



Washington State 988 Case Referral & Management System Discovery and Report October 29, 2021

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EXECUTIVE SUMMARY

Beginning July 16, 2022, callers anywhere in America that dial “988” will be connected to a new, national mental health emergency hotline. Washington’s House Bill 1477 (HB 1477) builds on the National Suicide Hotline Designation Act of 2020 and mandates an integrated crisis response system that will connect all Washington State residents in need to enhanced behavioral health crisis response and suicide prevention services. HB 1477 takes a community-first approach, envisioning a statewide crisis response system that provides culturally and linguistically competent services to save lives and stabilize individuals in crisis using the least restrictive means possible.

This report, prepared by Third Sector Capital Partners (Third Sector) and supported by the Ballmer Group, is intended to provide information to support Washington State and the public during this 988 implementation process, focusing on the case management and referral technology systems that will be necessary to meet the requirements of HB 1477.

Washington State Crisis Call Referral Systems & Crisis Services Facilitators

Washington State is served by the National Suicide Prevention Lifeline (the Lifeline), six crisis lines for specific populations, and ten regional crisis lines. With the exception of lines for specific populations, many of which connect with call centers outside the state, crisis calls in Washington State route to three call centers in the Lifeline’s national network, one private call center, and three regional crisis call systems. In addition to the call centers, the Washington Indian Behavioral Health Hub serves as both a pathway for members of Affiliated Tribes to access crisis services, and a source of culturally appropriate resources and support; the Hub is in the process of launching a specialized crisis line for indigenous and Tribal affiliated individuals in Washington State.

Each call center or regional system delivers customized services depending on the area code or region from which a crisis call originates, with the most common services including screening, assessment, resolution-focused crisis support over the phone, referral to community-based resources, and referral to crisis response teams and/or law enforcement if the call escalates to a behavioral health emergency. Mobile Crisis Response Teams (MCRTs) and designated crisis responders, supported by law enforcement and Emergency Medical Services (EMS), serve as the primary facilitators for crisis stabilization services if they are unable to resolve a crisis on site. Call centers and regional systems use a variety of telephony and case management platforms, including both vendor and proprietary technology, to log and share client data. Call centers and regional systems track metrics for performance management, but a fragmented landscape of case management platforms and EHRs, coupled with limited interoperability between these systems, presents a barrier to outcomes measurement or reporting.

988 & Crisis Response System Exemplars

To inform 988 implementation, this report showcases state crisis response systems in Arizona, Georgia, Colorado, and Maryland; and local crisis response systems in Olympia, WA; Denver, CO; San Francisco, CA; and Austin, TX, and also describes 988 implementation to date in a select number of states. This report provides in-depth summaries about Arizona and Georgia’s models because they are recognized as national leaders in crisis response and 911 alternatives. Innovations in these states have served as key inspiration for the widely adopted “Crisis Now” model. Additionally, Arizona and Georgia have robust crisis response

services and sophisticated technology for call management, mobile dispatch, and electronic health record integration. This report also highlights Colorado, which is well positioned for 988 implementation thanks to established statewide crisis response systems and recently passed legislation to fund 988 operations, and Maryland, which has a statewide crisis response system operated via a 211 number. The report also details several local systems with effective programs and processes for diverting calls from 911, taking direct calls for people in crisis, and dispatching mobile crisis response services.

Vendor Assessment

Third Sector interviewed nineteen technology vendors for this report. Of those, eight (Eustace Consulting, Microsoft, NavigatorCRE, Netsmart, Salesforce, OpenBeds, Social Solutions and Solari) had products that can fully meet the requirements of HB 1477, while the remaining vendors had products that can partially meet the requirements on their own (and could fully meet the requirements when combined with another platform). All vendors interviewed are HIPAA compliant, and most had products that are cloud-based using open Application Program Interfaces (APIs) and can present data in real-time as source databases are updated. While most vendors indicated that they would implement their product exclusively with an in-house team, five vendors (Amazon Web Services, Eustace Consulting, Microsoft, Salesforce and Zoho) indicated that they would likely sub-contract with external consultants for initial product rollout. Products have a variety of fee structures, including upfront fees and monthly/annual subscription fees, most with sliding scales. The scales vary based on the number of callers, the number of call center operators, the number of data sets integrated, and the number of mobile crisis teams using the system. Some products specialize in longer term, outcomes-focused post-care treatment. While not an explicit software requirement in HB 1477, these vendors expressed an interest in partnering with other companies to meet the full software requirements and better understand 988 call outcomes.

Conclusion

Washington's existing network of Lifeline Call Centers, Regional Crisis Call Systems, and the Washington Indian Behavioral Health Hub provide a strong foundation for meeting the requirements of HB 1477. However, implementation of a new technology platform meeting all requirements would provide a significant increase in capabilities system-wide, particularly with respect to bed availability, geolocation of crisis response teams, care coordination, and outcomes tracking. Crisis response systems in Georgia, Arizona, Colorado, and Maryland, as well as a variety of localities across the country, may provide examples of successful crisis coordination response. At the same time, Washington's HB 1477 and 988 planning process are unique in their approach and details. A number of software vendors may help Washington State meet the majority of requirements of HB 1477, while other vendors can support specific components of an overall platform. Third Sector hopes that the information shared in this report is useful to Washington state and the public as 988 is implemented in Washington in the coming months.

Note that this report was developed to benefit the public and the state of Washington's 988 implementation process and leverages publicly available information as well as information shared by interviews. Additional information may be needed from Washington's government agencies to provide a full assessment on these topics, including information on the expected scale of the 988 system (expected number of call center operators, callers, etc.) and the capabilities of Washington's current 911 system.

INTRODUCTION

Federal legislation passed in July 2020 requires that all telecommunications services implement a new three-digit number for mental health emergencies, including suicide. Beginning on July 16, 2022, callers who dial 988 will be connected to the National Suicide Prevention Hotline (the Lifeline) or to a local crisis response center. In April 2021, with the passage of House Bill 1477 (HB 1477), the Washington state legislature charged the Washington Department of Health and the Washington Health Care Authority with the development and implementation of an integrated crisis response system that will connect all Washington residents in need to enhanced behavioral health crisis response and suicide prevention services statewide. HB 1477 aims to measurably reduce reliance on emergency rooms, decrease the use of law enforcement in response to behavioral health crises, stabilize individuals experiencing behavioral health crises in the community whenever possible, provide culturally and linguistically competent services, and save lives. The legislature also aims to reduce harm to Black, Indigenous and People of Color (BIPOC) communities in Washington. Suicide rates are higher among American Indians/Alaska Natives than among the general population in Washington, while BIPOC communities in Washington face disproportionate criminal justice involvement and interactions with law enforcement, including violent responses to mental health crises by police.

HB 1477 calls on the Department of Health (the Department) and the Health Care Authority (the Authority) to establish a crisis response improvement strategy committee to advise on the development of an integrated behavioral health crisis response and suicide prevention system. The legislation also calls on the Department and the Authority to invest in new technology to create a crisis call center hub system in order to triage calls and link individuals to follow-up care. In addition, the legislation calls for the expansion of mobile crisis response teams and the deployment of an array of crisis stabilization services, including 23-hour crisis stabilization units, crisis stabilization centers, short-term respite facilities, peer-run respite centers, and same-day walk-in behavioral health clinics.

To develop this report, Third Sector staff conducted a literature review, as well as desk research about the current crisis response systems in Washington and other key states, including systems that have developed culturally and linguistically competent services aimed at especially serving BIPOC populations. Third Sector staff also interviewed key informants within the current behavioral health and crisis responses systems in Washington and other states, as well as software vendors currently providing services or able to provide services to crisis response systems. Appendix A (attached) details the conversations that informed this report.

HB 1477 Technical Requirements Overview

HB 1477 requires that the Department and the Authority establish a Behavioral Health Integrated Client Referral System that will coordinate information with crisis call center hubs and behavioral health entities. This Behavioral Health Integrated Client Referral System must be capable of:

- Providing real-time availability of behavioral health crisis response and suicide prevention services as well as information on the caller themselves, including information on less restrictive alternative treatment orders or mental health advance directives related to the person and other information needed to establish a safety plan for the person;
- Deploying services, including requesting services, tracking local response by global positioning technology, and providing geographically, culturally, and linguistically appropriate services to persons who are part of high-risk populations or otherwise have need of specialized services or accommodations;
- Documenting these services or accommodations; and
- Tracking call outcomes, including any immediate services dispatched and reports generated from the encounter; the validation of a safety plan established for the caller; the next steps for the caller to follow in transition to non-crisis follow-up care, including a next-day appointment for callers experiencing urgent, symptomatic behavioral health care needs, and verifying and documenting whether the caller was successful in making the transition to appropriate non-crisis care as indicated in their safety plan.

Crisis call centers, regional crisis call systems, service providers, and other stakeholders in the crisis response system will be partners and participants to ensure successful implementation. During implementation of the system, providers will be responsible for: updating bed availability on a consistent basis; maintaining an up-to-date list of services and programs, with eligibility requirements; and maintaining real time location data. Providers will also be responsible for outcome tracking within their own service ecosystem, which will include verifying and documenting a person's transition to follow up non-crisis care.

To support Washington State and the public's understanding of opportunities to implement and deploy systems that would meet the requirements of the HB 1477 bill, this report: (1) reviews the current Washington State crisis call center referral systems and crisis service facilitators; (2) describes national exemplars in crisis call center and 988 implementation; and (3) summarizes the capabilities of software vendors that may be able to help meet the technological requirements of the bill.

WASHINGTON STATE CRISIS CALL REFERRAL SYSTEMS

Washington State's crisis call referral system plays a vital role in the overall crisis response system, providing access to screening, counseling, connection to resources, and (when necessary) direct intervention. Within this system, a total of seven Lifeline Call Centers and Regional Crisis Call Systems serve as the primary point of contact for people in crisis, families seeking help for their loved ones, and facilitators in the crisis system (i.e., clinicians, counselors, law enforcement, Emergency Medical Service). Callers reach these centers through the Lifeline and regional crisis lines for each of the state's ten integrated managed care regions. Washington State is also served by a variety of crisis lines for specific populations, most of which route to call centers outside the state. See Appendix B for a detailed breakdown of Washington State crisis lines.

Key Terminology for Crisis Call Referral Systems

Designated Crisis Responder (DCR): DCRs are behavioral health professionals responsible for conducting Involuntary Treatment Act (ITA) investigations, and the only professionals in Washington State trained and authorized to determine whether individuals meet criteria for involuntary treatment under the ITA.

Mobile Crisis Response Team (MCRT): MCRTs are field-based teams that travel to provide in-person crisis support and stabilization services for individuals who are experiencing a behavioral health emergency.

Behavioral Health Administrative Services Organization (BH-ASO): BH-ASOs are entities selected by HCA to administer behavioral health services, including a 24/7/365 crisis hotline, mental health crisis services, short-term SUD crisis services, and involuntary treatment under ITA, for each of ten regional services areas in Washington State

Crisis call operators: Crisis call operators may also be referred to as crisis counselors. However, in certain cases when these terms are not interchangeable, the report provides clarifications on the distinctions between the two roles.

Crisis Call Systems in Washington State

Crisis call systems operating in Washington State fall into two general categories: Lifeline Call Centers and Regional Crisis Call Systems. The Washington Indian Behavioral Health Hub, which is co-located with one of the state's Lifeline Call Centers, serves a distinct role in the statewide system by providing an access point for indigenous and Tribal affiliated individuals.

Lifeline Call Centers are members of the Lifeline Network, which comprises more than 180 call centers nationwide that receive calls from the Lifeline. There are three Lifeline Call Centers in Washington State, each operated by a different nonprofit organization: Crisis Connections in Seattle, Volunteers of America in Eureka, and Frontier Behavioral Health in Spokane. All Lifeline Call Centers based in Washington State receive calls from both the Lifeline and regional crisis lines. Calls to the Lifeline are routed to the closest call center based on area code, with the goal of connecting all calls to a counselor within Washington State. In the event that none of the Washington State call centers are able to field an incoming call, the call will be routed to another of the ~180 call centers in the Lifeline Network. The private company ProtoCall, another member of the Lifeline Network based in Portland, Oregon, also fields calls to regional crisis lines for the Greater Columbia region of Washington State. This role is separate and distinct from ProtoCall's role as a Lifeline Call Center serving other states.

Seven out of ten BH-ASOs contract with Lifeline Call Centers to provide crisis line services for their regions. However, the Great Rivers, Greater Columbia, and Thurston Mason BH-ASOs each operate Regional Crisis Call Systems. Regional Crisis Call Systems are operated by BH-ASOs with in-house staff or contracted out to a local behavioral health provider. These systems are distinct from Lifeline Call Centers in that staff are

often members of a local MCRT or DCRs, may have established personal relationships with callers, and may respond directly to a mental health emergency instead of referring the call to another agency. In addition to the Regional Crisis Call Systems, some local behavioral health providers maintain their own agency “after hours” lines for clients to facilitate crisis response. These lines are not designed for emergencies and are not promoted as crisis lines to the general public. The most common users of these lines are current clients of these behavioral health providers, who are often provided with the after-hours line as part of a treatment and/or safety plan, and system facilitators like law enforcement or Emergency Medical Services (EMS).

The Washington Indian Behavioral Health Hub is a unique resource for members of Tribal nations in Washington State. The Hub does not provide crisis services itself; rather, it serves as a first point of contact for indigenous and Tribal affiliated individuals that aims to prevent mental health challenges from escalating, provide resources and referrals for support, and connect callers with immediate crisis support in the event of a behavioral health emergency. The Hub is co-located with a Lifeline Call Center and is currently in the process of launching a dedicated crisis line for indigenous and Tribal affiliated individuals in Washington State. Table 1 below summarizes data on the Crisis Call Centers in Washington State.

Table 1: Crisis Call Center Overview

Call Center	Regions Served	Annual Call / Text Volume	Phone Management Software	Call Center Case Management Software	Communication (chat/text functions) Software
Volunteers of America	Statewide, Salish, and North Sound	108,970	Elevate UC	Proprietary Software - CCDS	PureConnect
Crisis Connections	9 counties (King, Pierce, Clark, Skamania, Klickitat, Grant, Okanogan, Chelan, and Douglas)	134,210	InContact	CareLogic	iCarol
Frontier Behavioral Health	Spokane	41,615	CISCO CCM	Coordinated Care Platform	None
ProtoCall	Greater Columbia	13,200 / 7,200 clinical calls	Proteus	Protoconnect	<i>Data Request Pending</i>

Call Center	Regions Served	Annual Call / Text Volume	Phone Management Software	Call Center Case Management Software	Communication (chat/text functions) Software
Columbia Wellness	Great Rivers	53,875	Mitel	Credible	None
Thurston Mason BH-ASO	Thurston Mason	23,606	Comcast	myAvatar	Tiger Connect ¹

Call Center & Crisis System Profiles

Third Sector developed profiles for all Crisis Call Centers and Regional Crisis Call Systems in Washington State for our landscape assessment. Third Sector gathered basic overview information for each Center or System, including service type, scope of services (i.e., crisis resolution, “warm” line support, and related processes), duration of operations, integration with 911, and overall structure. Third Sector also gathered specific information to determine how Centers and Systems are currently delivering components of the desired system articulated in HB 1477, including:

- **Call & Case Management:** The Center or System’s process, software, and systems for managing intake of crisis line calls and deployment of crisis response services, which may include mobile crisis teams, co-responder teams, designated crisis responders, fire department mobile integrated health teams, or community assistance referral and educational services programs, and the Center or System’s capacity for tracking next steps for an individual’s transition to follow-up non-crisis care; to enable appropriate follow up, cross-system coordination, and accountability, including immediate services dispatched and reports generated from the encounter
- **Care Coordination:** The Center or System’s process, software and systems that support care coordination, including 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
- **Equity & Cultural Competency:** The Center or System’s ability to provide geographically, culturally, and linguistically appropriate services or other specialized services for specific populations

Each profile includes Third Sector’s findings for each of these categories of information. Where relevant, this report included the specific software platforms, vendors, and other infrastructure that Centers and

¹ Communication software used between mobile crisis teams

Systems use to coordinate crisis response. Because the landscape assessment is focused on software and related considerations, this report highlights specific behavioral health providers and local services where relevant but does not include a comprehensive assessment of behavioral health service providers or software beyond the Centers and Systems themselves.

Lifeline Call Centers

Crisis Connections

Overview

Crisis Connections is a nonprofit organization based in Seattle, WA. Crisis Connections operates a crisis call center serving nine counties: King, Pierce, Clark, Skamania, Klickitat, Grant, Okanogan, Chelan, and Douglas, serving as a hub to provide referrals for both acute and sub-acute services. The call center receives calls from individuals, transfer calls from 911, and business calls from outpatient services, hospitals, law enforcement, and other first responders. Crisis Connections follows the Lifeline model for crisis call response, with crisis line operators conducting an initial assessment for each incoming call and offering resolution-focused crisis support over the phone.

In 2020, Crisis Connections received 134,210 calls (~11,184 per month) through the Lifeline, regional line, and statewide lines. Of these, 6% were Lifeline calls, 67% were from regional lines, and the remainder were from their statewide lines: Teen Link, the Warm Line, and the Recovery Help Line. Crisis Connections answers 95% of calls within 30 seconds, with an abandonment rate of less than <5%. Average answer time was 11-13 seconds. The average handle time for crisis line calls was 5 minutes and 15 minutes for Lifeline calls. Crisis Connections crisis line operators include volunteers, call screening and coordination specialists, bachelor's level crisis intervention specialists, crisis service clinicians with a master's level mental health professional certification, and crisis supervisors with a masters level mental health professional certification. The call center runs 4 volunteer shifts along with 3 paid staff shifts during each 24-hour period. Regional crisis lines are staffed with a maximum of 12 volunteers and the graveyard staff consists of 7 staff answering client facing crisis line calls

Call & Case Management

Crisis Connections uses inContact telephony software to display and monitor metrics related to call volume, average wait time, and other access measures. iCarol software adds texting and chat functionality for the call center. Crisis counselors document their efforts, services, and connections to care using CareLogic case management software. Crisis Connections collects demographic data voluntarily, and also records narrative notes (e.g., where the call came from, the type of call, etc.) in CareLogic.

