2SHB 1134 - H AMD **312**
By Representative Orwall

ADOPTED 03/06/2023

Strike everything after the enacting clause and insert the following:

"Sec. 1. RCW 71.24.025 and 2021 c 302 s 402 are each reenacted and amended to read as follows:

Unless the context clearly requires otherwise, the definitions in this section apply throughout this chapter.

(1) "988 crisis hotline" means the universal telephone number within the United States designated for the purpose of the national suicide prevention and mental health crisis hotline system operating through the national suicide prevention lifeline.

(2) "Acutely mentally ill" means a condition which is limited to a short-term severe crisis episode of:

(a) A mental disorder as defined in RCW 71.05.020 or, in the case of a child, as defined in RCW 71.34.020;

(b) Being gravely disabled as defined in RCW 71.05.020 or, in the case of a child, a gravely disabled minor as defined in RCW 71.34.020; or

(c) Presenting a likelihood of serious harm as defined in RCW 71.05.020 or, in the case of a child, as defined in RCW 71.34.020.

(3) "Alcoholism" means a disease, characterized by a dependency on alcoholic beverages, loss of control over the amount and circumstances of use, symptoms of tolerance, physiological or psychological withdrawal, or both, if use is reduced or discontinued, and impairment of health or disruption of social or economic functioning.

(4) "Approved substance use disorder treatment program" means a program for persons with a substance use disorder provided by a treatment program licensed or certified by the department as meeting standards adopted under this chapter.

(5) "Authority" means the Washington state health care authority.

(6) "Available resources" means funds appropriated for the purpose of providing community behavioral health programs, federal

funds, except those provided according to Title XIX of the Social Security Act, and state funds appropriated under this chapter or chapter 71.05 RCW by the legislature during any biennium for the purpose of providing residential services, resource management services, community support services, and other behavioral health services. This does not include funds appropriated for the purpose of operating and administering the state psychiatric hospitals.

(7) "Behavioral health administrative services organization" means an entity contracted with the authority to administer behavioral health services and programs under RCW 71.24.381, including crisis services and administration of chapter 71.05 RCW, the involuntary treatment act, for all individuals in a defined regional service area.

(8) "Behavioral health aide" means a counselor, health educator, and advocate who helps address individual and community-based behavioral health needs, including those related to alcohol, drug, and tobacco abuse as well as mental health problems such as grief, depression, suicide, and related issues and is certified by a community health aide program of the Indian health service or one or more tribes or tribal organizations consistent with the provisions of 25 U.S.C. Sec. 1616l and RCW 43.71B.010 (7) and (8).

(9) "Behavioral health provider" means a person licensed under chapter 18.57, 18.71, 18.71A, 18.83, 18.205, 18.225, or 18.79 RCW, as it applies to registered nurses and advanced registered nurse practitioners.

(10) "Behavioral health services" means mental health services as described in this chapter and chapter 71.36 RCW and substance use disorder treatment services as described in this chapter that, depending on the type of service, are provided by licensed or certified behavioral health agencies, behavioral health providers, or integrated into other health care providers.

(11) "Child" means a person under the age of eighteen years.

(12) "Chronically mentally ill adult" or "adult who is chronically mentally ill" means an adult who has a mental disorder and meets at least one of the following criteria:

(a) Has undergone two or more episodes of hospital care for a mental disorder within the preceding two years; or

(b) Has experienced a continuous psychiatric hospitalization or residential treatment exceeding six months' duration within the preceding year; or

(c) Has been unable to engage in any substantial gainful activity by reason of any mental disorder which has lasted for a continuous period of not less than twelve months. "Substantial gainful activity" shall be defined by the authority by rule consistent with Public Law 92-603, as amended.

(13) "Clubhouse" means a community-based program that provides rehabilitation services and is licensed or certified by the department.

(14) "Community behavioral health program" means all expenditures, services, activities, or programs, including reasonable administration and overhead, designed and conducted to prevent or treat substance use disorder, mental illness, or both in the community behavioral health system.

(15) "Community behavioral health service delivery system" means public, private, or tribal agencies that provide services specifically to persons with mental disorders, substance use disorders, or both, as defined under RCW 71.05.020 and receive funding from public sources.

(16) "Community support services" means services authorized, planned, and coordinated through resource management services including, at a minimum, assessment, diagnosis, emergency crisis intervention available twenty-four hours, seven days a week, prescreening determinations for persons who are mentally ill being considered for placement in nursing homes as required by federal law, screening for patients being considered for admission to residential services, diagnosis and treatment for children who are acutely mentally ill or severely emotionally or behaviorally disturbed discovered under screening through the federal Title XIX early and periodic screening, diagnosis, and treatment program, investigation, legal, and other nonresidential services under chapter 71.05 RCW, case management services, psychiatric treatment including medication supervision, counseling, psychotherapy, assuring transfer of relevant patient information between service providers, recovery services, and other services determined by behavioral health administrative services organizations.

(17) "Community-based crisis team" means a team that is part of an emergency medical services agency, a fire service agency, a public health agency, a medical facility, or a city or county government entity, other than a law enforcement agency, that provides the on-

site community-based interventions of a mobile rapid response crisis team for individuals who are experiencing a behavioral health crisis.

(18) "Consensus-based" means a program or practice that has general support among treatment providers and experts, based on experience or professional literature, and may have anecdotal or case study support, or that is agreed but not possible to perform studies with random assignment and controlled groups.

((~~(18)~~)) (19) "County authority" means the board of county commissioners, county council, or county executive having authority to establish a behavioral health administrative services organization, or two or more of the county authorities specified in this subsection which have entered into an agreement to establish a behavioral health administrative services organization.

((~~(19) "Crisis call center hub" means a state-designated center participating in the national suicide prevention lifeline network to respond to statewide or regional 988 calls that meets the requirements of RCW 71.24.890.~~))

(20) "Crisis stabilization services" means services such as 23-hour crisis stabilization units based on the living room model, crisis stabilization units as provided in RCW 71.05.020, triage facilities as provided in RCW 71.05.020, short-term respite facilities, peer-run respite services, and same-day walk-in behavioral health services, including within the overall crisis system components that operate like hospital emergency departments that accept all walk-ins, and ambulance, fire, and police drop-offs.

(21) "Department" means the department of health.

(22) "Designated 988 contact hub" means a state-designated contact center that streamlines clinical interventions and access to resources for people experiencing a behavioral health crisis and participates in the national suicide prevention lifeline network to respond to statewide or regional 988 contacts that meets the requirements of RCW 71.24.890.

(23) "Designated crisis responder" has the same meaning as in RCW 71.05.020.

((~~(23)~~)) (24) "Director" means the director of the authority.

((~~(24)~~)) (25) "Drug addiction" means a disease characterized by a dependency on psychoactive chemicals, loss of control over the amount and circumstances of use, symptoms of tolerance, physiological or psychological withdrawal, or both, if use is reduced or discontinued,

and impairment of health or disruption of social or economic functioning.

((~~(25)~~)) (26) "Early adopter" means a regional service area for which all of the county authorities have requested that the authority purchase medical and behavioral health services through a managed care health system as defined under RCW 71.24.380((~~(6)~~)) (7).

((~~(26)~~)) (27) "Emerging best practice" or "promising practice" means a program or practice that, based on statistical analyses or a well established theory of change, shows potential for meeting the evidence-based or research-based criteria, which may include the use of a program that is evidence-based for outcomes other than those listed in subsection ((~~(27)~~)) (28) of this section.

((~~(27)~~)) (28) "Evidence-based" means a program or practice that has been tested in heterogeneous or intended populations with multiple randomized, or statistically controlled evaluations, or both; or one large multiple site randomized, or statistically controlled evaluation, or both, where the weight of the evidence from a systemic review demonstrates sustained improvements in at least one outcome. "Evidence-based" also means a program or practice that can be implemented with a set of procedures to allow successful replication in Washington and, when possible, is determined to be cost-beneficial.

((~~(28)~~)) (29) "Indian health care provider" means a health care program operated by the Indian health service or by a tribe, tribal organization, or urban Indian organization as those terms are defined in the Indian health care improvement act (25 U.S.C. Sec. 1603).

((~~(29)~~)) (30) "Intensive behavioral health treatment facility" means a community-based specialized residential treatment facility for individuals with behavioral health conditions, including individuals discharging from or being diverted from state and local hospitals, whose impairment or behaviors do not meet, or no longer meet, criteria for involuntary inpatient commitment under chapter 71.05 RCW, but whose care needs cannot be met in other community-based placement settings.

((~~(30)~~)) (31) "Licensed or certified behavioral health agency" means:

(a) An entity licensed or certified according to this chapter or chapter 71.05 RCW;

(b) An entity deemed to meet state minimum standards as a result of accreditation by a recognized behavioral health accrediting body recognized and having a current agreement with the department; or

(c) An entity with a tribal attestation that it meets state minimum standards for a licensed or certified behavioral health agency.

((~~(31)~~)) (32) "Licensed physician" means a person licensed to practice medicine or osteopathic medicine and surgery in the state of Washington.

((~~(32)~~)) (33) "Long-term inpatient care" means inpatient services for persons committed for, or voluntarily receiving intensive treatment for, periods of ninety days or greater under chapter 71.05 RCW. "Long-term inpatient care" as used in this chapter does not include: (a) Services for individuals committed under chapter 71.05 RCW who are receiving services pursuant to a conditional release or a court-ordered less restrictive alternative to detention; or (b) services for individuals voluntarily receiving less restrictive alternative treatment on the grounds of the state hospital.

