Behavioral Health Agency Rulemaking Workshop – Notes
August 2, 2021

Type/category of Service	Core Requirements	Current individual services under the category	Potential individual services under the category	Talking points/ Notes
Information, Assistance, and Referral	• No assessment No ISP • No clinical record	• Alcohol and drug information school • SUD information and crisis • Emergency service patrol	• Alcohol and drug information school • Emergency service patrol • Crisis telephone support • Housing assistance • Employment assistance	• Found another existing category: **Information, Assistance, and Referral** • Column on left are sort of existing categories • Pulled out very high-level general requirements • Listed current services under each category • Considered modifications based on core requirements and where services might be a better fit • Housing and employment assistance AKA supportive housing and supported employment. Do you agree that no clinical assessment, no ISP and no clinical record required? • Telephone support- think call center. Does this category make sense? ***Notes****: These are non-clinical services. Do Supported Housing & Supported Employment fit here or in support services?* ***Pattie Marshall****: Can all Certified agencies do Info, Assist, & Referral, like a resource room or referral service? It seems it would be a service all might provide?* ***Answer****: Any agency should be able to provide.* ***Paul Nagle-McNaughton:*** *Our supported housing services are typically in conjunction with your treatment services.* ***Answer****: Some agencies only provide information/assistance/referral. We want to make it easier for these agencies. If you get a certification for the higher level of care, you can add on these lower level of care services.* ***Becky Olsen****: If Supported Housing/Employment are in HCA WAC do they need to be here?* ***Amiee Champion****: I think having regs that reflect the services that do get provided in this context (i.e. housing and employment assistance) helps bolster funding for the work. In reality, people don't live in WAC categories exclusively, so the more we can integrate &/or cross-reference the more reflective we are as a service system.* ***Pattie Marshall****: there are agencies that do F0oundational Currently, Peer run org that do Foundational Community Supports (Housing & Employment) require assessments and service plans, some of those agencies this is the highest "level " of service that is provided at those community agencies. They are not required to*

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				be "certified" just contracted w Amerigroup. Don't need a BHA license. would this change that and possibly require a certification? That might be a concern for some organizations. ***Answer****: No* ***Alicia Ferris****: I believe both supportive employment and supportive housing are designed to be a part of treatment. A "support to treatment". Which would mean having it stand alone doesn't make a ton of sense.* ***Answer****: Medicaid reimbursement requirements make this tricky. We want our WAC to be about minimum licensure standards* ***Kelly Tongg:*** *Does Alcohol and drug information school now include SUD information and crisis? Or is this proposing to remove SUD information and crisis altogether from this category?* ***Paul Nagle-McNaughton:*** *Statement not question: I like the idea of nested certification. If you can do a higher level of service, certification for lower levels are not needed.* ***Mike McIntosh:*** *I support the concept that DOH certification at a higher (or more prescriptive) level are eligible to provide all categories of services that have less prescriptive regulatory requirements.* ***Becky****: Amerigroup contracts with providers for supported housing/employment. This function is like concierge – housing facility requests help, we'd provide it. This doesn't work in practical terms. We do an assessment of functional areas & planning activities, so if we're going to do it, it needs to mirror HCA. But why include it if HCA has it. If we do include, it should be the same.* ***Answer****: Let's explore if there's added value by having in this WAC.* ***Pattie Marshall****: It makes sense for the individual who does not be engaged in treatment or prefer to get services from a peer run org (very effective when org coordinates w treatment) and sometimes treatment isn't offering those supports* ***Ryan Sain:*** *I have concerns that Applied Behavior Analysis is listed under 'support' and not Interventions, assessment and testament level. What are the implications of moving it to the IAT category?* ***Jessie Ellis:*** *I'm a bit confused, wouldn't this potential service be along the lines of thought that someone should be able to do a referral to Housing/Employment*