Incoming calls to Crisis Connections are answered first by call screeners who ensure the call is connected to the caller's local region. If the caller is not in one of the nine counties served by Crisis Connections, the call screener identifies the call center that is local to them and forwards the call to the caller's local crisis

call center. If the caller is within one of the nine counties Crisis Connections serves, the call screener determines urgency/emergency and if it is determined to be an emergent situation, the call screener will immediately notify a mental health professional for guidance on next steps, which can include notification to the 911 system in the background. If the call is not a mental health emergency, the call is then forwarded to crisis operators.

While counselors stabilize the majority of calls over the phone, Crisis Connections operators also provide referrals and dispatch through phone calls, with service availability based on the county where the call originates. Each county that Crisis Connections serves has a different availability of services, which dictates the types of response Crisis Connections can provide. For King County, Crisis Connections resolves 67% of calls on the phone, and makes referrals to a wider variety of community resources compared with other Crisis Call Centers or Regional Crisis Systems. Referrals include the Children's Crisis Outreach System, emergency rooms, next day appointments, law enforcement, case managers at behavioral health providers, and public mental health clinics, along with MCRTs and DCRs.

Care Coordination

Select Crisis Connections staff have access to the Extended Client Lookup System (ECLS). This system stores client information such as inpatient psychiatric admissions, outpatient treatment services, and other specialized behavioral health services. The level of detail available in the system is dependent on details that are sent to King County from MCOs. Authorized staff use the system to ensure efficient provision of services to enrolled and unenrolled residents of King County by avoiding duplication of services and facilitating continuity of care. Information contained in the ECLS is confidential and is only accessed and disclosed under certain conditions. First responders such as EMS are also able to contact the Crisis Connections pilot program One Call to determine if the individual is established with a care provider and connect them with that provider instead of routing them to an ED or jail. The One Call program has had success to date in the Seattle pilot and is expanding to include all of King County.

Prior to WA's managed care integration, Crisis Connections had access to client-level behavioral health information and outpatient treatment plans for all providers contracted with the regions. Following managed care integration, they lost access to that platform and are no longer able to access previous or follow-up care across behavioral health providers within the region. Data across regions is not integrated at this time. Because the call center and behavioral health providers use different case management and EHR platforms, interoperability and data sharing is limited. For example, Crisis Connections is not currently able to "close the loop" on referrals by receiving outcomes data from providers. The call center is not currently able to collect and integrate longer-term outcomes data, including the rate of follow-up on caller action items, if a caller called multiple times, and placement details. The exception to this is King County, as Crisis Connections is still able to access client-level behavioral health data through ECLS for contracted providers.

Crisis Connections is currently monitoring bed availability utilizing their Patient Placement Team. The Patient Placement Team calls regional hospitals multiple times a day and regularly updates and maintains the placement log that Crisis Connections uses to provide updated bed availability to DCR's in the field. However, it is important to note both that this is not a real-time bed registry that is updated by the hospitals, and that bed registries implemented in the past failed because they were not updated by all facilities.

Crisis Connections is the primary crisis line for counties covered in the Beacon Health Options regions. OpenBeds has built a customized integrated platform for Beacon Health Options which will replace phone communication for crisis dispatch, enabling the crisis line to directly transmit information to the crisis team in the field. OpenBeds will also allow GPS real-time enabled dispatch, so that the nearest crisis team member to the crisis responds. OpenBeds will also enable crisis response follow-up data collection along with closed loop referral analysis and long-term outcomes tracking and analysis. OpenBeds will also include a real-time bed registry and decrease the need for DCR's to call individual facilities in search of an open and available bed. Beacon Health plans to implement OpenBeds for the company's regions in November 2021.

Equity & Cultural Competency

Crisis Connections is currently engaging with a DEI consulting firm on a company-wide level and is committed to tracking outcomes that will better measure impact on equity in crisis call management, crisis response, and longer-term outcomes. Crisis Connections aims to provide culturally responsive and relevant care for all callers to the Lifeline and regional crisis lines.

Volunteers of America Western Washington

Overview

Volunteers of America Western Washington (VOAWW) is a nonprofit organization based in Everett, WA. Volunteers of America (VOA) operates a call center that provides regional crisis line support to both the Salish and North Sound BH-ASO regions, and the National Suicide Prevention Lifeline (NSPL) for 32 of Washington's Counties. VOA also provides backup crisis line services to the 6 counties covered by Frontier Behavioral Health for NSPL as they only began Lifeline service in July 2021.

In 2020, The Volunteers of America call center received 108,970 calls (~9080 per month) from the Lifeline and regional crisis lines. 28% of crisis calls were routed from the Lifeline and 71 % from a regional line. The VOA call center answered 91.2% of calls within 30 seconds, with an abandonment rate of 4.6%. The average speed of answer was 27.4 seconds, and the average talk time was 6.34 minutes. Last year 92% of calls were resolved on the phone by crisis line operators, while the remainder were referred to MCRTs and law enforcement (see below for further details). VOA crisis line operators are Bachelor/Master Level Clinicians, trained to conduct an initial assessment and offer resolution-focused crisis support over the phone. VOA uses a "hybrid" staffing model, with both remote and in-office operators fielding calls,

including some VOA staff based outside of Washington State. VOA generally staffs 18-20 operators per shift, with 3 shifts per day (24 hours).

Call & Case Management

The VOA call center uses proprietary software called CCDS for case management, the Elevate UC platform for telephony, and PureConnect for chat/text support. CCDS has a nightly update cycle, with ad hoc updates as needed, but VOA notes that software updates have a negligible impact on operations. While these systems are not currently integrated, VOA aspires to have a single unified system in the future. All incoming calls are recorded and transcribed in real time. Operators enter clinical notes and updates to caller information into the case management database manually during each call, using dropdown boxes wherever possible to streamline data entry.

VOA's case management software maintains data records with name and date of birth identifiers; repeat callers generally develop individual profiles with relevant and available demographic information (e.g., veteran status), number of contacts, clinical notations, and outcome data from referrals to mobile crisis response, particularly whether the individual was voluntarily or involuntarily hospitalized. This software provides operators with real-time access to profile data for each caller, provided that the caller elects to disclose a name. VOA maintains a separate resource list with locally available behavioral health resources for each region, which is stored and displayed on operators' desktop computers.

In 2020, MCRTs were dispatched for 6.2% of calls, and law enforcement was dispatched for 1.8% of calls, generally when VOA operators were unable to resolve a crisis over the phone. VOA provides centralized regional dispatch for MCRTs, DCRs, and other crisis responders in cases where a field response is needed. For dispatch, VOA operators use phone calls to relay demographics, presenting information (nature and details of crisis), mental health history, labs, safety screening, and any collateral information that may be important for a DCR investigation. Information sources include community/family members, hospital staff, law enforcement/EMS, or other requestors (agencies requesting outreach). VOA operators may also coordinate with fire, police, and EMS services via phone calls to 911 dispatch. Information shared with the 911 system is similar to the information shared with MCRTs, including demographics, location, presenting information, mental health history, known weapons, intent/means, and any relevant collateral information.

VOA's CCDS software does not have geolocation capabilities for MCRTs, so once a crisis response is handed off to dispatch VOA cannot track the response beyond that point. VOA maintains a bed availability list with every in-patient unit in Washington State, which VOA operators use to provide the best available information to MCRTs when they make a referral. The list is updated twice daily through phone calls to hospitals and other stabilization facilities, with some hospitals submitting updates via email through pre-determined arrangements with VOA. VOA's current process for collecting outcomes data varies by regional crisis line. While these twice-daily updates provide vital information for crisis referrals, the current process falls short of the real-time bed availability envisioned by HB 1477.

Care Coordination

Prior to WA's managed care integration, VOA had password-protected access to crisis services and outpatient treatment plans operated by many behavioral health providers and could access patient/caller data including crisis treatment plans, legal mental health holds and detainment information, last hospital visit, and need for follow-up care. VOA could schedule follow-up appointments, including next-day appointments when available, and notify outpatient service providers of their clients' interactions with the crisis system. However, the call center lost access to these capabilities after the move to Managed Care and has been unable to find a workaround.

VOA identified tracking an individual's transition to stabilization and non-crisis follow-up support as an important gap that the organization is actively working to address, and a gap between current capabilities and the capacity to support follow-up and cross-system accountability envisioned in HB 1477. Outcomes data and reporting processes vary by region served. For the Salish region, the Salish BH-ASO sends outcomes data to VOA electronically on a daily basis, and a VOA staffer enters that data manually into the database. For the North Sound region, crisis responders call in with outcomes and VOA operators handle data entry. Follow-up calls from crisis responders are inconsistent; sometimes they call in with outcomes from an encounter, but in other cases VOA never receives that data. VOA's software platform is not integrated with EHRs at hospitals or behavioral health providers, so interoperability remains a challenge.

Equity & Cultural Competency

VOA is home to the Washington Indian Behavioral Health Hub (the Hub), a unique Washington State resource for indigenous and Tribal affiliated individuals to access behavioral health support and post-crisis follow-up care. VOA, the Hub, and the Tribal Centric Behavioral Health Advisory Board are in the process of setting up the first tribal crisis line in the nation. The tribal crisis line will connect callers with Tribal/Native counselors who can offer culturally appropriate crisis resolution support. See the Washington Indian Behavioral Health hub section below for further details.

Frontier Behavioral Health

Overview

Frontier Behavioral Health is a nonprofit organization based in Spokane, WA and runs the 24/7 Regional Crisis Line (RCL) for Spokane BH-ASO region. Frontier Behavioral Health is also the largest behavioral health provider in the Spokane region and offers a full spectrum of behavioral health services including mental health assessments, outpatient treatment including Program for Assertive Community Treatment (PACT) and New Journeys First Episode Psychosis, a clubhouse - Evergreen Club, crisis response services, medication management, psychological assessments, Trueblood programs, inpatient evaluation and treatment facilities, and a Stabilization Unit.

As a Lifeline call center, Frontier's crisis line operators conduct an initial assessment for each incoming call and offer resolution-focused crisis support over the phone. Frontier also provides centralized regional dispatch for crisis response services, including referrals to mobile crisis response teams, DCRs, and other crisis responders in cases where a field response is needed. Frontier operators may coordinate with fire, police, and EMS services to support mobile crisis response as well. In addition, Frontier manages the mobile crisis response teams and DCR's within Spokane county.

Frontier Behavioral Health received 41,615 calls in 2020 (3,467 a month). Around 99% of calls were answered within 30 seconds, with an abandonment rate of less than .32%. Most of these calls come from somewhere in Washington state, but 7.4% calls do come from out of state. The average speed of answering a call was 8 seconds and the average talk time during a call was 6 minutes, 29 seconds. Frontier crisis line operators have a bachelor's degree and are agency affiliated. Frontier generally staffs 3 shifts per day (24 hours), with 1 supervisor always on and 6 additional staff on weekdays, 4 staff on weekends, and 3 staff on nights all week.

Call & Case Management

The Frontier call center uses CISCO Unified Contact Center call management software and the Coordinated Care Platform (CCP) EHR. Frontier also has access to Raintree, the EHR system for the regional Spokane BH-ASO. Callers are connected directly to clinically trained crisis operators. Frontier collects demographic information along with details of each call, including an overall risk assessment and other assessments such as the Columbia-Suicide Severity Rating Scale (C-SSRS). Prior to WA's managed care integration Frontier had access to crisis services data, inpatient psychiatric admissions, and outpatient treatment crisis plans for all Spokane County Regional Behavioral Health Organization (SCRBHO) contracted providers. Following managed care integration, the organization lost access to that platform and are no longer able to access previous or follow-up care across behavioral health providers within the region.

In 2020, 24% of crisis calls required a mobile crisis response. Frontier provides referral to MCRTs and DCR's via phone calls. Frontier made 7,668 referrals to DCRs in 2020, along with 2,211 referrals to Mobile Community Assertive Treatment (MCAT), 99 referrals to 911, and 25 referrals to mobile crisis response for Trueblood programs, a diversion program designed to minimize justice involvement for people with serious mental illness. There are currently no geolocation capabilities for tracking crisis responders. Between Raintree access and Frontier's role as both a behavioral health provider and crisis call center, the organization has the ability to track the outcomes of crisis response within Spokane county. However, outcomes tracking is limited for other counties in the region, and Frontier will only receive outcomes data from a field intervention if the dispatched team calls back with a status update.

Care Coordination

As the largest behavioral health provider in the Spokane region, Frontier manages care coordination across a range of directly provided services. Frontier offers services to individuals from children to older

adults, including general and specialized outpatient treatment programs, crisis line operation and management, mobile crisis response, crisis intervention & ITA evaluation, inpatient and stabilization services, and psychiatric care. Frontier has a Crisis Stabilization unit designed to provide voluntary short-term care to adults experiencing a mental health crisis, as well as two Evaluation and Treatment (E&T) facilities designed to provide involuntary or voluntary inpatient care to adults experiencing psychiatric instability, who are at risk of harming themselves or others, or are gravely disabled due to their psychiatric condition. Just .06% of field responses need transport to a voluntary bed or facility, but 71% are transported to an involuntary bed or facility. If behavioral health services are provided outside the Frontier system of care, the organization is only able to track and update follow-up care received if a provider follows up with service outcome status. If a follow-up is required by Lifeline, in absence of updates from the provider or agency Frontier referred the individual to, Frontier will attempt calling the individual to follow-up with them.

Frontier uses Coordinated Care Platform (CCP) as their EHR and also has access to Raintree, the data system utilized by the Spokane County Regional BH-ASO and is able to access related services for non-Medicaid clients in this system if it is related to emergent crisis services. The DCRs have access to Epic, the local hospital's EHR system. As the largest behavioral health provider in the region, Frontier has access to all records related to services that Frontier manages within Spokane county, however data outside Spokane county is not integrated into their current system. Frontier's data systems are not currently integrated with other behavioral health providers or hospitals in the region.

No bed registry is currently in place. Access to real-time data and the staffing levels required to keep this information continuously updated were expressed as primary barriers for bed registry implementation. Currently, individual DCRs check bed availability on a case-by-case basis if involuntary treatment is deemed necessary. In the event no bed is available for an involuntary psychiatric admission, Frontier has single bed certification compatibility at 4 hospitals in Spokane. Single bed certification is the allowance for a hospital bed to be temporarily designated as a crisis bed until appropriate placement can be found. During this time, DCR's continue to call hospitals and treatment facilities throughout the state in search of an open bed.

Equity & Cultural Competency

The Spokane Regional Service Area (RSA) (which coincides with the Spokane BH-ASO region) includes rural and frontier areas. Individuals living in these areas, DCRs, and mobile crisis response service providers responding to these areas experience additional barriers when navigating through a crisis. There are regional equity considerations related to the current shortage of behavioral health staff and the disproportionate impact this can have on remote regions. There are concerns related to crisis response time, especially with current vacancy rates and the limited capacity of current crisis response services across the region.

Regional Crisis Call Systems

Thurston-Mason

Overview

The Thurston-Mason BH-ASO has worked in their region for nearly 25 years and has gone through several iterations before becoming the regional BH-ASO. Thurston-Mason is the only BH-ASO in Washington that provides crisis line services as well as crisis response services in-house instead of relying on contracted call centers or providers. Services include crisis response and stabilization, jail and hospital diversion, and involuntary treatment.

Thurston-Mason often receives calls through 911 and referrals from law enforcement. The ASO recently launched a co-responder program in mid-August with the Olympia police department. Crisis peers are dispatched alongside law enforcement when calls regarding individuals experiencing homelessness come through 911. Finding secure transport for individuals that need to be detained in the field has been a recurring issue. Higher reimbursement rates for crisis response were flagged as a potential solution.

In 2020, the Thurston-Mason BHASO call received 23,606 calls (roughly 1,967 calls per month). 96% of these calls were answered within 30 seconds, with an abandonment rate of less than 4%. Calls were answered within 7.5 seconds on average. Thurston-Mason crisis line operators are either agency affiliated BA or MA level counselors, masters-level licensed clinicians, or certified peers. 3-4 operators work each per shift, with 3 shifts per day (24 hours).

Call & Case Management

The Thurston-Mason crisis line is staffed 24/7 with DCRs, clinically trained crisis operators, and crisis peers that are familiar with frequent callers and community needs. Crisis peers are operators that have direct experience as consumers of behavioral health services or are family members of a consumer. If the operator is unable to address the crisis directly and a field-based or specialized crisis response service is needed, they will provide a warm hand off over the phone to the relevant crisis worker and triage with an MCRT/DCR for involuntary placement as needed. In 2020, 11% of DCR events referred individuals to voluntary inpatient services and 29% of DCR events resulted in detention to an involuntary bed or facility.

Case management data for the Thurston-Mason region is stored in a central EHR that can be accessed by all Thurston-Mason staff and crisis response staff in 7 neighboring counties. Non-billable call data (i.e., call volume) is tracked via reports from the Internet Service Provider (ISP) Comcast. Data from each call is entered manually into a MyAvatar EHR system while the call is in progress. Crisis line operators, DCRs, MCRTs, and program staff employed by Thurston-Mason and neighboring counties can access client level data to help inform crisis response and client interaction. The crisis line is integrated with local DCRs and community dispatches that work with 11 other service providers. Thurston Mason DCRs provide coverage for certain areas within the Great Rivers region as well. After dispatch, crisis response teams track location and coordinate service provision through the secure, text-based app called TigerText. While the system is highly integrated, geolocation technology to track response progress is currently unavailable.

Care Coordination

Thurston-Mason Regional Navigators help connect individuals to reentry and diversion programs for both jail and hospitalization as well as housing assistance and other Thurston-Mason programs. DCRs, Crisis Peers, and Crisis Clinicians are all trained to direct individuals to relevant services, with the aim of “no wrong door” to seeking care.