((~~(33)~~)) (34) "Managed care organization" means an organization, having a certificate of authority or certificate of registration from the office of the insurance commissioner, that contracts with the authority under a comprehensive risk contract to provide prepaid health care services to enrollees under the authority's managed care programs under chapter 74.09 RCW.

((~~(34)~~)) (35) "Mental health peer-run respite center" means a peer-run program to serve individuals in need of voluntary, short-term, noncrisis services that focus on recovery and wellness.

((~~(35)~~)) (36) Mental health "treatment records" include registration and all other records concerning persons who are receiving or who at any time have received services for mental illness, which are maintained by the department of social and health services or the authority, by behavioral health administrative services organizations and their staffs, by managed care organizations and their staffs, or by treatment facilities. "Treatment records" do not include notes or records maintained for personal use by a person providing treatment services for the entities listed in this subsection, or a treatment facility if the notes or records are not available to others.

((~~(36)~~)) (37) "Mentally ill persons," "persons who are mentally ill," and "the mentally ill" mean persons and conditions defined in

subsections (2), (12), ((~~(44)~~)) (45), and ((~~(45)~~)) (46) of this section.

((~~(37)~~)) (38) "Mobile rapid response crisis team" means a team that provides professional on-site community-based intervention such as outreach, de-escalation, stabilization, resource connection, and follow-up support for individuals who are experiencing a behavioral health crisis, that shall include certified peer counselors as a best practice to the extent practicable based on workforce availability, and that meets standards for response times established by the authority.

((~~(38)~~)) (39) "Recovery" means a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

((~~(39)~~)) (40) "Research-based" means a program or practice that has been tested with a single randomized, or statistically controlled evaluation, or both, demonstrating sustained desirable outcomes; or where the weight of the evidence from a systemic review supports sustained outcomes as described in subsection ((~~(27)~~)) (28) of this section but does not meet the full criteria for evidence-based.

((~~(40)~~)) (41) "Residential services" means a complete range of residences and supports authorized by resource management services and which may involve a facility, a distinct part thereof, or services which support community living, for persons who are acutely mentally ill, adults who are chronically mentally ill, children who are severely emotionally disturbed, or adults who are seriously disturbed and determined by the behavioral health administrative services organization or managed care organization to be at risk of becoming acutely or chronically mentally ill. The services shall include at least evaluation and treatment services as defined in chapter 71.05 RCW, acute crisis respite care, long-term adaptive and rehabilitative care, and supervised and supported living services, and shall also include any residential services developed to service persons who are mentally ill in nursing homes, residential treatment facilities, assisted living facilities, and adult family homes, and may include outpatient services provided as an element in a package of services in a supported housing model. Residential services for children in out-of-home placements related to their mental disorder shall not include the costs of food and shelter, except for children's long-term residential facilities existing prior to January 1, 1991.

((~~(41)~~)) (42) "Resilience" means the personal and community qualities that enable individuals to rebound from adversity, trauma, tragedy, threats, or other stresses, and to live productive lives.

((~~(42)~~)) (43) "Resource management services" mean the planning, coordination, and authorization of residential services and community support services administered pursuant to an individual service plan for: (a) Adults and children who are acutely mentally ill; (b) adults who are chronically mentally ill; (c) children who are severely emotionally disturbed; or (d) adults who are seriously disturbed and determined by a behavioral health administrative services organization or managed care organization to be at risk of becoming acutely or chronically mentally ill. Such planning, coordination, and authorization shall include mental health screening for children eligible under the federal Title XIX early and periodic screening, diagnosis, and treatment program. Resource management services include seven day a week, twenty-four hour a day availability of information regarding enrollment of adults and children who are mentally ill in services and their individual service plan to designated crisis responders, evaluation and treatment facilities, and others as determined by the behavioral health administrative services organization or managed care organization, as applicable.

((~~(43)~~)) (44) "Secretary" means the secretary of the department of health.

((~~(44)~~)) (45) "Seriously disturbed person" means a person who:

(a) Is gravely disabled or presents a likelihood of serious harm to himself or herself or others, or to the property of others, as a result of a mental disorder as defined in chapter 71.05 RCW;

(b) Has been on conditional release status, or under a less restrictive alternative order, at some time during the preceding two years from an evaluation and treatment facility or a state mental health hospital;

(c) Has a mental disorder which causes major impairment in several areas of daily living;

(d) Exhibits suicidal preoccupation or attempts; or

(e) Is a child diagnosed by a mental health professional, as defined in chapter 71.34 RCW, as experiencing a mental disorder which is clearly interfering with the child's functioning in family or school or with peers or is clearly interfering with the child's personality development and learning.

((~~(45)~~)) (46) "Severely emotionally disturbed child" or "child who is severely emotionally disturbed" means a child who has been determined by the behavioral health administrative services organization or managed care organization, if applicable, to be experiencing a mental disorder as defined in chapter 71.34 RCW, including those mental disorders that result in a behavioral or conduct disorder, that is clearly interfering with the child's functioning in family or school or with peers and who meets at least one of the following criteria:

(a) Has undergone inpatient treatment or placement outside of the home related to a mental disorder within the last two years;

(b) Has undergone involuntary treatment under chapter 71.34 RCW within the last two years;

(c) Is currently served by at least one of the following child-serving systems: Juvenile justice, child-protection/welfare, special education, or developmental disabilities;

(d) Is at risk of escalating maladjustment due to:

(i) Chronic family dysfunction involving a caretaker who is mentally ill or inadequate;

(ii) Changes in custodial adult;

(iii) Going to, residing in, or returning from any placement outside of the home, for example, psychiatric hospital, short-term inpatient, residential treatment, group or foster home, or a correctional facility;

(iv) Subject to repeated physical abuse or neglect;

(v) Drug or alcohol abuse; or

(vi) Homelessness.

((~~(46)~~)) (47) "State minimum standards" means minimum requirements established by rules adopted and necessary to implement this chapter by:

(a) The authority for:

(i) Delivery of mental health and substance use disorder services; and

(ii) Community support services and resource management services;

(b) The department of health for:

(i) Licensed or certified behavioral health agencies for the purpose of providing mental health or substance use disorder programs and services, or both;

(ii) Licensed behavioral health providers for the provision of mental health or substance use disorder services, or both; and

(iii) Residential services.

((~~(47)~~)) (48) "Substance use disorder" means a cluster of cognitive, behavioral, and physiological symptoms indicating that an individual continues using the substance despite significant substance-related problems. The diagnosis of a substance use disorder is based on a pathological pattern of behaviors related to the use of the substances.

((~~(48)~~)) (49) "Tribe," for the purposes of this section, means a federally recognized Indian tribe.

Sec. 2. RCW 71.24.037 and 2019 c 446 s 23 and 2019 c 325 s 1007 are each reenacted and amended to read as follows:

(1) The secretary shall license or certify any agency or facility that: (a) Submits payment of the fee established under RCW 43.70.110 and 43.70.250; (b) submits a complete application that demonstrates the ability to comply with requirements for operating and maintaining an agency or facility in statute or rule; and (c) successfully completes the prelicensure inspection requirement.

(2) The secretary shall establish by rule minimum standards for licensed or certified behavioral health agencies that must, at a minimum, establish: (a) Qualifications for staff providing services directly to persons with mental disorders, substance use disorders, or both; (b) the intended result of each service; and (c) the rights and responsibilities of persons receiving behavioral health services pursuant to this chapter and chapter 71.05 RCW. The secretary shall provide for deeming of licensed or certified behavioral health agencies as meeting state minimum standards as a result of accreditation by a recognized behavioral health accrediting body recognized and having a current agreement with the department.

(3) The department shall review reports or other information alleging a failure to comply with this chapter or the standards and rules adopted under this chapter and may initiate investigations and enforcement actions based on those reports.

(4) The department shall conduct inspections of agencies and facilities, including reviews of records and documents required to be maintained under this chapter or rules adopted under this chapter.

(5) The department may suspend, revoke, limit, restrict, or modify an approval, or refuse to grant approval, for failure to meet the provisions of this chapter, or the standards adopted under this chapter. RCW 43.70.115 governs notice of a license or certification

denial, revocation, suspension, or modification and provides the right to an adjudicative proceeding.

(6) No licensed or certified behavioral health ((~~service provider~~)) agency may advertise or represent itself as a licensed or certified behavioral health ((~~service provider~~)) agency if approval has not been granted or has been denied, suspended, revoked, or canceled.

(7) Licensure or certification as a behavioral health ((~~service provider~~)) agency is effective for one calendar year from the date of issuance of the license or certification. The license or certification must specify the types of services provided by the behavioral health ((~~service provider~~)) agency that meet the standards adopted under this chapter. Renewal of a license or certification must be made in accordance with this section for initial approval and in accordance with the standards set forth in rules adopted by the secretary.

(8) Licensure or certification as a licensed or certified behavioral health ((~~service provider~~)) agency must specify the types of services provided that meet the standards adopted under this chapter. Renewal of a license or certification must be made in accordance with this section for initial approval and in accordance with the standards set forth in rules adopted by the secretary.

(9) The department shall develop a process by which a provider may obtain dual licensure as an evaluation and treatment facility and secure withdrawal management and stabilization facility.

(10) Licensed or certified behavioral health ((~~service providers~~)) agencies may not provide types of services for which the licensed or certified behavioral health ((~~service provider~~)) agency has not been certified. Licensed or certified behavioral health ((~~service providers~~)) agencies may provide services for which approval has been sought and is pending, if approval for the services has not been previously revoked or denied.

