Workbook for Workshop #6

RCW Requirement:

(4) The rules must include standards for the number of recliner chairs that may be licensed or certified in a 23-hour crisis relief center and the appropriate variance for temporarily exceeding that number in order to provide the no-refusal policy for law enforcement.

(5) The department shall specify physical environment standards for the construction review process that are responsive to the unique characteristics of the types of interventions used to provide care for all levels of acuity in facilities operating under the 23-hour crisis relief center model

SAMHSA Guidelines	• National Guidelines for Behavioral Health Crisis Care-SAMHSA
	• To fully align with best practice guidelines, centers must meet the minimum expectations and:
	  • Function as a 24 hour or less crisis receiving and stabilization facility;
	  • Offer a dedicated first responder drop-off area;
	  • Incorporate some form of ***intensive support beds*** into a partner program (could be within the services' own program or within another provider) to support flow for individuals who need additional support;
		Notes:
		• There are some facilities that may already have beds in individual rooms or bays that may want to repurpose them for 23-hour use.
		• There have been beds that are just a big block on the ground and if there is a quadriplegic individual needing services, it is hard to get them transferred over.
		• Someone in a psychiatric crisis may need to get out of the chair. If it is hard to have them moved, that can lead to bed sores.
		• People in wheelchairs and other mobility devices need access to crisis beds. As a wheelchair user, access can be difficult in facilities.
		• What about ADA considerations for space accessibility?
		  ○ ADA is a federal set of requirements. However, Chapter 11 of the State Building Code is around accessibility and is

		broadly considered safe harbor for ADA. • Make the building "ADA-beautiful." • There may be different options for lifts – ceiling lift, mobile lift, mounted lift that can help. • Need to be careful to not use the intensive support beds as a dumping ground for people. Separate area might become an out of sight, out of mind place with restraints, etc. and inappropriate interventions. • Intensive care beds may not be available in a given community.

Arizona Rules	• "Observation chair" means a physical piece of equipment that:
	  • Is located in a designated area where behavioral health observation/stabilization services are provided,
	  • Allows an individual to fully recline, and
	  • Is used by the individual while receiving crisis services.
	• A patient admitted for behavioral health observation / stabilization services is provided:
	  • An observation chair; or
	  • A separate piece of equipment for the patient to use to sit or recline that:
		Notes:
		• The AZ rules use and define the term "observation chair." Do we need to define "recliner" in our WA rules?
		• Look at the language/wording as either performance-based or prescriptive, depending on the intent. The intent may be to accommodate people of different body types. In this case, performance-based language would likely provide the greatest flexibility – whatever the equipment is, it needs to have a reclining feature.
		• "Chair" sends a message that it is a "temporary" place to rest and does not send a message that this is a place to have extended care. Is there a cap on the number of chairs allowed?

	• Is at least 12 inches from the floor; and • Has sufficient space around the piece of equipment to allow a personnel member to provide behavioral health services and physical health services, including emergency services, to the patient; • An observation chair: • Effective on July 1, 2015, has at least three feet of clear floor space: • On at least two sides of the observation chair, and • Between the observation chair and any other observation chair • Behavioral health observation/stabilization services are provided in a designated area that: • Is used exclusively for behavioral health observation/stabilization services; • Has the space for a patient to receive privacy in treatment and care for personal needs; and • For every 15 observation chairs or less, has at least one bathroom that contains:	• It needs to lift all body types, as much as possible…a bariatric chair. • Would like to see reference to bed and not just chair. • The AZ definition seems like it would cover both beds and chairs. • "A space and place that supports and provides crisis intervention that does not stigmatize, nor negatively impact the individual." • Would prefer some minimum standards at the very least. • Agree with some minimum standard, for example, minimum equipment weight and/or fixation to the floor for stability. • Eventually, there will be commonality of equipment because only certain equipment will survive the constant turnover of clients. • Definition works, but it is still saying "chair." • Would love to see that it "needs to be comfortable." • If beds are allowed, they need to be able to raise the head (and likely the feet) of the bed. A hospital bed and not a conventional bed. • How is privacy accomplished? There has to be privacy in treatment. Individuals would likely not be receiving treatment at the actual chair. • For spacing, it is important to consider the individual's ability to get up, move