Thurston-Mason uses the MyAvatar EHR, along with all 7 counties that work with their direct crisis DCR services (including those in the Great Rivers Region). This provides greater access to follow-up data including crisis response outcomes and subsequent follow-ups, as all crisis services are coordinated directly by the region. Having a common EHR system across counties provides Thurston Mason with a higher level of data sharing and interoperability compared with most other regions in Washington State. However, this system is not currently connected with any of the statewide hubs or with Lifeline, limiting data sharing and coordination between Thurston Mason, Lifeline Call Centers, and other regions. Service providers across Thurston-Mason’s crisis response practice can view client level data, including what programs the client is participating in and where the client falls along in a crisis continuum.

Although there are acute psychiatric facilities available in the region, there are no crisis stabilization units. Crisis stabilization is done in the field by the crisis response team. Thurston-Mason provides follow-up support through a peer-led stabilization team that visits individuals (generally at their residence) post-crisis, and connects them to outpatient behavioral health providers, as well as other community resources such as Medicaid, employment, and housing. Since Thurston-Mason’s crisis response programs all use MyAvatar, an individual's short-term outcomes and progress along a crisis continuum is able to be tracked, but long-term outcomes with local behavioral health providers are not.

No bed registry is currently in place, although it has been discussed in the past. Accuracy of the information provided and clarity on who will be accepted were both flagged as potential barriers for successful bed registry implementation. Most often a DCR will wait until medical clearance is provided and then make a phone call to confirm bed availability with a clearance from either the ER or after a telehealth appointment in the office.

Equity & Cultural Competency

The Thurston-Mason BH-ASO region is unique in that it includes both rural areas as well as heavily trafficked communities along the I-5 corridor. The transient nature of individuals seeking care requires additional equity considerations around access and coordinated care across multiple providers.

ProtoCall / Greater Columbia

Overview

The Greater Columbia BH-ASO provides crisis line services through both local providers and the nationwide provider ProtoCall, depending on where in the region the crisis occurs. Greater Columbia

providers received 45,950 calls in 2020 (3,836 calls per month). Greater Columbia answered 95.1% of calls within 30 seconds, with an abandonment rate of 3.1%. The average speed of answer was 18 seconds, and the average talk time was 10 minutes, the highest amongst Crisis Call Centers and Regional Crisis Call Systems surveyed for this report.

ProtoCall is a nationwide crisis line provider that supports 3 separate crisis lines for the Greater Columbia region (one for the BH-ASO's region wide Toll-Free line, and two for local BHA community specific lines). ProtoCall has call centers in Oregon, New Mexico, and Michigan, and acts as the statewide crisis line provider for New Mexico. These centers receive calls from individuals in crisis, regional service providers, law enforcement, and other first responders. ProtoCall estimates that 80-85% of calls are resolved on the crisis line. For the Greater Columbia region, ProtoCall received 7,200 clinical calls and 13,200 total calls in 2020, approximately (600 clinical and 1,100 total calls per month).

Call & Case Management

ProtoCall has designed and implemented a proprietary call management software called "Proteus." Proteus is managed in-house by the ProtoCall IT team. Data collection fields can be engineered for any data point and customized for a wide variety of client needs, including Community-Based Organizations (CBOs), hospitals, and law enforcement. Crisis call operators receive pop-ups with local resources and care options in real time based on the source of the call and the contracting agency's guidelines. Data reports are available 24 hours a day and are available to customers through an online portal. ProtoCall is developing a suite of apps called ProtoConnect, which will include Proteus along with other tools, and serve as a central point of access to support coordinated dispatch as well as provide a platform for tracking follow-up outcomes.

Crisis call response and dispatch vary depending on geography. For counties served by the nonprofits Comprehensive Healthcare & Palouse River Counseling, calls are directed to a ProtoCall crisis call operator. ProtoCall will work to stabilize individuals over the phone and follow local agency guidelines if a field-based response is necessary. ProtoCall uses proprietary software to collect information in the call center as well as in the field through a mobile app. Depending on the community, ProtoCall will work with a local MCRT and assess if there is a need for 911 dispatch. After the call, ProtoCall provides the BH-ASO with daily Crisis Logs for care coordination.

Calls made throughout the rest of the Greater Columbia BH-ASO region go directly to local providers. In these cases, the crisis call operator might also be a DCR that is familiar with the caller. Operators at local providers will attempt to resolve crisis calls on the phone, much like a Lifeline Call Center operator, often with an increased level of rapport based on established relationships and knowledge of the local community.

Care Coordination Information

Care coordination occurs at the BH-ASO and directly at the Provider level. Since crisis response is delivered by staff at the local BHAs, after care and inpatient coordination occurs seamlessly. As services beyond crisis response are provided, data is collected in the practice management system, RainTree. The BH-ASO also receives daily Crisis Logs which are distributed to the applicable MCO or used directly by the BH-ASO to facilitate coordination. The BH-ASO also is alerted to the need for care coordination through its authorization process.

In the event that bed placement is needed, DCRs call through a list of hospitals and other placement providers based on proximity and reputation. Limited interoperability between Proteus and case management and EHR platforms at behavioral health providers pose a barrier to sharing data on short- or long-term outcomes from crisis calls or subsequent follow-ups

Equity & Cultural Competency

Much of the Greater Columbia BH-ASO region is rural with providers that have local context and deep relationships with the communities they serve. Individuals may be used to speaking with the same vendor and contacting the same person and crisis operator for care coordination or case management. These remote regions of Washington State may not have the telecoms infrastructure to share caller location and other relevant real-time data that is available in other regions. A smaller community also means major investments in technology and new information systems can be disproportionately costly compared to other regions of the state with more people.

Columbia Wellness

Overview

The Great Rivers BH-ASO contracts with Columbia Wellness, a local crisis line and behavioral health service provider based in Cowlitz County, WA. Columbia Wellness has behavioral health facilities in both Cowlitz and Grays Harbor Counties and offers services ranging from outpatient treatment services for both mental health and SUD needs, to crisis response services including crisis stabilization units. Columbia Wellness serves children, families, adults, and older adults. Columbia Wellness also operates the crisis line for all of the Great Rivers region, with all five county crisis numbers routing to the Columbia Wellness crisis call center.

Crisis line operators at Columbia Wellness provide assessment and triage incoming calls which are then transferred to counselors for resolution-focused crisis support over the phone. Crisis line operators and crisis counselors at Columbia Wellness have different and distinct roles. Crisis line operators only triage calls and do not handle crisis resolution. The crisis counselors the operators transfer the calls to are responsible for crisis resolution and crisis counseling support. In the event all crisis line operators are busy, the counselors may also answer incoming calls from the crisis line directly. Columbia Wellness also provides centralized regional dispatch for crisis response services, including referrals to mobile crisis

response teams, DCRs, and other crisis responders in cases where a field response is needed. Crisis counselors may coordinate with fire, police, and EMS services to support mobile crisis response as well. In addition, Columbia Wellness manages mobile crisis response teams within both Cowlitz and Grays Harbor Counties.

In 2020, Columbia Wellness received 53,875 calls (~4,489 per month) through their regional crisis line. Columbia Wellness answered 99.82% of calls within 30 seconds with an abandonment rate of 1.45%. The average speed of answer was 3 seconds, and average talk time was 1 minute and 20 seconds. Columbia Wellness staffs 1-2 operators per shift with support from counselors as needed. There are 3 shifts per day (24 hours).

Call & Case Management

Columbia Wellness uses Mitel (telephone software) to track call volume, average wait time, and other access measures and uses Credible as their EHR system.

Columbia Wellness crisis operators collect demographic information along with a callback number and basic information needed to pass along to the counselor when they transfer the call. Occasionally (approximately 15% of the time) the call is not transferred because it is an information call, meaning the caller is seeking connection to regional resources and the crisis line operator is able to provide this information. The majority of calls are routed to a counselor and approximately 50% of the time the call requires a mobile crisis response in the field. If a crisis is not resolved over the phone, Columbia Wellness will dispatch to one of 18 crisis response providers, based on the caller's location. Columbia Wellness provides referrals and information to crisis responders via a phone call. There are currently no geolocation capabilities for tracking crisis responders.

The crisis response team may include a DCR and/or a MCRT, depending on local resources. Columbia Wellness also acts as a behavioral health agency with its own mobile crisis unit and outpatient services, coordinating dual management between their crisis system of care and outpatient treatment in Cowlitz and Grays Harbor Counties. The other 3 counties in Great Rivers have MCRTs that are separate from Columbia Wellness.

Care Coordination Information

Columbia Wellness offers services to individuals from children to older adults, across the spectrum of behavioral healthcare including general and specialized outpatient treatment programs. In addition to operating and managing the crisis line for the Great Rivers BH-ASO region, Columbia Wellness also offers mobile crisis response, crisis intervention & ITA evaluation, and crisis stabilization services in both Cowlitz and Grays Harbor Counties. Columbia Wellness is able to support care coordination across all directly provided services. If behavioral health services are provided outside of the Columbia Wellness system of care, the organization is only able to track and update follow-up care received if a provider follows up with service outcome status.

Through the behavioral health EHR software Credible, Columbia Wellness can access personal health and demographic information of callers, as well as update outpatient providers within the Columbia Wellness system of care when their client is in crisis. However, providers not within the Columbia Wellness system maintain separate EHR systems that are not interoperable with Credible, so Columbia Wellness has limited data sharing or outcomes measurement capacity for calls that are referred to other crisis response providers. If the outpatient provider of a caller is known, Columbia Wellness will call the provider to update them on the client and communicate any safety concerns, but currently do not have a data sharing system in place to conduct outcomes tracking or closed loop referral analysis.

Although crisis call encounters are tracked in their EHR, call management software and the Columbia Wellness' EHR don't currently work together. Great Rivers BH-ASO maintains a common data structure across the region for data collection and reporting; however, interoperability will remain a challenge as regional providers have a variety of different EHR programs.

No bed registry is currently in place. For crisis stabilization units operated by Columbia Wellness, availability is emailed daily to the Columbia Wellness crisis teams with updates. For all facilities outside of Columbia Wellness, real-time bed availability is determined via a phone call.

Equity & Cultural Competency

Columbia Wellness honors agreements that have been established with individual tribes in the region on which protocols to follow when a tribal member reaches out to the crisis line and/or requires a crisis response in the field. If a crisis response is required and the tribal member is on tribal lands, Columbia Wellness will contact tribal leadership for permission to do a face-to-face in the field with the individual in crisis.

The Great Rivers BH-ASO region includes rural and frontier areas. Individuals living in these areas and mobile crisis response teams responding to these areas experience additional barriers when navigating through a crisis. Rural communities struggle to keep up and proposed technology solutions should be adaptable to be accessible to these remote areas as well. Regional equity concerns are also an important consideration as there are already existing resource gaps in rural areas and the effectiveness of any crisis intervention system is based in large part upon the resources available to that area and system.

Washington Indian Behavioral Health Hub & Tribal Crisis Line

Overview

The Washington Indian Behavioral Health Hub is a unique resource for American Indian/Alaska Native (AI/AN) communities in Washington State, based at the VOA call center in Everett, WA. While the Hub is not a crisis line itself, the Hub line provides culturally appropriate behavioral health support for indigenous/Tribal peoples, and a point of connection to other crisis lines if needed. The Hub was

developed through a partnership between the Tribal Centric Behavioral Health Advisory Board (TCBHAB), the American Indian Health Commission, Volunteers of America, Washington HCA, and Washington DOH. The same partnership is currently in the process of launching a Tribal Crisis Line for Washington State, which will serve the entire state via the 988 system.

Call & Case Management

Currently, callers can reach the Hub via a direct number, or through a referral from a VOA crisis call operator. The Hub will serve not only members of Tribes within Washington State, but any indigenous or Tribal affiliated individuals needing help throughout Washington. If a caller identifies as being indigenous or having Tribal affiliation with a VOA operator, VOA crisis counselors will inform the Hub after the call so that the Hub can provide appropriate follow-up resources and support. Conversely, if a call to the Hub escalates into a mental health emergency, the Hub can transfer the call directly to a VOA crisis operator. This system of mutual support and follow-up utilizes existing VOA telephony platform and proprietary case management software.

The Hub collects data from callers with a “trust first” philosophy that recognizes that Tribal callers are often very private. Hub navigators will record a caller’s name (often only a first name), tribe, region, and county if the caller is willing to share, but not a home address. Many callers choose to remain anonymous. If a call to the Hub becomes a mental health emergency, the Hub and VOA will gather more detailed information, including name, date of birth, and address to facilitate crisis response.

The Tribal Crisis Line currently under development will connect any indigenous, First Nations, or other Tribal affiliated callers with crisis counselors at the VOA call center with specific training in providing culturally appropriate support and navigation of the behavioral health system. The vision for the Tribal Crisis Line is that all crisis counselors staffing the line will be Tribal affiliated themselves. Tribal Crisis Line counselors will provide crisis resolution and referral services similar to Lifeline operators, with a higher level of cultural sensitivity and the lived experience to connect more deeply with Tribal callers in crisis. The Hub will provide prevention and post-crisis resources and support in coordination with the Tribal Crisis Line, creating a more comprehensive set of supports. The Washington State Tribal Crisis Line will go live in July 2022.

Care Coordination

An integrated collaboration between the Hub and Tribal Crisis Line comes closest to the system for follow-up care and wraparound support proposed in HB 1477. The Hub provides a follow-up and care coordination function, with services including:

- Care coordination for individuals experiencing behavioral health concerns prior to a crisis.
- Assistance with accessing crisis beds (voluntary or involuntary).
- Care coordination after a client has been discharged from a facility (psychiatric hospital, emergency room visit, outpatient crisis treatment services).
- Culturally appropriate crisis resources and assistance with overcoming barriers to treatment.

- Assistance for Tribal and non-Tribal DCRs to connect with Tribal and non-Tribal behavioral health service resources and follow Tribal crisis coordination protocols.
- Light case management for callers (follow-up for two weeks).
- Collection of individual feedback on cultural sensitivity of crisis facilities and programs.
- Navigation of the Joel's Law² petition process.

Because the Hub provides follow-up and light case management, the Hub team has greater visibility into post-crisis outcomes than a call center that only fields crisis calls. However, data sharing in the system is still highly manual, with most information exchanged via direct follow-up with callers/clients, or phone calls and emails from MCRTs or DCRs.

The Hub utilizes an Excel resource directory for referrals and follow-up support. However, the Hub staff aspire to have a customized resource directory that captures specific information such as distinctions in eligibility criteria between tribal behavioral health facilities that accept all AI/AN communities, only members of specific tribes, First Nations, and members of the broader community. The current resource directory can also be difficult to navigate, and information is not updated in real time. The Hub is planning to mitigate these challenges in part by hiring regional navigators to provide additional follow-up support; given the diversity of geographies and Tribes within Washington State, the Hub team views navigator's local context and relationships as a critical resource to improve quality and outcomes.

Crisis Line Staff

Crisis line staff vary significantly between Lifeline Call Centers and Regional Crisis Call Systems. Calls to Lifeline Call Centers are handled by dedicated call center staff, while calls to Regional Crisis Call Systems are often handled by clinicians, MCRT members, and DCRs. In many cases, the staff who answer calls to Regional Crisis Call Systems are the same individuals who respond to the crisis in the field.

Lifeline Call Center Operators

Each Lifeline Call Center is staffed with operators trained in crisis mitigation and an understanding of local behavioral health resources. When a call comes in, the call center operator will provide resolution-focused crisis support and reach out to local providers if necessary.

- **ProtoCall:** Crisis call operators at ProtoCall are masters-level clinical professionals who are trained to provide immediate support, crisis intervention, and crisis stabilization. If the crisis is unresolved over the phone, crisis operators then assess if the caller needs additional support. If the crisis call

² Joel's Law allows a person's immediate family member, legal guardian, conservator, or a federally recognized Indian Tribe (Tribe), if the person is a member (citizen) of such tribe, to petition the superior court for initial detention under certain conditions.

operator determines immediate crisis response is needed in the form of field-based response, the operator will follow outreach guidance based on criteria set by the behavioral health agency contracting with ProtoCall. Because response capacities and resources available vary by region, area, and time of the call (for example, after hours for local behavioral health providers), the operator determines the best fit for a field response to the individual in crisis, then communicates the nature of the crisis, location, and any pertinent information to the agency/staff responsible for field response.

- **Crisis Connections:** Crisis call operators at Crisis Connections are mental health professionals trained in crisis mitigation who may have either a bachelor or masters-level clinical degree and include both paid staff and volunteers. The volunteer model helps to minimize compassion fatigue among operators. Crisis call operators have extensive knowledge of regional resources available for individuals in crisis. If an operator is unable to resolve a crisis over the phone, the operator will determine if an emergent/urgent crisis response is needed in the form of field-based support, then contact local mobile crisis units to respond. Operators may also reach out to local law enforcement if needed. Crisis call operators then communicate the nature of the crisis, location, and any pertinent information to the agency/staff doing field response.
- **Volunteers of America:** Crisis call operators (crisis counselors) at Volunteers of America (VOA) have either a bachelor or masters-level clinical degree and are trained to provide crisis intervention and brief supportive counseling to individuals in crisis. Crisis call operators also have extensive knowledge of regional resources available for individuals in crisis. If the crisis is unable to be resolved over the phone, crisis operators then assess what type of support the individual in crisis needs. If the crisis call operator determines that a mobile crisis response is needed, VOA acts as the centralized access point to mobilize crisis teams in each region and coordinate getting all necessary information to the team responding in the field.
- **Frontier Behavioral Health:** Telephone crisis interventionists at Frontier Behavioral Health are bachelor's-level clinical professionals who are trained to provide telephone triage, de-escalation, and referral services for individuals in crisis under the supervision of a master's level Mental Health Professional. Phone calls may range from requests for community resources to imminent crisis situations that are life-threatening. Crisis call operators have extensive knowledge of regional resources available for individuals in crisis. If the crisis is unable to be resolved over the phone, crisis operators then assess what type of support the individual in crisis needs. If the operator determines an urgent crisis response is needed in the form of field-based support, the operator contacts local mobile crisis units or DCRs to respond and may also reach out to local law enforcement if needed. Crisis call operators then communicate the nature of the crisis, location, and any pertinent information to the agency/staff doing field response.