(11) The department periodically shall inspect licensed or certified behavioral health ((~~service providers~~)) agencies at reasonable times and in a reasonable manner.

(12) Upon petition of the department and after a hearing held upon reasonable notice to the facility, the superior court may issue a warrant to an officer or employee of the department authorizing him or her to enter and inspect at reasonable times, and examine the books and accounts of, any licensed or certified behavioral health

((~~service provider~~)) agency refusing to consent to inspection or examination by the department or which the department has reasonable cause to believe is operating in violation of this chapter.

(13) The department shall maintain and periodically publish a current list of licensed or certified behavioral health ((~~service providers~~)) agencies.

(14) Each licensed or certified behavioral health ((~~service provider~~)) agency shall file with the department or the authority upon request, data, statistics, schedules, and information the department or the authority reasonably requires. A licensed or certified behavioral health ((~~service provider~~)) agency that without good cause fails to furnish any data, statistics, schedules, or information as requested, or files fraudulent returns thereof, may have its license or certification revoked or suspended.

(15) The authority shall use the data provided in subsection (14) of this section to evaluate each program that admits children to inpatient substance use disorder treatment upon application of their parents. The evaluation must be done at least once every twelve months. In addition, the authority shall randomly select and review the information on individual children who are admitted on application of the child's parent for the purpose of determining whether the child was appropriately placed into substance use disorder treatment based on an objective evaluation of the child's condition and the outcome of the child's treatment.

(16) Any settlement agreement entered into between the department and licensed or certified behavioral health ((~~service providers~~)) agencies to resolve administrative complaints, license or certification violations, license or certification suspensions, or license or certification revocations may not reduce the number of violations reported by the department unless the department concludes, based on evidence gathered by inspectors, that the licensed or certified behavioral health ((~~service provider~~)) agency did not commit one or more of the violations.

(17) In cases in which a behavioral health ((~~service provider~~)) agency that is in violation of licensing or certification standards attempts to transfer or sell the behavioral health ((~~service provider~~)) agency to a family member, the transfer or sale may only be made for the purpose of remedying license or certification violations and achieving full compliance with the terms of the license or certification. Transfers or sales to family members are

prohibited in cases in which the purpose of the transfer or sale is to avoid liability or reset the number of license or certification violations found before the transfer or sale. If the department finds that the owner intends to transfer or sell, or has completed the transfer or sale of, ownership of the behavioral health ((~~service provider~~)) agency to a family member solely for the purpose of resetting the number of violations found before the transfer or sale, the department may not renew the behavioral health ((~~service provider's~~)) agency's license or certification or issue a new license or certification to the behavioral health service provider.

(18) Every licensed or certified outpatient behavioral health agency shall display the 988 crisis hotline number in common areas of the premises and include the number as a calling option on any phone message for persons calling the agency after business hours.

(19) Every licensed or certified inpatient or residential behavioral health agency must include the 988 crisis hotline number in the discharge summary provided to individuals being discharged from inpatient or residential services.

NEW SECTION. **Sec. 3.** A new section is added to chapter 71.24 RCW to read as follows:

The department shall develop informational materials and a social media campaign related to the 988 crisis hotline, including call, text, and chat options, and other crisis hotline lines for veterans, American Indians and Alaska Natives, and other populations. The informational materials must include appropriate information for persons seeking services at behavioral health clinics and medical clinics, as well as media audiences and students at K-12 schools and higher education institutions. The department shall make the informational materials available to behavioral health clinics, medical clinics, media, K-12 schools, higher education institutions, and other relevant settings. The informational materials shall be made available to professionals during training in suicide assessment, treatment, and management under RCW 43.70.442. To tailor the messages of the informational materials and the social media campaign, the department must consult with tribes, the American Indian health commission of Washington state, the native and strong lifeline, the Washington state department of veterans affairs, representatives of agricultural communities, and persons with lived

experience related to mental health issues, substance use disorder issues, a suicide attempt, or a suicide loss.

Sec. 4. RCW 43.70.442 and 2020 c 229 s 1 and 2020 c 80 s 30 are each reenacted and amended to read as follows:

(1)(a) Each of the following professionals certified or licensed under Title 18 RCW shall, at least once every six years, complete training in suicide assessment, treatment, and management that is approved, in rule, by the relevant disciplining authority:

(i) An adviser or counselor certified under chapter 18.19 RCW;

(ii) A substance use disorder professional licensed under chapter 18.205 RCW;

(iii) A marriage and family therapist licensed under chapter 18.225 RCW;

(iv) A mental health counselor licensed under chapter 18.225 RCW;

(v) An occupational therapy practitioner licensed under chapter 18.59 RCW;

(vi) A psychologist licensed under chapter 18.83 RCW;

(vii) An advanced social worker or independent clinical social worker licensed under chapter 18.225 RCW; and

(viii) A social worker associate—advanced or social worker associate—independent clinical licensed under chapter 18.225 RCW.

(b) The requirements in (a) of this subsection apply to a person holding a retired active license for one of the professions in (a) of this subsection.

(c) The training required by this subsection must be at least six hours in length, unless a disciplining authority has determined, under subsection (10)(b) of this section, that training that includes only screening and referral elements is appropriate for the profession in question, in which case the training must be at least three hours in length.

(d) Beginning July 1, 2017, the training required by this subsection must be on the model list developed under subsection (6) of this section. Nothing in this subsection (1)(d) affects the validity of training completed prior to July 1, 2017.

(2)(a) Except as provided in (b) of this subsection:

(i) A professional listed in subsection (1)(a) of this section must complete the first training required by this section by the end of the first full continuing education reporting period after January 1, 2014, or during the first full continuing education reporting

period after initial licensure or certification, whichever occurs later.

(ii) Beginning July 1, 2021, the second training for a psychologist, a marriage and family therapist, a mental health counselor, an advanced social worker, an independent clinical social worker, a social worker associate-advanced, or a social worker associate-independent clinical must be either: (A) An advanced training focused on suicide management, suicide care protocols, or effective treatments; or (B) a training in a treatment modality shown to be effective in working with people who are suicidal, including dialectical behavior therapy, collaborative assessment and management of suicide risk, or cognitive behavior therapy-suicide prevention. If a professional subject to the requirements of this subsection has already completed the professional's second training prior to July 1, 2021, the professional's next training must comply with this subsection. This subsection (2)(a)(ii) does not apply if the licensee demonstrates that the training required by this subsection (2)(a)(ii) is not reasonably available.

(b)(i) A professional listed in subsection (1)(a) of this section applying for initial licensure may delay completion of the first training required by this section for six years after initial licensure if he or she can demonstrate successful completion of the training required in subsection (1) of this section no more than six years prior to the application for initial licensure.

(ii) Beginning July 1, 2021, a psychologist, a marriage and family therapist, a mental health counselor, an advanced social worker, an independent clinical social worker, a social worker associate-advanced, or a social worker associate-independent clinical exempt from his or her first training under (b)(i) of this subsection must comply with the requirements of (a)(ii) of this subsection for his or her first training after initial licensure. If a professional subject to the requirements of this subsection has already completed the professional's first training after initial licensure, the professional's next training must comply with this subsection (2)(b)(ii). This subsection (2)(b)(ii) does not apply if the licensee demonstrates that the training required by this subsection (2)(b)(ii) is not reasonably available.

(3) The hours spent completing training in suicide assessment, treatment, and management under this section count toward meeting any

applicable continuing education or continuing competency requirements for each profession.

(4)(a) A disciplining authority may, by rule, specify minimum training and experience that is sufficient to exempt an individual professional from the training requirements in subsections (1) and (5) of this section. Nothing in this subsection (4)(a) allows a disciplining authority to provide blanket exemptions to broad categories or specialties within a profession.

(b) A disciplining authority may exempt a professional from the training requirements of subsections (1) and (5) of this section if the professional has only brief or limited patient contact.

(5)(a) Each of the following professionals credentialed under Title 18 RCW shall complete a one-time training in suicide assessment, treatment, and management that is approved by the relevant disciplining authority:

(i) A chiropractor licensed under chapter 18.25 RCW;

(ii) A naturopath licensed under chapter 18.36A RCW;

(iii) A licensed practical nurse, registered nurse, or advanced registered nurse practitioner, other than a certified registered nurse anesthetist, licensed under chapter 18.79 RCW;

(iv) An osteopathic physician and surgeon licensed under chapter 18.57 RCW, other than a holder of a postgraduate osteopathic medicine and surgery license issued under RCW 18.57.035;

(v) A physical therapist or physical therapist assistant licensed under chapter 18.74 RCW;

(vi) A physician licensed under chapter 18.71 RCW, other than a resident holding a limited license issued under RCW 18.71.095(3);

(vii) A physician assistant licensed under chapter 18.71A RCW;

(viii) A pharmacist licensed under chapter 18.64 RCW;

(ix) A dentist licensed under chapter 18.32 RCW;

(x) A dental hygienist licensed under chapter 18.29 RCW;

(xi) An athletic trainer licensed under chapter 18.250 RCW;

(xii) An optometrist licensed under chapter 18.53 RCW;

(xiii) An acupuncture and Eastern medicine practitioner licensed under chapter 18.06 RCW; and

(xiv) A person holding a retired active license for one of the professions listed in (a)(i) through (xiii) of this subsection.

