Workbook for Workshop #8

Draft Language	Notes

WAC 246-341-0110
 	
Behavioral health—Available certifications.
 	
(f) Behavioral health outpatient crisis <u>services,</u> ~~observation, and intervention~~;
<u>(g) 23-hour crisis relief center services;</u>
(<u>n</u>~~m)~~ Crisis stabilization unit ~~and triage~~;
	<u>Workshop participant comments/feedback</u>
	• Will "involuntary crisis triage facility" be replaced with "23-hour crisis relief center" in WAC 246-337-110 "Use of restraint and seclusion"? This was not in the PDF that was shared. "(2) The following facilities must have a minimum of one seclusion room for seclusion or temporary holding of residents awaiting transfer: (a) Any RTF certified under chapter 388-865 WAC as an evaluation and treatment facility, competency restoration facility or involuntary crisis triage facility;"
	  ○ 23-hour crisis relief will not replace triage. Triage and CSU will be combined. And there is an option to be voluntary or involuntary or both.
	• Got it, thank you. So does that mean that WAC 246-337-110 will be updated to remove "involuntary crisis triage facility" from (2)(a) and replace with CSU, or not replace with CSU? (I.e., will CSUs be required to have S&R?)
	  ○ Great questions! Yes, we will eventually remove the references to triage in the RTF WAC and the construction standards will remain status quo. Also, construction standards aren't applied retroactively, so if rulemaking is ever done to change construction standards existing facility are "grandfathered" in.
	• What would need to happen if a current CSU wants to add 23 hr beds, since they fall into OP rules would the CSU have to worry about IMD status.

	○ Based on conversations the department has had with HCA, IMD does not apply to the recliner/23-hour portion of the facility. • For more clarification, if we put 23 hr recliners in a CSU that already has 16 beds does it throw the CSU into IMD status? ○ The recliners do not count as beds and would not be counted toward the 16 bed limit for IMD status.
WAC 246-341-0200 **Behavioral health – Definitions.** "23-hour crisis relief center" means the same as defined in RCW 71.24.025.	There were no comments regarding this draft language.
WAC 246-341-0365 **Agency licensure and certification – Fee requirements.** (8) Agencies providing mental health peer respite services, 23-hour crisis relief center services, intensive behavioral health treatment services, evaluation and treatment services, and competency evaluation and restoration treatment services must pay the following certification fees: (a) Ninety dollars initial certification fee, per bed or recliner; and (b) Ninety dollars annual certification fee, per bed or recliner.	There were no comments regarding this draft language.
WAC 246-341-0901	There were no comments regarding this draft language.

Behavioral health outpatient crisis ~~outreach, observation and intervention~~ services – Certification standards. (1) Agencies certified for outpatient behavioral health crisis ~~outreach, observation and intervention~~ services provide face-to-face and other means of services to stabilize an individual in crisis to prevent further deterioration <u>and</u> provide immediate treatment or intervention in the least restrictive environment at a location best suited to meet the needs of the individual which may be in the community, a behavioral health agency, or other setting. (2) An agency certified for outpatient behavioral health crisis ~~outreach, observation and intervention~~ services does not need to meet the requirements in WAC 246-341-0640. (3) An agency providing outpatient behavioral health crisis ~~outreach, observation and intervention~~ services for substance use disorder must ensure a professional appropriately credentialed to provide substance use disorder treatment is available or on staff 24 hours a day, seven days a week. (4) An agency providing any outpatient behavioral health crisis ~~outreach, observation and intervention~~ services must:	
NEW SECTION WAC 246-341-XXXX **23-hour Crisis relief center services – Certification standards.**	**<u>Workshop participant comments/feedback on subsection (1)</u>** • What is the language in (k), regarding seclusion and restraint, there for?