	• An administrator of an outpatient treatment center that is authorized to provide behavioral health observation/stabilization services shall:
	  • Have a room used for seclusion that complies with requirements for seclusion rooms in R9-10-316, and
	  • Comply with the requirements for restraint and seclusion in R9-10-316.
		around, use the restroom, etc. How do you evacuate the building if necessary? This becomes a life safety issue.
		• Space from nurses' station to chairs is important.
		• Space between is important for things like taking vitals. Not just square feet.
		• A bathroom (toilet and sink) for 15 doesn't seem like enough. I would also think that a need for a shower room might come up?
		• There were multiple comments regarding restraint and seclusion, with workshop participants expressing confusion regarding why R&S is being mentioned if this is an unlocked and voluntary facility.
		  ○ There are individuals who are going to be dropped off by law enforcement and EMS and who will be waiting for crisis responders. CRCs are not E&Ts, but they are at the same level as a CSU where people can be brought in involuntary by police. They are not ITA'd but are also not necessarily there on their own will. The FGI guidelines reference quiet rooms, whereas SAMHSA references seclusion and restraint. Individuals will not be involuntary committed at the CRC but the DCR would need to do the

		evaluation at the CRC to them to a proper place. • How does staffing differ from an E&T if we have to be able to do S&R at any time? ○ The staffing will potentially differ, as the minimum standards for a CRC will be different from an E&T. We do not want to get prescriptive in rule regarding staffing. • It appears that the only difference between this model and a CSU that takes involuntary folks is length of stay. Operationally the two models are very similar and the addition to our continuum of care isn't evident. • It really is about safety. You have to have a minimum number of people for S&R. That means the cost increases. • In practice, there is usually a minimum number of staff on duty for application of restraints to be safe. The makeup of that staffing can vary (although an RN is required) and typically would exclude peers. In my experience, the number is 5 people. • If they need restraint, it is not voluntary. That is a level of care deciding line. • The former E&T at Metropolitan Development Council (Tacoma) was constructed with an open milieu and 16 individual rooms. The structural space sounds like it would fit into this

		discussion of standards. It allowed for an incredible amount of interaction with staff and guests and privacy - there were also counseling areas and a seclusion room. • Whatever the current DOH rules are for crisis stabilization facilities, but also the standards around seclusion and restraint if that is expected.

Draft Language	**Notes**

(A) Have no more than (#) of recliners per every (#) square foot of floor space	We can pick a specific number of recliners or say that the facility can have an unlimited number of recliners as long as they have the appropriate space and staff to hold all of them.
	
	• One license, one building, one floor within a building? If you want to license for 40 recliners, they should be in proximity.
	• Is there a limit to the number of actual "reclining devices"? Can it be more than 16?
	  ○ There aren't IMD considerations because this is an outpatient service.
	• By space and staff, rather than a fixed amount please.
	• Will each facility be licensed for a specific number or can it be based on # per sq foot?
	  ○ This really has to do with sustainability, safety and spacing.
	  ○ The building code will prescribe the means of egress system (exiting system) based on maximum occupancy. If you have a big bay with a 50-person maximum occupancy, the building code will require at least two exits.
	  ○ Maximum occupancy has to make sense with the no-refusal policy.
	• It should be up to the community to determine how many recliners can be supported in their community.