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				without the person needing to be a client. It would just allow referrals. The actual assistance for either would fall under the support category if our organization was to provide it. ***Answer****: We can think about this. I'm really curious about HCA WAC component.* ***Michael Carpenter****: I would also agree with the concept of "nesting."* ***Pattie Marshall:*** *the added value is that not all treatment providers are going to do the same model of Housing and Employment (such as FCS). if it stays here then the agencies can provide those supports via a different model and not contract w Amerigroup.* ***Pam Brown:*** *No added value to add it to WAC's. (FCS)* ***Becky Olson-Hernandez****: The Foundational Community Supports WAC is 182-559 (last topic area)* ***Action: Have a conversation with HCA about these services****.* SUD Information and Crisis services: is kind of a version of MH Crisis outreach & telephone services. Out in the community and over the phone. We would like to try to harmonize things that have a MH & SUD version to come up with a BH version. *Crisis Telephone Support: Does telephone support require an assessment, ISP, clinical record? If all you are doing is acting as a call center?* ***Pattie Marshall****: People I've worked with were in treatment but needed phone support for something new. Maybe this needs to be with treatment options or in both places.* ***Answer****: It currently doesn't live under treatment options. The nested options allow for both places.* ***Alicia Ferris****: tto dive into semantics again, I think calling it assistance changes it. supportive housing and supportive employment are models* ***Paul Nagle-McNaugton****: Statement: From an integrated care perspective, creating a single behavioral health certification by combining MH and SUD is a good idea whenever possible.*

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				Becky Olson-Hernandez: *It fits best where you have now located it.* ***Michael Carpenter***: *I agree. A "stand-alone" crisis phone support seems to fit best with Information, Assistance, and Referral.* ***Pattie Marshall***: *Thank you for combining MH&SUD! Is there a legal push to have parity between MH and SUD survives?* ***Answer***: *We've been taking steps where we can. Like licensing SWMS & E&T together. Hints from the Legislature.* ***Michael Carpenter***: *Combining MH with SUD as "Behavioral Health" whenever possible seems to make sense as well.* ***Mary Stone-Smith:*** *I'm a little confused about where mobile crisis teams fit?* *Answer: Outreach*
Support	• Assessment and ISP informed • Modified clinical record/documentation of service	• Supported employment • Supportive housing • Peer support • Peer respite • Applied behavioral analysis • Consumer-run clubhouse	• Peer support • **Peer respite** • Applied behavioral analysis • Consumer-run clubhouse • Rehabilitative case management mental health services • **Psychiatric medication management services** • Medication monitoring services • Day support mental health services • Crisis stabilization (or crisis support)	• Most challenging section. • Agencies not required to do the assessment and ISP themselves but can partner with another agency to meet this requirement. • Would rehab case management fit with these core requirements? • Is medication management a higher level of care than a support service? Is it appropriate for this service to rely on an outside assessment? • Is medication monitoring appropriate for this section? • There are sort of two versions of day support (clubhouse and PHP). Description of day support says MAY include therapy. Should we break out day support and PHP? If so, can day support fit in this section? • If you read the outpatient crisis stabilization section it describes it as support services. Can we move it to this section? Can we call it crisis support instead of stabilization to avoid confusion? • Peer respite isn't fitting in nicely anywhere, so I'd like to circle back to this later. ABA: ***Ryan Sain***: *I understand that it's currently a support service. But it doesn't seem to be the best fit. No one that I'm aware of is qualified to write behavior analytic*

