Enrolled
House Bill 2417

Sponsored by Representatives SANCHEZ, MARSH, SOLLMAN; Representatives ALONSO LEON, CAMPOS, DEXTER, EVANS, FAHEY, GOMBERG, GRAYBER, HOLVEY, KROPF, MCLAIN, NERON, NOSSE, PHAM, PRUSAK, REARDON, REYNOLDS, RUIZ, SCHOUTEN, WILDE, WILLIAMS, Senators GELSER, LIEBER, PATTERSON, WAGNER (Presession filed.)

CHAPTER .....

AN ACT

Relating to crisis intervention resources; creating new provisions; amending ORS 403.110, 403.115 and 403.135; and declaring an emergency.

Be It Enacted by the People of the State of Oregon:

SECTION 1. As used in sections 1 to 3 of this 2021 Act:

(1) "Coordinated care organization" has the meaning given that term in ORS 414.025.

(2) "Crisis stabilization center" means a facility licensed by the Oregon Health Authority that meets the requirements adopted by the authority by rule under section 2 of this 2021 Act.

(3) "Crisis stabilization services" includes diagnosis, stabilization, observation and follow-up referral services provided to individuals in a community-based, developmentally appropriate homelike environment to the extent practicable.

(4) "Mobile crisis intervention team" means a team of qualified behavioral health professionals that may include peer support specialists, as defined in ORS 414.025, and other health care providers such as nurses or social workers who provide timely, developmentally appropriate and trauma-informed interventions, screening, assessment, de-escalation and other services necessary to stabilize an individual experiencing a behavioral health crisis in accordance with requirements established by the authority by rule.

(5) "Peer respite center" means voluntary, nonclinical, short-term residential peer support provided:

(a) In a homelike setting to individuals with mental illness, substance use disorder or trauma response symptoms who are experiencing acute distress, anxiety or emotional pain that may lead to the need for a higher level of care such as psychiatric inpatient hospital services; and

(b) By a peer-run organization and directed and delivered by individuals with lived experience in coping with, seeking recovery from or overcoming mental illness, substance use disorder or trauma response challenges.

(6) "Veterans Crisis Line" means the crisis hotline maintained by the United States Department of Veterans Affairs and the United States Department of Health and Human Services.

SECTION 2. (1) The purposes of sections 1 to 3 of this 2021 Act are to build upon and improve the statewide coordinated crisis system in this state and to:

(a) Remove barriers to accessing quality behavioral health crisis services;

(b) Improve equity in behavioral health treatment and ensure culturally, linguistically and developmentally appropriate responses to individuals experiencing behavioral health crises, in recognition that, historically, crisis response services placed marginalized communities at disproportionate risk of poor outcomes and criminal justice involvement;

(c) Ensure that all residents of this state receive a consistent and effective level of behavioral health crisis services no matter where they live, work or travel in the state; and

(d) Provide increased access to quality community behavioral health services to prevent interactions with the criminal justice system and prevent hospitalizations, if appropriate, by investing in:

(A) New technology for a crisis call center system to triage calls and link individuals to follow-up care;

(B) The expansion of mobile crisis intervention teams; and

(C) A wide array of crisis stabilization services, including services provided by:

(i) Crisis stabilization centers;

(ii) Facilities offering short-term respite services;

(iii) Peer respite centers;

(iv) Behavioral health urgent care walk-in centers; and

(v) A crisis hotline center to receive calls, texts and chats from individuals or other crisis hotlines to provide crisis intervention services and crisis care coordination anywhere in this state 24 hours per day, seven days per week, 365 days per year.

(2) The Oregon Health Authority shall adopt by rule requirements for crisis stabilization centers that, at a minimum, require a center to:

(a) Be designed to prevent or ameliorate a behavioral health crisis or reduce acute symptoms of mental illness or substance use disorder, for individuals who do not require inpatient treatment, by providing continuous 24-hour observation and supervision;

(b) Be staffed 24 hours per day, seven days per week, 365 days per year by a multidisciplinary team capable of meeting the needs of individuals in the community experiencing all levels of crisis, that may include, but is not limited to:

(A) Psychiatrists or psychiatric nurse practitioners;

(B) Nurses;

(C) Licensed or credentialed clinicians in the region where the crisis stabilization center is located who are capable of completing assessments; and

(D) Peers with lived experiences similar to the experiences of the individuals served by the center;

(c) Have a policy prohibiting rejecting patients brought in or referred by first responders, and have the capacity, at least 90 percent of the time, to accept all referrals;

(d) Have services to address substance use crisis issues;

(e) Have the capacity to assess physical health needs and provide needed care and a procedure for transferring an individual, if necessary, to a setting that can meet the individual's physical health needs if the facility is unable to provide the level of care required;

(f) Offer walk-in and first responder drop-off options;

(g) Screen for suicide risk and complete comprehensive suicide risk assessments and planning when clinically indicated;

(h) Screen for violence risk and complete more comprehensive violence risk assessments and planning when clinically indicated; and

(i) Meet other requirements prescribed by the authority.