Regional Crisis Staff

In Regional Crisis Call Systems like Thurston Mason or Great Rivers, a DCR or crisis clinician may answer the phone directly. In other cases, the call may be transferred to a local provider, or a call center might reach out directly to dispatch a DCR, MCRT, EMS, or law enforcement. Crisis response varies depending on which call center or region is answering the phone. MCRT and DCRs are primary users in the region-operated and regional provider lines. An individual calling a region-operated crisis line will likely speak directly with the same MCRT staff or DCR who will respond to the crisis in the field if it is not resolved over the phone. An individual in crisis calling a regional provider crisis line after hours (generally after 5pm) will likely have their call answered by the on-call DCR, especially if calling in from a rural or frontier area or county:

- **Mobile Crisis Response Teams (MCRT):** In regions that have regional providers or region-operated crisis lines, MCRT staff often answer calls directly. MCRTs are composed of behavioral health professionals which may include licensed clinicians, DCRs, case managers, peer specialists, and others, including multidisciplinary team members. DCRs may be a part of the MCRT or may respond as a separate entity. MCRTs typically receive referrals from crisis call centers, DCRs, law enforcement, and EMS, or take calls directly via region-operated crisis lines. Due to the mobile nature of MCRT work, and the remote locations in which these teams sometimes operate, MCRTs will benefit from access to case management and bed registry software that has mobile capabilities and functions effectively in areas with limited wireless coverage.
- **Designated Crisis Responders (DCRs):** DCRs may also answer crisis calls for regional providers or region-operated crisis lines. DCR services are divided between counties, provided by BH-ASOs, and may be called out by crisis line staff, MCRTs, other behavioral health professionals, EMS and/or law enforcement to lead assessments for individuals experiencing behavioral health crises. Once the DCR takes the call or receives the referral, they travel to the individual who is in crisis.

Crisis Facilitators in Washington State

Mobile Crisis Response Teams (MCRT)

The primary function of the MCRT is to respond to individuals in crisis and connect them with stabilization services. A person calling into a Lifeline Call Center would speak with call center staff and if the crisis is not resolved over the phone, would first meet crisis response personnel when they responded in the field. In the field, the MCRT works to identify the least restrictive care alternative to support the individual in resolving the crisis. These teams also work closely with first responders on site and support the DCR in their assessment to determine the individual's risk of harm to themselves or others. In addition to crisis stabilization services, MCRTs also help locate transportation to crisis and treatment centers. The MCRT may also support individuals in crisis in connecting with other services including ongoing outpatient behavioral health treatment options and community resources such as housing, food, and medical care.

Many DCRs are experiencing limitations in technology reliability, barriers to data access needed for quality care coordination, recent decreases in law enforcement support, and are being impacted by the current shortage of behavioral health staff. Many of these teams utilize cell phones for communication and referrals for individuals in crisis. This can be challenging as cell phone service is not available or reliable in many rural and frontier areas, and oftentimes isn't available within large buildings such as hospitals or jails, where MCRTs are often called to assess crisis situations. Prior to managed care integration, mobile crisis staff may have been able to access behavioral health history and provider information for the individual in crisis, but once managed care integration happened, this capacity was lost. Mobile crisis staff also does not have access to past law enforcement encounter information. Having access to this information would increase MCRT ability to enhance safety when responding to crisis situations in the field. In response to the passage of House Bill 1310 which limits police use of force in certain situations, law enforcement response to individuals in crisis has decreased, placing responding MCRTs under additional strain.

Designated Crisis Responders (DCR)

The primary function of the DCR is to assess and determine if involuntary detention is needed, and if so, to facilitate placement for individuals in crisis. Based on a holistic crisis investigation process, the DCR determines the least restrictive level of treatment needed. If the DCR decides that an individual needs further stabilization services, the DCR then works to find space at a psychiatric or crisis behavioral health facility. Most often this involves the DCR directly calling individual facilities to check for open space and bed availability. The DCR also helps locate transportation to crisis and treatment centers as well as ED's when medical clearance is needed for placement facilitation.

Many DCRs are experiencing limitations in technology reliability, barriers to data access needed for quality care coordination, recent decreases in law enforcement support, and are being impacted by the current shortage of behavioral health staff. Similar to crisis response teams, many DCR's must rely on cell phones for communication with providers/facilities when navigating the system of care for individuals in crisis. Again, this presents challenges as cell phone service is often not available or reliable in many rural and frontier areas, and usually isn't consistent within large buildings such as hospitals or jails where DCRs are called to assess crisis situations. Prior to managed care integration, DCRs may have been able to access behavioral health history and provider information for the individual in crisis, but once managed care integration happened, this capacity was lost. DCRs also do not have access to past law enforcement encounter information. Having access to this information would increase DCRs ability to enhance safety when responding to crisis situations in the field. House Bill 1310 which limits police use of force in certain situations, law enforcement response to individuals in crisis has decreased, which is also placing DCRs under additional strain.

Law Enforcement

Law enforcement is typically dispatched to crisis situations through 911 calls, or called by MCRTs, DCRs, or other first responders including paramedics, EMTs, and fire department staff to ensure safety for both the behavioral health and medical professionals, as well as the individual in crisis. Law enforcement may also play a role in connecting individuals in crisis to services by transporting the individual in crisis to a secure facility. Certain areas in Washington have co-responder models, where behavioral health professional(s) and law enforcement respond as a unit to individuals experiencing behavioral health crises. In a notable development for law enforcement involvement in crisis response, House Bill 1310 passed, limiting police use of force in certain situations. A number of stakeholders interviewed for this report noted that since HB 1310 took effect in July 2021, law enforcement response to individuals in crisis decreased.

First Responders

EMS staff such as paramedics, EMT's, fire, and other related first responders are often on scene with MCRTs and DCRs when an individual is experiencing a behavioral health crisis. As a result of decreased law enforcement response following HB 1310, these first responders as well as crisis response personnel have been under additional strain, especially in cases when safety is a concern and also in cases when the DCR determines the individual in crisis needs transportation for involuntary treatment. If there is no way to secure the individual for transportation, it presents barriers to ensuring the individual in crisis gets to the needed facility for treatment.

Facilitator Placement Referrals & Coordination

The DCR is generally the primary facilitator into crisis stabilization services and facilities. There is no centralized system available for DCRs to check for real-time bed availability or eligibility. King County is currently the only region in Washington State that uses a software program (OpenBeds by Apriss Health) to track bed availability. Some regions, such as in Spokane, maintain a list of available beds, manually updated by local CBOs that routinely call treatment facilities directly. Beacon Health Options plans to implement OpenBeds for the company's regions in October 2021. Without a centralized system, DCRs will generally call facilities individually until they find a match based on the following criteria:

- **Availability:** Placement in a stabilization or treatment facility is dependent initially on space and bed availability.
- **Acuity Level & Complexity:** Certain facilities do not have medical personnel on-site at the level needed to ensure individuals experiencing both mental and physical health challenges will have the adequate care needed and are unable to accept individuals with complex medical needs.
- **Voluntary / Involuntary:** Placement determination is also impacted by whether the individual experiencing a crisis is willing to be voluntarily hospitalized or held at a crisis stabilization unit. Certain facilities offer only voluntary spaces and beds, and the remaining facilities that do accept

involuntary admissions usually also have voluntary admissions, leaving a limited number of involuntary spaces available.

Additionally, because there is currently no centralized way to access space or bed availability, DCRs typically must call multiple types of facilities when working to facilitate placement into a crisis stabilization unit or facility. There are different types of crisis stabilization units and psychiatric facilities that DCRs may refer to for individuals in crisis.

Crisis Mental Health Facilities

Crisis Mental Health Facilities are short-term non-residential facilities designed to avoid hospitalization while providing stabilization for individuals experiencing a mental health crisis.

- **Crisis Respite Centers:** Crisis Respite Centers are treatment facilities that provide crisis stabilization services to individuals in crisis who are voluntarily seeking services. A combination of services is offered to divert the individual from hospitalization while linking them with ongoing outpatient care.
- **Triage Facilities:** Triage Facilities can be locked or open and are designed for short-term crisis stabilization. These facilities may accept both involuntary and voluntary admissions and have a mental health professional on-site or available 24 hours a day. If the facility is licensed for involuntary services, Individuals can be held for up to 12 hours while being assessed for further placement. Unlike CSU's there is typically no nursing care available at triage facilities, although some triage facilities do have nursing care onsite.
- **Crisis Stabilization Units:** Crisis Stabilization Units (CSU's) are locked facilities and are designed to accept involuntary admissions. These facilities normally have 24-hour nursing care present. Individuals can be held for up to 12 hours while being assessed for further placement.
- **Hospital Emergency Departments:** While not a crisis mental health facility, if an individual in crisis is seen in a hospital emergency department, and emergency department personnel are unable to find available and appropriate placement, the individual could be held in the hospital ED for crisis stabilization until a space opens in another facility.

Inpatient Psychiatric Treatment Facilities

If acuity level exceeds crisis center capacity, if there is no space at any crisis center, or if the crisis center was unable to stabilize the individual experiencing a crisis, they may be placed at an inpatient psychiatric facility for stabilization and treatment after receiving ED medical clearance. There are different types of inpatient psychiatric facilities.

- **Evaluation Treatment Centers:** Evaluation Treatment Centers are inpatient psychiatric facilities, typically limited to 16 beds, that accept both voluntary and involuntary admissions. These centers are not staffed to treat individuals who have complex or ongoing medical needs.

- **Free-standing Psychiatric Hospitals:** Free-standing Psychiatric Hospitals are inpatient psychiatric facilities that are designed to accept both voluntary and involuntary admissions. These hospitals also are not staffed to treat individuals who have complex or ongoing medical needs.
- **Psychiatric Units in Acute Care Hospitals:** Psychiatric units embedded within Acute Care & Community Hospitals are inpatient psychiatric facilities that accept a mix of voluntary and involuntary admissions. Because these units are located within an existing acute care hospital facility, they are able to accept individuals in crisis who also have ongoing medical needs.

Equity & Cultural Competency

Tribal Equity & Cultural Competency

The information in this section is based on input from several Tribal leaders and is not representative of all Tribes.

Technology access and reliability is consistently reported as a challenge on Tribal lands, and technology use is cited as a barrier, particularly for elders seeking support. There is currently work being done within Washington state to map current broadband weaknesses and areas that need additional technological improvements. Increased care coordination, consistent communication, and data integrations throughout the crisis system of care are currently lacking but are especially needed and relevant for Tribal members in crisis.

The importance of behavioral health providers staying open to family members being involved and active in the client's treatment process is often a priority for Tribal members, as family and the community is seen as integral to wellness. Some stigma may exist and need to be addressed in order for Tribal members to seek support when struggling with behavioral health challenges. Some Tribal members have concerns related to maintaining privacy and sometimes even anonymity when calling into crisis lines for support. Another equity consideration is the work being done around staffing crisis teams and DCRs who are Tribal affiliated to better support cultural competence in services being provided. Washington state is currently working on establishing Tribal DCRs.

Additionally, the current shortage of behavioral health staff is having a disproportionate impact on rural and frontier areas, especially within reservations. Services and treatment related to chemical dependency are even more scarce than mental health services in many of these remote areas.

Regional Equity Concerns

Many remote regions in Washington state may not have the telecoms infrastructure to share caller location and other relevant real-time data that is available in other regions. A smaller community also means major investments in technology and new information systems can be disproportionately costly

compared to other regions of the state with more people. Rural and frontier communities struggle to keep up with technology, and proposed technology solutions should be designed to be accessible in remote areas as well.

Additionally, as noted in tribal equity considerations, the current shortage of behavioral health staff is having a disproportionate impact in remote and harder-to-reach areas. Many regions report staff relying heavily on longstanding professional relationships with other behavioral health staff as one strategy to navigate barriers encountered within the system of care. Technology solutions that support rapid response to these areas and care coordination across counties are important considerations for rural and frontier communities.

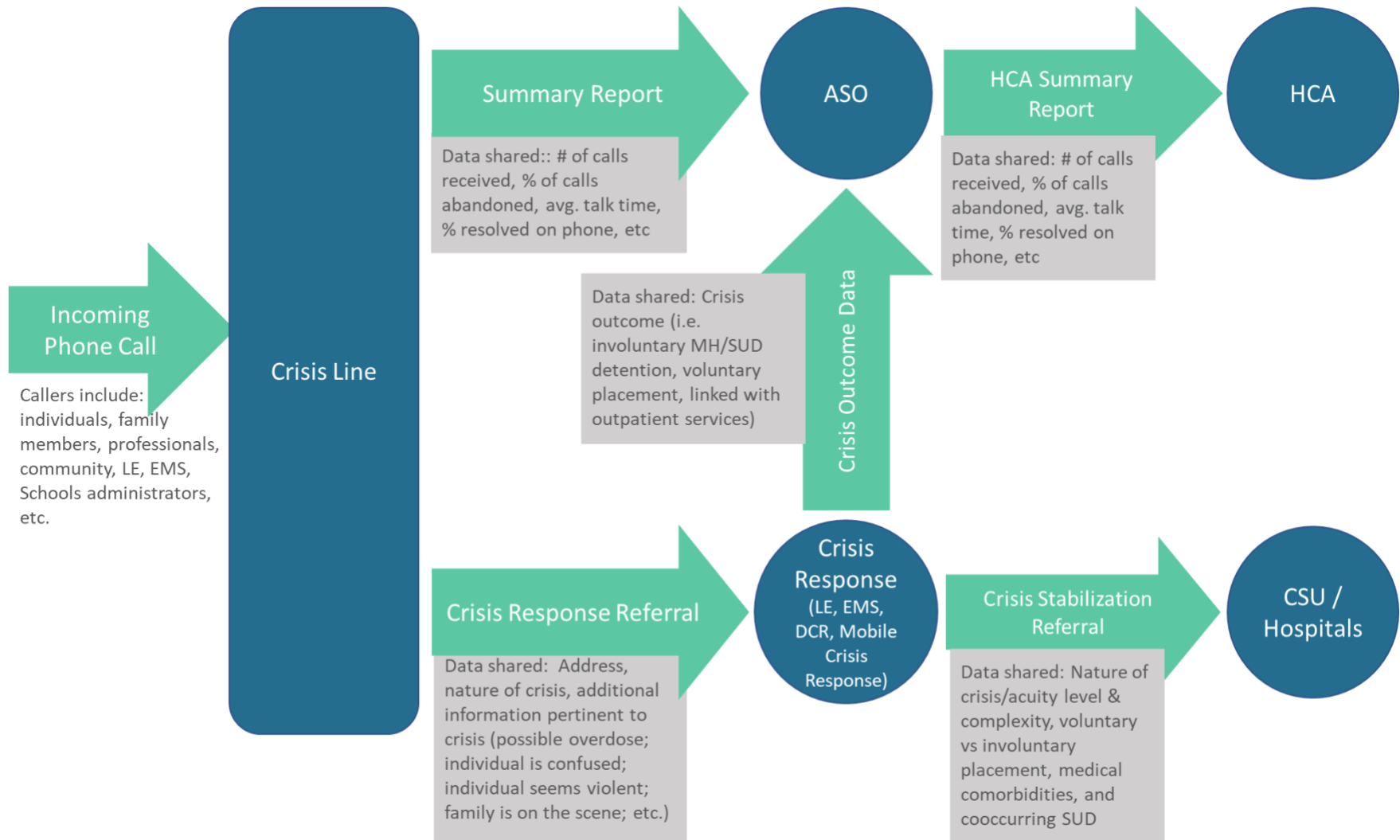
Other Considerations

One consideration related to care coordination efforts is certain callers' desire for anonymity. Some callers phoning into the crisis line are doing so because it is anonymous, and they do not wish to discuss what is happening with their current care provider. Multiple stakeholders brought up the complex questions that arise when balancing the preservation of caller autonomy and a caller's wish to remain anonymous with the potential benefits of care coordination.

Data Flows

The technology platform proposed in HB 1477 would integrate many of the data sharing processes currently in place in Washington State. With each Lifeline Call Center and Regional Crisis Call System using different software, and different systems in place at BH-ASOs and behavioral health providers, current data sharing processes are largely manual. Referrals for field-based crisis response are generally handled through phone calls and email and logged in case management systems or EHRs for individual behavioral health agencies. Because interoperability between these systems is highly limited, data on outcomes resulting from referrals is rarely aggregated, reported, or shared. Similarly, MCRTs, DCRs, and other facilitators provide CSUs and hospitals with relevant data on client needs, but outcomes are rarely shared back with behavioral health providers, Lifeline Call Centers, or Regional Crisis Call Systems. However, BH-ASOs are able to aggregate operational metrics like call volume, abandon rate, and rate of calls requiring field-based response through reports from Lifeline Call Centers and Regional Crisis Call Systems, and report those metrics to HCA:

Figure 1: Crisis Referral System Data Flows



988 & CRISIS RESPONSE SYSTEM EXEMPLARS

As Washington prepares for 988 implementation and the development of an integrated crisis response case management system, it is helpful to understand how other well-regarded crisis response and referral systems around the country operate. Third Sector reviewed crisis systems around the country and has chosen to profile four state and four local systems due to the robust nature of their crisis call center and referral system resources, the availability of culturally and linguistically appropriate services, and the availability of appropriate services for clients with disabilities or other populations; there are surely other exemplary systems not covered here as well.

This section summarizes how these state and local crisis response systems connect callers to appropriate crisis response services, how they interact with local referral resources, and how they track outcomes. Where available, the section provides information on the software in use (including implementation and deployment timelines), statewide system operability relative to local referral resources, and how these systems are working to meet the new requirements of the national 988 system.