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				plans so it should be a stand-alone. Consider it to be its own certification under treatment. Don't outsource the assessment. ***Answer****: ABA is something we needed to come back to.* ***Holly Borso****: Please put ABA in a separate category. Separate referral, qualification source – When ABA was put into this WAC there was no intention for there to be overlap because the training is so specific. That might be a better place for that.* ***Becky Olson-Hernandez: ABA*** *most accurately belongs in Intervention, Assessment, and Treatment. It may mean that they have responsibilities under WAC that they don't currently have.* ***Action: When we run a special workshop just for ABA, add these 3 comments to that conversation.*** Rehabilitative Case Management Can we just have a general Case Management certification? Is it a support service or intervention, assessment & treatment? ***Alicia Ferris:*** *I've spent a lot of time looking at this WAC. We were trying to operate under it with juvenile justice. Above & beyond care coordination. We were doing brief MH assessment, referrals, crisis – not doing treatment. Goal was getting them from JJ system into BH system. Given the legislation to those transitions to meet MH needs in child welfare & JJ – there is a place for Rehab Case Mgt if it's expanded from institutions and instead 'systems transition' without requiring an ISP and making it a full treatment program. That would be amazing.* ***Answer****: If that were the case, would it fit in support or intervention?* ***Alicia****: It would fit in support right along crisis. The WAC didn't allow us to use this for juvenile detention. WAC needs significant changes in language to meet that need.* ***Becky Olson-Hernandez****: intervention, assessment and treatment should include Case Management. There may be a different category that is "support" and is more like a care coordination model. Can we broaden this and call it Care*

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				Coordination? I get twitchy when we provide treatment without an assessment? Maybe Care Coordination. Separate the 2 things. ***Timothy Joliff****: Is the idea that rehabilitative case mgmt is time limited?* ***Answer****: This is from Medicaid state plan, so not sure. Because if rehab case mgmt is for folks who are coming out of inpatient, you would be working towards the clt staying at baseline during the transition and move to "standard" case mgmt. I'm also thinking because recovery is cyclical, is there a way for folks to go b/t rehab case mgmt and individual case mgmt. To answer the question, I think it should be in support.* ***Mary Stone Smith:*** *Agrees with comments. Rehab Case Management needs to be expanded beyond a facility and if a change allows that, it would be helpful.* ***Paul Nagle-McNaughton****: There may be a good case to separate "case management / care coordination" in support from "rehabilitative case management services" under the IAT category.* ***Pattie Marshall****: Rehab Case management, like you said, is utilized, often by certified peer provider types coordinating and supporting individuals as they transition from institutional settings, they are working at a variety of BHA, peer run orgs, community treatment programs. It would need to be a "billable service" for most agency certifications, we have to be careful because the service is essential before they leave the institution, such as state hospital.* ***Kate Rowe:*** *I know for WISe, we can only use rehab case management code 30 days after admission and 30 days before discharge inpatient (time limit)* ***LaVonne Fachner:*** *a simple vote of placement in that category. However, the dissemination of the different types of case management would be pertinent.* Psychiatric Medication Management: Is medication management a higher level of care than a support service? Is it appropriate for this service to rely on an outside assessment? ***Sara Brown****: Requiring the ISP will significantly limit the ability of agencies to serve clients.*

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				Alicia Ferris*: would be absolutely wonderful if an agency could stand alone in providing meds only. This is a huge need in individuals discharging from Behavioral Health Agencies who need continued meds but can't find a provider comfortable continuing those meds* ***Jessie Ellis:*** *Vote for keep in support and not move to IAT* *Medication Monitoring: Support Service.* ***Sara Brown:*** *We have seen an influx of clients that cannot find medication services but will not engage in clinical services. Having the ISP for both Medication Monitoring and Psychiatric Medication management will put increased burden on clients and providers* ***Becky Olson****-Hernandez I think these med areas have some increased risk that will have to be dealt with.* ***Answer****: We're getting into provider's scope of practice and provider decision making which falls under provider's clinical judgment.* There are sort of two versions of day support - clubhouse and partial hospitalization program (PHP). Description of day support says MAY include therapy. Should we break out day support (support) and PHP (treatment)? If so, can day support fit in this section ***Becky Olson-Hernandez:*** *Should day support specify MH?* ***Answer****: we could think about it. Billing and licensing rules might be different.* ***Melanie Green:*** *If this WAC work is related to certifications vs. billing, why wouldn't Clubhouse be certified under Clubhouse and Day Support be Day Support (including partial hospitalization). I was just wondering what the need was for a Partial Hospitalization certification* ***Answer****: That is an option for the licensing rules. A clubhouse wouldn't also have to get a day support certification. If that's the case, do we need a day support service or just have clubhouse and PHP? Are there non consumer run agencies that want to do day support?* ***Pattie Marshall****: (maybe it has to wait for larger peer respite services) would peer respite fall under this category, for individuals that do not need overnight respite?*

