H-1548.1

SUBSTITUTE HOUSE BILL 1427

State of Washington 69th Legislature 2025 Regular Session

By House Health Care & Wellness (originally sponsored by Representatives Davis, Caldier, Obras, Eslick, Lekanoff, Ramel, Ormsby, and Santos)

READ FIRST TIME 02/21/25.

AN ACT Relating to certified peer support specialists; amending RCW 74.09.871, 71.24.920, 18.420.005, 18.420.010, 18.420.020, 18.420.030, 18.420.040, 18.420.050, 18.420.060, 18.420.090, 18.420.800, 43.70.250, 48.43.825, 71.24.585, 71.24.903, 71.24.920, 71.24.922, 71.24.924, 71.40.040, and 71.40.090; reenacting and amending RCW 18.130.040, 18.130.175, 71.24.025, and 71.24.890; and adding a new section to chapter 41.05 RCW.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

Sec. 1. RCW 74.09.871 and 2023 c 292 s 2 are each amended to read as follows:

(1) Any agreement or contract by the authority to provide behavioral health services as defined under RCW 71.24.025 to persons eligible for benefits under medicaid, Title XIX of the social security act, and to persons not eligible for medicaid must include the following:

(a) Contractual provisions consistent with the intent expressed in RCW 71.24.015 and 71.36.005;

(b) Standards regarding the quality of services to be provided, including increased use of evidence-based, research-based, and promising practices, as defined in RCW 71.24.025;

(c) Accountability for the client outcomes established in RCW 71.24.435, 70.320.020, and 71.36.025 and performance measures linked to those outcomes;

(d) Standards requiring behavioral health administrative services organizations and managed care organizations to maintain a network of appropriate providers that is supported by written agreements sufficient to provide adequate access to all services covered under the contract with the authority and to protect essential behavioral health system infrastructure and capacity, including a continuum of substance use disorder services;

(e) Provisions to require that medically necessary substance use disorder and mental health treatment services be available to clients;

(f) Standards requiring the use of behavioral health service provider reimbursement methods that incentivize improved performance with respect to the client outcomes established in RCW 71.24.435 and 71.36.025, integration of behavioral health and primary care services at the clinical level, and improved care coordination for individuals with complex care needs;

(g) Standards related to the financial integrity of the contracting entity. This subsection does not limit the authority of the authority to take action under a contract upon finding that a contracting entity's financial status jeopardizes the contracting entity's ability to meet its contractual obligations;

(h) Mechanisms for monitoring performance under the contract and remedies for failure to substantially comply with the requirements of the contract including, but not limited to, financial deductions, termination of the contract, receivership, reprocurement of the contract, and injunctive remedies;

(i) Provisions to maintain the decision-making independence of designated crisis responders; and

(j) Provisions stating that public funds appropriated by the legislature may not be used to promote or deter, encourage, or discourage employees from exercising their rights under Title 29, chapter 7, subchapter II, United States Code or chapter 41.56 RCW.

(2) At least six months prior to releasing a medicaid integrated managed care procurement, but no later than January 1, 2025, the authority shall adopt statewide network adequacy standards that are assessed on a regional basis for the behavioral health provider networks maintained by managed care organizations pursuant to

subsection (1)(d) of this section. The standards shall require a network that ensures access to appropriate and timely behavioral health services for the enrollees of the managed care organization who live within the regional service area. At a minimum, these standards must address each behavioral health services type covered by the medicaid integrated managed care contract. This includes, but is not limited to: Outpatient, inpatient, and residential levels of care for adults and youth with a mental health disorder; outpatient, inpatient, and residential levels of care for adults and youth with a substance use disorder; crisis and stabilization services; providers of medication for opioid use disorders; specialty care; other facility-based services; and other providers as determined by the authority through this process. The authority shall apply the standards regionally and shall incorporate behavioral health system needs and considerations as follows:

(a) Include a process for an annual review of the network adequacy standards;

(b) Provide for participation from counties and behavioral health providers in both initial development and subsequent updates;

(c) Account for the regional service area's population; prevalence of behavioral health conditions; types of minimum behavioral health services and service capacity offered by providers in the regional service area; number and geographic proximity of providers in the regional service area; an assessment of the needs or gaps in the region; and availability of culturally specific services and providers in the regional service area to address the needs of communities that experience cultural barriers to health care including but not limited to communities of color and the LGBTQ+ community;

(d) Include a structure for monitoring compliance with provider network standards and timely access to the services;

(e) Consider how statewide services, such as residential treatment facilities, are utilized cross-regionally; and

(f) Consider how the standards would impact requirements for behavioral health administrative service organizations.

(3) Before releasing a medicaid integrated managed care procurement, the authority shall identify options that minimize provider administrative burden, including the potential to limit the number of managed care organizations that operate in a regional service area.

(4) The following factors must be given significant weight in any medicaid integrated managed care procurement process under this section:

(a) Demonstrated commitment and experience in serving low-income populations;

(b) Demonstrated commitment and experience serving persons who have mental illness, substance use disorders, or co-occurring disorders;

(c) Demonstrated commitment to and experience with partnerships with county and municipal criminal justice systems, housing services, and other critical support services necessary to achieve the outcomes established in RCW 71.24.435, 70.320.020, and 71.36.025;

(d) The ability to provide for the crisis service needs of medicaid enrollees, consistent with the degree to which such services are funded;

(e) Recognition that meeting enrollees' physical and behavioral health care needs is a shared responsibility of contracted behavioral health administrative services organizations, managed care organizations, service providers, the state, and communities;

(f) Consideration of past and current performance and participation in other state or federal behavioral health programs as a contractor;

(g) The ability to meet requirements established by the authority;

(h) The extent to which a managed care organization's approach to contracting simplifies billing and contracting burdens for community behavioral health provider agencies, which may include but is not limited to a delegation arrangement with a provider network that leverages local, federal, or philanthropic funding to enhance the effectiveness of medicaid-funded integrated care services and promote medicaid clients' access to a system of services that addresses additional social support services and social determinants of health as defined in RCW 43.20.025;

(i) Demonstrated prior national or in-state experience with a full continuum of behavioral health services that are substantially similar to the behavioral health services covered under the Washington medicaid state plan, including evidence through past and current data on performance, quality, and outcomes; ((~~and~~))

(j) Demonstrated commitment by managed care organizations to the use of alternative pricing and payment structures between a managed

care organization and its behavioral health services providers, including provider networks described in subsection (b) of this section, and between a managed care organization and a behavioral administrative service organization, in any of their agreements or contracts under this section, which may include but are not limited to:

(i) Value-based purchasing efforts consistent with the authority's value-based purchasing strategy, such as capitated payment arrangements, comprehensive population-based payment arrangements, or case rate arrangements; or

(ii) Payment methods that secure a sufficient amount of ready and available capacity for levels of care that require staffing 24 hours per day, 365 days per year, to serve anyone in the regional service area with a demonstrated need for the service at all times, regardless of fluctuating utilization; and

(k) The accessibility of peer services, as demonstrated in the application through a required comprehensive analysis of access to peer services in the managed care organization's network. The analysis must evaluate the availability of certified peer counselors and peer support specialists certified under chapter 18.420 RCW who are:

(i) Adults in recovery from a mental health condition;

(ii) Adults in recovery from a substance use disorder;

(iii) Youth and young adults in recovery from a mental condition;

(iv) Youth and young adults in recovery from a substance use disorder; and

(v) The parent or legal guardian of a youth who is receiving or has received behavioral health services.

(5) The authority may use existing cross-system outcome data such as the outcomes and related measures under subsection (4)(c) of this section and chapter 338, Laws of 2013, to determine that the alternative pricing and payment structures referenced in subsection (4)(j) of this section have advanced community behavioral health system outcomes more effectively than a fee-for-service model may have been expected to deliver.

(6)(a) The authority shall urge managed care organizations to establish, continue, or expand delegation arrangements with a provider network that exists on July 23, 2023, and that leverages local, federal, or philanthropic funding to enhance the effectiveness of medicaid-funded integrated care services and promote medicaid

clients' access to a system of services that addresses additional social support services and social determinants of health as defined in RCW 43.20.025. Such delegation arrangements must meet the requirements of the integrated managed care contract and the national committee for quality assurance accreditation standards.

(b) The authority shall recognize and support, and may not limit or restrict, a delegation arrangement that a managed care organization and a provider network described in (a) of this subsection have agreed upon, provided such arrangement meets the requirements of the integrated managed care contract and the national committee for quality assurance accreditation standards. The authority may periodically review such arrangements for effectiveness according to the requirements of the integrated managed care contract and the national committee for quality assurance accreditation standards.

(c) Managed care organizations and the authority may evaluate whether to establish or support future delegation arrangements with any additional provider networks that may be created after July 23, 2023, based on the requirements of the integrated managed care contract and the national committee for quality assurance accreditation standards.

(7) The authority shall expand the types of behavioral health crisis services that can be funded with medicaid to the maximum extent allowable under federal law, including seeking approval from the centers for medicare and medicaid services for amendments to the medicaid state plan or medicaid state directed payments that support the 24 hours per day, 365 days per year capacity of the crisis delivery system when necessary to achieve this expansion.

(8) The authority shall, in consultation with managed care organizations, review reports and recommendations of the involuntary treatment act work group established pursuant to section 103, chapter 302, Laws of 2020 and develop a plan for adding contract provisions that increase managed care organizations' accountability when their enrollees require long-term involuntary inpatient behavioral health treatment and shall explore opportunities to maximize medicaid funding as appropriate.

(9) In recognition of the value of community input and consistent with past procurement practices, the authority shall include county and behavioral health provider representatives in the development of any medicaid integrated managed care procurement process. This shall

include, at a minimum, two representatives identified by the association of county human services and two representatives identified by the Washington council for behavioral health to participate in the review and development of procurement documents.