The crisis response models developed in Georgia and Arizona inspired the nationally recognized Crisis Now model, which features centralized call centers that refer to multiple crisis response services. Other states have since replicated this model or developed similar models adapted to the local context. Multiple municipalities and regions have also developed specialized crisis response systems that operate as 911 alternatives; many of these services resemble what the Center for American Progress has dubbed the [“Community Responder Model.”](#) This section describes the current statewide systems in Arizona, Colorado, Georgia, and Maryland, and also provides information on local crisis response/alternatives to 911 in Olympia (WA), Denver (CO), San Francisco (CA), and Austin (TX).

The overview tables below summarize key features and components of these state and local crisis response systems, noting details about the program structure, services, and software.

Table 2: State Exemplars

	Arizona - Solari	Colorado	Georgia	Maryland
Program / Operator	Solari (nonprofit) covers two regions; Nursewise/Centene Health covers the third region	Colorado Crisis Services (Department of Human Services, Office of Behavioral Health)	Georgia Crisis and Access Line (Department of Behavioral Health & Developmental Disabilities)	Maryland Department of Health Behavioral Health Administration
System Structure	Region-based, not statewide; Managed care entities contracts with crisis line services	Statewide; BH-ASOs and MSOs also contract with CDHS to provide behavioral health services	Statewide call center integrated into the local healthcare system	Statewide call line integrated with 211
Services Offered	24/7/365 line with GPS; ability to dispatch mobile response	24/7/365 line, mobile response, walk-in centers, CSUs, respite	24/7/365 line, mobile response; single point of entry for CSUs and state hospitals	24/7/365 line, mobile response, walk-in centers
Cultural Competence	Telephonic language translation available	Telephonic language translation available	Specialized population services; peer support	Specialized population services
Software	Solari: Custom-built CRNexus operates a call tracking through Interactive Intelligence for call tracking with GPS that connects to a Dispatch Management System, and an EHR through CoCENTRIX	Currently Solari and soon to transition to custom-built Zoho, operates call tracking; no integrated EHR	Behavioral Health Link operates the call tracking, GPS for mobile crisis dispatch, and EHR for real time disposition tracking, outpatient scheduling and bed inventory	iCarol operates call center software
Notable Features	Solari: Sophisticated custom software and integrated technology	Robust statewide coordination	Statewide-coordinated mobile response with arrival within 59 minutes	Access through statewide 211 call line
State Legislation	None	Legislation passed to set up operating structure and issue fees	None	None

Arizona - Solari		Colorado	Georgia	Maryland
for 988		to set up 988 funds		

Table 3: Local Exemplars

	Austin, TX	Denver, CO	Olympia, WA	San Francisco, CA
Program/ Operator	Integral Care (nonprofit contractor), City of Denver	Support Team Assisted Response (STAR), civilian program under the Mental Health Center of Denver	Civilian team operating under Olympia Police Department	San Francisco Street Crisis Response Team (SCRT), Department of Public Health and the Fire Department
Services Offered	De-escalation in community, transport and referral to other services	Stabilization over phone, independent mobile dispatch, transport and referral to other services	De-escalation in community, transport and referral to other services	De-escalation in community, transport and referral to other services
Interoperability with 911	EMCOT is co-located at 911 call center to screen calls; responds independently	911 diverts to STAR; responds independently	CRU uses police radios to screen 911 calls; responds independently	SCRT screens 911 calls; co-responds with fire department
Software	Solacom (the CAD system)	Computer Aided Dispatch (CAD)	Custom-built app for case tracking	SF Fire Department software; EHR through Avatar developed by Netsmart
Notable Features	Co-location with 911 and call diversion strategy	Sophisticated data dashboards	Preventative program through Familiar Faces	Integrated software with health data systems

State Exemplars

Arizona -- Solari Crisis and Human Services

Arizona contracts with managed care entities which then contract crisis line services to cover three separate regions of the state. Arizona's [Solari Crisis and Human Services](#) (Solari), formerly Crisis Response Network, covers two of the regions, while Nursewise/Centene Health acts as crisis response line for Southern Arizona. For this report, Third Sector has chosen to profile Solari's system because of its technical complexity and geographic reach; the Nursewise system appears similarly complex albeit serving a smaller region of Arizona.

Solari Crisis and Human Services operates the largest crisis hotline in the country, serving $\frac{2}{3}$ of Arizona's population across $\frac{3}{4}$ of the state's geography. Solari began operation in 2007 and developed the system as it currently operates in 2014. Overall, the crisis hotline manages 28,000-30,000 calls a month, including both inbound and outbound (referral) calls. This system is held in high regard due to the well-resourced nature of its crisis hotline, advanced data and technological platforms, and culturally responsive services.

Solari operates a 24/7/365 hub approach centered around an "air traffic control model." Solari provides referrals to independent state-funded mobile teams to use the most appropriate resources when stabilizing individuals in crisis. Most incoming calls are directly from the individual in crisis, and families calling on behalf of individuals make up the second largest category of calls. Diversion from 911 is also a significant source of referrals into Solari. In addition to the crisis response line, Solari also operates a 24/7/365 warm line that is staffed by trained Peer Support Specialists who have experienced mental health challenges of their own.

Solari made three separate attempts to purchase software for its Dispatch Management System (DMS) but ended up developing a platform in house. Solari has a particularly robust technology team for a crisis call center, with 25 IT staff out of a total staff of 400 people. Some of these staff support Solari's other business lines; Solari staff caution that their organization has resources other systems may not have, because the organization operates multiple business lines and has the capacity to bill costs for almost 60% of calls to Medicaid. Solari's EHR and billing team are able to draw 85% reimbursement for those clients from federal dollars, which appears to be a higher reimbursement rate than other states have achieved with Medicaid administrative dollars.

Solari plans to move to a single statewide hotline in 2022; once 988 is implemented in Arizona, they expect inbound calls will be processed through a central call center. While the current system is well suited to the regions in which they currently operate, Solari reports particular challenges with what they describe as rural frontier areas of the state, which may require a different set of services/dispatch expectations.

Solari has provided consulting services to other states as they implement crisis response services and has licensed their customized EHR system to the Colorado and Utah statewide crisis response systems.

Call & Case Management

Solari takes inbound calls and uses Global Positioning System (GPS) technology to identify the caller's location and dispatch to the closest community-based mobile team. The phone system is managed through a company called Interactive Intelligence and is a platform with access to backend data and ability to set up complex workflows for call center employees. Implementation of the phone system took six months. Solari tracks many key performance indicators including two leading metrics of average speed of answer (7 seconds) and abandonment rate (<3%), and has a public [data dashboard](#) reporting on success metrics available online.

To manage calls, referrals, and client data, Solari uses an integrated case management platform called CRNexus. CRNexus integrates two technology platforms 1) a phone system and 2) an electronic health record (EHR) through CoCENTRIX, which connects to the Dispatch Management System (DMS) that works on smartphones and tablets and has the ability to initiate geolocation-based dispatch. EHR platform implementation required nine months. Information from all of these platforms feed into each other, allowing Solari the ability to track long-term information for each client. Solari's combination of multiple advanced technological platforms allow detailed data tracking and performance monitoring.

Care Coordination Information

The Interactive Intelligence system feeds information into the EHR and apps the mobile teams can access on mobile devices so responders can follow individuals in real time through each transfer over the course of a response. The electronic health record, which Solari customized extensively, captures information related to the caller's care including notes on past referrals, health conditions, and disposition data on whether the individual was stabilized in the community or brought to inpatient facility.

Equity & Cultural Competency

In order to meet callers' linguistic needs, Solari hires bilingual staff (primarily Spanish-speaking) and also works with a translation service (the second most common language needed in Arizona is Arabic). Staff complete cultural competency training and Solari has had success working with different populations. Solari has resisted requests to set up specialized lines focused on veterans and LGBT+ communities (Lesbian, Gay, Bisexual, Transgender, and related communities) because their clinical staff has training and is well equipped to work with these individuals. However, Solari is setting up a separate call line specifically for Native American/Indigenous clients given the high level of need and lack of adequate qualifications of clinical staff in working with these individuals through conventional approaches. Solari is currently working with tribal liaisons from Salt-River Maricopa to develop that dedicated line and also exploring a possible line that would be operated in conjunction with the Navajo Nation.

Georgia

The Department of Behavioral Health & Developmental Disabilities (DBHDD) manages the state-run 24/7/365 [Georgia Crisis and Access Line \(GCAL\)](#) with text and chat features. DBHDD contracts with Beacon Health Options to provide administrative services; its partners Behavioral Health Link (BHL) and Qlarant operate together as the Georgia Collaborative BH-ASO. GCAL is held in high regard due to their integrated “care traffic control” approach that goes beyond a hotline and provides a crisis hub with multiple real-time technology and dispatch features that connect clients to high-quality services and response approaches. GCAL began in 2006 as a region-based call center; by 2008, GCAL began dispatching mobile response, and in 2011, GCAL adopted the Behavioral Health Link software (through competitive procurement).

The GCAL call center triage process is to receive the call and provide an assessment, during which call operators can collect demographic information, and determine the best course of action. Callers can receive support on the phone, mobile crisis response, and referral to local services or support with making appointments. GCAL aims to direct people to more natural support rather than moving to inpatient or more restrictive care. Depending on the situation, GCAL may transfer the call to 911 (for example if weapons are involved), but for most cases the goal is to avoid involvement from law enforcement. GCAL is used as the single point of entry for state-funded contract beds at private hospitals and is the preferred point of entry for crisis stabilization units and state hospitals. The GCAL website also contains a resource database for individuals who want to be directly connected to a service provider for a certain issue.

Call & Case Management

With [Behavioral Health Link \(BHL\)](#) technology, GCAL staff are able to track the progress of the call from when the call is taken, to when mobile crisis is dispatched, and disposition is reached. DBHDD sets a number of mobile response standards including arrival on site within 59 minutes of the GCAL dispatch anywhere in the state. BHL has GPS for mobile dispatch and can calculate transit time in real time. The licensed clinician or Board-Certified Behavior Analyst (BCBA) tracks case information including description of precipitating events, assessment and interventions provided, diagnosis or diagnostic impressions, response to interventions, crisis plan, recommendations for continued interventions, and linkage and referral for additional support.

Care Coordination Information

GCAL BHL is integrated with multiple data systems. It has the following features and capabilities:

- Status disposition for intensive referrals display details of patient wait experience including location of wait and wait times
- 24/7 outpatient scheduling where providers are required to give open slots so patients can be placed
- Availability of state funded beds in the DBHDD network
- Secure portal for Emergency Rooms to check on patient progress and update referrals

- Real-time performance outcomes dashboards

Because GCAL is strategically anchored to their BH-ASO, GCAL has the ability to match information of known persons, if for example previously served through managed care, and can match to Medicaid insurance information. GCAL can see the history of engagement and look at each episode of care. This level of detail can help practitioners study trends and continuously improve services to individuals with the highest need.

Equity & Cultural Competency

DBHDDD focuses on peer support and certified professionals with lived experience for adult mental health, adult addictive disease, parents, and youth mental health as a part of the full crisis continuum. GCAL utilizes a language line for individuals who do not speak English and supports for individuals who are deaf or hard of hearing. GCAL is also unique in its design as it supports not only individuals with behavioral health emergencies but also individuals with autism or other intellectual and developmental disabilities (IDD).

Mobile Crisis Teams are trained to identify and handle situations; certain practitioners are on-call for consultation for individuals with autism. There is a targeted initiative in coastal areas for IDD crisis stabilization.

Colorado

Colorado Crisis Services (CCS) is a statewide crisis response service run by the Colorado Department of Human Services (CDHS) Office of Behavioral Health (OBH). The CCS hotline is available to all Coloradans and can dispatch mobile services to meet clients in the community anywhere in the state. Walk-in centers, CSUs, and respite services are available in many locations throughout the state.

CCS services include support in mental health, substance use, or emotional crises. CCS operates services 24/7/365 in all 7 regions including access by phone, text, or in-person crisis support at walk-in centers or mobile crisis teams. While CCS mostly serves cases through direct inbound calls into the hotline, there is a process in place to ensure hand-off to 911 if the situation requires. In those scenarios, the CCS operator will connect directly with the police department and provide hand-off with both call responders on the line.

CCS may refer to other crisis services provided by CDHS, which are managed through various entities:

- **Administrative Service Organizations (BH-ASOs):** BH-ASOs in all 7 regions can dispatch 19 mobile crisis teams across the state, and also connect to a network of walk-in crisis centers, crisis stabilization and respite centers.
- **Managed Service Organizations (MSOs):** CDHS OBH contracts with MSOs to provide substance use treatment services for individuals who are uninsured or under-insured.

- **Mobile Health Units (MHUs):** Under MSOs, MHUs specialize in medication-assisted treatment (MAT) in rural and underserved areas of Colorado.
- **Mental Health Centers (CMHCs):** Colorado’s public behavioral health system also includes 17 CMHCs, which provide mental health treatment services in every county, specifically to individuals who are low income or not covered by insurance.

Individuals can find providers through the OBH Licensing and Designation Database and Electronic Records System (LADDERS), which is a searchable online directory to find mental health or substance use providers. Callers to the CCS crisis line can also receive information or referrals over the phone or text.

Call & Case Management

CDHS contracts with Rocky Mountain Crisis Partners (RMCP) to manage the software and technology platform for the hotline component of CCS. RMCP currently operates the hotline on a platform purchased from Solari in Arizona, however, the program will transition to Zoho, which will be custom-built by Rocky Mountain Crisis Partners. The decision to build a custom platform was primarily driven by a desire to reduce limitations in data management and sharing. The Zoho platform will use CoConnect software and will have the ability to track common metrics such as call time, call duration etc. There are no GPS capabilities to locate the caller; the caller needs to provide location information.

The current platform manages calls through central data including metrics such as incoming call volume, answer speed, call duration; demographics if known including gender and age; crisis issue; and disposition such as follow up scheduled, non-urgent referral, emergent referral, etc. There is no current integration with an Electronic Health Record.

The Zoho platform will be able to track the progress of the call and will also allow for follow-ups if needed. As of now, data platforms for walk-in centers, CSUs, and respite are managed separately.

Care Coordination Information

The CCS hotline focuses on referrals to crisis services for which they are the “front door,” which includes mobile crisis and walk-in centers. From mobile crisis and walk-in centers, further referrals can be made to crisis stabilization units, respite, emergency room, welfare checks, etc. CCS does not have the ability to see bed availability. The Zoho platform will house its own HIPAA compliant EHR.

Equity & Cultural Competency

CCS staff undergo extensive training, focused on best practices for serving any type of caller, as well as specialized training for priority populations. The crisis line has engaged in consultation for improving hiring and retention practices, employs Spanish speakers, and uses a relay line that can be translated to more than 200 languages over the phone.

Maryland

Maryland Department of Health Behavioral Health Administration developed a statewide crisis line which started in the 1990s as a youth suicide prevention hotline, later evolving into what is now known as their 24/7 statewide 211 Press One system, which is available for all ages and behavioral health conditions through call, text, and chat functions. The 211 Press One system can connect users to regional mobile dispatch services and walk-in centers/CSUs for crisis stabilization. The 211 Press One database also allows users to search for counseling or other behavioral health services through their 211 website. Another notable feature in some Maryland jurisdictions is the use of fire stations and police stations as safe stations. Individuals in crisis can go to a safe station 24/7 and contact the mobile crisis team to respond if necessary. Safe stations are able to provide individuals with immediate medical provisions, refer individuals to treatment programs for behavioral health services, and contact medical help on site or mobile crisis as necessary. This approach encourages strong partnership with public safety and increases points of access for those in need.

For behavioral health services other than 211 Press One, the Maryland system is decentralized and organized by region. The state is continuing to invest in making regional systems more robust through a Regional Partnership Catalyst Program that allocates special funding to build infrastructure around stronger partnerships between hospitals and community partners. There are eight regional partnerships; three of the eight are currently implementing behavioral health crisis services programs that include call center and call management elements. The Lower Eastern Shore Regional Partnership is adopting practices from the Crisis Now model, including creating a crisis stabilization center and providing 23-hour crisis stabilization as an alternative to emergency department and psychiatric hospitalization admission. The Baltimore, Howard, and Carroll Counties Regional Partnership is investing \$45 million in behavioral health crisis response infrastructure and services, with the goal of reducing unnecessary police interactions for people experiencing behavioral health crises. These investments will pay for a regional hotline with technology that allows responders to see real-time systems capacity and will increase the availability of mobile crisis teams. The Prince George's County Regional Partnership is creating a Crisis Call Center where staff will have the ability to see appointment and/or bed availability, view electronic health record data, facilitate digital referrals, and coordinate with the first responder systems. The partnership is also expanding Mobile Crisis Teams to reduce response time and address SUD-related emergencies in addition to mental health emergencies. The partnership is also investing in the expansion of behavioral health crisis services in urban, suburban, and rural areas to increase access for individuals living in "treatment deserts."

Call & Case Management

When a caller seeking crisis services dials 211, they press 1 to be directed to the crisis hotline and are prioritized in the queue. The system can pinpoint the general location of the caller and route them to 1 of 5 call centers that is closest to their location. All 211 Press One regional call centers use iCarol, and

report standardized data. There is no statewide database to track individuals and the current platform does not contain bed availability information.

Equity & Cultural Competency

Maryland has specialized services for veterans and individuals struggling with problem gambling. The state is targeting ARPA funds toward alleviating service deserts.

Local Exemplars

The following section showcases several local crisis response programs, which were set up in part to divert calls about behavioral health crises away from the 911 and police dispatch system. Many of the local programs detailed below built their systems based on an innovative community-based public safety model based in Eugene, Oregon, [CAHOOTS](#). Because there are many reports available about CAHOOTS, this report does not go into detail about their model.