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				Answer*: Peer Respite is overnight. If there was a non-overnight respite it could be day support potentially.* ***Brooke Evans****; I think this is a great thing to consider. Partial hospitalization "day support" is very different - different level of care. This would be a good future conversation.* ***Paul Nagle-McNaughton****: I like having the three choices: Peer Run Clubhouse, agency Day Support, and Partial Hospitalization.* ***Becky Olson-Hernandez****: Partial hospitalization might be good to include, but not as a "support" as it's more like step-down treatment* ***Sean Davis:*** *Prefer having all 3 options* ***Melanie Green****: I agree with those who have suggested having all three* Outpatient Crisis Stabilization: Currently lives under crisis services. If you read the outpatient crisis stabilization section it describes it as support services. Can we move it to this section? Can we call it crisis support instead of stabilization to avoid confusion? ***Becky Olson-Hernandez****: Crisis support seems clearer than stabilization* ***Paul Nagle-McNaughton:*** *I would agree: Crisis Support Services outpatient and Crisis Stabilization Unit* ***Brooke Evans****: Agree would be helpful to re-label. Crisis support is different than stabilization.* ***Sara Brown****: Will crisis outpatient fall under the IAR?* ***Michael Carpenter****: Crisis support seems like a more accurate description.* ***Ann Payne****: Crisis support fine as this assumes includes stabilization* ***Alicia Ferris****: Back to the systems issue, crisis is often provided outside of traditional "crisis line" or mobile outreach" and the WACS currently don't account for that*

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Intervention, Assessment and Treatment	• Assessment • ISP • Clinical record	• Individual mental health treatment services • Brief mental health intervention treatment services • Group mental health therapy services • Family therapy mental health services • Rehabilitative case management mental health services • Psychiatric medication management services • Medication monitoring services • Day support mental health services • Substance use disorder level	• Individual mental health treatment services • Brief mental health intervention treatment services • Group mental health therapy services • Family therapy mental health services • Substance use disorder level one outpatient services • Substance use disorder level two intensive outpatient services • Substance use disorder assessment only services • PHP	• We'll talk more about bundling these services, what we do with this section is informed by what we've already talked about • Should we add PHP to the list? ***Becky Olson Hernandez****: don't know that we need a separate brief category...* ***Mike McIntosh****: IAT category looks great. Move in the right direction for integrated MH/SUD service* ***Pattie Marshall****: Peer Support services are not included ...* ***Answer****: Those would be nested.*

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		one outpatient services • Substance use disorder level two intensive outpatient services • Substance use disorder assessment only services		
Outpatient Crisis	• No assessment • No ISP • Modified clinical record/documentation of service • 24/7	• Crisis telephone support • Crisis outreach • Crisis stabilization	• Crisis outreach • Crisis stabilization/walk-in?? (<24 hour on-site care) • **Peer respite**	• Again, we discussed some of this already. • I would like to consider adding an additional service to the list. • We currently have programs that we are smushing into the crisis outreach category because they provide the same service, but in a walk-in clinic types setting. Less than 24 hr. care, but inside a facility. *What about splitting outreach & walk in?* ***Pattie Marshall**: In both this and the previous category: I do understand that some of those services can be provided by different provider types, but personally, I like it listed as often as possible as a "standard". Answer: Crisis Outreach has its own standards – within that it is more prescriptive. Those requirements will still exist in the WAC. They just aren't on this chart.* ***Alicia Ferris**: Do we need to break out all the services so distinctly in that category (Intervention, assessment and treatment)? **Answer**: Great question. I have another option.* ***Kelly Tongg:** Yes, we need the language to differentiate outreach vs. in or at a facility* ***Alicia Ferris**: Under crisis: can we leave the category simply as "crisis" and cover those various forms? **Answer**: This is an option. Regulation looks the same. The*