(10) For purposes of purchasing behavioral health services and medical care services for persons eligible for benefits under medicaid, Title XIX of the social security act and for persons not eligible for medicaid, the authority must use regional service areas. The regional service areas must be established by the authority as provided in RCW 74.09.870.

(11) Consideration must be given to using multiple-biennia contracting periods.

(12) Each behavioral health administrative services organization operating pursuant to a contract issued under this section shall serve clients within its regional service area who meet the authority's eligibility criteria for mental health and substance use disorder services within available resources.

NEW SECTION. **Sec. 2.** A new section is added to chapter 41.05 RCW to read as follows:

(1) The authority shall contract with one or more external entities to expand access to peer support services.

(2) Beginning December 31, 2025, the entity or entities shall:

(a) Provide technical assistance to support primary care clinics, urgent care clinics, and hospitals to integrate certified peer support specialists into their clinical care models and bill health insurance carriers for those services;

(b) Develop detailed and innovative proposals to create low barrier and cost-effective opportunities for:

(i) Community-based agencies, including peer-run agencies and organizations that are not currently licensed as behavioral health agencies under chapter 71.24 RCW, to bill health carriers for peer support services;

(ii) Service providers to bill health carriers for behavioral health services that are currently funded by the state general fund, including the law enforcement assisted diversion program established under RCW 71.24.589, the recovery navigator program established under RCW 71.24.115, the arrest and jail alternatives program established under RCW 36.28A.450, and the homeless outreach stabilization transition program established under RCW 71.24.145;

(iii) Community-based victim services agencies, including agencies that support domestic violence, sexual assault, and human trafficking victims, to bill health carriers for peer support services provided to victims of gender-based violence; and

(iv) Tribes, tribal health providers, and urban Indian health programs to bill for peer support serivces provided by tribal elders;

(c) Develop a proposal to establish the concept of, and billing mechanisms for, substance use disorder peer-run respite centers that are modeled after the mental health peer-run respite centers established under RCW 71.24.649; and

(d) Explore options for health carriers to pay for peer support services through capitated payment arrangements rather than on a fee-for-service basis.

(3) By November 1, 2026, the contracted entity or entities shall submit reports to the authority to describe the type and quantity of technical assistance that have been provided, the proposals that have been developed, and the trends in health carriers providing payment for peer support services, and any policy or budget recommendations to encourage health carriers to reimburse providers for peer support services.

Sec. 3. RCW 71.24.920 and 2023 c 469 s 13 are each amended to read as follows:

(1)(a) By January 1, 2025, the authority must develop a course of instruction to become a certified peer specialist under chapter 18.420 RCW. The course must be approximately 80 hours in duration and based upon the curriculum offered by the authority in its peer counselor training as of July 23, 2023, as well as additional instruction in the principles of recovery coaching and suicide prevention. The authority shall establish a peer engagement process to receive suggestions regarding subjects to be covered in the 80-hour curriculum beyond those addressed in the peer counselor training curriculum and recovery coaching and suicide prevention curricula, including the cultural appropriateness of the 80-hour training. The education course must be taught by certified peer specialists. The education course must be offered by the authority with sufficient frequency to accommodate the demand for training and the needs of the workforce. The authority must establish multiple configurations for offering the education course, including offering the course as an uninterrupted course with longer class hours held on consecutive days

for students seeking accelerated completion of the course and as an extended course with reduced daily class hours, possibly with multiple days between classes, to accommodate students with other commitments. Upon completion of the education course, the student must pass an oral examination administered by the course trainer.

(b) The authority shall develop an expedited course of instruction that consists of only those portions of the curriculum required under (a) of this subsection that exceed the authority's certified peer counselor training curriculum as it exists on July 23, 2023. The expedited training shall focus on assisting persons who completed the authority's certified peer counselor training as it exists on July 23, 2023, to meet the education requirements for certification under RCW 18.420.050.

(2) By January 1, 2025, the authority must develop a training course for certified peer specialists providing supervision to certified peer specialist trainees under RCW 18.420.060.

(3)(a) By July 1, 2025, the authority shall offer a 40-hour specialized training course in peer crisis response services for individuals employed as peers who work with individuals who may be experiencing a behavioral health crisis. When offering the training course, priority for enrollment must be given to certified peer specialists employed in a crisis-related setting, including entities identified in (b) of this subsection. The training shall incorporate best practices for responding to 988 behavioral health crisis line calls, as well as processes for co-response with law enforcement when necessary.

(b) Beginning July 1, 2025, any entity that uses certified peer specialists as peer crisis responders, may only use certified peer specialists who have completed the training course established by (a) of this subsection. A behavioral health agency that uses certified peer specialists to work as peer crisis responders must maintain the records of the completion of the training course for those certified peer specialists who provide these services and make the records available to the state agency for auditing or certification purposes.

(4) By July 1, 2025, the authority shall offer a course designed to inform licensed or certified behavioral health agencies of the benefits of incorporating certified peer specialists and certified peer specialist trainees into their clinical staff and best practices for incorporating their services. The authority shall encourage entities that hire certified peer specialists and certified peer

specialist trainees, including licensed or certified behavioral health agencies, hospitals, primary care offices, and other entities, to have appropriate staff attend the training by making it available in multiple formats.

(5)(a) The authority, in collaboration with the office of crime victims advocacy established under RCW 43.280.080, must contract with one or more training entities for the development of three separate courses of instruction related to the provision of peer support services to persons who have experienced domestic violence, sexual assault, or human trafficking. The courses must supplement the instruction received by certified peer support specialists and incorporate competencies that are typically taught in training programs for victim advocates, including safety planning, a foundational understanding of domestic violence, sexual assault, or human trafficking, as applicable, and advocacy across legal, medical, social services, and other systems.

(b) Beginning October 1, 2026, a victim services agency may only bill for peer support services if the certified peer support specialist providing the services has completed a course in domestic violence, sexual assault, or human trafficking, as relevant to the client's experience, developed under (a) of this subsection (5).

(6) The authority shall:

(a) Hire clerical, administrative, investigative, and other staff as needed to implement this section to serve as examiners for any practical oral or written examination and assure that the examiners are trained to administer examinations in a culturally appropriate manner and represent the diversity of applicants being tested. The authority shall adopt procedures to allow for appropriate accommodations for persons with a learning disability, other disabilities, and other needs and assure that staff involved in the administration of examinations are trained on those procedures;

(b) Develop oral and written examinations required under this section. The initial examinations shall be adapted from those used by the authority as of July 23, 2023, and modified pursuant to input and comments from the Washington state peer specialist advisory committee. The authority shall assure that the examinations are culturally appropriate;

(c) Prepare, grade, and administer, or supervise the grading and administration of written examinations for obtaining a certificate;

(d) Approve entities to provide the educational courses required by this section and approve entities to prepare, grade, and administer written examinations for the educational courses required by this section. In establishing approval criteria, the authority shall consider the recommendations of the Washington state peer specialist advisory committee;

(e) Develop examination preparation materials and make them available to students enrolled in the courses established under this section in multiple formats, including specialized examination preparation support for students with higher barriers to passing the written examination; and

(f) ((~~The authority shall administer~~)) Administer, through contract, a program to link eligible persons in recovery from behavioral health challenges who are seeking employment as peers with employers seeking to hire peers, including certified peer specialists. The authority must contract for this program with an organization that provides peer workforce development, peer coaching, and other peer supportive services. The contract must require the organization to create and maintain a statewide database which is easily accessible to eligible persons in recovery who are seeking employment as peers and potential employers seeking to hire peers, including certified peer specialists. The program must be fully implemented by July 1, 2024.

((~~(6)~~)) (7) For the purposes of this section((~~, the term "peer~~)):

(a) "Peer crisis responder" means a peer specialist certified under chapter 18.420 RCW who has completed the training under subsection (3) of this section whose job involves responding to behavioral health emergencies, including those dispatched through a 988 crisis hotline or the 911 system.

(b) "Victim services agency" means a program or organization that provides, as its primary purpose, assistance and advocacy for persons who have experienced domestic violence, sexual assault, or human trafficking. Services may include crisis intervention, individual and group support, information, referrals, and safety planning.

Sec. 4. RCW 18.130.040 and 2024 c 362 s 8, 2024 c 217 s 7, and 2024 c 50 s 5 are each reenacted and amended to read as follows:

(1) This chapter applies only to the secretary and the boards and commissions having jurisdiction in relation to the professions licensed under the chapters specified in this section. This chapter

does not apply to any business or profession not licensed under the chapters specified in this section.

