Designated Crisis Responder (DCR):** A mental health professional appointed by the county, by an entity appointed by the county, or by the authority in consultation with a federally recognized Indian tribe or after meeting and conferring with an Indian health care provider, to perform the duties specified the involuntary treatment statutes, RCW 71.05 for adults and RCW 71.34 for adolescents.

**E2SHB 1477:** Engrossed 2nd Substitute House Bill 1477 in Washington State Legislature implementing the national 988 system to enhance and expand behavioral health crisis response and suicide prevention services.

**Electronic Health Record (EHR):** An electronic version of a patient's medical record, maintained by a provider over time, and may include all of the key administrative clinical data relevant to a person's care under a particular provider, including demographics, progress notes, problems, and medications.

**Electronic Health Record as a Service (EHRaaS):** HCA's Epic EHR implementation that, when implemented, is made available to targeted providers in the state (behavioral health, rural, tribal, and Long-Term Care (LTC)) to support equitable services, care coordination, and whole person care.

**Emergent:** An emergent crisis is an extreme risk and requires a two-hour response time

**Federal Communications Commission (FCC):** Regulates interstate and international communications through cable, radio, television, satellite, and wire.

**Frontier Behavioral Health (FBH):** A nonprofit trauma-informed care organization that provides clinically and culturally appropriate behavioral healthcare and related services.

**Genesys Cloud** (formerly PureCloud): A platform that helps the user connect with customers, manage relationships, see trends, and deliver real-time information to agents and employees

**HB1181:** House Bill 1181 Washington State Legislature, establishing programs and measures to prevent suicide among veterans and military members.

**HB1644:** House Bill 1644 Washington State Legislature, permitting funds in the transportation vehicle fund to be used for electric and other clean pupil transportation vehicle feasibility planning and fueling station infrastructure.

**HB1688:** House Bill 1688 Washington State Legislature, protecting consumers from charges for out-of-network health care services, by aligning state law and federal no surprises act and addressing coverage of treatment for emergency conditions.

**HB7105:** Part of Veterans Health Care and Benefits Improvement Act of 2020. The bill implements various updates to policies and programs for veterans, including those related to education, pandemic assistance, benefits, health care, homelessness, personnel, and financial matters.

**Health Care Authority (HCA):** Purchaser of health care for more than 2.5 million Washington residents through Apple Health (Medicaid), the Public Employees Benefits Board (PEBB) Program, the School Employees Benefits Board (SEBB) Program, and the COFA Islander Health Care Program. As the largest health care purchaser in the state, HCA leads the effort to transform health care, helping ensure Washington residents have access to better health and better care at a lower cost.

**HealthierHere (HH):** A non-profit dedicated to improving health and advancing equity. An Accountable Community of Health (ACH) serving King County and Cowlitz, Muckleshoot, and Snoqualmie Tribes.

**HTML:** Hypertext markup language, a formatting system for displaying material retrieved over the Internet. Each retrieval unit is known as a Web page (from World Wide Web), and such pages frequently contain hypertext links that allow related pages to be retrieved.

**Washington Indian Behavioral Health Hub:** A central resource point for those affiliated with the Native American and Alaskan Native Communities.

**Integration:** A connection between software systems that allows for the exchange of data and information in a way that all software systems involved can process and understand.

**Interoperability:** The ability of different information systems, devices and applications (systems) to access, exchange, integrate and cooperatively use data in a coordinated manner, within and across

organizational, regional and national boundaries, to provide timely and seamless portability of information and optimize the health of individuals and populations globally (HIMSS).

**JavaScript Object Notation (JSON):** An open data interchange format that is both human and machine-readable. JSON is independent of any programming language and is a common API output in a wide variety of applications.

**LGBTQ+:** An abbreviation for **lesbian**, **gay**, **bisexual**, **transgender**, and **queer** (or **questioning)**. The "+" at the end symbolizes inclusivity of other sexual orientations or gender identities that are not cishet **(**cisgender**,** heterosexual**).**

**Long-Term Care (LTC):** A variety of services designed to meet a person's health or personal care needs during a short or long period of time.

**Managed Care Organizations (MCOs):** A health care delivery system organized to manage cost, utilization, and quality. Medicaid managed care provides for the delivery of Medicaid health benefits and additional services through contracted arrangements between state Medicaid agencies and managed care organizations (MCOs) that accept a set per member per month (capitation) payment for these services.

**Mental Health Advanced Directive (MHAD):** A psychiatric or mental health advance directive is a legal tool that allows a person with mental illness to state their preferences for treatment in advance of a crisis.

**Mental Health Crisis:** A situation in which a person's thoughts, emotions, and behaviors can put them in jeopardy of harming themselves or others and/or put them at risk of being unable to care for themselves or access food, clothing, and shelter.

**Mobile Crisis Team (Unit):** Crisis professionals, typically therapists or social workers, who will go to an individual in crisis for an onsite assessment. When possible, they will attempt to de-escalate and stabilize the patient at the site, so the patient does not need to be moved offsite to access a higher level of care.