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				level of detail we collect for each type is for data. We can ask ourselves after we have the categories, we'll ask if we want these individuals listed. *Becky Olson-Hernandez: I've been involved with these 23-hour recliner types – they serve a good function. It's a facility & I can transfer to inpatient if necessary. I'm a little uncomfortable not attaching facility to the title. Intent was to take an opportunity to evaluate & stabilize someone with multiple medically trained staff available. Triage or CSU – where we can help someone stabilize within 12 or 14 hours. I get uncomfortable with walk in. Would like it to be a facility based multidimensional triage process (not sitting in my waiting room for 6 hours).* ***Answer**: We kind of do have 2 models. Kind of like a BH emergency room that is attached to a facility. Some people want it to have more of an urgent care, which is not attached to a facility. We almost have these 2 similar but different types.* ***Becky:** more like urgent care. Open access within all of our current licensing structures. This is more than that 23-hour observation bed/recliner. More like urgent care (maybe between urgent care and ER). Not staffed with MDs but may have telepsychiatry or something. Definitely different than outreach. Answer: We're putting it in outreach since we don't have a category.* ***Becky**: If we do create a category for this should we create some specific requirements differentiating this from outreach & inpatient or residential crisis. You can't bill for a recliner slot though. But if DOH things this is a modality; we should more clearly define what is more appropriate level of care. Crisis observation services.* ***Paul Nagle McNaughton:** Perhaps Crisis Management Services, or Crisis Monitoring Services. Don't like 'walk in' – it's referrals from DCRs with the hope that we can stabilize them in the community.* ***Melanie Green**: the model you are talking about fit under either PHP or day support?* ***Mary Stone Smith**: Could Crisis be defined as either outreach or on-site?* ***G'Nell Ashley**: Crisis Services in agency setting* ***Ann Payne**: Need additional clarity regarding distinction between crisis out versus on-site. Would crisis "out" be similar to 'crisis mobilization' that our BHASO is*

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				tracking. Crisis 'walk in' or otherwise on site falls under crisis category Answer: it might be the best fit. ***Sara Brown****: Are you expecting walk-in to be 24X7 as well? Our community has expressed a high need for SUD crisis services. Is there a way to allow for SUDP to provide crisis services* ***Answer****: take them 24 hours but not stay 24 hours. It would be nice to be crisis BH outreach. But we don't know if this messes with reimbursement.* ***Kelly Tongg: Yes****, we would like to know. DESC provides SIGNIFICANT crisis outreach services and crisis walk-in type services. For data collection purposes, I think it's important to differentiate the two for health equity purposes.* ***Michael Carpenter****: Crisis services "community" and/or "agency" services could be a good "catch all"* ***G'Nell Ashley****: Crisis services look differently between SUD and Mental Health. Answer: Yes, there are differences – who provides them, etc. But is it different in how we regulate? We will think this through.* *Melanie Green: I would avoid the term "walk-in" because it may not be a walk-in service, people may need to be referred or screened somehow* ***Mary Stone Smith:*** *I agree with differentiating between outpatient and inpatient for Crisis* ***Pattie Marshall****: Behavior health crisis often may need to meet people in the community, so I am wondering, can we have both? having the crisis outreach would create the opportunity for people to be supported in the place of their choice, then refer or stabilize with referral etc. Answer: We want to maintain outreach component.* ***Robert Hamilton****: crisis behavioral health services is preferred over bifurcated approach to MH & SUD silos* ***Ann Payne****: Does the data collection needs/interests need to be incorporated in the WAC? This could change..? Agree Inpatient & outpatient separation makes sense*

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Inpatient/Residential Crisis	• Assessment • ISP • Clinical record			
Residential	• Assessment • ISP • Clinical record			
Involuntary inpatient/residential	• Assessment • ISP • Clinical record			