(2)(a) The secretary has authority under this chapter in relation to the following professions:

(i) Dispensing opticians licensed and designated apprentices under chapter 18.34 RCW;

(ii) Midwives licensed under chapter 18.50 RCW;

(iii) Ocularists licensed under chapter 18.55 RCW;

(iv) Massage therapists and businesses licensed under chapter 18.108 RCW;

(v) Dental hygienists licensed under chapter 18.29 RCW;

(vi) Acupuncturists or acupuncture and Eastern medicine practitioners licensed under chapter 18.06 RCW;

(vii) Radiologic technologists certified and X-ray technicians registered under chapter 18.84 RCW;

(viii) Respiratory care practitioners licensed under chapter 18.89 RCW;

(ix) Hypnotherapists registered, agency affiliated counselors registered, certified, or licensed, and advisors and counselors certified under chapter 18.19 RCW;

(x) Persons licensed as mental health counselors, mental health counselor associates, marriage and family therapists, marriage and family therapist associates, social workers, social work associates—advanced, and social work associates—independent clinical under chapter 18.225 RCW;

(xi) Persons registered as nursing pool operators under chapter 18.52C RCW;

(xii) Nursing assistants registered or certified or medication assistants endorsed under chapter 18.88A RCW;

(xiii) Dietitians and nutritionists certified under chapter 18.138 RCW;

(xiv) Substance use disorder professionals, substance use disorder professional trainees, or co-occurring disorder specialists certified under chapter 18.205 RCW;

(xv) Sex offender treatment providers and certified affiliate sex offender treatment providers certified under chapter 18.155 RCW;

(xvi) Persons licensed and certified under chapter 18.73 RCW or RCW 18.71.205;

(xvii) Orthotists and prosthetists licensed under chapter 18.200 RCW;

(xviii) Surgical technologists registered under chapter 18.215 RCW;

(xix) Recreational therapists under chapter 18.230 RCW;

(xx) Animal massage therapists certified under chapter 18.240 RCW;

(xxi) Athletic trainers licensed under chapter 18.250 RCW;

(xxii) Home care aides certified under chapter 18.88B RCW;

(xxiii) Genetic counselors licensed under chapter 18.290 RCW;

(xxiv) Reflexologists certified under chapter 18.108 RCW;

(xxv) Medical assistants-certified, medical assistants-hemodialysis technician, medical assistants-phlebotomist, forensic phlebotomist, medical assistant-EMT, and medical assistants-registered certified and registered under chapter 18.360 RCW;

(xxvi) Behavior analysts, assistant behavior analysts, and behavior technicians under chapter 18.380 RCW;

(xxvii) Birth doulas certified under chapter 18.47 RCW;

(xxviii) Music therapists licensed under chapter 18.233 RCW;

(xxix) Behavioral health support specialists certified under chapter 18.227 RCW; and

(xxx) Certified peer <u>support</u> specialists and certified peer <u>support</u> specialist trainees under chapter 18.420 RCW.

(b) The boards and commissions having authority under this chapter are as follows:

(i) The podiatric medical board as established in chapter 18.22 RCW;

(ii) The chiropractic quality assurance commission as established in chapter 18.25 RCW;

(iii) The dental quality assurance commission as established in chapter 18.32 RCW governing licenses issued under chapter 18.32 RCW, licenses and registrations issued under chapter 18.260 RCW, licenses issued under chapter 18.265 RCW, and certifications issued under chapter 18.350 RCW;

(iv) The board of hearing and speech as established in chapter 18.35 RCW;

(v) The board of examiners for nursing home administrators as established in chapter 18.52 RCW;

(vi) The optometry board as established in chapter 18.54 RCW governing licenses issued under chapter 18.53 RCW;

(vii) The board of osteopathic medicine and surgery as established in chapter 18.57 RCW governing licenses issued under chapter 18.57 RCW;

(viii) The pharmacy quality assurance commission as established in chapter 18.64 RCW governing licenses issued under chapters 18.64 and 18.64A RCW;

(ix) The Washington medical commission as established in chapter 18.71 RCW governing licenses and registrations issued under chapters 18.71, 18.71A, and 18.71D RCW;

(x) The board of physical therapy as established in chapter 18.74 RCW;

(xi) The board of occupational therapy practice as established in chapter 18.59 RCW;

(xii) The board of nursing as established in chapter 18.79 RCW governing licenses and registrations issued under that chapter and under chapter 18.80 RCW;

(xiii) The examining board of psychology and its disciplinary committee as established in chapter 18.83 RCW;

(xiv) The veterinary board of governors as established in chapter 18.92 RCW;

(xv) The board of naturopathy established in chapter 18.36A RCW, governing licenses and certifications issued under that chapter; and

(xvi) The board of denturists established in chapter 18.30 RCW.

(3) In addition to the authority to discipline license holders, the disciplining authority has the authority to grant or deny licenses. The disciplining authority may also grant a license subject to conditions, which must be in compliance with chapter 18.415 RCW.

(4) All disciplining authorities shall adopt procedures to ensure substantially consistent application of this chapter, the uniform disciplinary act, among the disciplining authorities listed in subsection (2) of this section.

Sec. 5. RCW 18.130.175 and 2023 c 469 s 19 and 2023 c 425 s 25 are each reenacted and amended to read as follows:

(1) In lieu of disciplinary action under RCW 18.130.160 and if the disciplining authority determines that the unprofessional conduct may be the result of an applicable impairing or potentially impairing health condition, the disciplining authority may refer the license holder to a physician health program or a voluntary substance use disorder monitoring program approved by the disciplining authority.

The cost of evaluation and treatment shall be the responsibility of the license holder, but the responsibility does not preclude payment by an employer, existing insurance coverage, or other sources. Evaluation and treatment shall be provided by providers approved by the entity or the commission. The disciplining authority may also approve the use of out-of-state programs. Referral of the license holder to the physician health program or voluntary substance use disorder monitoring program shall be done only with the consent of the license holder. Referral to the physician health program or voluntary substance use disorder monitoring program may also include probationary conditions for a designated period of time. If the license holder does not consent to be referred to the program or does not successfully complete the program, the disciplining authority may take appropriate action under RCW 18.130.160 which includes suspension of the license unless or until the disciplining authority, in consultation with the director of the applicable program, determines the license holder is able to practice safely. The secretary shall adopt uniform rules for the evaluation by the disciplining authority of return to substance use or program violation on the part of a license holder in the program. The evaluation shall encourage program participation with additional conditions, in lieu of disciplinary action, when the disciplining authority determines that the license holder is able to continue to practice with reasonable skill and safety.

(2) In addition to approving the physician health program or the voluntary substance use disorder monitoring program that may receive referrals from the disciplining authority, the disciplining authority may establish by rule requirements for participation of license holders who are not being investigated or monitored by the disciplining authority. License holders voluntarily participating in the approved programs without being referred by the disciplining authority shall not be subject to disciplinary action under RCW 18.130.160 for their impairing or potentially impairing health condition, and shall not have their participation made known to the disciplining authority, if they meet the requirements of this section and the program in which they are participating.

(3) The license holder shall sign a waiver allowing the program to release information to the disciplining authority if the licensee does not comply with the requirements of this section or is unable to practice with reasonable skill or safety. The physician health

program or voluntary substance use disorder program shall report to the disciplining authority any license holder who fails to comply with the requirements of this section or the program or who, in the opinion of the program, is unable to practice with reasonable skill or safety. License holders shall report to the disciplining authority if they fail to comply with this section or do not complete the program's requirements. License holders may, upon the agreement of the program and disciplining authority, reenter the program if they have previously failed to comply with this section.

(4) Program records including, but not limited to, case notes, progress notes, laboratory reports, evaluation and treatment records, electronic and written correspondence within the program, and between the program and the participant or other involved entities including, but not limited to, employers, credentialing bodies, referents, or other collateral sources, relating to license holders referred to or voluntarily participating in approved programs are confidential and exempt from disclosure under chapter 42.56 RCW and shall not be subject to discovery by subpoena or admissible as evidence except:

(a) To defend any civil action by a license holder regarding the restriction or revocation of that individual's clinical or staff privileges, or termination of a license holder's employment. In such an action, the program will, upon subpoena issued by either party to the action, and upon the requesting party seeking a protective order for the requested disclosure, provide to both parties of the action written disclosure that includes the following information:

(i) Verification of a health care professional's participation in the physician health program or voluntary substance use disorder monitoring program as it relates to aspects of program involvement at issue in the civil action;

(ii) The dates of participation;

(iii) Whether or not the program identified an impairing or potentially impairing health condition;

(iv) Whether the health care professional was compliant with the requirements of the physician health program or voluntary substance use disorder monitoring program; and

(v) Whether the health care professional successfully completed the physician health program or voluntary substance use disorder monitoring program; and

(b) Records provided to the disciplining authority for cause as described in subsection (3) of this section. Program records relating

to license holders mandated to the program, through order or by stipulation, by the disciplining authority or relating to license holders reported to the disciplining authority by the program for cause, must be released to the disciplining authority at the request of the disciplining authority. Records held by the disciplining authority under this section are exempt from chapter 42.56 RCW and are not subject to discovery by subpoena except by the license holder.

(5) This section does not affect an employer's right or ability to make employment-related decisions regarding a license holder. This section does not restrict the authority of the disciplining authority to take disciplinary action for any other unprofessional conduct.

(6) A person who, in good faith, reports information or takes action in connection with this section is immune from civil liability for reporting information or taking the action.

(a) The immunity from civil liability provided by this section shall be liberally construed to accomplish the purposes of this section, and applies to both license holders and students and trainees when students and trainees of the applicable professions are served by the program. The persons entitled to immunity shall include:

(i) An approved physician health program or voluntary substance use disorder monitoring program;

(ii) The professional association affiliated with the program;

(iii) Members, employees, or agents of the program or associations;

(iv) Persons reporting a license holder as being possibly impaired or providing information about the license holder's impairment; and

(v) Professionals supervising or monitoring the course of the program participant's treatment or rehabilitation.

(b) The courts are strongly encouraged to impose sanctions on program participants and their attorneys whose allegations under this subsection are not made in good faith and are without either reasonable objective, substantive grounds, or both.

(c) The immunity provided in this section is in addition to any other immunity provided by law.

(7) In the case of a person who is applying to be a substance use disorder professional or substance use disorder professional trainee certified under chapter 18.205 RCW, an agency affiliated counselor

registered under chapter 18.19 RCW, or a peer support specialist or peer support specialist trainee certified under chapter 18.420 RCW, if the person is:

(a) Less than one year in recovery from a substance use disorder, the duration of time that the person may be required to participate in an approved substance use disorder monitoring program may not exceed the amount of time necessary for the person to achieve one year in recovery; or

(b) At least one year in recovery from a substance use disorder, the person may not be required to participate in the approved substance use disorder monitoring program.

(8) The provisions of subsection (7) of this section apply to any person employed as a peer support specialist as of July 1, 2025, participating in a program under this section as of July 1, 2025, and applying to become a certified peer support specialist under RCW 18.420.050, regardless of when the person's participation in a program began. To this extent, subsection (7) of this section applies retroactively, but in all other respects it applies prospectively.