(1) General requirements: An agency certified for 23-hour crisis relief center services must: (a) Follow requirements for outpatient crisis services in WAC 246-341-0901; (b) Provide services to address mental heath and substance use crisis issues; (c) Limit patient stays to a maximum of 23 hours and 59 minutes, except in the following circumstances in which the patient may stay up to a maximum of up to 36 hours when: (i) A patient is waiting on a designated crisis responder evaluation; or (ii) A patient is making an imminent transition to another setting as part of an established aftercare plan; (d) Be staffed 24 hours a day, seven days a week, with a multidisciplinary team capable of meeting the needs of individuals experiencing all levels of crisis in the community, including nurses, credentialed professionals who can provide mental health and substance use disorder assessments, peers, and access to a prescriber; (e) Offer walk-in options and drop-off options for first responders and persons referred through the 988 system, without a requirement for medical clearance for these individuals; (f) Only accept emergency medical services drop-offs of individuals determined to be medically stable by emergency medical services in accordance with department guidelines developed per RCW 70.168.170; (g) Have a no-refusal policy for law enforcement, including tribal law enforcement;	○ We already have guidelines in the RTF rules around seclusion and restraint, so this language references those existing guidelines. • Are there standards that would encourage alternative methods, rather than seclusion and restraint? ○ It is hard to but something in rule that encourages good practices, but the department can look at rephrasing how (k) is written so that it does not read as an assumption that the agency is using seclusion and restraint all of the time. ○ Additionally, WAC 246-337-110 goes into great detail into when it is acceptable to order seclusion and restraint. There are very limited circumstances under which it is used. It specifies how a person has to be monitored, immediate release, etc. • When referencing WAC 246-337-110, do we need to identify specific sections or amend (k) to make it more clear which parts of -110 apply? It is unclear which parts of the WAC apply here. ○ The department will revisit this. Additionally, in the future, we can amend the RTF WAC to make that clearer as well. • How about: When all other attempts have been exhausted, resorting to restraint and/or seclusion may be used with a plan to remove them as soon as safely possible. ○ Here is a link to the WAC that was referenced, which was based on federal language: WAC 246-337-110: • (f) Not understanding this. The person can have a hangnail but not a broken finger? ○ The individual must be medically stable to receive services.

(h) Provide the ability to dispense medications and provide medication management in accordance with WAC 246-337-105; (i) Maintain capacity to deliver minor wound care for nonlife-threatening wounds, and provide care for most minor physical or basic health needs that can be identified and addressed through a nursing assessment; (j) Identify pathways to transfer individuals to more medically appropriate services if needed; (k) Follow requirements in WAC 246-337-110 any time restraint or seclusion is used; (l) Maintain relationships with entities capable of providing for reasonably anticipated ongoing service needs of clients, unless the licensee itself provides sufficient services; (m) When appropriate, coordinate connection to ongoing care; and (n) Have an infection control plan including: (i) Hand hygiene; (ii) Cleaning and disinfection; (iii) Environmental management; and (iv) Housekeeping functions. (2) Initial screening: An agency certified for 23-hour crisis relief center services must: (a) Screen all walk-in's and drop-off's within sixty minutes of their arrival whenever possible for: (i) Suicide risk and, when clinically indicated, engage in comprehensive suicide risk assessment and planning; (ii) Violence risk and, when clinically indicated, engage in comprehensive violence risk assessment and planning;	○ The EMS team talked about these points during our third workshop on August 15th. The notes can be found here: Workshop 3 notes (wa.gov) **Workshop participant comments/feedback on subsection (2)** • 60 minutes seems like a really long time!! Anything can happen. Why is it so long? ○ During a previous workshop, the department conducted a poll on this topic and the greater consensus was that 60 minutes allows more flexibility. • Engaging a Peer Specialist on slide 16 makes a lot of sense. • Is the 23-hour clock running while someone is waiting? • What's the ED standard for when medical screening exam is required? ○ There is no specific timeframe in the acute care hospital regulations. • It's based on triage level for ED. • I agree with Laura - 60 minutes is wayyyyyy too long to wait for that screening - Immediate screening should be the goal - I can see the receiving agency's need to take the time it takes to do the screening - but certainly an immediate check on the patient's condition should happen! One of the biggest issues in the past (and still present, I would have to believe, is the inordinate length of wait times at ER's - during which many behaviorally challenged folks choose to leave (or more often) "run" away from the facility. • I think expecting facilities to triage, similar to an ED is reasonable. Some people may be fully capable of waiting for more than an hour, while others may need to be seen in 5mins.