(3) The authority shall establish a crisis hotline center to receive calls, texts and chats from the 9-8-8 suicide prevention and behavioral health crisis hotline and to provide crisis intervention services and crisis care coordination anywhere in this state 24 hours per day, seven days per week. The crisis hotline center shall:

(a) Have an agreement to participate in the National Suicide Prevention Lifeline network.

(b) Meet National Suicide Prevention Lifeline requirements and best practices guidelines for operational and clinical standards and any additional clinical and operational standards prescribed by the authority.

(c) Record data, provide reports and participate in evaluations and related quality improvement activities.

(d) Establish formal agreements to collaborate with other agencies to ensure safe, integrated care for people in crisis who reach out to the 9-8-8 suicide prevention and behavioral health crisis hotline.

(e) Contact and coordinate with the local community mental health programs for rapid deployment of a local mobile crisis intervention team and follow-up services as needed.

(f) Utilize technologies, including chat and text applications, to provide a no-wrong-door approach for individuals seeking help from the crisis hotline and ensure collaboration among crisis and emergency response systems used throughout this state, such as 9-1-1 and 2-1-1, and with other centers in the National Suicide Prevention Lifeline network.

(g) Establish policies and train staff on serving high-risk and specialized populations, including but not limited to lesbian, gay, bisexual, transgender and queer youth, minorities, veterans and individuals who have served in the military, rural residents and individuals with co-occurring disorders. Policies and training established under this paragraph must include:

(A) Policies and training on transferring calls made to the 9-8-8 suicide prevention and behavioral health crisis hotline to an appropriate specialized center within or external to the National Suicide Prevention Lifeline network; and

(B) Training on providing linguistically and culturally competent care and follow-up services to individuals accessing the 9-8-8 suicide prevention and behavioral health crisis hotline consistent with guidance and policies established by the National Suicide Prevention Lifeline.

(4) The staff of the crisis hotline center described in subsection (3) of this section shall:

(a) Have access to the most recently reported information regarding available mental health and behavioral health crisis services.

(b) Track and maintain data regarding responses to calls, texts and chats to the 9-8-8 suicide prevention and behavioral health crisis hotline.

(c) Work to resolve crises with the least invasive intervention possible.

(d) Connect callers whose crisis is de-escalated or otherwise managed by hotline staff with appropriate follow-on services and undertake follow-up contact with the caller when appropriate.

(5) Crisis stabilization services provided to individuals accessing the 9-8-8 suicide prevention and behavioral health crisis hotline shall be reimbursed by the authority, coordinated care organizations or commercial insurance, depending on the individual's insurance status.

(6) The authority shall adopt rules to allow appropriate information sharing and communication across all crisis service providers as necessary to carry out the requirements of this section and shall work in concert with the National Suicide Prevention Lifeline and the Veterans Crisis Line for the purposes of ensuring consistency of public messaging about 9-8-8 suicide prevention and behavioral health crisis hotline services.

SECTION 3. (1) In consultation with local community mental health programs, the Oregon Health Authority shall, to the extent funding is available, require each community mental health program to provide crisis stabilization services to individuals contacting the 9-8-8 suicide prevention and behavioral health crisis hotline who need crisis stabilization services in the community by enhancing and expanding the use of mobile crisis intervention teams.

(2) A city may request funding from a county to establish and maintain one or more mobile crisis intervention teams.

(3) Mobile crisis intervention teams must operate in compliance with rules adopted by the authority.