Sec. 6. RCW 18.420.005 and 2023 c 469 s 1 are each amended to read as follows:

(1) The legislature finds that peers play a critical role along the behavioral health continuum of care, from outreach to treatment to recovery support. Peers deal in the currency of hope and motivation. Peers bring hope to individuals receiving services and are incredibly adept at supporting people with behavioral health challenges on their recovery journeys. Peers represent the only segment of the behavioral health workforce where there is not a shortage, but a surplus of willing workers. Peers, however, are presently limited to serving only medicaid recipients and working only in community behavioral health agencies. As a result, youth and adults with commercial insurance have no access to peer services. Furthermore, peers who work in other settings, such as emergency departments and behavioral health urgent care, cannot bill insurance for their services.

(2) Therefore, it is the intent of the legislature to address the behavioral health workforce crisis, expand access to peer services, eliminate financial barriers to professional licensing, and honor the contributions of the peer profession by creating the profession of certified peer support specialists.

Sec. 7. RCW 18.420.010 and 2023 c 469 s 2 are each amended to read as follows:

The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) ((~~"Advisory committee" means the Washington state certified peer specialist advisory committee established under section 4 of this act.~~

~~(2)~~)) "Approved supervisor" means:

(a) Until July 1, 2028, a behavioral health provider, as defined in RCW 71.24.025 with at least two years of experience working in a behavioral health practice that employs peer support specialists or certified peer counselors as part of treatment teams; or

(b) A certified peer support specialist who has completed:

(i) At least 1,500 hours of work as a fully certified peer support specialist engaged in the practice of peer support services, with at least 500 hours attained through the joint supervision of peers in conjunction with another approved supervisor; and

(ii) The training developed by the health care authority under RCW 71.24.920.

((~~(3)~~)) (2) "Certified peer support specialist" means a person certified under this chapter to engage in the practice of peer support services.

((~~(4)~~)) (3) "Certified peer support specialist trainee" means an individual working toward the supervised experience and written examination requirements to become a certified peer support specialist under this chapter.

((~~(5)~~)) (4) "Department" means the department of health.

((~~(6)~~)) (5) "Practice of peer support services" means the provision of interventions by a peer who is either a person in recovery from a mental health condition or substance use disorder, or both, or the parent or legal guardian of a youth who is receiving or has received behavioral health services((~~. The client receiving the interventions receives them from a person~~)), to a person with a similar lived experience ((~~as either a person in recovery from a mental health condition or substance use disorder, or both, or the parent or legal guardian of a youth who is receiving or has received behavioral health services~~)). The ((~~person~~)) peer provides the interventions through the use of shared experiences to assist ((~~a client~~)) the participant in the acquisition and exercise of skills needed to support the ((~~client's~~)) participant's recovery.

Interventions may include activities that assist ((~~clients~~)) participants in accessing or engaging in treatment and in symptom management; promote social connection, recovery, and self-advocacy; provide guidance in the development of natural community supports and basic daily living skills; and support ((~~clients~~)) participants in engagement, motivation, and maintenance related to achieving and maintaining health and wellness goals.

((~~(7)~~)) (6) "Secretary" means the secretary of health.

Sec. 8. RCW 18.420.020 and 2023 c 469 s 3 are each amended to read as follows:

In addition to any other authority, the secretary has the authority to:

(1) Adopt rules under chapter 34.05 RCW necessary to implement this chapter;

(2) Establish all certification, examination, and renewal fees for certified peer support specialists in accordance with RCW 43.70.110 and 43.70.250;

(3) Establish forms and procedures necessary to administer this chapter;

(4) Issue certificates to applicants who have met the education, training, and examination requirements for obtaining a certificate and to deny a certificate to applicants who do not meet the requirements;

(5) Coordinate with the health care authority to confirm an applicants' successful completion of the certified peer support specialist education course offered by the health care authority under RCW 71.24.920 and successful passage of the associated oral examination as proof of eligibility to take a qualifying written examination for applicants for obtaining a certificate;

(6) Establish practice parameters consistent with the definition of the practice of peer support services;

(7) ((~~Provide staffing and administrative support to the advisory committee;~~

~~(8)~~)) Determine which states have credentialing requirements equivalent to those of this state, and issue certificates to applicants credentialed in those states without examination;

((~~(9)~~)) (8) Define and approve any supervised experience requirements for certification;

((~~(10) Assist the advisory committee with the review of peer counselor apprenticeship program applications in the process of being approved and registered under chapter 49.04 RCW;~~

~~(11)~~)) (9) Adopt rules implementing a continuing competency program; and

((~~(12)~~)) (10) Establish by rule the procedures for an appeal of an examination failure.

Sec. 9. RCW 18.420.030 and 2023 c 469 s 5 are each amended to read as follows:

Beginning July 1, 2025, except as provided in RCW 71.24.920, the decision of a person practicing peer support services to become certified under this chapter is voluntary. A person may not use the title certified peer support specialist unless the person holds a credential under this chapter.

Sec. 10. RCW 18.420.040 and 2023 c 469 s 6 are each amended to read as follows:

Nothing in this chapter may be construed to prohibit or restrict:

(1) An individual who holds a credential issued by this state, other than as a certified peer support specialist or certified peer support specialist trainee, to engage in the practice of an occupation or profession without obtaining an additional credential from the state. The individual may not use the title certified peer support specialist unless the individual holds a credential under this chapter; or

(2) The practice of peer support services by a person who is employed by the government of the United States while engaged in the performance of duties prescribed by the laws of the United States.

Sec. 11. RCW 18.420.050 and 2023 c 469 s 7 are each amended to read as follows:

(1) Beginning July 1, 2025, except as provided in subsections (2) and (3) of this section, the secretary shall issue a certificate to practice as a certified peer support specialist to any applicant who demonstrates to the satisfaction of the secretary that the applicant meets the following requirements:

(a) Submission of an attestation to the department that the applicant self-identifies as:

(i) A person with one or more years of recovery from a mental health condition, substance use disorder, or both; or

(ii) The parent or legal guardian of a youth who is receiving or has received behavioral health services;

(b) Successful completion of the education course developed and offered by the health care authority under RCW 71.24.920;

(c) Successful passage of an oral examination administered by the health care authority upon completion of the education course offered by the health care authority under RCW 71.24.920;

(d) Successful passage of a written examination administered by the health care authority upon completion of the education course offered by the health care authority under RCW 71.24.920;

(e) Successful completion of an experience requirement of at least 1,000 supervised hours as a certified peer support specialist trainee engaged in the volunteer or paid practice of peer support services, in accordance with the standards in RCW 18.420.060; and

(f) Payment of the appropriate fee required under this chapter.

(2) The secretary((~~, with the recommendation of the advisory committee,~~)) shall establish criteria for the issuance of a certificate to engage in the practice of peer support services based on prior experience as a peer specialist attained before July 1, 2025. The criteria shall establish equivalency standards necessary to be deemed to have met the requirements of subsection (1) of this section. An applicant under this subsection shall have until July 1, 2026, to complete any standards in which the applicant is determined to be deficient.

(3) The secretary((~~, with the recommendation of the advisory committee,~~)) shall issue a certificate to engage in the practice of peer support services based on completion of an apprenticeship program registered and approved under chapter 49.04 RCW ((~~and reviewed by the advisory committee under RCW 18.420.020~~)).

(4) A certificate to engage in the practice of peer support services is valid for two years. A certificate may be renewed upon demonstrating to the department that the certified peer support specialist has successfully completed 30 hours of continuing education approved by the department. As part of the continuing education requirement, every six years the applicant must submit proof of successful completion of at least three hours of suicide prevention training and at least six hours of coursework in

professional ethics and law, which may include topics under RCW 18.130.180.

Sec. 12. RCW 18.420.060 and 2023 c 469 s 8 are each amended to read as follows:

(1) Beginning July 1, 2025, the secretary shall issue a certificate to practice as a certified peer support specialist trainee to any applicant who demonstrates to the satisfaction of the secretary that:

(a) The applicant meets the requirements of RCW 18.420.050 (1)(a), (b), (c), (d), and (4) and is working toward the supervised experience requirements to become a certified peer support specialist under this chapter; or

(b) The applicant is enrolled in an apprenticeship program registered and approved under chapter 49.04 RCW and approved by the secretary under RCW 18.420.020.

(2) An applicant seeking to become a certified peer support specialist trainee under this section shall submit to the secretary for approval an attestation, in accordance with rules adopted by the department, that the certified peer support specialist trainee is actively pursuing the supervised experience requirements of RCW 18.420.050(1)((~~(d)~~)) (e). This attestation must be updated with the trainee's annual renewal.

(3) A certified peer support specialist trainee certified under this section may practice only under the supervision of an approved supervisor. Supervision may be provided through distance supervision. Supervision may be provided by an approved supervisor who is employed by the same employer that employs the certified peer support specialist trainee or by an arrangement made with a third-party approved supervisor to provide supervision, or a combination of both types of approved supervisors.

(4) A certified peer support specialist trainee certificate is valid for one year and may only be renewed four times.

Sec. 13. RCW 18.420.090 and 2023 c 469 s 12 are each amended to read as follows:

The uniform disciplinary act, chapter 18.130 RCW, governs uncertified practice of peer support services, the issuance and denial of certificates, and the discipline of certified peer support

specialists and certified peer support specialist trainees under this chapter.

Sec. 14. RCW 18.420.800 and 2023 c 469 s 11 are each amended to read as follows:

(1) The department((~~, in consultation with the advisory committee,~~)) shall conduct an assessment and submit a report to the governor and the committees of the legislature with jurisdiction over health policy issues by December 1, 2027.