(b)(i) A professional listed in (a)(i) through (vii) of this subsection or a person holding a retired active license for one of the professions listed in (a)(i) through (vii) of this subsection

must complete the one-time training by the end of the first full continuing education reporting period after January 1, 2016, or during the first full continuing education reporting period after initial licensure, whichever is later. Training completed between June 12, 2014, and January 1, 2016, that meets the requirements of this section, other than the timing requirements of this subsection (5)(b), must be accepted by the disciplining authority as meeting the one-time training requirement of this subsection (5).

(ii) A licensed pharmacist or a person holding a retired active pharmacist license must complete the one-time training by the end of the first full continuing education reporting period after January 1, 2017, or during the first full continuing education reporting period after initial licensure, whichever is later.

(iii) A licensed dentist, a licensed dental hygienist, or a person holding a retired active license as a dentist shall complete the one-time training by the end of the full continuing education reporting period after August 1, 2020, or during the first full continuing education reporting period after initial licensure, whichever is later. Training completed between July 23, 2017, and August 1, 2020, that meets the requirements of this section, other than the timing requirements of this subsection (5)(b)(iii), must be accepted by the disciplining authority as meeting the one-time training requirement of this subsection (5).

(iv) A licensed optometrist or a licensed acupuncture and Eastern medicine practitioner, or a person holding a retired active license as an optometrist or an acupuncture and Eastern medicine practitioner, shall complete the one-time training by the end of the full continuing education reporting period after August 1, 2021, or during the first full continuing education reporting period after initial licensure, whichever is later. Training completed between August 1, 2020, and August 1, 2021, that meets the requirements of this section, other than the timing requirements of this subsection (5)(b)(iv), must be accepted by the disciplining authority as meeting the one-time training requirement of this subsection (5).

(c) The training required by this subsection must be at least six hours in length, unless a disciplining authority has determined, under subsection (10)(b) of this section, that training that includes only screening and referral elements is appropriate for the profession in question, in which case the training must be at least three hours in length.

(d) Beginning July 1, 2017, the training required by this subsection must be on the model list developed under subsection (6) of this section. Nothing in this subsection (5)(d) affects the validity of training completed prior to July 1, 2017.

(6)(a) The secretary and the disciplining authorities shall work collaboratively to develop a model list of training programs in suicide assessment, treatment, and management. Beginning July 1, 2021, for purposes of subsection (2)(a)(ii) of this section, the model list must include advanced training and training in treatment modalities shown to be effective in working with people who are suicidal.

(b) The secretary and the disciplining authorities shall update the list at least once every two years.

(c) By June 30, 2016, the department shall adopt rules establishing minimum standards for the training programs included on the model list. The minimum standards must require that six-hour trainings include content specific to veterans and the assessment of issues related to imminent harm via lethal means or self-injurious behaviors and that three-hour trainings for pharmacists or dentists include content related to the assessment of issues related to imminent harm via lethal means. By July 1, 2024, the minimum standards must be updated to require that both the six-hour and three-hour trainings include content specific to the availability of and the services offered by the 988 crisis hotline and the behavioral health crisis response and suicide prevention system and best practices for assisting persons with accessing the 988 crisis hotline and the system. Beginning September 1, 2024, trainings submitted to the department for review and approval must include the updated information in the minimum standards for the model list as well as all subsequent submissions. When adopting the rules required under this subsection (6)(c), the department shall:

(i) Consult with the affected disciplining authorities, public and private institutions of higher education, educators, experts in suicide assessment, treatment, and management, the Washington department of veterans affairs, and affected professional associations; and

(ii) Consider standards related to the best practices registry of the American foundation for suicide prevention and the suicide prevention resource center.

(d) Beginning January 1, 2017:

(i) The model list must include only trainings that meet the minimum standards established in the rules adopted under (c) of this subsection and any three-hour trainings that met the requirements of this section on or before July 24, 2015;

(ii) The model list must include six-hour trainings in suicide assessment, treatment, and management, and three-hour trainings that include only screening and referral elements; and

(iii) A person or entity providing the training required in this section may petition the department for inclusion on the model list. The department shall add the training to the list only if the department determines that the training meets the minimum standards established in the rules adopted under (c) of this subsection.

(e) By January 1, 2021, the department shall adopt minimum standards for advanced training and training in treatment modalities shown to be effective in working with people who are suicidal. Beginning July 1, 2021, all such training on the model list must meet the minimum standards. When adopting the minimum standards, the department must consult with the affected disciplining authorities, public and private institutions of higher education, educators, experts in suicide assessment, treatment, and management, the Washington department of veterans affairs, and affected professional associations.

(7) The department shall provide the health profession training standards created in this section to the professional educator standards board as a model in meeting the requirements of RCW 28A.410.226 and provide technical assistance, as requested, in the review and evaluation of educator training programs. The educator training programs approved by the professional educator standards board may be included in the department's model list.

(8) Nothing in this section may be interpreted to expand or limit the scope of practice of any profession regulated under chapter 18.130 RCW.

(9) The secretary and the disciplining authorities affected by this section shall adopt any rules necessary to implement this section.

(10) For purposes of this section:

(a) "Disciplining authority" has the same meaning as in RCW 18.130.020.

(b) "Training in suicide assessment, treatment, and management" means empirically supported training approved by the appropriate

disciplining authority that contains the following elements: Suicide assessment, including screening and referral, suicide treatment, and suicide management. However, the disciplining authority may approve training that includes only screening and referral elements if appropriate for the profession in question based on the profession's scope of practice. The board of occupational therapy may also approve training that includes only screening and referral elements if appropriate for occupational therapy practitioners based on practice setting.

(11) A state or local government employee is exempt from the requirements of this section if he or she receives a total of at least six hours of training in suicide assessment, treatment, and management from his or her employer every six years. For purposes of this subsection, the training may be provided in one six-hour block or may be spread among shorter training sessions at the employer's discretion.

(12) An employee of a community mental health agency licensed under chapter 71.24 RCW or a chemical dependency program certified under chapter 71.24 RCW is exempt from the requirements of this section if he or she receives a total of at least six hours of training in suicide assessment, treatment, and management from his or her employer every six years. For purposes of this subsection, the training may be provided in one six-hour block or may be spread among shorter training sessions at the employer's discretion.

Sec. 5. RCW 71.24.890 and 2021 c 302 s 102 are each amended to read as follows:

(1) Establishing the state ((~~crisis call center~~)) designated 988 contact hubs and enhancing the crisis response system will require collaborative work between the department and the authority within their respective roles. The department shall have primary responsibility for establishing and designating the ((~~crisis call center~~)) designated 988 contact hubs. The authority shall have primary responsibility for developing and implementing the crisis response system and services to support the work of the ((~~crisis call center~~)) designated 988 contact hubs. In any instance in which one agency is identified as the lead, the expectation is that agency will be communicating and collaborating with the other to ensure seamless, continuous, and effective service delivery within the statewide crisis response system.

(2) The department shall provide adequate funding for the state's crisis call centers to meet an expected increase in the use of the call centers based on the implementation of the 988 crisis hotline. The funding level shall be established at a level anticipated to achieve an in-state call response rate of at least 90 percent by July 22, 2022. The funding level shall be determined by considering standards and cost per call predictions provided by the administrator of the national suicide prevention lifeline, call volume predictions, guidance on crisis call center performance metrics, and necessary technology upgrades. In contracting with the crisis call centers, the department:

(a) May provide funding to support crisis call centers and designated 988 contact hubs to enter into limited on-site partnerships with the public safety answering point to increase the coordination and transfer of behavioral health calls received by certified public safety telecommunicators that are better addressed by clinic interventions provided by the 988 system. Tax revenue may be used to support on-site partnerships;

(b) Shall require that crisis call centers enter into data-sharing agreements, when appropriate, with the department, the authority, and applicable regional behavioral health administrative services organizations to provide reports and client level data regarding 988 crisis hotline calls, as allowed by and in compliance with existing federal and state law governing the sharing and use of protected health information, including dispatch time, arrival time, and disposition of the outreach for each call referred for outreach by each region. The department and the authority shall establish requirements that the crisis call centers report the data identified in this subsection (2)(b) to regional behavioral health administrative services organizations for the purposes of maximizing medicaid reimbursement, as appropriate, and implementing this chapter and chapters 71.05 and 71.34 RCW including, but not limited to, administering crisis services for the assigned regional service area, contracting with a sufficient number or licensed or certified providers for crisis services, establishing and maintaining quality assurance processes, maintaining patient tracking, and developing and implementing strategies to coordinate care for individuals with a history of frequent crisis system utilization.

(3) The department shall adopt rules by ((~~July~~)) January 1, ((~~2023~~)) 2025, to establish standards for designation of crisis call

centers as ((~~crisis call center~~)) designated 988 contact hubs. The department shall collaborate with the authority and other agencies to assure coordination and availability of services, and shall consider national guidelines for behavioral health crisis care as determined by the federal substance abuse and mental health services administration, national behavioral health accrediting bodies, and national behavioral health provider associations to the extent they are appropriate, and recommendations from the crisis response improvement strategy committee created in RCW 71.24.892.

(4) The department shall designate ((~~crisis call center~~)) designated 988 contact hubs by ((~~July~~)) January 1, ((~~2024~~)) 2026. The ((~~crisis call center~~)) designated 988 contact 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.

(a) To be designated as a ((~~crisis call center~~)) designated 988 contact hub, the applicant must demonstrate to the department the ability to comply with the requirements of this section and to contract to provide ((~~crisis call center~~)) designated 988 contact hub services. The department may revoke the designation of any ((~~crisis call center~~)) designated 988 contact hub that fails to substantially comply with the contract.