Austin, TX

Integral Care is the local mental health authority and local intellectual and developmental disability authority of Travis County, located in Austin, TX. Integral Care's Expanded Mobile Crisis Outreach Team (EMCOT) is a crisis response program that serves people in psychiatric crises in partnership with Austin Travis County Emergency Medical Services (EMS), Austin Police Department (APD), and Travis County Sheriff's Office (TCSO), and other law enforcement agencies. Integral Care's EMCOT has partnered with first responders and the criminal justice system since 2013 to provide a real-time co-response to people in mental health crisis. In 2019, EMCOT clinicians began co-locating at Austin's 911 Call Center for purposes of diverting police response, when appropriate, to a mental health expert who provides clinical screening and triage to determine the most appropriate resource and response for the individual. The system is held in high regard due to its co-location approach with 911 calls and its call diversion strategy.

Call & Case Management

EMCOT employs Crisis Center Clinicians, or C3s, who are co-located at Austin's 911 Call Center, and are available to respond when 911 calls come in focused on a behavioral health crisis. The calls are on the same platform as 911 telecommunicators to ensure faster response times, no dropped calls, and simultaneous real-time updated information that responders (e.g., EMCOT, Police, and EMS) can utilize in lieu of call transfers. EMCOT uses Austin's Computer Aided Dispatch (CAD) first responder communication system, which is the same system used by police, and EMS responders. EMCOT clinicians are trained to use CAD, including how to utilize the system, how to input communication into the system, and what is appropriate information to update in the system to ensure safety of the individual, while also being mindful of HIPAA standards. Police officers also carry iPads to connect directly to C3s and dispatch teams to the field.

Care Coordination Information

Bed availability for individuals who are unfunded are managed through Integral Care's Utilization Management Department. Following EMCOT's clinical assessment, if a recommendation for a crisis residential, respite or inpatient facility is warranted, EMCOT calls our UM department to provide the clinical information and determine bed availability for placement. If a client is insured, EMCOT contacts local community inpatient hospitals directly to determine bed availability and approval of admission by the facility. EMCOT utilizes trauma informed and person-centered approaches during assessment.

Equity & Cultural Competency

EMCOT clinicians co-located at the 911 Call Center and EMCOT field response clinicians are diverse in clinical licensure and areas of expertise. Staff are trained to be culturally competent in their response and the team is composed of a diverse staff to meet the community needs (gender, race, ethnicity, age and languages spoken). Additionally, EMCOT receives referrals from the Travis County Correctional Complex (TCCC) to connect individuals post-release to services in order to prevent future engagement with the criminal justice system.

Denver, CO

Support Team Assisted Response (STAR) is a civilian crisis response program that responds to 911 calls in Denver, Colorado. STAR is a partnership between the Mental Health Center of Denver, Denver Health, Denver Police Department, Denver Department of Public Health and Environment. STAR was originally piloted with a specific geographic focus in certain police districts and has now been expanded to the entire city, seven days a week between 6 a.m. and 10 p.m. The system is held in high regard due to their sophisticated data systems.

STAR receives referrals through 4 channels: 911 operators flag calls and dispatch STAR, uniformed response personnel independently request STAR on scene, individuals call the STAR hotline, and STAR self-initiates a field-based crisis response. When dispatched, STAR responds with a clinician in mental health, substance use peer navigator, and paramedic/EMT. STAR is not a co-responder model; police are not involved. The Denver Department of Public Safety offers other crisis response, which does include police co-responding with clinicians.

Call & Case Management

Most STAR cases are directed from 911 where calls are managed through the Computer Aided Dispatch (CAD). Calls are assigned a nature code and a copy of the call is sent to the appropriate dispatch (fire, EMS, STAR, etc.). STAR responds to several different nature codes assigned by 911 dispatch, such as: assist, intoxicated person, suicidal series, welfare check, indecent exposure, trespass unwanted person, and syringe disposal through the Harm Reduction Action Center (HRAC).

STAR vans have interconnected radio systems that are on the same radio system as all other first responders (PD, Fire, & EMS). However, the vans do not have the capability to pick up cell phone locations

or identify caller locations. All caller location information is determined during the initial triage by a 911 call taker, who inputs information into the CAD system that can be pulled out and shared via data dashboards using Microsoft Power BI. Additionally, if it is a STAR call, it only gets sent to the police dispatcher, who then dispatches a STAR unit. Fire and EMS dispatch are not notified of the initial call.

Equity & Cultural Competency

Due to cultural competency being a core ethic in social work, EMCOT has been intentional about ensuring that all of their clinicians are trained in it. Additionally, their clinicians are able to tap into different resources and community providers to address specific cultural needs.

Olympia, WA

The Crisis Response Unit (CRU) in Olympia, Washington is a crisis response unit operating out of the Olympia Police Department (OPD). CRU is funded by a public safety levy and other city funds, and provides crisis counseling, first aid and non-emergency medical care/connections, conflict resolution, and mediation to individuals with chronic mental health disorders, substance abuse, and co-occurring disorders. A particularly notable partner program is Familiar Faces, which focuses crisis prevention support on individuals with the highest engagement with law enforcement.

CRU has been established for 2.5 years, and measures its success by asking:

1. Does the community know about us and use us (as measured by TCOMM data)?
2. Does law enforcement use us (as measured by OPD referrals)?
3. Are we truly an alternative first response and are clients better off with our assistance (as measured by reduced use of police force, reduced law enforcement contact, and clients voluntarily entering treatment programs)?

Call & Case Management

The CRU Team has access to OPD radios and the Thurston County 911 communications center (TCOMM 911) to screen inbound 911 calls and Olympia's non-emergency line to identify cases that would be more appropriate for CRU. CRU cites trust-based relationships between the police department and CRU volunteers as an essential foundation for this level of integration between CRU and the police department. CRU manages cases through an app developed specifically for the program. The app has capabilities to track the client and view interactions in real time. CRU is able to pull data reports from the app, including number of contacts, amount of time spent with clients, cost savings, duration of crisis response, environmental factors to share with Familiar Faces, the Police Chief, and the City Council. Additionally, CRU itself does not have the capacity to look into bed availability alone. Through OPD's contract with Olympic Health and Recovery Services (OHRS), they obtained a Designated Crisis Responder (DCR) to work at the Police Department (40 hours per week) and the DCR has access to bed availability.

Equity & Cultural Competency

OPD employs two Diversity, Equity, & Inclusion (DEI) dedicated staff members who work directly with the CRU team to ensure that they are hiring and training around cultural competency needs related to community members in Olympia.

San Francisco, CA

The San Francisco Street Crisis Response Team (SCRT) is a collaboration between the San Francisco Department of Public Health, the San Francisco Fire Department, the Department of Emergency Management, Health Right 360, and RAMS, Inc. The system is held in high regard due to its integrated software with health data systems. The first SCRT team was launched in November 2020, and the program scaled to 6 neighborhood-based teams with 24/7 citywide geographic coverage by October of 2021.

In San Francisco, 911 calls for law enforcement are received by DEM and prioritized by severity. Dispatchers identify calls appropriate for non-police response. If SCRT is identified as the appropriate resource the team is dispatched. Each SCRT response team consists of a community paramedic with the Fire Department and, through the Department of Public Health, a clinician and a peer specialist. SCRT attempts to de-escalate in the community or alternatively providing or coordinating transport to hospitals (including involuntary hold), shelters, detoxification programs, respite, psychiatric urgent care or other voluntary services. SCRT also works with San Francisco's Office of Coordinated Care, which serves as a central access point to connect individuals to services.

Call & Case Management

SCRT operates on technology and software provided by the fire department, including radios and 911 computer systems, which are accessed via the fire department vehicles used in field-based crisis response. The SCRT system integrates with the MyAvatar EHR developed by Netsmart. Used by the San Francisco Community Behavioral Health Services (CBHS), MyAvatar contains information on client insurance information, as well as clinical and service information such as assessments, treatment plans, progress notes, and medications. The DPH Business Intelligence Unit can pull data from MyAvatar and the fire department system to produce monthly reports including case counts, response times, client demographic information disaggregated by race, etc.

Care Coordination Information

SCRT is able to see real time bed availability through their treatment partner's website (<https://findtreatment-sf.org/>). They work with their treatment partner's directly on cases of psychiatric respite, and psychiatric urgent care.

Equity & Cultural Competency

SCRT understands that hiring individuals who not only have lived experiences with behavioral health, but also lived experiences in the communities they serve is important. Their team has done extensive equity

training and continues to center equity in their work. Additionally, their partners and Civil Service employees are offered pay differentials for their ability to provide services in SF threshold languages.

State Responses to Federal Legislation

All states must implement 988 systems by July 16, 2022. States at the forefront of 988 development to meet the legislative requirements include Colorado, Nevada, and Virginia as well as Washington.

Virginia

Virginia has been conducting research and engaged in planning efforts for more than three years to develop a crisis response system using the Crisis Now model. Currently, 40 different community service boards across Virginia operate emergency services on separate technology platforms. The current system provides diversion and safety planning, but state leaders report it has a heavy reliance on hospital beds, which has made for a high acuity, high-cost system. In the lead up to 988 implementation, Virginia will create a new system based on the Crisis Now model, with 5 regional lines. There will be one technology platform across regions; Virginia just completed a Request for Proposals (RFP) for a vendor and has selected NetSmart as the technology solution. This new system will include a bed registry for public and private providers including hospitals, which will be mandated by law to provide information in order to receive referrals and provide services. The technology implementation also has a second phase where call center staff will gain the ability to upload and send pre-screening reports to hospitals for a more timely response.

The new system's call center will be funded through state general funds and supplemented through 988 tax funds. One feature that may be unique to Virginia is a plan for a 72-hour window for mobile crisis response, with added community stabilization services to help people connect to ongoing community service. This will allow for 3 days of crisis prevention to keep people from cycling in and out of crisis. One notable feature of Virginia's developing 988 system is that the Commonwealth has had a focused crisis response service for clients with developmental disabilities for more than 7 years. REACH (Regional, Education, Assessment, Crisis Services, Habilitation) operates statewide and is available 24/7 for individuals of all ages with documented evidence of intellectual and/or developmental disability. This system is run out of Virginia's Behavioral Health & Developmental Services and services will be folded into the new crisis response system.

Colorado

Colorado passed [legislation](#) to set up an operating structure and the necessary fees to establish a fund for 988 implementation. Features of the legislation include a new 988 crisis hotline enterprise (the Enterprise) in the Department of Human Services. The Enterprise will collect a surcharge per service user and fund a nonprofit organization to operate the 988 crisis hotline and provide intervention services and crisis care coordination. The act also appropriates \$5.7M to the Colorado Department of Human Services for use by

the Office of Behavioral Health to implement the act, which will provide important funding for state technology systems and staff; Third Sector anticipates Colorado will be well positioned to integrate its current crisis response system into a statewide 988 structure.

Nevada

Nevada passed [legislation](#) setting aside a significant fund to operate 988. The Advisory Committee for a Resilient Nevada and Nevada 988 Planning Coalition lead the state planning efforts. Features of the legislation include a mandate that the Division of Public and Behavioral Health of the Department of Health and Human Services is responsible for implementing 988, including establishing at least one support center to answer and respond to calls, and establishing mobile crisis teams. Nevada will impose a surcharge on mobile communication services, IP-enabled voice services and landline telephone services, with funds dedicated to 988 implementation. Legislation has provided for the Fund for a Resilient Nevada to also share in dollars received by any public agency from litigation against opioid manufacturers, distributors, and marketers. As part of the 988 planning efforts, the Nevada 988 Planning Coalition has released RFPs to purchase technology platforms and information management software to enable implementation of 988 using criteria and best practices offered by Vibrant.

VENDOR ASSESSMENT

Introduction

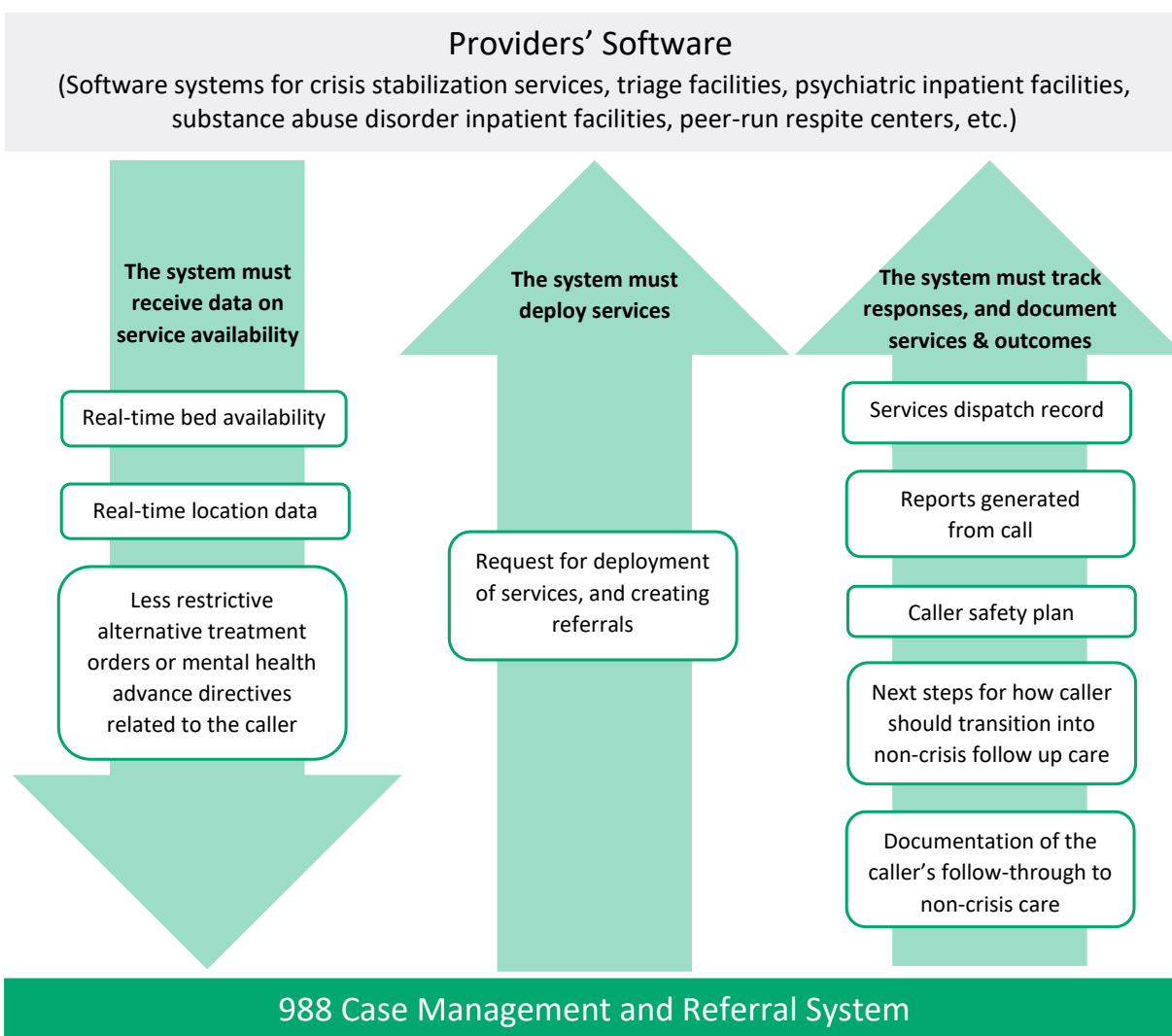
HB 1477 details the specific software requirements for the 988 case management and referral system that will be managed by the Washington State Health Care Authority. This system will help accomplish the legislation's ultimate goals of stabilizing individuals experiencing behavioral health crises, reducing reliance on emergency room services, and minimizing the use of law enforcement to resolve behavioral health crises. HB 1477 requires that the system integrates and accesses data from an array of services (including crisis stabilization services, psychiatric inpatient services, substance abuse disorder inpatient services) in real time, has the means to deploy appropriate crisis response services or create referrals, and is able to track the outcome of the 988 call to enable appropriate follow-up.

This section details the HB 1477 988 case management and referral system criteria and provides a high-level review of software vendors with software that may be capable of meeting these fundamental requirements. Some vendors have software that are also able to provide additional capabilities beyond the core HB 1477 software requirements for the case management and referral system; this section notes those capabilities as well, especially as they relate to patient engagement in the platform, longer term outcomes tracking, post-care treatment, and interoperability with 911 and other emergency response systems used throughout the state. Note that this is not a comprehensive review of all possible permutations for the crisis system, or all additional software capabilities and software vendors, but rather, interesting and useful features that were highlighted by a number of vendors in the context of the overall 988 platform.

HB 1477 Software Requirements

Per HB 1477, the 988 case management and referral system must track real-time service and bed availability, allow for referrals and deployment of appropriate services, and track outcomes of the 988 call such as non-crisis follow-up care. Figure 2 outlines the required flow of data between behavioral health care providers and the Washington 988 case management and referral system. Note that this diagram exclusively represents the case management and referral aspect of the 988 system and does not provide detail on the back-end telephony system setup for the call center:

Figure 2: HB 1477 988 Case Management and Referral System Data Flow Requirements



Comparison of Services Offered by Vendors

Third Sector initially identified potential vendors with software that could meet these requirements based on desk research of software vendors focused on healthcare and mental health with case management and referral systems, and major software providers capable of creating a customizable platform. Additional vendors were added to the list based on insights from calls conducted by the landscape and exemplar workstreams of this project, and competitors mentioned or recommended in vendor calls. As a result, Third Sector interviewed nineteen vendors to gauge how their software could fit the 988 case management and referral system requirements of HB 1477. After being interviewed, one vendor, NowPow, was acquired by another vendor, UniteUs (also interviewed) and requested to exclude

NowPow's content from this report. Thus, only information pertaining to the remaining eighteen vendors are detailed.