(2) The report in subsection (1) of this section shall provide:

(a) An analysis of the adequacy of the supply of certified peer support specialists serving as approved supervisors pursuant to RCW 18.420.010((~~(2)~~)) (1)(b) with respect to the ability to meet the anticipated supervision needs of certified peer support specialist trainees upon the expiration of behavioral health providers serving as approved supervisors pursuant to RCW 18.420.010((~~(2)~~)) (1)(a);

(b) An assessment of whether or not it is necessary to extend the expiration of behavioral health providers serving as approved supervisors pursuant to RCW 18.420.010((~~(2)~~)) (1)(a) in order to meet the anticipated supervision needs of certified peer support specialist trainees;

(c) Recommendations for increasing the supply of certified peer support specialists serving as approved supervisors pursuant to RCW 18.420.010((~~(2)~~)) (1)(b), including any potential modifications to the requirements to become an approved supervisor; and

(d) Recommendations for alternative methods of providing supervision to certified peer support specialist trainees, including options for team-based supervision that incorporate supervision from both behavioral health providers serving as approved supervisors pursuant to RCW 18.420.010((~~(2)~~)) (1)(a) and certified peer support specialists serving as approved supervisors pursuant to RCW 18.420.010((~~(2)~~)) (1)(b).

Sec. 15. RCW 43.70.250 and 2024 c 366 s 14 are each amended to read as follows:

(1) It shall be the policy of the state of Washington that the cost of each professional, occupational, or business licensing program be fully borne by the members of that profession, occupation, or business.

(2) The secretary shall from time to time establish the amount of all application fees, license fees, registration fees, examination fees, permit fees, renewal fees, and any other fee associated with licensing or regulation of professions, occupations, or businesses administered by the department. Any and all fees or assessments, or both, levied on the state to cover the costs of the operations and activities of the interstate health professions licensure compacts with participating authorities listed under chapter 18.130 RCW shall be borne by the persons who hold licenses issued pursuant to the authority and procedures established under the compacts. In fixing said fees, the secretary shall set the fees for each program at a sufficient level to defray the costs of administering that program and the cost of regulating licensed volunteer medical workers in accordance with RCW 18.130.360, except as provided in RCW 18.79.202. In no case may the secretary impose any certification, examination, or renewal fee upon a person seeking certification as a certified peer support specialist trainee under chapter 18.420 RCW or, between July 1, 2025, and July 1, 2030, impose a certification, examination, or renewal fee of more than $100 upon any person seeking certification as a certified peer support specialist under chapter 18.420 RCW. Subject to amounts appropriated for this specific purpose, between July 1, 2024, and July 1, 2029, the secretary may not impose any certification or certification renewal fee on a person seeking certification as a substance use disorder professional or substance use disorder professional trainee under chapter 18.205 RCW of more than $100.

(3) All such fees shall be fixed by rule adopted by the secretary in accordance with the provisions of the administrative procedure act, chapter 34.05 RCW.

Sec. 16. RCW 48.43.825 and 2023 c 469 s 16 are each amended to read as follows:

By July 1, 2026, each carrier shall provide access to services provided by certified peer support specialists and certified peer support specialist trainees in a manner sufficient to meet the network access standards set forth in rules established by the office of the insurance commissioner.

Sec. 17. RCW 71.24.025 and 2024 c 368 s 2, 2024 c 367 s 1, and 2024 c 121 s 25 are each reenacted and amended to read as follows:

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

(1) "23-hour crisis relief center" means a community-based facility or portion of a facility which is licensed or certified by the department of health and open 24 hours a day, seven days a week, offering access to mental health and substance use care for no more than 23 hours and 59 minutes at a time per patient, and which accepts all behavioral health crisis walk-ins drop-offs from first responders, and individuals referred through the 988 system regardless of behavioral health acuity, and meets the requirements under RCW 71.24.916.

(2) "988 crisis hotline" means the universal telephone number within the United States designated for the purpose of the national suicide prevention and mental health crisis hotline system operating through the national suicide prevention lifeline.

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

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

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

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

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

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

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

(7) "Available resources" means funds appropriated for the purpose of providing community behavioral health programs, federal funds, except those provided according to Title XIX of the Social Security Act, and state funds appropriated under this chapter or chapter 71.05 RCW by the legislature during any biennium for the

purpose of providing residential services, resource management services, community support services, and other behavioral health services. This does not include funds appropriated for the purpose of operating and administering the state psychiatric hospitals.

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

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

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

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

(12) "Child" means a person under the age of 18 years.

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

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

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

(c) Has been unable to engage in any substantial gainful activity by reason of any mental disorder which has lasted for a continuous period of not less than 12 months. "Substantial gainful activity"

shall be defined by the authority by rule consistent with Public Law 92-603, as amended.

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

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

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

(17) "Community support services" means services authorized, planned, and coordinated through resource management services including, at a minimum, assessment, diagnosis, emergency crisis intervention available 24 hours, seven days a week, prescreening determinations for persons who are mentally ill being considered for placement in nursing homes as required by federal law, screening for patients being considered for admission to residential services, diagnosis and treatment for children who are acutely mentally ill or severely emotionally or behaviorally disturbed discovered under screening through the federal Title XIX early and periodic screening, diagnosis, and treatment program, investigation, legal, and other nonresidential services under chapter 71.05 RCW, case management services, psychiatric treatment including medication supervision, counseling, psychotherapy, assuring transfer of relevant patient information between service providers, recovery services, and other services determined by behavioral health administrative services organizations.

(18) "Community-based crisis team" means a team that is part of an emergency medical services agency, a fire service agency, a public health agency, a medical facility, a nonprofit crisis response provider, or a city or county government entity, other than a law enforcement agency, that provides the on-site community-based interventions of a mobile rapid response crisis team for individuals who are experiencing a behavioral health crisis.

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

(20) "Coordinated regional behavioral health crisis response system" means the coordinated operation of 988 call centers, regional crisis lines, certified public safety telecommunicators, and other behavioral health crisis system partners within each regional service area.

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

(22) "Crisis stabilization services" means services such as 23-hour crisis relief centers, crisis stabilization units, short-term respite facilities, peer-run respite services, and same-day walk-in behavioral health services, including within the overall crisis system components that operate like hospital emergency departments that accept all walk-ins, and ambulance, fire, and police drop-offs, or determine the need for involuntary hospitalization of an individual.

(23) "Crisis stabilization unit" has the same meaning as under RCW 71.05.020.

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

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

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

(27) "Director" means the director of the authority.

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

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

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

(30) "Emerging best practice" or "promising practice" means a program or practice that, based on statistical analyses or a well established theory of change, shows potential for meeting the evidence-based or research-based criteria, which may include the use of a program that is evidence-based for outcomes other than those listed in subsection (31) of this section.

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

(32) "First responders" includes ambulance, fire, mobile rapid response crisis team, coresponder team, designated crisis responder, fire department mobile integrated health team, community assistance referral and education services program under RCW 35.21.930, and law enforcement personnel.

(33) "Immediate jeopardy" means a situation in which the licensed or certified behavioral health agency's noncompliance with one or more statutory or regulatory requirements has placed the health and safety of patients in its care at risk for serious injury, serious harm, serious impairment, or death.

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

(35) "Intensive behavioral health treatment facility" means a community-based specialized residential treatment facility for individuals with behavioral health conditions, including individuals discharging from or being diverted from state and local hospitals,

whose impairment or behaviors do not meet, or no longer meet, criteria for involuntary inpatient commitment under chapter 71.05 RCW, but whose care needs cannot be met in other community-based placement settings.

(36) "Licensed or certified behavioral health agency" means:

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

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

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

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

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

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

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

(41) Mental health "treatment records" include registration and all other records concerning persons who are receiving or who at any time have received services for mental illness, which are maintained by the department of social and health services or the authority, by behavioral health administrative services organizations and their staffs, by managed care organizations and their staffs, or by

treatment facilities. "Treatment records" do not include notes or records maintained for personal use by a person providing treatment services for the entities listed in this subsection, or a treatment facility if the notes or records are not available to others.

(42) "Mentally ill persons," "persons who are mentally ill," and "the mentally ill" mean persons and conditions defined in subsections (3), (13), (51), and (52) of this section.

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

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

(45) "Regional crisis line" means the behavioral health crisis hotline in each regional service area which provides crisis response services 24 hours a day, seven days a week, 365 days a year including but not limited to dispatch of mobile rapid response crisis teams, community-based crisis teams, and designated crisis responders.

(46) "Research-based" means a program or practice that has been tested with a single randomized, or statistically controlled evaluation, or both, demonstrating sustained desirable outcomes; or where the weight of the evidence from a systemic review supports sustained outcomes as described in subsection (31) of this section but does not meet the full criteria for evidence-based.

(47) "Residential services" means a complete range of residences and supports authorized by resource management services and which may involve a facility, a distinct part thereof, or services which support community living, for persons who are acutely mentally ill, adults who are chronically mentally ill, children who are severely emotionally disturbed, or adults who are seriously disturbed and determined by the behavioral health administrative services organization or managed care organization to be at risk of becoming acutely or chronically mentally ill. The services shall include at least evaluation and treatment services as defined in chapter 71.05 RCW, acute crisis respite care, long-term adaptive and rehabilitative

care, and supervised and supported living services, and shall also include any residential services developed to service persons who are mentally ill in nursing homes, residential treatment facilities, assisted living facilities, and adult family homes, and may include outpatient services provided as an element in a package of services in a supported housing model. Residential services for children in out-of-home placements related to their mental disorder shall not include the costs of food and shelter, except for children's long-term residential facilities existing prior to January 1, 1991.