(b) The contracts entered shall require designated ((~~crisis call center~~)) 988 contact hubs to:

(i) Have an active agreement with the administrator of the national suicide prevention lifeline for participation within its network;

(ii) Meet the requirements for operational and clinical standards established by the department and based upon the national suicide prevention lifeline best practices guidelines and other recognized best practices;

(iii) Employ highly qualified, skilled, and trained clinical staff who have sufficient training and resources to provide empathy to callers in acute distress, de-escalate crises, assess behavioral health disorders and suicide risk, triage to system partners for callers that need additional clinical interventions, and provide case management and documentation. Call center staff shall be trained to make every effort to resolve cases in the least restrictive

environment and without law enforcement involvement whenever possible. Call center staff shall coordinate with certified peer counselors to provide follow-up and outreach to callers in distress as available. It is intended for transition planning to include a pathway for continued employment and skill advancement as needed for experienced crisis call center employees;

(iv) Train employees to screen persons contacting the designated 988 contact hub to determine if they are associated with the agricultural community and if they prefer to be connected to a crisis hotline that specializes in working with members from the agricultural community. The training shall prepare staff to be able to provide appropriate assessments, interventions, and resources to members of the agricultural community in a way that maintains the anonymity of the person making contact;

(v) Prominently display 988 crisis hotline information on their websites, including a description of what the caller should expect when contacting the crisis call center and a description of the various options available to the caller, including call lines specialized in the behavioral health needs of veterans, American Indian and Alaska Native persons, Spanish-speaking persons, LGBTQ populations, and persons connected with the agricultural community;

(vi) Collaborate with the authority, the national suicide prevention lifeline, and veterans crisis line networks to assure consistency of public messaging about the 988 crisis hotline; ((~~and~~ ~~(v)~~)) (vii) Develop and submit to the department protocols between the designated 988 contact hub and 911 call centers within the region in which the designated crisis call center operates and receive approval of the protocols by the department and the state 911 coordination office;

(viii) Develop, in collaboration with the region's behavioral health administrative services organizations, and jointly submit to the authority protocols related to the dispatching of mobile rapid response crisis teams and community-based crisis teams endorsed under section 8 of this act and receive approval of the protocols by the authority;

(ix) Provide data and reports and participate in evaluations and related quality improvement activities, according to standards established by the department in collaboration with the authority. The data must include deidentified information regarding the number

of contacts connected to the agricultural community and the nature of those contacts; and

(x) Enter into data-sharing agreements with the department, the authority, and applicable regional behavioral health administrative services organizations to provide reports and client level data regarding 988 crisis hotline calls, including dispatch time, arrival time, and disposition of the outreach for each call referred for outreach by each region. The department and the authority shall establish requirements that the designated 988 contact hubs report the data identified in this subsection (4)(b)(x) to regional behavioral health administrative services organizations for the purposes of maximizing medicaid reimbursement, as appropriate, and implementing this chapter and chapters 71.05 and 71.34 RCW including, but not limited to, administering crisis services for the assigned regional service area, contracting with a sufficient number or licensed or certified providers for crisis services, establishing and maintaining quality assurance processes, maintaining patient tracking, and developing and implementing strategies to coordinate care for individuals with a history of frequent crisis system utilization.

(c) The department and the authority shall incorporate recommendations from the crisis response improvement strategy committee created under RCW 71.24.892 in its agreements with ((~~crisis call center~~)) designated 988 contact hubs, as appropriate.

(5) 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. The department and the authority must include the crisis call centers and designated 988 contact hubs in the decision-making process for selecting any technology platforms that will be used to operate the system. No decisions made by the department or the authority shall interfere with the routing of the 988 crisis hotline calls, texts, or chat as part of Washington's active agreement with the administrator of the national suicide prevention lifeline or 988 administrator that routes 988 contacts into Washington's system. The technologies developed must include:

(a) A new technologically advanced behavioral health and suicide prevention crisis call center system platform ((~~using technology demonstrated to be interoperable across crisis and emergency response systems used throughout the state, such as 911 systems, emergency~~

~~medical services systems, and other nonbehavioral health crisis services,~~)) for use in ((~~crisis call center~~)) designated 988 contact hubs designated by the department under subsection (4) of this section. This platform, which shall be fully funded by July 1, ((~~2023~~)) 2024, shall be developed by the department and 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; and

(b) A behavioral health integrated client referral system capable of providing system coordination information to ((~~crisis call center~~)) designated 988 contact hubs and the other entities involved in behavioral health care. This system shall be developed by the authority.

(6) In developing the new technologies under subsection (5) of this section, the department and the authority must coordinate to designate a primary technology system to provide each of the following:

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

(i) 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; and

(ii) Real-time information relevant to the coordination of behavioral health crisis response and suicide prevention services for a person, including the means to access:

(A) Information about any less restrictive alternative treatment orders or mental health advance directives related to the person; and

(B) Information necessary to enable the ((~~crisis call center~~)) designated 988 contact 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 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. To establish information-sharing guidelines that fulfill the intent of this section the authority shall consider input from the confidential information compliance and coordination subcommittee established under RCW 71.24.892;

((~~(b) 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; and~~

~~(c)~~)) The means to track the outcome of the 988 call to enable appropriate follow up, cross-system coordination, and accountability, including as appropriate: (i) Any immediate services dispatched and reports generated from the encounter; (ii) the validation of a safety plan established for the caller in accordance with best practices; (iii) 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; and (iv) the 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~~)) designated 988 contact hub;

((~~(d)~~)) (c) A 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~~)) designated 988 contact hub;

((~~(e)~~)) (d) 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; and

((~~(f)~~)) (e) When appropriate, consultation with tribal governments to ensure coordinated care in government-to-government relationships, and access to dedicated services to tribal members.

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

~~(8)~~)) The authority shall:

(a) Collaborate with county authorities and behavioral health administrative services organizations to develop procedures to dispatch behavioral health crisis services in coordination with ((~~crisis call center~~)) designated 988 contact hubs to effectuate the intent of this section;

(b) Establish formal agreements with managed care organizations and behavioral health administrative services organizations by January 1, 2023, to provide for the services, capacities, and coordination necessary to effectuate the intent of this section, which shall include a requirement to arrange next-day appointments for persons contacting the 988 crisis hotline experiencing urgent, symptomatic behavioral health care needs with geographically, culturally, and linguistically appropriate primary care or behavioral health providers within the person's provider network, or, if uninsured, through the person's behavioral health administrative services organization;

(c) Create best practices guidelines by July 1, 2023, for deployment of appropriate and available crisis response services by ((~~crisis call center~~)) designated 988 contact hubs to assist 988 hotline callers to minimize nonessential reliance on emergency room services and the use of law enforcement, considering input from relevant stakeholders and recommendations made by the crisis response improvement strategy committee created under RCW 71.24.892;

(d) Develop procedures to allow appropriate information sharing and communication between and across crisis and emergency response systems for the purpose of real-time crisis care coordination including, but not limited to, deployment of crisis and outgoing services, follow-up care, and linked, flexible services specific to crisis response; ((~~and~~))

(e) Establish guidelines to appropriately serve high-risk populations who request crisis services. The authority shall design these guidelines to promote behavioral health equity for all populations with attention to circumstances of race, ethnicity, gender, socioeconomic status, sexual orientation, and geographic location, and include components such as training requirements for call response workers, policies for transferring such callers to an appropriate specialized center or subnetwork within or external to the national suicide prevention lifeline network, and procedures for referring persons who access the 988 crisis hotline to linguistically and culturally competent care; and

(f) Monitor trends in 988 crisis hotline caller data, as reported by designated 988 contact hubs in subsection (4)(b)(x) of this section and submit an annual report to the governor and the appropriate committees of the legislature summarizing the data and trends in the information beginning December 1, 2027.

Sec. 6. RCW 71.24.892 and 2021 c 302 s 103 are each amended to read as follows:

(1) The crisis response improvement strategy committee is established for the purpose of providing advice in developing an integrated behavioral health crisis response and suicide prevention system containing the elements described in this section. The work of the committee shall be received and reviewed by a steering committee, which shall in turn form subcommittees to provide the technical analysis and input needed to formulate system change recommendations.

(2) The ((~~office of financial management shall contract with the~~)) behavioral health institute at Harborview medical center ((~~to~~)) shall facilitate and provide staff support to the steering committee and to the crisis response improvement strategy committee. The behavioral health institute may contract for the provision of these services.