(B) Recliners must be fastened to the ground or be of a variety that may prevent it from being picked up by a person.	Do we want to be specific as to whether these are mounted? We did not see safety standards for a particular type of furniture used in other models. • Facilities who provide this service know about safety related to furniture. I don't think we need to prescribe things like this. • There are going to be a lot of things in the environment besides the recliners. It seems odd to bolt them down. I do see the value, but practically it doesn't necessarily make sense. • Heavy chairs are not enough – must be secured to floor. • Secured to floor does not mean not able to be moved later.
(C) Recliners may be no less than 40 inches apart from one another.	
(D) Recliners must be sanitized between each use.	• Thought regarding sanitization: Since some physical health services will be provided perhaps the CRCs should be required to develop an infection control policy and procedure that addresses sanitization and infection control in general. • Air filtration?
(E) An agency may temporarily exceed the number of licensed recliners only to comply with the no-refusal policy for law enforcement.	• I think that would be good to have flexibility-it will come down to space, facility type, and minimal staffing per number of admitted individuals. • Folks interested in providing this service need to know how to figure out things like overflow beds and no-refusal issues...the more scripting, the worse it gets for providers.
(F) Provide a system or systems within the building that give staff awareness of the movements of individuals within the facility. If a door control system is used, it shall not prevent a resident from leaving the licensed space on their own accord, except temporary delays. Such systems include: (i) Limited egress systems consistent with state building code, such as delayed egress; (ii) Appropriate staffing levels to address safety and security; and (G) Policies and procedures that:	• It worked well at Crisis Solutions Center-15 second delay helped staff intervene to ensure the individual was safe to discharge and provide necessary interventions. We would orient each admitted person that there is a delay. • If your intent is that those brought "involuntarily" by police, how would they not be able to exit though the limited egress system? Are the 12 hour holds brought by police meant to be kept separate and away from the limited egress areas? • If the need for a DCR is established and the individual is asked to stay, but they do not want to stay, is the facility going to need to restrain?

(i) Are consistent with the assessment of the individual's care needs and plan; and (ii) Do not limit the rights of a voluntary individual.	○ If the person is a danger to self or others and they are trying to leave, then R&S may be appropriate to keep them safe. • Having provided limited egress facilities before, clients figure out how to exit. If the expectation is that the facility is going to restrain individuals prior to a DCR eval, then keeping them in a limited egress area is risky and I wouldn't want to get cited down the road due to not preventing someone from exiting if they were there for a 12-hour hold. Seems like it needs to be a locked facility with the intent of allowing exit to whomever asks if they are voluntary. • Delayed egress seems reasonable. It gives time to engage with those headed out unexpectedly and also makes it impossible for those inside to open the door to the outside without some planning and engagement from staff.
(H) Provide a restraint and seclusion rooms to the specificity of WAC 246-337-127	• Need to reconcile between "meet all levels of acuity" and seclusion and restraint requirements. • Solitary confinement is cruel and can cause trauma to patients. • Strong concerns about the use of restraints and/or solitary confinement.
(I) Restraint and seclusion policies and procedures must follow 246-337-105	
(J) Provide secure medication storage	

Brainstorming Activity: What physical environment standards should be included in rule? (ex. room capable of R/S, quiet room, nurses station, medication storage, personal belongings storage, bathroom ratio, shower, nourishment room, kitchen, intake room, exam room, beds, "recliner" standards, ambulance bay, delayed egress, cleaning supply room).

- S&R room
- Shower room, laundry room
- Secure storage for personal belongings
- Separate entrance for LE and EM
- Food storage and prep

- Staff spaces (break rooms, parking, belongings storage, etc.)
- Med room, 1 bathroom/shower for 7-8 people, 1-2 quiet rooms, intake room, nursing station, personal belongings, nursing storage room, clean laundry, storage closet, one entrance for all with intake room off of the lobby
- Storage of personal stuff can be a nightmare.
- Processes for what to do with weapons, substances, and other personally held contraband items
- Safe drop off area for ambulance and LE
- Please do not add additional requirements onto the already heavily regulated S&R WACs
- Bathroom/shower rooms/individual rooms should be ligature proof. Yes to secure medication storage/medication room, personal belongings storage. Housekeeping, laundry, decontamination device (bed bug oven), physical exam room, interview room, intake room.
- You can just follow the current crisis stabilization RTF requirements and hit all of the things mentioned.
- Pet accommodations?
- Storage for things you don't want in the facility – knives, for example, or prescription/non-prescription drugs.
- Locking doors (which ones?), separate bathrooms for staff, kitchen needs for patients and staff.
- Kitchen, laundry room, place where donations for clothing or bedding are kept.
- Telehealth options for DCR evaluation and court proceedings
- Space for support folks. Spouses, family, friends.
- We should not implement by only relying on one location. Please obtain patient data to help determine specifications.
- Staff office where computers and printers should be safe.
- Space for peers should be considered.
- Private telephone space.
- Space for bathing, secure record keeping, thermal sensitive drugs, linen storage, personal belongings storage, access to a phone.
- Secure outdoor spaces that are therapeutic.