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

(49) "Resource management services" mean the planning, coordination, and authorization of residential services and community support services administered pursuant to an individual service plan for: (a) Adults and children who are acutely mentally ill; (b) adults who are chronically mentally ill; (c) children who are severely emotionally disturbed; or (d) adults who are seriously disturbed and determined by a behavioral health administrative services organization or managed care organization to be at risk of becoming acutely or chronically mentally ill. Such planning, coordination, and authorization shall include mental health screening for children eligible under the federal Title XIX early and periodic screening, diagnosis, and treatment program. Resource management services include seven day a week, 24 hour a day availability of information regarding enrollment of adults and children who are mentally ill in services and their individual service plan to designated crisis responders, evaluation and treatment facilities, and others as determined by the behavioral health administrative services organization or managed care organization, as applicable.

(50) "Secretary" means the secretary of the department of health.

(51) "Seriously disturbed person" means a person who:

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

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

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

(d) Exhibits suicidal preoccupation or attempts; or

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

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

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

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

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

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

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

(ii) Changes in custodial adult;

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

(iv) Subject to repeated physical abuse or neglect;

(v) Drug or alcohol abuse; or

(vi) Homelessness.

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

(a) The authority for:

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

(ii) Community support services and resource management services;

(b) The department of health for:

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

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

(iii) Residential services.

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

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

Sec. 18. RCW 71.24.585 and 2019 c 314 s 28 are each amended to read as follows:

(1)(a) The state of Washington declares that substance use disorders are medical conditions. Substance use disorders should be treated in a manner similar to other medical conditions by using interventions that are supported by evidence, including medications approved by the federal food and drug administration for the treatment of opioid use disorder. It is also recognized that many individuals have multiple substance use disorders, as well as histories of trauma, developmental disabilities, or mental health conditions. As such, all individuals experiencing opioid use disorder should be offered evidence-supported treatments to include federal food and drug administration approved medications for the treatment of opioid use disorders and behavioral counseling and social supports to address them. For behavioral health agencies, an effective plan of treatment for most persons with opioid use disorder integrates access to medications and psychosocial counseling and should be consistent with the American society of addiction medicine patient placement criteria. Providers must inform patients with opioid use disorder or substance use disorder of options to access federal food and drug administration approved medications for the treatment of opioid use disorder or substance use disorder. Because some such medications are controlled substances in chapter 69.50 RCW, the state of Washington

maintains the legal obligation and right to regulate the uses of these medications in the treatment of opioid use disorder.

(b) The authority must work with other state agencies and stakeholders to develop value-based payment strategies to better support the ongoing care of persons with opioid and other substance use disorders.

(c) The department of corrections shall develop policies to prioritize services based on available grant funding and funds appropriated specifically for opioid use disorder treatment.

(2) The authority must promote the use of medication therapies and other evidence-based strategies to address the opioid epidemic in Washington state. Additionally, by January 1, 2020, the authority must prioritize state resources for the provision of treatment and recovery support services to inpatient and outpatient treatment settings that allow patients to start or maintain their use of medications for opioid use disorder while engaging in services.

(3) The state declares that the main goals of treatment for persons with opioid use disorder are the cessation of unprescribed opioid use, reduced morbidity, and restoration of the ability to lead a productive and fulfilling life.

(4) To achieve the goals in subsection (3) of this section, to promote public health and safety, and to promote the efficient and economic use of funding for the medicaid program under Title XIX of the social security act, the authority may seek, receive, and expend alternative sources of funding to support all aspects of the state's response to the opioid crisis.

(5) The authority must partner with the department of social and health services, the department of corrections, the department of health, the department of children, youth, and families, and any other agencies or entities the authority deems appropriate to develop a statewide approach to leveraging medicaid funding to treat opioid use disorder and provide emergency overdose treatment. Such alternative sources of funding may include:

(a) Seeking a section 1115 demonstration waiver from the federal centers for medicare and medicaid services to fund opioid treatment medications for persons eligible for medicaid at or during the time of incarceration and juvenile detention facilities; and

(b) Soliciting and receiving private funds, grants, and donations from any willing person or entity.

(6)(a) The authority shall work with the department of health to promote coordination between medication-assisted treatment prescribers, federally accredited opioid treatment programs, substance use disorder treatment facilities, and state-certified substance use disorder treatment agencies to:

(i) Increase patient choice in receiving medication and counseling;

(ii) Strengthen relationships between opioid use disorder providers;

(iii) Acknowledge and address the challenges presented for individuals needing treatment for multiple substance use disorders simultaneously; and

(iv) Study and review effective methods to identify and reach out to individuals with opioid use disorder who are at high risk of overdose and not involved in traditional systems of care, such as homeless individuals using syringe service programs, and connect such individuals to appropriate treatment.

(b) The authority must work with stakeholders to develop a set of recommendations to the governor and the legislature that:

(i) Propose, in addition to those required by federal law, a standard set of services needed to support the complex treatment needs of persons with opioid use disorder treated in opioid treatment programs;

(ii) Outline the components of and strategies needed to develop opioid treatment program centers of excellence that provide fully integrated care for persons with opioid use disorder;

(iii) Estimate the costs needed to support these models and recommendations for funding strategies that must be included in the report;

(iv) Outline strategies to increase the number of waivered health care providers approved for prescribing buprenorphine by the substance abuse and mental health services administration; and

(v) Outline strategies to lower the cost of federal food and drug administration approved products for the treatment of opioid use disorder.

(7) State agencies shall review and promote positive outcomes associated with the accountable communities of health funded opioid projects and local law enforcement and human services opioid collaborations as set forth in the Washington state interagency opioid working plan.

(8) The authority must partner with the department and other state agencies to replicate effective approaches for linking individuals who have had a nonfatal overdose with treatment opportunities, with a goal to connect certified peer counselors or certified peer support specialists with individuals who have had a nonfatal overdose.

(9) State agencies must work together to increase outreach and education about opioid overdoses to non-English-speaking communities by developing a plan to conduct outreach and education to non-English-speaking communities. The department must submit a report on the outreach and education plan with recommendations for implementation to the appropriate legislative committees by July 1, 2020.

Sec. 19. RCW 71.24.890 and 2024 c 368 s 4 and 2024 c 364 s 1 are each reenacted and amended to read as follows:

(1) Establishing the state designated 988 contact hubs and enhancing the crisis response system will require collaborative work between the department, the authority, and regional system partners within their respective roles. The department shall have primary responsibility for designating 988 contact hubs, and shall seek recommendations from the behavioral health administrative services organizations to determine which 988 contact hubs best meet regional needs. The authority shall have primary responsibility for developing, implementing, and facilitating coordination of the crisis response system and services to support the work of the designated 988 contact hubs, regional crisis lines, and other coordinated regional behavioral health crisis response system partners. In any instance in which one agency is identified as the lead, the expectation is that agency will communicate and collaborate with the other to ensure seamless, continuous, and effective service delivery within the statewide crisis response system.

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

volume predictions, guidance on crisis call center performance metrics, and necessary technology upgrades. Contracts with the 988 contact hubs:

(a) May provide funding to support designated 988 contact hubs to enter into limited partnerships with the public safety answering point to increase the coordination and transfer of behavioral health calls received by certified public safety telecommunicators that are better addressed by clinic interventions provided by the 988 system. Tax revenue may be used to support partnerships. These partnerships with 988 and public safety may be expanded to include regional crisis lines administered by behavioral health administrative services organizations;

(b) Shall require that 988 contact hubs enter into data-sharing agreements, when appropriate, with the department, the authority, regional crisis lines, and applicable regional behavioral health administrative services organizations to provide reports and client level data regarding 988 contact hub calls, as allowed by and in compliance with existing federal and state law governing the sharing and use of protected health information. Data-sharing agreements with regional crisis lines must include real-time information sharing. All coordinated regional behavioral health crisis response system partners must share dispatch time, arrival time, and disposition for behavioral health calls referred for outreach by each region consistent with any regional protocols developed under RCW 71.24.432. The department and the authority shall establish requirements for 988 contact hubs to report data to regional behavioral health administrative services organizations for the purposes of maximizing medicaid reimbursement, as appropriate, and implementing this chapter and chapters 71.05 and 71.34 RCW. The behavioral health administrative services organization may use information received from the 988 contact hubs in administering crisis services for the assigned regional service area, contracting with a sufficient number of licensed or certified providers for crisis services, establishing and maintaining quality assurance processes, maintaining patient tracking, and developing and implementing strategies to coordinate care for individuals with a history of frequent crisis system utilization.

(3) The department shall adopt rules by January 1, 2025, to establish standards for designation of crisis call centers as designated 988 contact hubs. The department shall collaborate with

the authority, other agencies, and coordinated regional behavioral health crisis response system partners to assure coordination and availability of services, and shall consider national guidelines for behavioral health crisis care as determined by the federal substance abuse and mental health services administration, national behavioral health accrediting bodies, and national behavioral health provider associations to the extent they are appropriate, and recommendations from behavioral health administrative services organizations and the crisis response improvement strategy committee created in RCW 71.24.892.

(4) The department shall designate 988 contact hubs considering the recommendations of behavioral health administrative services organizations by January 1, 2026. The designated 988 contact hubs shall provide connections to crisis intervention services, triage, care coordination, and referrals for individuals contacting the 988 contact hubs from any jurisdiction within Washington 24 hours a day, seven days a week, using the system platform developed under subsection (5) of this section. The department may not designate more than a total of four 988 contact hubs without legislative approval.

(a) To be designated as a 988 contact hub, the applicant must demonstrate to the department the ability to comply with the requirements of this section and to contract to provide 988 contact hub services. If a 988 contact hub fails to substantially comply with the contract, data-sharing requirements, or approved regional protocols developed under RCW 71.24.432, the department may revoke the designation of the 988 contact hub and, after consulting with the affected behavioral health administrative services organization, may designate a 988 contact hub recommended by a behavioral health administrative services organization which is able to meet necessary state and federal requirements.