(3) The steering committee shall consist of the five members specified as serving on the steering committee in this subsection and

one additional member who has been appointed to serve pursuant to the criteria in either (j), (k), (l), or (m) of this subsection. The steering committee shall select three cochairs from among its members to lead the crisis response improvement strategy committee. The crisis response improvement strategy committee shall consist of the following members, who shall be appointed or requested by the authority, unless otherwise noted:

(a) The director of the authority, or his or her designee, who shall also serve on the steering committee;

(b) The secretary of the department, or his or her designee, who shall also serve on the steering committee;

(c) A member representing the office of the governor, who shall also serve on the steering committee;

(d) The Washington state insurance commissioner, or his or her designee;

(e) Up to two members representing federally recognized tribes, one from eastern Washington and one from western Washington, who have expertise in behavioral health needs of their communities;

(f) One member from each of the two largest caucuses of the senate, one of whom shall also be designated to participate on the steering committee, to be appointed by the president of the senate;

(g) One member from each of the two largest caucuses of the house of representatives, one of whom shall also be designated to participate on the steering committee, to be appointed by the speaker of the house of representatives;

(h) The director of the Washington state department of veterans affairs, or his or her designee;

(i) The state ((~~enhanced~~)) 911 coordinator, or his or her designee;

(j) A member with lived experience of a suicide attempt;

(k) A member with lived experience of a suicide loss;

(l) A member with experience of participation in the crisis system related to lived experience of a mental health disorder;

(m) A member with experience of participation in the crisis system related to lived experience with a substance use disorder;

(n) A member representing each crisis call center in Washington that is contracted with the national suicide prevention lifeline;

(o) Up to two members representing behavioral health administrative services organizations, one from an urban region and one from a rural region;

(p) A member representing the Washington council for behavioral health;

(q) A member representing the association of alcoholism and addiction programs of Washington state;

(r) A member representing the Washington state hospital association;

(s) A member representing the national alliance on mental illness Washington;

(t) A member representing the behavioral health interests of persons of color recommended by Sea Mar community health centers;

(u) A member representing the behavioral health interests of persons of color recommended by Asian counseling and referral service;

(v) A member representing law enforcement;

(w) A member representing a university-based suicide prevention center of excellence;

(x) A member representing an emergency medical services department with a CARES program;

(y) A member representing medicaid managed care organizations, as recommended by the association of Washington healthcare plans;

(z) A member representing commercial health insurance, as recommended by the association of Washington healthcare plans;

(aa) A member representing the Washington association of designated crisis responders;

(bb) A member representing the children and youth behavioral health work group;

(cc) A member representing a social justice organization addressing police accountability and the use of deadly force; and

(dd) A member representing an organization specializing in facilitating behavioral health services for LGBTQ populations.

(4) The crisis response improvement strategy committee shall assist the steering committee to identify potential barriers and make recommendations necessary to implement and effectively monitor the progress of the 988 crisis hotline in Washington and make recommendations for the statewide improvement of behavioral health crisis response and suicide prevention services.

(5) The steering committee must develop a comprehensive assessment of the behavioral health crisis response and suicide prevention services system by January 1, 2022, including an inventory of existing statewide and regional behavioral health crisis response,

suicide prevention, and crisis stabilization services and resources, and taking into account capital projects which are planned and funded. The comprehensive assessment shall identify:

(a) Statewide and regional insufficiencies and gaps in behavioral health crisis response and suicide prevention services and resources needed to meet population needs;

(b) Quantifiable goals for the provision of statewide and regional behavioral health crisis services and targeted deployment of resources, which consider factors such as reported rates of involuntary commitment detentions, single-bed certifications, suicide attempts and deaths, substance use disorder-related overdoses, overdose or withdrawal-related deaths, and incarcerations due to a behavioral health incident;

(c) A process for establishing outcome measures, benchmarks, and improvement targets, for the crisis response system; and

(d) Potential funding sources to provide statewide and regional behavioral health crisis services and resources.

(6) The steering committee, taking into account the comprehensive assessment work under subsection (5) of this section as it becomes available, after discussion with the crisis response improvement strategy committee and hearing reports from the subcommittees, shall report on the following:

(a) A recommended vision for an integrated crisis network in Washington that includes, but is not limited to: An integrated 988 crisis hotline and ((~~crisis call center~~)) designated 988 contact hubs; mobile rapid response crisis teams and community-based crisis teams endorsed under section 8 of this act; mobile crisis response units for youth, adult, and geriatric population; a range of crisis stabilization services; an integrated involuntary treatment system; access to peer-run services, including peer-run respite centers; adequate crisis respite services; and data resources;

(b) Recommendations to promote equity in services for individuals of diverse circumstances of culture, race, ethnicity, gender, socioeconomic status, sexual orientation, and for individuals in tribal, urban, and rural communities;

(c) Recommendations for a work plan with timelines to implement appropriate local responses to calls to the 988 crisis hotline within Washington in accordance with the time frames required by the national suicide hotline designation act of 2020;

(d) The necessary components of each of the new technologically advanced behavioral health crisis call center system platform and the new behavioral health integrated client referral system, as provided under RCW 71.24.890, for assigning and tracking response to behavioral health crisis calls and providing real-time bed and outpatient appointment availability to 988 operators, emergency departments, designated crisis responders, and other behavioral health crisis responders, which shall include but not be limited to:

(i) Identification of the components ((~~crisis call center~~)) that designated 988 contact hub staff need to effectively coordinate crisis response services and find available beds and available primary care and behavioral health outpatient appointments;

(ii) Evaluation of existing bed tracking models currently utilized by other states and identifying the model most suitable to Washington's crisis behavioral health system;

(iii) Evaluation of whether bed tracking will improve access to all behavioral health bed types and other impacts and benefits; and

(iv) Exploration of how the bed tracking and outpatient appointment availability platform can facilitate more timely access to care and other impacts and benefits;

(e) The necessary systems and capabilities that licensed or certified behavioral health agencies, behavioral health providers, and any other relevant parties will require 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 system identified in RCW 71.24.890, as appropriate;

(f) A work plan to establish the capacity for the ((~~crisis call center~~)) designated 988 contact hubs to integrate Spanish language interpreters and Spanish-speaking call center staff into their operations, and to ensure the availability of resources to meet the unique needs of persons in the agricultural community who are experiencing mental health stresses, which explicitly addresses concerns regarding confidentiality;

(g) A work plan with timelines to enhance and expand the availability of ((~~community-based~~)) mobile rapid response crisis teams and community-based crisis teams endorsed under section 8 of this act based in each region, including specialized teams as appropriate to respond to the unique needs of youth, including American Indian and Alaska Native youth and LGBTQ youth, and

geriatric populations, including older adults of color and older adults with comorbid dementia;

(h) The identification of other personal and systemic behavioral health challenges which implementation of the 988 crisis hotline has the potential to address in addition to suicide response and behavioral health crises;

(i) The development of a plan for the statewide equitable distribution of crisis stabilization services, behavioral health beds, and peer-run respite services;

(j) Recommendations concerning how health plans, managed care organizations, and behavioral health administrative services organizations shall fulfill requirements to provide assignment of a care coordinator and to provide next-day appointments for enrollees who contact the behavioral health crisis system;

(k) Appropriate allocation of crisis system funding responsibilities among medicaid managed care organizations, commercial insurers, and behavioral health administrative services organizations;

(l) Recommendations for constituting a statewide behavioral health crisis response and suicide prevention oversight board or similar structure for ongoing monitoring of the behavioral health crisis system and where this should be established; and

(m) Cost estimates for each of the components of the integrated behavioral health crisis response and suicide prevention system.

(7) The steering committee shall consist only of members appointed to the steering committee under this section. The steering committee shall convene the committee, form subcommittees, assign tasks to the subcommittees, and establish a schedule of meetings and their agendas.

(8) The subcommittees of the crisis response improvement strategy committee shall focus on discrete topics. The subcommittees may include participants who are not members of the crisis response improvement strategy committee, as needed to provide professional expertise and community perspectives. Each subcommittee shall have at least one member representing the interests of stakeholders in a rural community, at least one member representing the interests of stakeholders in an urban community, and at least one member representing the interests of youth stakeholders. The steering committee shall form the following subcommittees:

(a) 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 American Indian health commission;

(b) A credentialing and training subcommittee, to recommend workforce needs and requirements necessary to implement chapter 302, Laws of 2021, including minimum education requirements such as whether it would be appropriate to allow ((~~crisis call center~~)) designated 988 contact hubs to employ clinical staff without a bachelor's degree or master's degree based on the person's skills and life or work experience;

(c) A technology subcommittee, to examine issues and requirements related to the technology needed to implement chapter 302, Laws of 2021;

(d) A cross-system crisis response collaboration subcommittee, to examine and define the complementary roles and interactions between mobile rapid response crisis teams and community-based crisis teams endorsed under section 8 of this act, designated crisis responders, law enforcement, emergency medical services teams, 911 and 988 operators, public and private health plans, behavioral health crisis response agencies, nonbehavioral health crisis response agencies, and others needed to implement chapter 302, Laws of 2021;

(e) A confidential information compliance and coordination subcommittee, to examine issues relating to sharing and protection of health information needed to implement chapter 302, Laws of 2021; ((~~and~~))

(f) A 988 geolocation subcommittee, to examine privacy issues related to federal planning efforts to route 988 crisis hotline calls based on the person's location, rather than area code, including ways to implement the federal efforts in a manner that maintains public and clinical confidence in the 988 crisis hotline. The 988 geolocation subcommittee must include persons with lived experience with behavioral health conditions as well as representatives of crisis call centers, the behavioral health interests of persons of color, and behavioral health providers; and

(g) Any other subcommittee needed to facilitate the work of the committee, at the discretion of the steering committee.

(9) The proceedings of the crisis response improvement strategy committee must be open to the public and invite testimony from a broad range of perspectives. The committee shall seek input from

tribes, veterans, the LGBTQ community, and communities of color to help discern how well the crisis response system is currently working and recommend ways to improve the crisis response system.

(10) Legislative members of the crisis response improvement strategy committee shall be reimbursed for travel expenses in accordance with RCW 44.04.120. Nonlegislative members are not entitled to be reimbursed for travel expenses if they are elected officials or are participating on behalf of an employer, governmental entity, or other organization. Any reimbursement for other nonlegislative members is subject to chapter 43.03 RCW.