Key takeaways from the eighteen interviews include:

- All vendors are HIPAA compliant and can provide functionality within their platforms to accommodate callers who would like to remain anonymous.
- Most vendors interviewed are cloud-based using open Application Program Interfaces (APIs) for interoperability with other software packages. Some vendors indicated that the ease of interoperability with providers' software platforms will vary depending on whether or not they use an open API.
- Some vendors exclusively specialize in longer term, outcomes-focused post-care treatment, although this is not an explicit software requirement in HB 1477. These vendors expressed an interest in partnering with other companies to meet the full software requirements including integration with services, access to real-time bed availability, deploying services and tracking the outcomes of the 988 call.
- Generally, the large vendors with a wide range of software options that could be applied across industries would meet HB 1477 requirements through a customized product development, and also had existing statewide implementations of their product. Other vendors indicated that they have an out-of-the-box product available, some of which have been applied on a more localized scale, while others had been implemented statewide.
- Vendors whose products had been implemented on a statewide level specifically for crisis response or behavioral health services generally estimated longer timelines for implementation (~ 6 to 18 months). Other vendors who were experienced in localized implementations or implementations outside of crisis response and behavioral health could either not provide an estimate or provided a much shorter timeline (e.g., ~4 weeks). Third Sector's assessment is that these more rapid implementation timeline estimates may change when products are applied on a larger scale and there is a better understanding of the 988 landscape. Although Third Sector was able to gather data on 2020 crisis call center volume and the current number of crisis call center operators (referenced in the landscape section of this report), call volume will likely change with 988 implementation and the number and type of emergency response systems. Third Sector was also not able to obtain information on which emergency medical services system and non-behavioral health crisis services will be a part of Washington's 988 platform; this information is also required to accurately assess implementation timelines and costs.
- Eight vendors (Eustace Consulting, Microsoft, NavigatorCRE, Netsmart, OpenBeds, Salesforce Social Solutions and Solari) indicated that their software could execute all 988 case management and referral requirements as indicated in HB 1477, with Eustace Consulting, Microsoft, NavigatorCRE and Salesforce adding caveats that their ease of interoperability is dependent on providers' software packages utilizing APIs. Two vendors, OpenBeds and Social Solutions, noted that their systems could also be fully interoperable with existing 911 systems in Washington. Netsmart's potential for 911 interoperability would be dependent on the makeup and capabilities of Washington's legacy systems.

- The following vendors expressed that they would likely employ the use of an external consultant or software developer to develop a 988 software platform for Washington: Amazon Web Services, Eustace Consulting, Microsoft, Salesforce, and Zoho. Other vendors utilize external consultants on a project-specific basis: Netsmart may use external consultants to meet specific requirements, NavigatorCRE has partnered with a not-for-profit organization, Opeeka has a relationship with a system integrator, and Social Solutions implements its Apricot system through the use of both internal and external teams. Examples of potential consulting partners included:
 - Microsoft examples: Deloitte, Accenture
 - NavigatorCRE example: RPrime
 - Opeeka example: Visionary Integration Professionals
 - Social Solutions examples: Sidekick Solutions, Treadwell, Capacity Collective
- Vendors approached equity in their software design in multiple ways, including:
 - Making software compliant with ADA and accessibility standards
 - Making pages accessible with screen readers
 - Supporting patient portals to allow patients to be an active part of their care

The two tables below provide detail on the vendors overall, and their ability to meet the case management and referral requirements of HB 1477. Both tables are subdivided into two categories: Type I (vendors whose software is already healthcare or crisis response specific), and Type II (vendors whose software can be customized to a wide variety of applications). Both tables are arranged alphabetically within each of the Type I and Type II vendors. Seven vendors have established healthcare related projects for customers in Washington State; these customers are indicated in **blue** in the “Comparable Customers” column of Table 4.

Table 4 provides an overview of the vendors, their core services, their years of operation (to understand company longevity and experience), and pricing information where available. Pricing for almost all of the vendors is based on the number of users (see definition in Glossary) rather than the number of calls received. As a general estimate of the number of users and organizations was not available at the time of the interviews, the implementation timeline and pricing information provided was not presented in a way that provides valuable comparison across vendor’s software at this time.

Table 5 provides a more detailed comparison of the vendors’ software features vis-a-vis the requirements of HB 1477.

Table 4: Vendor Overview

Vendor Summary	Comparable Customers	Years of Operation	Pricing
Type I vendors (healthcare or crisis response specific software)			
1. Collective Medical : Specializes in longitudinal care coordination	Statewide implementations in Washington , Oregon and New Mexico. Large-scale implementations in Alaska, Idaho, Montana, Utah and California. Washington and Oregon paramedicine teams and/or call centers using Collective Medical: Tacoma Fire and Rescue , Tri-County 911, Snohomish Fire District 1	12	<ul style="list-style-type: none"> ● One-time fees: If development is needed of Collective's platform to support the WA 988 process, there may be one-time development costs ● Subscription: Annual fee includes implementation, training, support, maintenance and software. Per member per month fee - amount varies based on: <ul style="list-style-type: none"> ○ No. of patients ○ Payer mix ○ Population Size ○ Geography ○ Risk profile
2. Epic : EHR platform including health information exchange	Walmart, CVS, NYU Langone, New York Presbyterian Hospital Mount Sinai Hospital, University of California - Los Angeles Medical Center, University of California-Irvine Medical Center, University of Washington , Evergreen Health , Providence , Confluence Health , King County (Washington state) , Kaiser Permanente Northwest , Skagit Health , Multicare , Vancouver Clinic , Seattle Children's , Overlake Hospital ,	42	<ul style="list-style-type: none"> ● One-time fees: Software license fees and implementation services. These license fees are tiered starting from a minimum. Tiers are based on volume of care related to the applications (e.g., annual inpatient days, annual ambulatory visits) ● Subscription: Some applications are provided as a subscription including MyChart the patient portal. Includes implementation, training, support, maintenance and software. Pricing is tiered with a minimum; rate varies based on:

Vendor Summary	Comparable Customers	Years of Operation	Pricing
	Yakima Valley Farmworkers Clinic, PeaceHealth		<ul style="list-style-type: none"> ○ Volume of care related to the applications (total inpatient days, total ambulatory visits etc.)
3. iCarol : Helpline software for crisis, referral and emotional support lines	Harris County (Texas), Crisis Solutions	16	<ul style="list-style-type: none"> ● One-time fees: <ul style="list-style-type: none"> ○ Training and implementation of Standard software ○ Training and implementation of ReferralQ ○ Training and implementation of Provider Portal ○ Telephony integration with phone system ○ Contact Record APIs and Resource database API ● Subscription: Includes ongoing use of Standard software, Provider Portal, ReferralQ, telephony integration, Contact Record APIs and Resource Database API, maintenance, and unlimited customer support for unlimited users. Pricing for Standard software is tiered and annual fee is based on: <ul style="list-style-type: none"> ○ Estimated no. of calls
4. Netsmart : Platform consists of multiple modules including electronic health record software, health information exchange and integration across providers	Commonwealth of Virginia Department of Behavioral Health and Development Services crisis call data center platform, 25+ state inpatient hospitals	50 years as a company (10 years in population health)	<ul style="list-style-type: none"> ● One-time fees: None ● Subscription: Includes software, services, maintenance, support, updated, implementation

Vendor Summary	Comparable Customers	Years of Operation	Pricing
	(Oregon, Nevada, New Mexico, Hawaii), Missouri Association of Behavioral Health, Thurston Mason BH-ASO (uses Netsmart's myAvatar module)		and training; amount varies based on: <ul style="list-style-type: none"> No. of lives in system No. of users Contract length <ul style="list-style-type: none"> Most clients use a SaaS model, but there is flexibility to work with a State's preferred cost model
5. Neuroflow: Specializes in long-term, collaborative, integrated behavioral health with engaged patients	U.S. Department of Defense, Naval Academy, Air Force, Capital Blue Cross, Prudential, Independent Medical Groups (IMGs), independent therapists	5	<ul style="list-style-type: none"> One-time fees: None Subscription: Varied monthly fee; rate varies based on: <ul style="list-style-type: none"> No. of engaged members on platform per month
6. Opeeka: Specializes in post-care that unifies and tracks care plans across health, social and human services.	Substance Use Disorder and Mental Health (SUD-MH) programs, CBOs, Marshall University	<1 year	<ul style="list-style-type: none"> One-time fee: Implementation. Dependent on number of programs integrated Subscription: Includes software, support, training and ticketing system. Flat annual fee starting at \$15/person in care/year; rate varies based on: <ul style="list-style-type: none"> No. of people in care using Opeeka
7. OpenBeds/Appriss Health: Specializes in case management and referral software for healthcare	Crisis lines in Delaware, Nevada, New Hampshire, Pierce and Clark counties, Washington	6	<ul style="list-style-type: none"> One-time fees: None Subscription: Includes software, implementation, operation, maintenance and support. Flat recurring fee for tech and crisis module; amount varies based on: <ul style="list-style-type: none"> No. of treatment providers and mobile crisis teams in platform

Vendor Summary	Comparable Customers	Years of Operation	Pricing
8. ProtoCall : ProtoConnect platform supports telephonic behavioral health services	Statewide crisis line in New Mexico	29	<ul style="list-style-type: none"> ● One-time fees: None ● Subscription: Includes software, implementation, operation, maintenance and support; amount varies based on: <ul style="list-style-type: none"> ○ Call volume ○ Number of anticipated users ○ Number of modules needed ○ Any additional software development needed to meet requirements <p>Note: Any system using the platform would need to purchase a subscription.</p>
9. Social Solutions : Specializes in case management software for health and human services agencies through their Apricot platform	King County Housing Authority , Riverside County Children and Families Commission, California Department of Social Services	20	<ul style="list-style-type: none"> ● One-time fees: Implementation and initial training ● Subscription: Includes software, training and ongoing dedicated support and maintenance. Flat annual fee; amount varies based on: <ul style="list-style-type: none"> ○ No. of users ○ Contract length
10. Solari : Specializes in data-driven crisis and human services programs	Statewide crisis response implementations in Arizona and Utah	14	<ul style="list-style-type: none"> ● One-time fees: Implementation, documentation, and training of “super users” ● Subscription: EHR and GPS modules only: Flat monthly fee; amount varies based on: <ul style="list-style-type: none"> ○ No. of users ○ Contract length

Vendor Summary	Comparable Customers	Years of Operation	Pricing
			<ul style="list-style-type: none"> Baseline case management platform in Arizona is funded through Medicaid. Non-Medicaid patient fees are covered through the legislature. A cost structure for the baseline platform would have to be coordinated for an implementation in Washington.
11. Unite Us : Coordinated care network of health and social service providers focusing on social determinants of health	Kaiser Permanente, Humana, United Way, North Carolina Health and Human Services	8	<ul style="list-style-type: none"> One-time fees: Integration with new providers Subscription: Includes software, training and maintenance. Flat annual fee; amount varies based on: <ul style="list-style-type: none"> No. of callers No. of users
Type II vendors (non-healthcare specific software)			
12. Amazon Web Services : Cloud computing platform	MetroLife, Axial Healthcare,	15	<ul style="list-style-type: none"> One-time fees: None Subscription: Monthly fee based on: <ul style="list-style-type: none"> Volume <p>Note: A potential cost structure for a 988 implementation was not provided. A cost calculator was provided if more specifics are known.</p>
13. Aunt Bertha : Connected social care platform	United Way, AARP, American Red Cross, City of Dallas, Mayo Clinic, University of Washington Medicine Valley Medical Center . Statewide implementations in:	11	<ul style="list-style-type: none"> One-time fees: Implementation & training (waived if purchased online) Subscription: Flat monthly fee (irrespective of no. of users); amount varies based on: <ul style="list-style-type: none"> Subscription plan tier

Vendor Summary	Comparable Customers	Years of Operation	Pricing
	<ul style="list-style-type: none"> - Florida with the Department of Children and Families - Colorado with the Health Insurance Marketplace - Indiana with LookUp Indiana to address mental and behavioral health needs for community members 		
14. Eustace Consulting : Specializes in customer relationship management (CRM) and cloud consulting solutions	Adams Clinical, Irvine Clinical, Massachusetts Housing Partnership	70	<ul style="list-style-type: none"> ● One-time fees: Implementation & training ● Subscription: Flat monthly fee per user; amount varies based on: <ul style="list-style-type: none"> ○ Subscription plan tier
15. Microsoft (Dynamics) : Specializes in customer relationship management (CRM)	King County LEAD , Los Angeles Department of Mental Health, Ohio Department of Developmental Disabilities, Hawaii Developmental Disabilities Division, Hawaii Department of Child and Family Services	20 (10 years as a cloud-based platform)	<ul style="list-style-type: none"> ● One-time fees: Implementation & training (for external consultant) ● Subscription: Flat monthly fee per user; amount varies based on: <ul style="list-style-type: none"> ○ No. of call center staff
16. NavigatorCRE : Specializes in data management, integration and analytics	Department of Defense, U.S. Army Analytics group, Autism initiative AS 360 in partnership with the University of Washington and Children's Hospital	6	<ul style="list-style-type: none"> ● One-time fees: None ● Subscription: Implementation, maintenance and software. Annual software license per user or monthly license per user; rate varies based on: <ul style="list-style-type: none"> ○ Structured users ○ Level of usage

Vendor Summary	Comparable Customers	Years of Operation	Pricing
17. Salesforce : Specializes in customer relationship management (CRM) and cloud consulting solutions	United Way, United Healthcare, 311 in various government jurisdictions, 988 crisis support center in a Midwestern state, United Vein Centers, MIMIT Healthcare, First Step Behavioral Health	22	<ul style="list-style-type: none"> ● One-time fees: Implementation & training ● Subscription: Flat annual fee per user; rate varies based on: <ul style="list-style-type: none"> ○ No. of users
18. Zoho : Specializes in customer relationship management (CRM) and cloud consulting solutions	Tesla, Amazon, Colorado Department of Health Services	>20	<ul style="list-style-type: none"> ● One-time fees: Implementation & training ● Subscription: Flat annual fee per user; rate varies based on: <ul style="list-style-type: none"> ○ Subscription plan tier

Table 5: Comparison of Software Features

Vendor Name	Interoperability	Service Availability & Referrals	Outcomes
	HB 1477 requires interoperability across crisis and emergency response systems used throughout the state including emergency medical services systems and other non-behavioral health crisis services	HB 1477 requires that platforms have access to real-time information relevant to the coordination of behavioral health crisis response services, the ability to refer the appropriate services, and use GPS tracking to locate (and subsequently deploy) mobile crisis response units	HB 1477 requires tracking the outcome of calls including services that were dispatched, safety plans that were established, next steps in transition to non-crisis care and verification that the caller was successful in receiving non-crisis follow-up care
Type I vendors (healthcare or crisis response specific software)			
1. Collective Medical	<ul style="list-style-type: none"> Yes, interoperable. (Collective's solution can receive and transmit data in many ways. Collective would look to the organization on how they intend to send electronic messages so that Collective can identify the individual calling in and provide necessary information back to the appropriate users.) 	<ul style="list-style-type: none"> Partial ability to access and manage real-time information related to bed and crisis response team availability. Real time data is available for all emergency rooms in Washington (except the Veteran's Hospital) Partial ability to deploy or create referrals for the appropriate services. Mobile crisis response units cannot be deployed from this system, and referrals are not made from a call center. Referrals can be made by case managers for patients with whom there is already a HIPAA relationship. 	<ul style="list-style-type: none"> Partial ability to track required outcomes. Outcomes are not tracked through the call center ticket, but through the Collective Medical platform being used by case managers (which would be separate from an initial 988 call)

Vendor Name	Interoperability	Service Availability & Referrals	Outcomes
		<ul style="list-style-type: none"> ● Not able to use GPS to track mobile crisis response units in real time ● Additional capabilities: Case managers can see information related to a patient and follow-up after discharge. The case manager can also refer patients to other systems across Washington. Case Managers will have access to the patient's care team consisting of primary care physicians, behavioral health providers, and other Care Managers from other organizations. 	
2. Epic	<ul style="list-style-type: none"> ● Yes, interoperable if providers use EHRs or HIE. If the provider does not use a compatible system, they can join Carequality to share data. ● Additional considerations: 90% of Washington residents have an Epic healthcare record 	<ul style="list-style-type: none"> ● Partial ability to access and manage real-time information related to bed and crisis response team availability. Providers would have to be using Epic as their EHR for real-time information to be shared. ● Partial ability to deploy or create referrals. Referrals are initiated in Epic and can be exchanged through connections to platforms UniteUs, Aunt Bertha, or other third-party vendors (but not necessarily all 988 providers). ● Not able to use GPS to track mobile crisis response units in real time 	<ul style="list-style-type: none"> ● Full ability to track required outcomes ● Additional capabilities: Care Everywhere is a tool that allows for EHRs to be sent and shared between providers
3. iCarol	<ul style="list-style-type: none"> ● Yes, interoperable if providers have APIs that can accept and digest the API 	<ul style="list-style-type: none"> ● Partial ability to access and manage real-time information related to bed 	<ul style="list-style-type: none"> ● Full ability to track required outcomes with ReferralQ.

Vendor Name	Interoperability	Service Availability & Referrals	Outcomes
	formats. An external consultant would be required if there are a significant number of API integrations required	<p>and crisis response team availability. Real time data is available with providers who have integrated with the system via API or through use of iCarol software.</p> <ul style="list-style-type: none"> • Full ability to deploy or create referrals for the appropriate services with their provider portal module. • Not able to use GPS to track mobile crisis response units in real-time. (iCarol is open to considering development for GPS tracking.) 	<ul style="list-style-type: none"> • Additional capabilities: Baseline system allows call centers to document calls, complete workflows and assessments, search resource databases and follow up with caller or internal teams for service outcomes.
4. Netsmart	<ul style="list-style-type: none"> • Yes, interoperable • Additional capabilities: Potentially interoperable with hotlines, EMS, phone systems etc. depending on the makeup and capabilities of Washington's legacy systems 	<ul style="list-style-type: none"> • Full ability to access and manage real-time information related to bed and crisis response team availability • Full ability to deploy or create referrals for the appropriate services • Full ability to use GPS to track mobile crisis response units in real time • Additional capabilities: Option to automate referral process. The Netsmart platform includes mobile dispatch that enables efficient call center management for mobile response team 	<ul style="list-style-type: none"> • Full ability to track required outcomes • Additional capabilities: Automatic updates when referrals are accepted, patient is seen etc. Uses analytics to track outcomes. Ex. heat maps to show crisis hot spots.