Construction Review Presentation

- Physical environment or building/construction rules are rules that describe what the physical environment of a BH facility would look like. Physical environment and construction standards are terms that are often used interchangeably.
- When you have facility licenses, typically there is some built environment component. The expectation is that the physical space will be relatively safe for the type of interventions or care performed. Typically, these standards are risk based – what is happening in the room and to what kind of person? Risk questions inform mitigation.
- Construction review is typically scalable.

- Construction review program at DOH consists of a group of people are familiar with how to put buildings together. It is a step in the regulatory process – when you purchase your site or building, you bring the construction plans to construction review. The construction review program provides technical assistance, plan review and inspection services.
- CRCs are a unique type of facility. They are not the typical outpatient urgent care or a psychiatric hospital. They need to be treated in a unique way. We have to understand the risks and provide appropriate mitigation of risks.
- There are three things that we can model our WA CRC rules after – the Facilities Guidelines Institute (FGI) national standards, the SAMHSA standards developed for CRCs and the AZ standards.
- For construction standards, some of the rules are performance-based and some are prescriptive. Performance-based standards can often be read in ways that are more inclusive of a lot of different special situations but are in the eye of the beholder. With prescriptive standards, you know exactly what the requirement is. For example: "provide sufficient space around the patient bed" (not very clear) vs "provide 80 sq feet around the patient bed." Having a clear standard is good so that we can all agree on what is safe.
- National standards (building, life safety code, FGI, etc.) provide a middle ground between performance and prescriptive.
- There is a waiver process that can be used to look at alternative methods.
- Poll question – is the idea of going through construction review valuable to you? 94% - yes; 6% - no
    - YES!
    - I've found it useful in the past.
    - Having built several RTFs, yes, the construction review is very important.
    - As a new provider, yes.
    - It seems like a no-brainer to me. Super valuable.
    - Very valuable and appreciated.
    - Without clear standards, we get different answers by different personnel. It makes for misunderstandings and mistrust of DOH in general.
- The building code is reviewed at the local level. Typically, construction review does not get involved in the occupancy side of building review.
- The building code will be applied by the local building officials no matter what, so we can add something about ADA or the application of the building code in the rules, but it will be duplicative.
- Is there a benefit in adopting a national standard over another standard?
    - When we look nationally, we get a broader look across the spectrum of different types of facilities. For example, we learn a lot from what other states are doing. The breadth is helpful because it involves information and innovation sharing. But we do build things differently in WA because, for example, we have different natural hazards.

- There is nothing prohibiting us from being more stringent if we believe that the access that the building code provides is not appropriate. We can take a closer look at specific issues and make sure we are providing the requisite level of access and safety.

General comments/questions

- Can WA CRCs be standalone, or must they be part of an ED?
    - Yes, they can be standalone.
- Are the AZ standards in the public domain?
    - Yes, they are.
- It would be helpful to have these questions and relevant materials distributed for consideration before we make any decisions on these topics.
- Can we get a table that does a compare and contrast across the 3 models so it's easy for people who are not deep in this to understand?
- How do the time frames affect the ability to get deaf/sign language interpreters and appropriate language services?
    - There are a lot of interpretive services available through HCA. Many are call-in services.
    - These are rights that individuals have through the ADA whether they are written into the rule or not.
- Would a building with historic designation follow the same guidelines for bed space?
    - Usually the historic designation has to do with the exterior façade of the building, but the department does not have a role in determining the historical significance of a building.
- Can the rules be tested out, via a pilot, and then returned to in the future?
    - Sometimes rulemaking is driven by data. If there were injuries occurring because the recliners were not bolted down, then rulemaking can take place, but it does not apply retroactively.
    - We can consider the alternative means/methods approach. The facility can submit a request for an exemption and if it gets approved, it can create a precedent.
- Longshot request for AMH/DOH how is quality measurement determining the kinds of standards we need? Have there been quality assurance survey data among patients in AZ or elsewhere about the receipt of services? This is one way to hear from Persons Served. Are there others?
- Will there be a patient review form for their experience?