SECTION 4. **No later than January 1, 2022, the Oregon Health Authority shall report to the interim committees of the Legislative Assembly related to mental or behavioral health, in the manner provided in ORS 192.245, recommendations on policies, legislative changes, if any, and funding to implement the National Suicide Hotline Designation Act of 2020 (P.L. 116-172) and establish a statewide coordinated crisis services system. The report shall address or include:**

(1) The establishment of the crisis hotline center under section 2 (3) of this 2021 Act to receive calls, texts and chats from the 9-8-8 suicide prevention and behavioral health crisis hotline, including coordination with mobile crisis intervention teams and other crisis services and projected costs for the necessary technology and ongoing operations;

(2) Projections for increased crisis stabilization services to meet the needs of individuals accessing the 9-8-8 suicide prevention and behavioral health crisis hotline, including:

(a) Policies and funding to provide access to adequate mobile crisis intervention teams statewide, addressing ongoing funding from Medicaid, commercial insurance or other funding sources, to coordinated mobile crisis response services between cities and counties and the appropriate number of teams and staffing;

(b) Policies and funding to provide statewide access to crisis stabilization centers, as defined in section 1 of this 2021 Act, addressing the statutory framework for such centers, licensing or regulatory structures, ongoing funding that maximizes Medicaid and commercial insurance, and a plan for the location and number of such facilities;

(c) Policies and funding to provide access to other crisis services, including peer respite centers, as defined in section 1 of this 2021 Act, behavioral health urgent care walk-in centers or other services for specific populations; and

(d) How the continuum of crisis services proposed in the report will:

(A) Address the needs of Oregonians in all stages of life who experience behavioral health crises; and

(B) Improve health equity by addressing the preventable differences in the burden of disease, injury, violence or opportunities to achieve optimal health that are experienced by socially disadvantaged populations;

(3) Proposed strategies and policies for coordination with 9-1-1 and law enforcement;

(4) Projections and proposed timeline for implementing the National Suicide Hotline Designation Act of 2020 (P.L. 116-172), and in particular for expanded service capacity and any proposed capital development, workforce needs or need for legislative changes or policies to remove barriers to the expansion of services;

(5) Whether a fee should be proposed to pay expenses that the state is expected to incur for:

(a) Ensuring the efficient and effective routing of calls made to the 9-8-8 suicide prevention and behavioral health crisis hotline to an appropriate crisis center and personnel; and

(b) Providing acute behavioral health, crisis outreach and stabilization services by directly responding to the 9-8-8 suicide prevention and behavioral health crisis hotline;

(6) If a fee is proposed:

(a) The proposed fee amount;

(b) The proposed mechanism for the fee, including the type of telecommunications lines or accounts on which the fee will be imposed;

(c) The allocation of the fee revenue, including the crisis services to which the fee will be allocated, the estimated cost of those services, and whether any portion of the fee revenue will be eligible for Medicaid match; and

(d) Whether the proposed fee revenue will supplant any existing funding;

(7) An assessment of existing and proposed crisis response services and any recommendations to improve the delivery and cost efficiency of crisis response services while maintaining quality care; and

(8) An assessment of existing and proposed crisis response services and any recommendations for maximizing federal financial participation in the funding of the services.

SECTION 5. The Oregon Health Authority may establish committees in accordance with ORS 430.075 or assign tasks to existing agencies, boards or committees to accomplish the planning required for implementation or ongoing oversight of sections 1 to 3 of this 2021 Act in coordination with the crisis hotline center established under section 2 (3) of this 2021 Act, the Office of Emergency Management, local public health and mental health authorities, hospitals and health systems, coordinated care organizations, as defined in ORS 414.025, telecommunication providers and the National Suicide Prevention Lifeline Local Mental Health Authority, certified peer support specialists, as defined in ORS 414.025, 9-1-1, law enforcement, individuals with lived experiences in mental illness or substance use disorder, consumers of behavioral health services, including youth and families, and other stakeholders identified by the authority.

SECTION 6. ORS 403.110 is amended to read:

403.110. (1) A provider**,** [*or*] a 9-1-1 jurisdiction**, a 9-8-8 coordinated crisis services system** or the employees or agents of a provider**,** [*or*] a 9-1-1 jurisdiction **or a 9-8-8 coordinated crisis services system** may be held civilly liable for the installation, performance, provision or maintenance of a 9-1-1 emergency reporting system**,** [*or*] enhanced 9-1-1 telephone service **or a 9-8-8 telephone service** if the provider**,** [*or*] the 9-1-1 jurisdiction**, the 9-8-8 coordinated crisis services system** or the employees or agents of the provider**,** [*or*] the 9-1-1 jurisdiction **or 9-8-8 coordinated crisis services system** act with willful or wanton conduct.

(2) A provider or seller is not liable for damages that result from providing or failing to provide access to the emergency communications system**, the 9-8-8 coordinated crisis services system** or from identifying or failing to identify the telephone number, address, location or name associated with any person or device accessing or attempting to access the emergency communications system **or the 9-8-8 coordinated crisis services system**.