(b) The contracts entered shall require designated 988 contact hubs to:

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

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

(iii) Employ highly qualified, skilled, and trained clinical staff who have sufficient training and resources to provide empathy to callers in acute distress, de-escalate crises, assess behavioral health disorders and suicide risk, triage to system partners for callers that need additional clinical interventions, and provide case management and documentation. Call center staff shall be trained to make every effort to resolve cases in the least restrictive environment and without law enforcement involvement whenever possible. Call center staff shall coordinate with certified peer counselors or certified peer support specialists to provide follow-up and outreach to callers in distress as available. It is intended for transition planning to include a pathway for continued employment and skill advancement as needed for experienced crisis call center employees;

(iv) Train employees on agricultural community cultural competencies for suicide prevention, which may include sharing resources with callers that are specific to members from the agricultural community. The training must prepare staff to provide appropriate assessments, interventions, and resources to members of the agricultural community. Employees may make warm transfers and referrals to a crisis hotline that specializes in working with members from the agricultural community, provided that no person contacting 988 shall be transferred or referred to another service if they are currently in crisis and in need of emotional support;

(v) Prominently display 988 crisis hotline information on their websites and social media, including a description of what the caller should expect when contacting the crisis call center and a description of the various options available to the caller, including call lines specialized in the behavioral health needs of veterans, American Indian and Alaska Native persons, Spanish-speaking persons, and LGBTQ populations. The website may also include resources for programs and services related to suicide prevention for the agricultural community;

(vi) Collaborate with the authority, the national suicide prevention lifeline, and veterans crisis line networks to assure consistency of public messaging about the 988 crisis hotline;

(vii) Collaborate with coordinated regional behavioral health crisis response system partners within the 988 contact hub's regional service area to develop protocols under RCW 71.24.432, including

protocols related to the dispatching of mobile rapid response crisis teams and community-based crisis teams endorsed under RCW 71.24.903;

(viii) Provide data and reports and participate in evaluations and related quality improvement activities, according to standards established by the department in collaboration with the authority; and

(ix) Enter into data-sharing agreements with the department, the authority, regional crisis lines, and applicable behavioral health administrative services organizations to provide reports and client level data regarding 988 contact hub calls, as allowed by and in compliance with existing federal and state law governing the sharing and use of protected health information, which shall include sharing real-time information with regional crisis lines. The department and the authority shall establish requirements that the designated 988 contact hubs report data to regional behavioral health administrative services organizations for the purposes of maximizing medicaid reimbursement, as appropriate, and implementing this chapter and chapters 71.05 and 71.34 RCW including, but not limited to, administering crisis services for the assigned regional service area, contracting with a sufficient number of licensed or certified providers for crisis services, establishing and maintaining quality assurance processes, maintaining patient tracking, and developing and implementing strategies to coordinate care for individuals with a history of frequent crisis system utilization.

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

(5) The department and authority must coordinate to develop the technology and platforms necessary to manage and operate the behavioral health crisis response and suicide prevention system. The department and the authority must include designated 988 contact hubs, regional crisis lines, and behavioral health administrative services organizations in the decision-making process for selecting any technology platforms that will be used to operate the system. No decisions made by the department or the authority shall interfere with the routing of the 988 contact hubs calls, texts, or chat as part of Washington's active agreement with the administrator of the national suicide prevention lifeline or 988 administrator that routes

988 contacts into Washington's system. The technologies developed must include:

(a) A new technologically advanced behavioral health and suicide prevention crisis call center system platform for use in 988 contact hubs designated by the department under subsection (4) of this section. This platform, which shall be implemented as soon as possible and fully funded by January 1, 2026, shall be developed by the department and must include the capacity to receive crisis assistance requests through phone calls, texts, chats, and other similar methods of communication that may be developed in the future that promote access to the behavioral health crisis system; and

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

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

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

(i) Real-time bed availability for all behavioral health bed types and recliner chairs, including but not limited to crisis stabilization services, 23-hour crisis relief centers, psychiatric inpatient, substance use disorder inpatient, withdrawal management, peer-run respite centers, and crisis respite services, inclusive of both voluntary and involuntary beds, for use by crisis response workers, first responders, health care providers, emergency departments, and individuals in crisis; and

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

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

(B) Information necessary to enable the designated 988 contact hubs to actively collaborate with regional crisis lines, emergency departments, primary care providers and behavioral health providers within managed care organizations, behavioral health administrative services organizations, and other health care payers to establish a

safety plan for the person in accordance with best practices and provide the next steps for the person's transition to follow-up noncrisis care. To establish information-sharing guidelines that fulfill the intent of this section the authority shall consider input from the confidential information compliance and coordination subcommittee established under RCW 71.24.892;

(b) The means to track the outcome of the 988 call to enable appropriate follow-up, cross-system coordination, and accountability, including as appropriate: (i) Any immediate services dispatched and reports generated from the encounter; (ii) the validation of a safety plan established for the caller in accordance with best practices; (iii) the next steps for the caller to follow in transition to noncrisis follow-up care, including a next-day appointment for callers experiencing urgent, symptomatic behavioral health care needs; and (iv) the means to verify and document whether the caller was successful in making the transition to appropriate noncrisis follow-up care indicated in the safety plan for the person, to be completed either by the care coordinator provided through the person's managed care organization, health plan, or behavioral health administrative services organization, or if such a care coordinator is not available or does not follow through, by the staff of the designated 988 contact hub;

(c) A means to facilitate actions to verify and document whether the person's transition to follow-up noncrisis care was completed and services offered, to be performed by a care coordinator provided through the person's managed care organization, health plan, or behavioral health administrative services organization, or if such a care coordinator is not available or does not follow through, by the staff of the designated 988 contact hub;

(d) The means to provide geographically, culturally, and linguistically appropriate services to persons who are part of high-risk populations or otherwise have need of specialized services or accommodations, and to document these services or accommodations; and

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

(7) The authority shall:

(a) Collaborate with county authorities and behavioral health administrative services organizations to develop procedures to

dispatch behavioral health crisis services in coordination with designated 988 contact hubs to effectuate the intent of this section;

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

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

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

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

(8) The department shall monitor trends in 988 crisis hotline caller data, as reported by designated 988 contact hubs under

subsection (4)(b)(ix) of this section, and submit an annual report to the governor and the appropriate committees of the legislature summarizing the data and trends beginning December 1, 2027.

(9) Subject to authorization by the national 988 administrator and the availability of amounts appropriated for this specific purpose, any Washington state subnetwork of the 988 crisis hotline dedicated to the crisis assistance needs of American Indian and Alaska Native persons shall offer services by text, chat, and other similar methods of communication to the same extent as does the general 988 crisis hotline. The department shall coordinate with the substance abuse and mental health services administration for the authorization.

Sec. 20. RCW 71.24.903 and 2023 c 454 s 9 are each amended to read as follows:

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

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

(a) Minimum staffing requirements to effectively respond in-person to individuals experiencing a significant behavioral health emergency. Except as provided in subsection (3) of this section, the team must include appropriately credentialed and supervised staff employed by a licensed or certified behavioral health agency and may include other personnel from participating entities listed in subsection (3) of this section. The team shall include certified peer counselors <u>or certified peer support specialists</u> as a best practice to the extent practicable based on workforce availability. The team may include fire departments, emergency medical services, public health, medical facilities, nonprofit organizations, and city or

county governments. The team may not include law enforcement personnel;

(b) Capabilities for transporting an individual experiencing a significant behavioral health emergency to a location providing appropriate level crisis stabilization services, as determined by regional transportation procedures, such as crisis receiving centers, crisis stabilization units, and triage facilities. The standards must include vehicle and equipment requirements, including minimum requirements for vehicles and equipment to be able to safely transport the individual, as well as communication equipment standards. The vehicle standards must allow for an ambulance or aid vehicle licensed under chapter 18.73 RCW to be deemed to meet the standards; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(iii) Issue supplemental performance payments in the form of an enhanced case rate higher than that available in (a)(ii) of this subsection (10) to mobile rapid response crisis teams and community-based crisis teams that have received an endorsement from the authority under either subsection (2) or (3) of this section and demonstrate to the authority that for the previous three months they met the following response time and in route time standards:

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

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

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

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

(B) On and after January 1, 2027:

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

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

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

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

(11) The authority shall contract with the actuaries responsible for development of medicaid managed care rates to conduct an analysis and develop options for payment mechanisms and levels for rate enhancements under subsection (10) of this section. The authority shall consult with staff from the office of financial management and the fiscal committees of the legislature in conducting this analysis. The payment mechanisms must be developed to maximize leverage of

allowable federal medicaid match. The analysis must clearly identify assumptions, include cost projections for the rate level options broken out by fund source, and summarize data used for the cost analysis. The cost projections must be based on Washington state specific utilization and cost data. The analysis must identify low, medium, and high ranges of projected costs associated for each option accounting for varying scenarios regarding the numbers of teams estimated to qualify for the enhanced case rates and supplemental performance payments. The analysis must identify costs for both medicaid clients, and for state-funded nonmedicaid clients paid through contracts with behavioral health administrative services organizations. The analysis must account for phasing in of the number of teams that meet endorsement criteria over time and project annual costs for a four-year period associated with each of the scenarios. The authority shall submit a report summarizing the analysis, payment mechanism options, enhanced performance payment and supplemental performance payment rate level options, and related cost estimates to the office of financial management and the appropriate committees of the legislature by December 1, 2023.