(11) The steering committee, with the advice of the crisis response improvement strategy committee, shall provide a progress report and the result of its comprehensive assessment under subsection (5) of this section to the governor and appropriate policy and fiscal committee of the legislature by January 1, 2022. The steering committee shall report the crisis response improvement strategy committee's further progress and the steering committee's recommendations related to ((~~crisis call center~~)) designated 988 contact hubs to the governor and appropriate policy and fiscal committees of the legislature by January 1, 2023, and January 1, 2024. The steering committee shall provide its final report to the governor and the appropriate policy and fiscal committees of the legislature by January 1, ((~~2024~~)) 2025.

(12) This section expires June 30, ((~~2024~~)) 2025.

Sec. 7. RCW 71.24.896 and 2021 c 302 s 108 are each amended to read as follows:

(1) When acting in their statutory capacities pursuant to chapter 302, Laws of 2021, the state, department, authority, state ((~~enhanced~~)) 911 coordination office, emergency management division, military department, any other state agency, and their officers, employees, and agents are deemed to be carrying out duties owed to the public in general and not to any individual person or class of persons separate and apart from the public. Nothing contained in chapter 302, Laws of 2021 may be construed to evidence a legislative intent that the duties to be performed by the state, department, authority, state ((~~enhanced~~)) 911 coordination office, emergency management division, military department, any other state agency, and their officers, employees, and agents, as required by chapter 302,

Laws of 2021, are owed to any individual person or class of persons separate and apart from the public in general.

(2) Each ((~~crisis call center~~)) designated 988 contact hub designated by the department under any contract or agreement pursuant to chapter 302, Laws of 2021 shall be deemed to be an independent contractor, separate and apart from the department and the state.

NEW SECTION. **Sec. 8.** A new section is added to chapter 71.24 RCW to read as follows:

(1) By April 1, 2024, the authority shall establish standards for issuing an endorsement to any mobile rapid response crisis team or community-based crisis team that meets the criteria under either subsection (2) or (3) of this section, as applicable. The endorsement is a voluntary credential that a mobile rapid response crisis team or community-based crisis team may obtain to signify that it maintains the capacity to respond to persons who are experiencing a significant behavioral health emergency requiring an urgent, in-person response. The attainment of an endorsement allows the mobile rapid response crisis team or community-based crisis team to become eligible for performance payments as provided in subsection (10) of this section.

(2) The authority's standards for issuing an endorsement to a mobile rapid response crisis team or a community-based crisis team must consider:

(a) Minimum staffing requirements to effectively respond in-person to individuals experiencing a significant behavioral health emergency. Except as provided in subsection (3) of this section, the team must include appropriately credentialed and supervised staff employed by a licensed or certified behavioral health agency and may include other personnel from participating entities listed in subsection (3) of this section. The team shall include certified peer counselors as a best practice to the extent practicable based on workforce availability. The team may include fire departments, emergency medical services, public health, medical facilities, nonprofit organizations, and city or county governments. The team may not include law enforcement personnel;

(b) Capabilities for transporting an individual experiencing a significant behavioral health emergency to a location providing appropriate level crisis stabilization services, as determined by regional transportation procedures, such as crisis receiving centers, crisis stabilization units, and triage facilities. The standards must

include vehicle and equipment requirements, including minimum requirements for vehicles and equipment to be able to safely transport the individual, as well as communication equipment standards. The vehicle standards must allow for an ambulance or aid vehicle licensed under chapter 18.73 RCW to be deemed to meet the standards; and

(c) Standards for the initial and ongoing training of personnel and for providing clinical supervision to personnel.

(3) The authority must adjust the standards for issuing an endorsement to a community-based crisis team under subsection (2) of this section if the team is comprised solely of an emergency medical services agency, whether it is part of a fire service agency or a private entity, that is located in a rural county in eastern Washington with a population of less than 60,000 residents. Under the adjusted standards, until January 1, 2030, the authority shall exempt a team from the personnel standards under subsection (2)(a) of this section and issue an endorsement to a team if:

(a) The personnel assigned to the team have met training requirements established by the authority under subsection (2)(c) of this section, as those requirements apply to emergency medical service and fire service personnel, including completion of the three-hour training in suicide assessment, treatment, and management under RCW 43.70.442;

(b) The team operates under a memorandum of understanding with a licensed or certified behavioral health agency to provide direct, real-time consultation through a behavioral health provider employed by a licensed or certified behavioral health agency while the team is responding to a call. The consultation may be provided by telephone, through remote technologies, or, if circumstances allow, in person; and

(c) The team does not include law enforcement personnel.

(4) Prior to issuing an initial endorsement or renewing an endorsement, the authority shall conduct an on-site survey of the applicant's operation.

(5) An endorsement must be renewed every three years.

(6) The authority shall establish forms and procedures for issuing and renewing an endorsement.

(7) The authority shall establish procedures for the denial, suspension, or revocation of an endorsement.

(8)(a) The decision of a mobile rapid response crisis team or community-based crisis team to seek endorsement is voluntary and does not prohibit a nonendorsed team from participating in the crisis response system when (i) responding to individuals who are not experiencing a significant behavioral health emergency that requires an urgent in-person response or (ii) responding to individuals who are experiencing a significant behavioral health emergency that requires an urgent in-person response when there is not an endorsed team available.

(b) The decision of a mobile rapid response crisis team not to pursue an endorsement under this section does not affect its obligation to comply with any standards adopted by the authority with respect to mobile rapid response crisis teams.

(c) The decision of a mobile rapid response crisis team not to pursue an endorsement under this section does not affect its responsibilities and reimbursement for services as they may be defined in contracts with managed care organizations or behavioral health administrative services organizations.

(9) The costs associated with endorsement activities shall be supported with funding from the statewide 988 behavioral health crisis response and suicide prevention line account established in RCW 82.86.050.

(10) The authority shall establish an endorsed mobile rapid response crisis team and community-based crisis team performance program with receipts from the statewide 988 behavioral health crisis response and suicide prevention line account.

(a) Subject to funding provided for this specific purpose, the performance program shall:

(i) Issue establishment grants to support mobile rapid response crisis teams and community-based crisis teams seeking to meet the elements necessary to become endorsed under either subsection (2) or (3) of this section;

(ii) Issue performance payments in the form of an enhanced case rate to mobile rapid response crisis teams and community-based crisis teams that have received an endorsement from the authority under either subsection (2) or (3) of this section; and

(iii) Issue supplemental performance payments in the form of an enhanced case rate higher than that available in (a)(ii) of this subsection (10) to mobile rapid response crisis teams and community-based crisis teams that have received an endorsement from the

authority under either subsection (2) or (3) of this section and demonstrate to the authority that for the previous three months they met the following response time and in route time standards:

(A) Between January 1, 2025, through December 31, 2026:

(I) Arrive to the individual's location within 30 minutes of being dispatched by the designated 988 contact hub, at least 80 percent of the time in urban areas;

(II) Arrive to the individual's location within 40 minutes of being dispatched by the designated 988 contact hub, at least 80 percent of the time in suburban areas; and

(III) Be in route within 15 minutes of being dispatched by the designated 988 contact hub, at least 80 percent of the time in rural areas; and

(B) On and after January 1, 2027:

(I) Arrive to the individual's location within 20 minutes of being dispatched by the designated 988 contact hub, at least 80 percent of the time in urban areas;

(II) Arrive to the individual's location within 30 minutes of being dispatched by the designated 988 contact hub, at least 80 percent of the time in suburban areas; and

(III) Be in route within 10 minutes of being dispatched by the designated 988 contact hub, at least 80 percent of the time in rural areas.

(b) The authority shall design the program in a manner that maximizes the state's ability to receive federal matching funds.

(11) The authority shall contract with the actuaries responsible for development of medicaid managed care rates to conduct an analysis and develop options for payment mechanisms and levels for rate enhancements under subsection (10) of this section. The authority shall consult with staff from the office of financial management and the fiscal committees of the legislature in conducting this analysis. The payment mechanisms must be developed to maximize leverage of allowable federal medicaid match. The analysis must clearly identify assumptions, include cost projections for the rate level options broken out by fund source, and summarize data used for the cost analysis. The cost projections must be based on Washington state specific utilization and cost data. The analysis must identify low, medium, and high ranges of projected costs associated for each option accounting for varying scenarios regarding the numbers of teams estimated to qualify for the enhanced case rates and supplemental

performance payments. The analysis must identify costs for both medicaid clients, and for state-funded nonmedicaid clients paid through contracts with behavioral health administrative services organizations. The analysis must account for phasing in of the number of teams that meet endorsement criteria over time and project annual costs for a four-year period associated with each of the scenarios. The authority shall submit a report summarizing the analysis, payment mechanism options, enhanced performance payment and supplemental performance payment rate level options, and related cost estimates to the office of financial management and the appropriate committees of the legislature by December 1, 2023.

(12) The authority shall conduct a review of the endorsed community-based crisis teams established under subsection (3) of this section and report to the governor and the health policy committees of the legislature by December 1, 2028. The report shall provide information about the engagement of the community-based crisis teams receiving an endorsement under subsection (3) of this section and their ability to provide a timely and appropriate response to persons experiencing a behavioral health crisis and any recommended changes to the teams to better meet the needs of the community including personnel requirements, training standards, and behavioral health provider consultation.

Sec. 9. RCW 82.86.050 and 2021 c 302 s 205 are each amended to read as follows:

(1) The statewide 988 behavioral health crisis response and suicide prevention line account is created in the state treasury. All receipts from the statewide 988 behavioral health crisis response and suicide prevention line tax imposed pursuant to this chapter must be deposited into the account. Moneys may only be spent after appropriation.