Vendor Name	Interoperability	Service Availability & Referrals	Outcomes
5. NeuroFlow	<ul style="list-style-type: none"> • Yes, interoperable if providers use a compatible API • Additional capabilities: Potentially interoperable with hotlines, EMS and phone systems if existing systems use a cloud-based API 	<ul style="list-style-type: none"> • Not able to access and manage real-time information related to bed and crisis response team availability (NeuroFlow recommended a system like OpenBeds for immediate inpatient referrals from 988 calls) • Not able to deploy or create referrals • Not able to use GPS to track mobile crisis response units in real time • Additional capabilities: NeuroFlow runs proactive claims analysis, identifying who should be targeted and recommending them for therapy etc. 	<ul style="list-style-type: none"> • Full ability to track required outcomes if the person is a NeuroFlow user • Additional capabilities: <ul style="list-style-type: none"> ○ Mobile app available for individualized, customizable patient content ○ Washington specific resources can be loaded into the platform ○ Patients can complete assessments and surveys that are used to gauge progress. ○ Behavioral economics: app aims to keep patients engaged (completed activities earn points, badges, gift cards etc.) ○ Employs care managers, care coordinators, and other roles to assist with getting patients to the right level of care and tracking their mental health outcomes over time
6. Opeeka	<ul style="list-style-type: none"> • Yes, interoperable within the post-care services that the software covers • Additional capabilities: Can schedule community-based services 	<ul style="list-style-type: none"> • Not able to access and manage real-time information related to bed and crisis response team availability (Would need to partner with another company to manage referrals and deployment from 988 call) • Partially able to create referrals. Only post-care referrals can be created, not 	<ul style="list-style-type: none"> • Full ability to track required outcomes • Additional capabilities: Patients can authorize their information in Opeeka so information on care and care coordination is available to providers in advance

Vendor Name	Interoperability	Service Availability & Referrals	Outcomes
		<p>pre-care or care needed at the time of the call</p> <ul style="list-style-type: none"> ● Not able to use GPS to track mobile crisis response units in real time 	
7. OpenBeds / Appriss Health	<ul style="list-style-type: none"> ● Yes, interoperable ● Additional capabilities: Is interoperable with hotlines, EMS and phone systems 	<ul style="list-style-type: none"> ● Full ability to access and manage real-time information related to bed and crisis response team availability ● Full ability to deploy or create referrals for the appropriate services ● Full ability to use GPS to track mobile crisis response units in real time 	<ul style="list-style-type: none"> ● Full ability to track required outcomes ● Additional capabilities: Tracking of response steps and time stamps from intake to final disposition so that stakeholders and end-users can analyze performance and recognize opportunities for improvement
8. ProtoCall	<ul style="list-style-type: none"> ● Not interoperable. However, data sharing can occur through the mobile application, ProtoMobile, or through specific URLs 	<ul style="list-style-type: none"> ● Full ability to access and manage real-time information related to bed, crisis response team availability via their mobile application, ProtoMobile, or through specific URLs ● Full ability to deploy or create referrals for the appropriate services ● Full ability to use GPS to track mobile crisis response units in real time via their mobile application, ProtoMobile 	<ul style="list-style-type: none"> ● Full ability to track required outcomes

Vendor Name	Interoperability	Service Availability & Referrals	Outcomes
9. Social Solutions	<ul style="list-style-type: none"> • Yes, interoperable • Additional capabilities: Is interoperable with hotlines, EMS and emergency phone systems in Washington 	<ul style="list-style-type: none"> • Full ability to access and manage real-time information related to bed and crisis response team availability • Full ability to deploy or create referrals for the appropriate services • Full ability to use GPS to track mobile crisis response units in real time 	<ul style="list-style-type: none"> • Full ability to track required outcomes • Additional capabilities: Includes a self-service portal that clients can use to login, add or update information, complete intake and assessment forms and view their progress. Supports closed-loop referrals and census data integration.
10. Solari	<ul style="list-style-type: none"> • Yes, interoperable 	<ul style="list-style-type: none"> • Full ability to access and manage real-time information related to bed and crisis response team availability • Full ability to deploy or create referrals for the appropriate services. (Referrals are currently made through email. Solari is working on a solution to automate this through a data warehouse and API feed). • Full ability to use GPS to track mobile crisis response units in real time 	<ul style="list-style-type: none"> • Full ability to track required outcomes. Solari will receive a disposition back informing that a caller/patient received the services for which they were referred.
11. Unite Us	<ul style="list-style-type: none"> • Not interoperable. However, data sharing can occur through single sign-on with the Unite Us platform. • Additional capabilities: Can schedule community-based services 	<ul style="list-style-type: none"> • Partial ability to access and manage real-time information related to bed and crisis response team availability. The system is able to show which facilities are currently accepting patients 	<ul style="list-style-type: none"> • Full ability to track required outcomes

Vendor Name	Interoperability	Service Availability & Referrals	Outcomes
		<ul style="list-style-type: none"> • Full ability to deploy or create referrals for the appropriate services. Referrals are not sent to a single provider; they are sent to multiple providers who indicated that they are accepting patients, and once a provider accepts the referral, the other providers will know that it has already been accepted • Not able to use GPS to track mobile crisis response units in real time 	
Type II vendors (non-healthcare specific software)			
12. Amazon	<ul style="list-style-type: none"> • Not interoperable with other systems (the product offered is solely a telephony product and is not designed for this purpose) 	<ul style="list-style-type: none"> • Not able to access and manage real-time information related to bed and crisis response team availability. • Not able to deploy or create referrals for the appropriate services. An external developer would need to create that capability that could then be supported on an AWS server. • Not able to use GPS to track mobile crisis units in real time 	<ul style="list-style-type: none"> • Partial ability to track required outcomes. Basic information on the caller can be stored within telephony software but more in-depth information may not be. Additionally, behavioral health providers would have to provide this information outside of the AWS system.
13. Aunt Bertha	<ul style="list-style-type: none"> • Yes, interoperable with platforms of behavioral health programs in the 988 system (once a provider has claimed 	<ul style="list-style-type: none"> • Full ability to access and manage real-time information related to bed and crisis response team availability 	<ul style="list-style-type: none"> • Full ability to track required outcomes • Additional capabilities:

Vendor Name	Interoperability	Service Availability & Referrals	Outcomes
	<p>their program, they can work within the Aunt Bertha platform or utilize webhook functionality developed by Aunt Bertha to respond to referrals in their system of record)</p> <ul style="list-style-type: none"> • Additional information: Have developed system integrations with EHRs like Epic and Cerner, Care Coordination platforms such as Altruista and Innovaccer, and case management systems like Salesforce, Apricot, and EMC Systems 	<p>(service providers who claim their program on Aunt Bertha can update capacity and eligibility in real time. Staff making referrals can also update availability in the notes section and share that information with other staff)</p> <ul style="list-style-type: none"> • Full ability to deploy or create referrals: Aunt Bertha can facilitate referrals with any service provider who claims their program. Claiming a program is required for sending electronic referrals. By claiming a program, a CBO agrees to Aunt Bertha's terms and conditions to handle any data sent to them in accordance with the security and privacy guidelines governing their industry • Not able to use GPS to track mobile crisis units in real time 	<ul style="list-style-type: none"> ○ Can review trends and details on the dashboard to quantify the impact of the platform and make operational and strategic decisions ○ Patient logins available
14. Eustace Consulting	<ul style="list-style-type: none"> • Yes, interoperable if behavioral health provider systems use a web-based API • Additional capabilities: Potentially interoperable with hotlines, EMS, phone systems etc. depending on the interface of Washington's 911 system. 	<ul style="list-style-type: none"> • Full ability to access and manage real-time information related to bed and crisis response team availability • Full ability to deploy or create referrals for the appropriate services once integrated with the platform 	<ul style="list-style-type: none"> • Full ability to track required outcomes • Additional capabilities: <ul style="list-style-type: none"> ○ Can create a customer portal to allow individuals to access online resources and documents

Vendor Name	Interoperability	Service Availability & Referrals	Outcomes
	(Eustace Consulting does not offer telephony engineering services)	<ul style="list-style-type: none"> • Full ability to use GPS to track mobile crisis response units in real time 	
15. Microsoft (Dynamics)	<ul style="list-style-type: none"> • Yes, interoperable (Interoperability is more streamlined if providers have open APIs but alternative solutions can be created for those who do not) 	<ul style="list-style-type: none"> • Full ability to access and manage real-time information related to bed and crisis response team availability • Full ability to deploy or create referrals for the appropriate services once integrated with the platform • Full ability to use GPS to track mobile crisis response units in real time 	<ul style="list-style-type: none"> • Full ability to track required outcomes
16. NavigatorCRE	<ul style="list-style-type: none"> • Yes, interoperable if systems have compatible API 	<ul style="list-style-type: none"> • Full ability to access and manage real-time information related to bed and crisis response team availability • Full ability to deploy or create referrals for the appropriate services but would require NavigatorCRE, in partnership with Zoho, to create a companion application to do so. • Fully able to use GPS to track mobile crisis units in real time 	<ul style="list-style-type: none"> • Full ability to track required outcomes
17. Salesforce	<ul style="list-style-type: none"> • Yes, interoperable if systems use an open API 	<ul style="list-style-type: none"> • Full ability to access and manage real-time information related to bed and crisis response team availability 	<ul style="list-style-type: none"> • Full ability to track required outcomes

Vendor Name	Interoperability	Service Availability & Referrals	Outcomes
		<ul style="list-style-type: none"> ● Full ability to deploy or create referrals for the appropriate services once integrated with the platform ● Full ability to use GPS to track mobile crisis response units in real time 	
18. Zoho	<ul style="list-style-type: none"> ● Yes, interoperable if behavioral health programs in the 988 system use REST API. ● Additional capabilities: Potentially interoperable with hotlines, EMS and phone systems in Washington if they use REST API 	<ul style="list-style-type: none"> ● Full ability to access and manage real-time information related to bed and crisis response team availability ● Full ability to deploy or create referrals for the appropriate services once integrated with the platform ● Not able to use GPS to track mobile crisis response units 	<ul style="list-style-type: none"> ● Full ability to track required outcomes

Additional Notes

Third Sector also identified five additional vendors who were not interviewed and whose software is not included in the above two tables. Third Sector corresponded with E-Psychiatry and LifeSpeak but found the companies' services and products do not meet the technology and platform requirements listed within HB 1477. LifeSpeak works primarily in mental health and wellbeing education, providing a library of videos for a fee. E-Psychiatry provides telehealth and video conferencing services for health providers. Third Sector also contacted Carequality, Cerner and Mark43 to schedule interviews. Cerner did not respond to inquiries and compatible interview schedules could not be coordinated with Carequality and Mark43 in time for the submission of this report. During the period of this report, NowPow was acquired by UniteUs. Although Third Sector interviewed NowPow, NowPow asked that their content be removed from the report in light of the acquisition.

Although Microsoft's Dynamics product is detailed in the above, it is possible that their Azure product may be able to support 988 implementation as well. Third Sector was not able to connect with Microsoft's Azure team prior to the delivery of this report.

Glossary of Vendor Terms

Engaged members: people actively using the post-care services available in the platform

Integration: a connection between software systems that allows for the exchange of data and information in a way that all software systems involved can process and understand

Interoperability: a connection between software systems where data and information can be shared in its original format between software systems without an intermediary

Lives in system: people within the total population who have been flagged for, or who have already received services through the platform

People in care: people currently receiving care and services through the platform

Program: services (housing, food, health etc.) that are integrated with the platform

Users: employees at the call centers and behavioral health crisis response systems who will be accessing and updating the platform

NEXT STEPS

While Third Sector was able to connect with a wide variety of stakeholders to develop this report, there are additional pieces of information needed to develop and finalize an implementation workplan for a technology platform meeting the goals of HB 1477, including associated costs and timelines. Third Sector suggests that Washington State explore the following topics, which we have organized into three

categories: Service Coordination; Implementation Scale and Approach; and Software, Data, and Outcomes.

Service Coordination

- *Law Enforcement and 911 Interoperability:* Third Sector noted points of interoperability between crisis call systems and the 911 system, but we did not conduct a detailed analysis of Washington's 911 system, nor did we conduct interviews with law enforcement or EMS. Our analysis of law enforcement and EMS role in the crisis response system relies upon interviews with crisis call centers, BH-ASOs, MCRTs, DCRs, and other crisis response professionals. This analysis is necessarily limited to law enforcement and EMS coordination with these other elements of the crisis response system, and a more detailed analysis of 911 interoperability and the role of the 911 system may further inform 988 implementation.
- *Local Alternatives to 911:* In the past several years, a number of cities have developed local programs intended to divert calls away from 911 and reduce law enforcement contact with people experiencing behavioral health crises. Several call centers interviewed for this report noted that they make referrals to these programs, but Third Sector was not able to fully explore the extent of integration between 911 alternatives and the crisis call system. Washington will need to coordinate with these local programs to ensure integrated operations, data sharing, and connection to services, while balancing the benefits that these localized options provide (e.g., specialized and culturally responsive services).

Implementation Scale and Approach

- *User base:* Third Sector did not have access to information on the anticipated number of callers, call centers, and call center operators for a 988 system in Washington State, although we were able to identify estimates of the current number of annual crisis calls and operators through a survey of existing call centers. It is likely that 988 implementation will increase the number of crisis calls statewide, and therefore the number of call centers and operators needed to field those calls.
- *Provider Integration:* The level of integration between mental health providers and the 988 software and case management system remains an open question. For example, it is possible that all mental health providers in Washington state would need to have some connection to a 988 platform to enable crisis call operators to access comprehensive data on the services callers receive and their outcomes beyond the point of referral. It is also possible that Washington State will benefit from different levels of integration and connection to the 988 system across inpatient, outpatient, public, private, and other provider types. Given the diversity of providers and the fragmented landscape of EHRs we encountered, the cost, complexity, and timeline of integration and implementation could vary significantly.
- *Insurance:* Integration between a 988 platform and managed care plans, MCOs, and insurance systems also remains an open question. It is not yet clear how a caller's health insurance will be

verified, if at all, and how the 988 system will claim for services rendered and referred, if at all. Additionally, it is not clear how callers will provide consent for insurance claiming, and how the 988 system can maintain up-to-date records of callers' insurance. As a result, Third Sector did not assess software vendors' products on this or related functionalities.

Software, Data, and Outcomes

- *Hospital and CBO Software and Data Quality:* While Third Sector focused our analysis on crisis calls and referrals, we found that most outcomes data (e.g., clinical outcomes) for crisis response is stored and reported via EHRs at hospitals and CBOs. We have included illustrative examples of the EHRs and case management platforms at some of these organizations, but we did not complete a comprehensive analysis of all EHRs and other platforms in use at hospitals and providers in Washington State. Our preliminary analysis and assessment indicates that many CBOs especially may be using older data tracking and systems, which may require upgrades and enhancements to integrate with any 988 case management and care coordination system.
- *911 Software, Data Quality, and Integration:* Third Sector did not assess or landscape the software system, capabilities, and data elements of Washington State's existing 911 system. Some vendors indicated that the complexity and effort to create a 988 system that can successfully interface with 911 is highly dependent on the existing 911 system setup. Additionally, Washington State will need to develop a plan for telephonic integration between 988 and 911.
- *Hospital/CBO Outcomes:* There are likely additional outcomes measured and tracked at hospitals and treatment providers that fell outside of the scope of this report, which may be useful for understanding the success of Washington's 988 system. Because Third Sector did not conduct a comprehensive survey of hospitals or other treatment providers for this report, outcomes measures and related metrics utilized for reporting, billing, performance management, and other functions at these organizations are not included here. As a result, our analysis generally stops at the point where a person in crisis has been successfully placed in a treatment facility; we have noted exceptions where longer-term outcomes are reported to call centers and BH-ASOs where relevant. If Washington State prioritizes tracking longer-term outcomes, a 988 software platform would likely need additional capabilities for integration and interoperability across multiple EHRs, and further investigation of these capabilities would be needed.
- *Software Accessibility and User Experience:* Third Sector did not conduct a first-hand assessment of each software product's user experience and level of accessibility. Washington State may want to conduct a deeper assessment of each software product's accessibility and user experience, including from a caller perspective (as it relates to language translation support and disability access), as well as a call center operator perspective (i.e., whether the system is user-friendly and what technical skills the software would require from a call center operator).

Finally, this report is not a complete or comprehensive review of every possible 988 case management and referral system; the eighteen vendors reviewed in this report are meant to be indicative of the universe of potential vendors.

CONCLUSION

This report provides a landscape assessment for the current state of Washington States' crisis call center systems, exemplars in 988 and crisis call centers nationwide, and technology vendors with software that could meet the requirements of HB 1477 and provide other benefits to Washington States' crisis call systems. Additional information may be needed to support Washington State in implementing HB 1477, including information on the anticipated size and scale of Washington States' 988 system and users thereof. Third Sector hopes that the information provided in this report benefits the public in Washington State and across the country in implementing 988 and associated call center systems, and more importantly, supports Washington States' 988 system in successfully responding to mental health crises for residents in need.

ABOUT THIRD SECTOR

Third Sector is a 501(c)(3) nonprofit organization that is transforming the way communities connect people with human services. Fulfilling our mission of transforming public systems to advance improved and equitable outcomes; we help governments, service providers, and their partners use public funding to generate positive, measurable outcomes for the people they serve. We work alongside communities to help build a future that includes stable employment and housing, increased income, stronger families, and physical and mental health. When our work is complete, agencies entrusted to use public funds will have the systems, tools, and data to do more and do better for their communities. Since 2011, our team has worked nationwide with over 50 communities and transitioned over \$1.2 billion in public funding to social programs that measurably improve lives.

The Ballmer Group was involved with the funding of this report, but not the results, assessments, or conclusions of this report. Third Sector conducted this assessment as a third party in order to benefit the public of Washington and the country in implementing 988 and associated call center systems.

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