(iii) Nature of the crisis; and (iv) Physical and cognitive health needs, including dementia screening. (b) Following initial screening, if admission is declined, the agency must: (i) Document and make available to the department instances of declined admissions, including those that were not eligible for admission, declined due to no capacity, or otherwise declined. (ii) Provide support to the individual to identify and, when appropriate, access services or resources necessary for the individual's health and safety. (3) Admission: An agency certified for 23-hour crisis relief center services must: (a) Accept eligible admissions 90 percent of the time when the facility is not at its full capacity. (b) Provide an assessment appropriate to the nature of the crisis to each individual admitted to a recliner. The assessment must inform the interval for monitoring the individual based on their medical condition, behavior, or suspected drug or alcohol misuse, and medication status. (4) For the purposes of this section: (a) Eligible admission includes individuals 18 years of age or older who are identified upon screening as needing behavioral health crisis services, and whose physical health needs can be addressed by the crisis relief center in accordance with WAC (xxx-xxx-xxxx).	• I thought one of the things that should happen when a patient/visitor enters the facility is that they are immediately met by a PEER counselor who likely would do a quick check on how the person is "presenting", thereafter calling for a medical professional to make a quick assessment. • With training of peers, I think that is a great idea. • This feels very specific for rule, especially dictating who (e.g. a peer) should be doing the greeting. • The focus should be on the patient, not the ability of the facility to receive the individual, for whatever reasons. • If these standards for Peers are to include prior training we need to make sure we are partnering around this with HCA as they move forward with their new training and certification program that starts rolling out soon. • Here is a link to the ESI triage that made ED's use as an example. Emergency Severity Index (ESI): A Triage Tool for Emergency Department Care, Version 4 (emscimprovement.center) • The expectation should be that people are seen and acknowledged upon their arrival at the facility. • During the workshop, there was a lengthy discussion with all these points about having a time requirement in it or not and what the time should be. There were good reasons 30 was not enough and 60 would be acceptable. Julie, Dan, please go back to those discussions before changing the language. **Workshop participant comments/feedback on subsections (3) and (4)** • Can you clarify why a percentage is needed?

(b) Full capacity means all licensed recliners are occupied by individuals receiving crisis services.	○ This comes directly from the statute. • Is there language anywhere else that specifies who is qualified to provide assessment? ○ See (1)(d) above – "with a multidisciplinary team capable of meeting the needs of individuals experiencing all levels of crisis in the community, including nurses, credentialed professionals who can provide mental health and substance use disorder assessments…" Rather than call out who does the assessments, refer to appropriately credentialed professionals. • How is full capacity defined? • Full capacity is going to be a moving target. These are not sleeping accommodations, they are chairs that tilt back and forth so full capacity won't be stable. People will be getting discharged and others will be coming in. They are awkward chairs and it's an awkward place to get services. • If an individual meets admission criteria or medical necessity, there is no option to not admit. • Concern about long-term care facilities using these as a dump site for individuals. ○ The statute requires DSHS and Department of Veterans Affairs to develop rules for the facilities that they license that would prevent this from happening. • There will be people in nursing homes who will be in crisis and could benefit from CRC services. • Patient dumping does happen and 23 hour CRCs will be tempting. • This is a new system of care in development, so there will be a long period of time before we see any systems data.