(2) Expenditures from the account may only be used for:

(a) ((~~ensuring~~)) Ensuring the efficient and effective routing of calls made to the 988 crisis hotline to an appropriate crisis hotline center or ((~~crisis call center~~)) designated 988 contact hub; and

(b) ((~~personnel~~)) Personnel and the provision of acute behavioral health, crisis outreach, and crisis stabilization services, as defined in RCW 71.24.025, by directly responding to the 988 crisis hotline and enhancing mobile crisis service standards and performance provided through mobile rapid response crisis teams and community-

based crisis teams endorsed under section 8 of this act. Ten percent of the annual receipts from the tax must be dedicated to the establishment grants, performance payments, and supplemental performance payments for mobile rapid response crisis teams and community-based crisis teams endorsed under section 8 of this act and endorsement activities in section 8 of this act, up to 30 percent of which is dedicated to mobile rapid response crisis teams and community-based crisis teams endorsed under section 8 of this act that are affiliated with a tribe in Washington.

(3) Moneys in the account may not be used to supplant general fund appropriations for behavioral health services or for medicaid covered services to individuals enrolled in the medicaid program.

NEW SECTION. **Sec. 10.** A new section is added to chapter 28B.20 RCW to read as follows:

(1)(a) The University of Washington school of social work, in consultation with the Washington council for behavioral health and the state's behavioral health administrative services organizations, shall plan for regional collaboration among behavioral health providers and first responders working within the 988 crisis response and suicide prevention system, standardize practices and protocols, and develop a needs assessment for trainings.

(b) The University of Washington shall convene, at a minimum, the following key stakeholders to assist in developing an assessment of training needs, a mapping of current and future funded crisis response providers, and a comprehensive review of all behavioral health training required in statute and in rule:

(i) At least two representatives from the behavioral health administrative services organizations, one from each side of the Cascade crest;

(ii) At least three crisis services providers identified by the Washington council for behavioral health, one from each side of the Cascade crest, and one dedicated to serving communities of color;

(iii) A representative of crisis call centers;

(iv) At least two members who are persons with lived experience related to mental health issues, substance use disorder issues, a suicide attempt, or a suicide loss; and

(v) A representative of a statewide organization of field experts consisting of first responders, behavioral health professionals, and project managers working in co-response programs in Washington.

(c) When making recommendations on future crisis provider training needs related to serving persons with developmental disabilities, veterans, American Indians and Alaska Native populations, LGBTQ populations, and persons connected with the agricultural community, the University of Washington school of social work must solicit public comment on the needs assessment from advocates from those populations and others as deemed appropriate by the stakeholder group, including persons with lived experience related to mental health issues, substance use disorder issues, a suicide attempt, or a suicide loss.

(d) The training needs assessment, mapping of crisis providers, and research on existing training requirements must be completed by June 30, 2024.

(2) The University of Washington school of social work, in collaboration with the stakeholder group established in subsection (1) of this section, shall develop recommendations for establishing crisis workforce and resilience training collaboratives that would offer voluntary regional trainings for behavioral health providers, peers, first responders, co-responders, 988 contact center personnel, designated 988 contact hub personnel, 911 operators, and interested members of the public, specific to a geographic region and the population they serve as informed by the needs assessment. The collaboratives shall encourage the development of foundational and advanced skills and practices in crisis response as well as foster regional collaboration. The recommendations must:

(a) Include strategies for better coordination and integration of 988-specific training into the broader scope of behavioral health trainings that are already required;

(b) Identify effective trainings to explain how the 988 system works with the 911 emergency response system, trauma-informed care, secondary trauma, suicide protocols and practices for crisis responders, supervisory best practices for first responders, lethal means safety, violence assessments, cultural competency, and essential care for serving individuals with serious mental illness, substance use disorder, or co-occurring disorders;

(c) Identify best practice approaches to working with veterans, intellectually and developmentally disabled populations, youth, LGBTQ populations, communities of color, agricultural communities, and American Indian and Alaska Native populations;

(d) Identify ways to provide the designated 988 contact hubs and other crisis providers with training that is tailored to the agricultural community using training that is agriculture-specific with information relating to the stressors unique to persons connected with the agricultural community such as weather conditions, financial obligations, market conditions, and other relevant issues. When developing the recommendations, consideration must be given to national experts, such as the AgriSafe network and other entities;

(e) Identify ways to promote a better informed and more involved community on topics related to the behavioral health crisis system by increasing public access to and participation in trainings on the topics identified in (b) and (c) of this subsection (2), including through remote audiovisual technology;

(f) Establish suggested protocols for ways to sustain the collaboratives as new mobile rapid response crisis teams and community-based crisis teams endorsed under section 8 of this act, co-responder teams, and crisis facilities are funded and operationalized;

(g) Discuss funding needs to sustain the collaboratives and support participation in attending the trainings; and

(h) Offer a potential timeline for implementing the collaboratives on a region-by-region basis.

(3) The University of Washington school of social work shall submit a report on the items developed in this section to the governor and the appropriate committees of the legislature by December 31, 2024. Prior to submission of the report, the University of Washington school of social work shall consult with the department of health and the health care authority.

NEW SECTION. **Sec. 11.** A new section is added to chapter 71.24 RCW to read as follows:

(1) No act or omission related to the dispatching decisions of any crisis call center staff or designated 988 contact hub staff with endorsed mobile rapid response crisis team and community-based crisis team dispatching responsibilities done or omitted in good faith within the scope of the individual's employment responsibilities with the crisis call center or designated 988 contact hub and in accordance with dispatching procedures adopted both by the behavioral health administrative services organization and the crisis call

center or the designated 988 contact hub and approved by the authority shall impose liability upon:

(a) The clinical staff of the crisis call center or designated 988 contact hub or their clinical supervisors;

(b) The crisis call center or designated 988 contact hub or its officers, staff, or employees;

(c) Any member of a mobile rapid response crisis team or community-based crisis team endorsed under section 8 of this act;

(d) The certified public safety telecommunicator or the certified public safety telecommunicator's supervisor; or

(e) The public safety answering point or its officers, staff, or employees.

(2) This section shall not apply to any act or omission which constitutes either gross negligence or willful or wanton misconduct.

NEW SECTION. **Sec. 12.** A new section is added to chapter 38.60 RCW to read as follows:

(1) No act or omission of any certified public safety telecommunicator or crisis call center staff or designated 988 contact hub staff related to the transfer of calls from the 911 line to the 988 crisis hotline or from the 988 crisis hotline to the 911 line, done or omitted in good faith, within the scope of the certified public safety telecommunicator's employment responsibilities with the public safety answering point and the crisis call center or designated 988 contact hub and in accordance with call system transfer protocols adopted by both the department of health and the emergency management division shall impose liability upon:

(a) The certified public safety telecommunicator or the certified public safety telecommunicator's supervisor;

(b) The public safety answering point or its officers, staff, or employees;

(c) The clinical staff of the crisis call center or designated 988 contact hub or their clinical supervisors;

(d) The crisis call center or designated 988 contact hub or its officers, staff, or employees; or

(e) Any member of a mobile rapid response crisis team or community-based crisis team endorsed under section 8 of this act.

(2) This section shall not apply to any act or omission which constitutes either gross negligence or willful or wanton misconduct.

NEW SECTION. **Sec. 13.** If specific funding for the purposes of this act, referencing this act by bill or chapter number, is not provided by June 30, 2023, in the omnibus appropriations act, this act is null and void."

Correct the title.

EFFECT: Eliminates the term "988 rapid response crisis team" and restores the definition of a "mobile rapid response crisis team." Defines a "community-based crisis team" as a team that is part of an emergency medical services agency, fire service agency, public health agency, medical facility, or city or county, other than a law enforcement agency, that provides the on-site community interventions of a mobile rapid response crisis team. Specifies that the endorsement from the Health Care Authority (HCA) is available to both mobile rapid response crisis teams and community-based crisis teams. Removes the response time and in route time standards as requirements for receiving an endorsement.

Maintains the establishment grants and replaces the technical assistance grants and participation grants with performance payments and enhanced performance payments. Allows mobile rapid response crisis teams and community-based crisis teams with an endorsement to receive a performance payment in the form of an enhanced case rate. Allows mobile rapid response crisis teams and community-based crisis teams with an endorsement and that also meet response time and in route time standards to receive, subject to funding, a supplemental performance payment in the form of a higher enhanced case rate. Directs the HCA to design the payments in a manner that maximizes the ability to receive federal matching funds. Clarifies that the use of the Statewide 988 Behavioral Health Crisis Response and Suicide Prevention Line Account includes the establishment grants, performance payments, and supplemental performance payments. Directs the HCA to contract with the Medicaid managed care rate actuary to conduct an analysis and develop options for payment mechanisms and levels for the rate enhancements in a way that allows for maximum leverage of Medicaid federal match. Directs the HCA to submit a report to the Governor and the appropriate committees of the Legislature by December 1, 2023, with a summary of the actuarial analysis, payment mechanism options, payment rate level options, and related cost estimates.

Directs the Department and the Authority to require crisis call centers and designated 988 contact hubs to enter into data-sharing agreements with the DOH, the HCA, and behavioral health administrative services organizations to provide reports and data regarding 988 crisis hotline calls.

Removes the requirement that the new crisis call center platform be interoperable across crisis and emergency response systems throughout the state.

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