**Mobile Crisis Response (MCR) team:** Community-based outreach team with the ability to respond to and provide crisis services in the community (e.g., homes, schools, shelters). These are crisis professionals, typically therapists or social workers, who will go to an individual in crisis for an onsite assessment. When possible, they will attempt to de-escalate and stabilize the patient at the site, so the patient does not need to be moved offsite to access a higher level of care.

**Mobile Response and Stabilization Services (MRSS):** Youth and family crisis continuum of care model adapted by states nationwide. Key concepts are the youth, parent or caregiver define the crisis, not the call taker, there is an in-person response without law enforcement, developmentally appropriate interventions, engagement and outreach, partnerships with all child serving systems of care, a separate but connected in-home stabilization phase up to eight weeks in most states. The youth is maintained in their home environment and lessen out of home interventions, ED use, inpatient units or residential care, and the MCR team does warm handoffs to additional clinical services as needed.

**National Suicide Prevention Lifeline (NSPL):** National network of providers that offer free and confidential emotional support services for individuals in crisis. NSPLs are now referred to as "988

Suicide and Crisis Lifelines." The three NSPLs in Washington offer multiple lines of business, one of which is NSPL/988 crisis calls. For purposes of the Technical and Operational Plan, the acronym "NSPL" is used to refer to the organizations in Washington State that receive 988 crisis calls.

**Office of Cyber Security (OCS):** A WaTech office providing strategic direction for cybersecurity and protects the state government network from growing cyber threats.

**Office of Financial Management (OFM):** Supplier of vital information, fiscal services, and policy support that the Governor, Legislature and state agencies need to serve the people of Washington.

**Office of the Chief Information Officer (OCIO):** Sets information technology (IT) policy and direction for the State of Washington. The State CIO is a member of the Governor's Executive Cabinet and advisor to the Governor on technology issues.

**Public Safety Answering Points (PSAPs):** Sometimes called public-safety access point, a PSAP is a call center where emergency/non-emergency calls (like police, fire brigade, ambulance) initiated by any mobile or landline subscriber are terminated.

**Regional Crisis Lines (RCLs):** Often the main access point for a person seeking behavioral health services and serve as a way for someone to navigate a complex system and find the support they need. RCLs are operated by BH-ASOs.

**Representational State Transfer (REST):** A software architectural style that describes a uniform interface between decoupled components on the Internet in a Client-Server architecture. REST defines four interface constraints: identification of resources, manipulation of resources, self-descriptive messages, and hypermedia as the engine of application state.

**RESTful Web Services:** REST Architecture based Web Services. In REST Architecture everything is a resource. RESTful web services are light weight, highly scalable and maintainable and are very commonly used to create APIs for web-based applications.

**Routine/Follow-up:** Care that occurs after crisis response services are provided by an MCR team

**SB5644:** Senate Bill 5644 in Washington State Legislature concerning providing quality behavioral health co-response services.

**Safety Plan:** A written document that includes strategies and sources of support to help an individual prepare for and stay safe during a crisis. A safety plan may include names of and contact information for persons who may be able help the individual.

**Substance Abuse and Mental Health Services Administration (SAMHSA):** The agency within the U.S. Department of Health and Human Services (HHS) that leads public health efforts to advance the behavioral health of the nation. Charged with reducing the impact of substance abuse and mental illnesses of America's communities.

**Service Level Agreement:** Specifies expectations between the service provider and the customer and describes the products or services to be delivered, point of contact for problems, and metrics to monitor the process.

**Tribal Centric Behavioral Health Advisory Board (TCBHAB):** A statewide board to oversee the implementation and operation of tribally operated inpatient behavioral health facilities across Washington State.

**U.S. Department of Health and Human Services:** The federal agency whose mission is to enhance the health and well-being of all Americans, by providing for effective health and human services and by fostering sound, sustained advances in the sciences underlying medicine, public health, and social services. HHS is comprised of the Office of the Secretary and 11 operating divisions, which includes the Centers for Medicare and Medicaid Services (CMS) and SAMHSA.

**Urgent:** Urgent crises are moderate to serious risk and require a 24-hour response.

**Vibrant Unified Platform (Vibrant UP):** The national platform that will be implemented for the 988 crisis call system.

**Volunteers of America (VOA) Western Washington:** A crisis call center that assists with food banks, rent and utility assistance, crisis counseling, mediation, and other services.

**Washington Indian Behavioral Health Hub:** Central resource point for those affiliated with the American Indian and Alaskan Native (AI/AN) communities.

**Wellness Recovery Action Plan (WRAP):** A recovery and crisis prevention plan created by the patient. WRAP is a tool for patients to learn how to take charge of their own health and wellness, and ways to cope with illness on a daily basis.

**YAML:** A data serialization language that is often used for writing configuration files.

**Youth:** "Child," "juvenile," and "youth" are any unemancipated individuals under the chronological age of 18 years.