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

Sec. 21. RCW 71.24.920 and 2023 c 469 s 13 are each amended to read as follows:

(1)(a) By January 1, 2025, the authority must develop a course of instruction to become a certified peer <u>support</u> specialist under chapter 18.420 RCW. The course must be approximately 80 hours in duration and based upon the curriculum offered by the authority in its peer counselor training as of July 23, 2023, as well as additional instruction in the principles of recovery coaching and suicide prevention. The authority shall establish a peer engagement

process to receive suggestions regarding subjects to be covered in the 80-hour curriculum beyond those addressed in the peer counselor training curriculum and recovery coaching and suicide prevention curricula, including the cultural appropriateness of the 80-hour training. The education course must be taught by certified peer support specialists. The education course must be offered by the authority with sufficient frequency to accommodate the demand for training and the needs of the workforce. The authority must establish multiple configurations for offering the education course, including offering the course as an uninterrupted course with longer class hours held on consecutive days for students seeking accelerated completion of the course and as an extended course with reduced daily class hours, possibly with multiple days between classes, to accommodate students with other commitments. Upon completion of the education course, the student must pass an oral examination administered by the course trainer.

(b) The authority shall develop an expedited course of instruction that consists of only those portions of the curriculum required under (a) of this subsection that exceed the authority's certified peer counselor training curriculum as it exists on July 23, 2023. The expedited training shall focus on assisting persons who completed the authority's certified peer counselor training as it exists on July 23, 2023, to meet the education requirements for certification under RCW 18.420.050.

(2) By January 1, 2025, the authority must develop a training course for certified peer support specialists providing supervision to certified peer support specialist trainees under RCW 18.420.060.

(3)(a) By July 1, 2025, the authority shall offer a 40-hour specialized training course in peer crisis response services for individuals employed as peers who work with individuals who may be experiencing a behavioral health crisis. When offering the training course, priority for enrollment must be given to certified peer support specialists employed in a crisis-related setting, including entities identified in (b) of this subsection. The training shall incorporate best practices for responding to 988 behavioral health crisis line calls, as well as processes for co-response with law enforcement when necessary.

(b) Beginning July 1, 2025, any entity that uses certified peer support specialists as peer crisis responders, may only use certified peer support specialists who have completed the training course

established by (a) of this subsection. A behavioral health agency that uses certified peer support specialists to work as peer crisis responders must maintain the records of the completion of the training course for those certified peer support specialists who provide these services and make the records available to the state agency for auditing or certification purposes.

(4) By July 1, 2025, the authority shall offer a course designed to inform licensed or certified behavioral health agencies of the benefits of incorporating certified peer support specialists and certified peer support specialist trainees into their clinical staff and best practices for incorporating their services. The authority shall encourage entities that hire certified peer support specialists and certified peer support specialist trainees, including licensed or certified behavioral health agencies, hospitals, primary care offices, and other entities, to have appropriate staff attend the training by making it available in multiple formats.

(5) The authority shall:

(a) Hire clerical, administrative, investigative, and other staff as needed to implement this section to serve as examiners for any practical oral or written examination and assure that the examiners are trained to administer examinations in a culturally appropriate manner and represent the diversity of applicants being tested. The authority shall adopt procedures to allow for appropriate accommodations for persons with a learning disability, other disabilities, and other needs and assure that staff involved in the administration of examinations are trained on those procedures;

(b) Develop oral and written examinations required under this section. The initial examinations shall be adapted from those used by the authority as of July 23, 2023((~~, and modified pursuant to input and comments from the Washington state peer specialist advisory committee~~)). The authority shall assure that the examinations are culturally appropriate;

(c) Prepare, grade, and administer, or supervise the grading and administration of written examinations for obtaining a certificate;

(d) Approve entities to provide the educational courses required by this section and approve entities to prepare, grade, and administer written examinations for the educational courses required by this section((~~. In establishing approval criteria, the authority shall consider the recommendations of the Washington state peer specialist advisory committee~~));

(e) Develop examination preparation materials and make them available to students enrolled in the courses established under this section in multiple formats, including specialized examination preparation support for students with higher barriers to passing the written examination; and

(f) ((~~The authority shall administer~~)) Administer, through contract, a program to link eligible persons in recovery from behavioral health challenges who are seeking employment as peers with employers seeking to hire peers, including certified peer support specialists. The authority must contract for this program with an organization that provides peer workforce development, peer coaching, and other peer supportive services. The contract must require the organization to create and maintain a statewide database which is easily accessible to eligible persons in recovery who are seeking employment as peers and potential employers seeking to hire peers, including certified peer support specialists. The program must be fully implemented by July 1, 2024.

(6) For the purposes of this section, the term "peer crisis responder" means a peer support specialist certified under chapter 18.420 RCW who has completed the training under subsection (3) of this section whose job involves responding to behavioral health emergencies, including those dispatched through a 988 crisis hotline or the 911 system.

Sec. 22. RCW 71.24.922 and 2023 c 469 s 14 are each amended to read as follows:

Behavioral health agencies must reduce the caseload for approved supervisors who are providing supervision to certified peer support specialist trainees seeking certification under chapter 18.420 RCW((~~, in accordance with standards established by the Washington state certified peer specialist advisory committee~~)).

Sec. 23. RCW 71.24.924 and 2023 c 469 s 15 are each amended to read as follows:

(1) Beginning January 1, 2027, a person who engages in the practice of peer support services and who bills a health carrier or medical assistance or whose employer bills a health carrier or medical assistance for those services must hold an active credential as a certified peer support specialist or certified peer support specialist trainee under chapter 18.420 RCW.

(2) A person who is registered as an agency affiliated counselor under chapter 18.19 RCW who engages in the practice of peer support services and whose agency, as defined in RCW 18.19.020, bills medical assistance for those services must hold a certificate as a certified peer support specialist or certified peer support specialist trainee under chapter 18.420 RCW no later than January 1, 2027.

Sec. 24. RCW 71.40.040 and 2022 c 134 s 4 are each amended to read as follows:

The state office of behavioral health consumer advocacy shall assure performance of the following activities, as authorized in contract:

(1) Selection of a name for the contracting advocacy organization to use for the advocacy program that it operates pursuant to contract with the office. The name must be selected by the statewide advisory council established in this section and must be separate and distinguishable from that of the office;

(2) Certification of behavioral health consumer advocates by October 1, 2022, and coordination of the activities of the behavioral health consumer advocates throughout the state according to standards adopted by the office;

(3) Provision of training regarding appropriate access by behavioral health consumer advocates to behavioral health providers or facilities according to standards adopted by the office;

(4) Establishment of a toll-free telephone number, website, and other appropriate technology to facilitate access to contracting advocacy organization services for patients, residents, and clients of behavioral health providers or facilities;

(5) Establishment of a statewide uniform reporting system to collect and analyze data relating to complaints and conditions provided by behavioral health providers or facilities for the purpose of identifying and resolving significant problems, with permission to submit the data to all appropriate state agencies on a regular basis;

(6) Establishment of procedures consistent with the standards adopted by the office to protect the confidentiality of the office's records, including the records of patients, residents, clients, providers, and complainants;

(7) Establishment of a statewide advisory council, a majority of which must be composed of people with lived experience, that shall include:

(a) Individuals with a history of mental illness including one or more members from the black community, the indigenous community, or a community of color;

(b) Individuals with a history of substance use disorder including one or more members from the black community, the indigenous community, or a community of color;

(c) Family members of individuals with behavioral health needs including one or more members from the black community, the indigenous community, or a community of color;

(d) One or more representatives of an organization representing consumers of behavioral health services;

(e) Representatives of behavioral health providers and facilities, including representatives of facilities offering inpatient and residential behavioral health services;

(f) One or more certified peer support specialists;

(g) One or more medical clinicians serving individuals with behavioral health needs;

(h) One or more nonmedical providers serving individuals with behavioral health needs;

(i) One representative from a behavioral health administrative services organization;

(j) Two parents or caregivers of a child who received behavioral health services, including one parent or caregiver of a child who received complex, multisystem behavioral health services, one parent or caregiver of a child ages one through 12, or one parent or caregiver of a child ages 13 through 17;

(k) Two representatives of medicaid managed care organizations, one of which must provide managed care to children and youth receiving child welfare services;

(l) Other community representatives, as determined by the office; and

(m) One representative from a labor union representing workers who work in settings serving individuals with behavioral health conditions;

(8) Monitoring the development of and recommend improvements in the implementation of federal, state, and local laws, rules, regulations, and policies with respect to the provision of behavioral health services in the state and advocate for consumers;

(9) Development and delivery of educational programs and information statewide to patients, residents, and clients of

behavioral health providers or facilities, and their families on topics including, but not limited to, the execution of mental health advance directives, wellness recovery action plans, crisis services and contacts, peer services and supports, family advocacy and rights, family-initiated treatment and other behavioral health service options for minors, and involuntary treatment; and

(10) Reporting to the office, the legislature, and all appropriate public agencies regarding the quality of services, complaints, problems for individuals receiving services from behavioral health providers or facilities, and any recommendations for improved services for behavioral health consumers.

Sec. 25. RCW 71.40.090 and 2022 c 134 s 5 are each amended to read as follows:

The contracting advocacy organization shall develop and submit, for approval by the office, a process to train and certify all behavioral health consumer advocates, whether paid or volunteer, authorized by this chapter as follows:

(1) Certified behavioral health consumer advocates must have training or experience in the following areas:

(a) Behavioral health and other related social services programs, including behavioral health services for minors;

(b) The legal system, including differences in state or federal law between voluntary and involuntary patients, residents, or clients;

(c) Advocacy and supporting self-advocacy;

(d) Dispute or problem resolution techniques, including investigation, mediation, and negotiation; and

(e) All applicable patient, resident, and client rights established by either state or federal law.

(2) A certified behavioral health consumer advocate may not have been employed by any behavioral health provider or facility within the previous twelve months, except as a certified peer <u>support</u> specialist or where prior to July 25, 2021, the person has been employed by a regional behavioral health consumer advocate.

(3) No certified behavioral health consumer advocate or any member of a certified behavioral health consumer advocate's family may have, or have had, within the previous twelve months, any

significant ownership or financial interest in the provision of behavioral health services.

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