(3) This section does not affect any liability a 9-1-1 jurisdiction may have for employee negligence in receiving emergency calls from the public and dispatching emergency services to the public.

SECTION 7. ORS 403.115 is amended to read:

403.115. (1) The primary emergency telephone number within this state is 9-1-1, but a public or private safety agency shall maintain both a separate 10-digit secondary emergency number for use by a telephone operator or provider and a separate 10-digit nonemergency number.

(2) Every public and private safety agency in this state shall participate in the emergency communications system.

(3) An emergency telephone number other than 9-1-1 may not be published on the top three-quarters of the emergency listing page of a telephone book. However, an alternative nonemergency telephone number for a 9-1-1 jurisdiction may be printed on the top three-quarters of the emergency listing page of a telephone book. The publisher may use the remainder of the page to list the Oregon Poison Center, Federal Bureau of Investigation, [*a designated mental health crises service*] **9-8-8 coordinated crisis services system** and United States Coast Guard, where applicable. [*If there is more than one mental health crises service in a jurisdiction, the local health department shall decide which mental health crises service the publisher may list by using the criteria of a 24-hour staffed service, nonprofit organization and non-9-1-1 participating agency.*] The publisher shall refer to the community services section for other numbers.

(4) The emergency communications system must provide:

(a) Interconnectivity between public safety answering points and interconnectivity with providers of the same or similar emergency response services nationally;

(b) The capability, within each primary public safety answering point, to receive all emergency calls placed locally within each 9-1-1 service area; and

(c) The automatic location identification accurately portraying the location from which each emergency call originates.

SECTION 8. ORS 403.135 is amended to read:

403.135. (1) A provider may not block delivery or forwarding to a public safety answering point of location **or a 9-8-8 coordinated crisis services system** information, a call-back number or other identifying information related to an emergency call.

(2) Automatic number identifications received by public safety answering points **and 9-8-8 coordinated crisis services system** are confidential and are not subject to public disclosure unless and until an official report is written by the public or private safety agency and that agency does not withhold the telephone number under ORS 192.311 to 192.478 or other state and federal laws. The official report of a public safety answering point **or a 9-8-8 coordinated crisis services system** may not include nonpublished or nonlisted telephone numbers. The official report of a public or private safety agency may not include nonpublished or nonlisted telephone numbers. Nonpublished or nonlisted telephone numbers are not otherwise subject to public disclosure without the permission of the subscriber.

(3) A provider is not subject to an action for civil damages for providing in good faith confidential or nonpublic information, including nonpublished and nonlisted subscriber information, to emergency **and 9-8-8** services providers who are:

(a) Responding to an emergency call;

(b) Responding to emergency situations that involve the risk of death or serious physical harm to an individual, as provided in ORS 403.132; or

(c) Notifying the public of an emergency.

(4) Subsection (3) of this section does not compel a provider to provide nonpublished and nonlisted subscriber information directly to emergency **or 9-8-8** services providers or law enforcement agencies prior to placement of an emergency call without process of law.

(5) Subscriber information acquired by a 9-1-1 jurisdiction **or the 9-8-8 coordinated crisis services system** for the purpose of providing emergency communications services under ORS 403.105 to 403.250 **or coordinated crisis services under sections 1 to 3 of this 2021 Act** is not subject to public disclosure and may not be used by other public agencies except:

(a) To respond to an emergency call;

(b) To respond to an emergency situation that involves the risk of death or serious physical harm to an individual, as provided in ORS 403.132; or

(c) To notify the public of an emergency by utilizing an automated notification system if a provider has provided subscriber information to the 9-1-1 jurisdiction or emergency services provider.

SECTION 9. In addition to and not in lieu of any other appropriation, there is appropriated to the Oregon Health Authority, for the biennium beginning July 1, 2021, out of the General Fund, the amount of:

(1) $5,000,000, which may be expended for costs associated with the crisis hotline center established in section 2 of this 2021 Act; and

(2) $10,000,000, for distribution to counties to establish and maintain mobile crisis intervention teams.

SECTION 10. This 2021 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2021 Act takes effect July 1, 2021.

Passed by House June 24, 2021

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Timothy G. Sekerak, Chief Clerk of House

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Tina Kotek, Speaker of House

Passed by Senate June 26, 2021

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Peter Courtney, President of Senate

Received by Governor:

.....M.,....., 2021

Approved:

.....M.,....., 2021

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Kate Brown, Governor

Filed in Office of Secretary of State:

.....M.,....., 2021

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Shemia Fagan, Secretary of State