	• Facilities will have staffing challenges – health care staffing is difficult right now. If the facility can't staff one day, they will still be held to the same "full capacity" number. If the facility is only able to staff to half of their licensed recliners one day, they'll need to turn down more individuals than that.
	  ○ If the department was to change the definition to staffed capacity, we would need to add requirements that CRCs have documented staffing plans, in order to help the department understand the facility's staffing model.
	  ○ The language would allow the facility to decline admissions due to short staffing 10% of the time and be in compliance with the WAC. Also, to Laura's previous point, census at these facilities will likely be very dynamic so remaining at full capacity for long periods of time would hopefully be rare.
	• Can DOH provide waivers or exemptions?
	  ○ If the facility has a chronic staffing shortage, they could decrease the number of licensed recliners temporarily.
	  ○ If there is a flu or COVID surge and staff are out sick, there is an option for the facility to request temporary exemptions or alternative methods of compliance.

WAC 246-341-1140 **Crisis stabilization unit ~~and triage~~ – Certification standards.** An agency certified to provide crisis stabilization unit ~~or triage~~ services must meet all of the following criteria: ~~(1) A triage facility must be licensed as a residential treatment facility under chapter 71.12 RCW.~~	There were no comments regarding this draft language.

(2) If a crisis stabilization unit ~~or triage~~ facility is part of a jail… (5) For persons admitted to the crisis stabilization unit ~~or triage facility~~ on a voluntary basis, the individual service record must meet the individual service record requirements in WAC 246-341-0640. (6) An agency certified to provide crisis stabilization unit ~~or triage~~ services must meet the service standards for residential and inpatient behavioral health services in WAC 246-341-1105 and the applicable standards in WAC 246-341-1131 if providing involuntary crisis stabilization unit ~~or triage~~ services.	
WAC 246-341-0912 **Designated crisis responder (DCR) services – Certification standards.** Designated crisis responder (DCR) services are services provided by a DCR to evaluate an individual in crisis and determine if involuntary services are required. An agency providing DCR services must do all of the following: (1) Ensure that services are provided by a DCR; (2) Ensure staff members utilize the protocols for DCRs required by RCW 71.05.214; (3) Document that services provided to the individual were in accordance with the requirements in chapter 71.05 or 71.34 RCW, as applicable; and	There were no comments regarding this draft language.

(4) Meet the outpatient behavioral health crisis ~~outreach, observation and intervention~~ services certification standards in WAC 246-341-0901.	

RCW Requirement:

(7) The department shall coordinate with the authority to establish rules that prohibit a hospital that is licensed under chapter 70.41 RCW from discharging or transferring a patient to a 23-hour crisis relief center unless the hospital has a formal relationship with the 23-hour crisis relief center.

Draft Language	Notes
WAC 246-320-111 **Hospital responsibilities.** This section identifies a hospital obligation, actions and responsibilities to comply with the hospital law and rules. (1) Hospitals must:… <u>(3) A hospital that wishes to discharge or transfer a patient to a 23-hour crisis relief center, as defined in RCW 71.24.025, that is not owned and operated by the hospital, must have a documented formal relationship, such as an agreement or memorandum of understanding, with the 23-hour crisis relief center the patient will be discharged or transferred to.</u>	**<u>Workshop participant comments/feedback</u>** • If they own and operate a CRC, as long as they are the same entity, such as UW already having a formal relationship with Harborview, that should be allowed within the statute, right? ○ If the CRC is part of Harborview and they have a formal relationship with UW, that existing agreement should cover them. If Harborview has a free-standing CRC and they don't list it under their hospital license, then the existing agreement would be hospital-to-hospital, so then UW would need to set up an agreement with Harborview. • Would this language apply to a patient who comes to the ED but won't need inpatient admission, could they be referred to a 23-hour facility? • "Discharge" and "transfer" are not defined terms. It would be helpful to have clarity around what they mean. If a patient comes to the ED but they don't need inpatient level care, they cannot be discharged. There will be patients that need outpatient BH care. Can a hospital refer them to the CRC or is that a transfer? • A referral is different from a transfer. If someone comes into the ED, they would receive a screening. But if it is identified

	that they can be served by a CRC, it is appropriate for the ER to refer them to the 23-hour service. • Even if the facility is owned and operated by the hospital, surely the hospital and/or the 23-hour CRC would have a written policy & procedure for this instance? **Department comment/response** The department will take these comments into consideration and will revisit this language.