Behavioral Health Agency Rulemaking Workshop – Notes
July 27, 2021

Slide 1

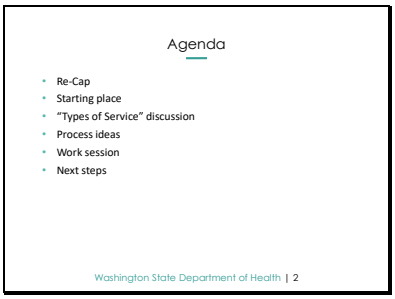
Welcome to meeting #2 in our workshop series.

DOH team: Facilities Program Managers, providing technical assistance and conducting policy work for our assigned facilities types.

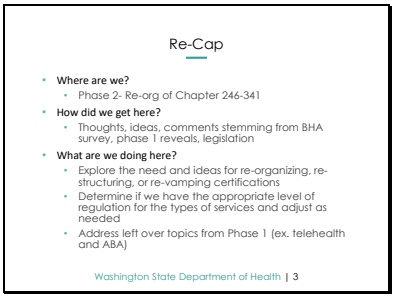
- Julie Tomaro, Oversee/supervise all facility type work and lead for acute care hospitals.
- Michelle Weatherly, Outpatient behavioral health.
- Dan Overton, Inpatient/residential behavioral health facilities.
- Stephanie Vaughn, policy analyst support.
- Kseniya Efremova, policy analyst support.

A list of attendees may be provided if requested.

Slide 2



Slide 3



Goals:

- Support a behavioral health agency's ability to provide services for co-occurring mental health and substance use disorders.
- Improve the ability for an individual to have continuity as they transition through levels of care.
- Simplify

Goals:

- Scope rules to align more closely with the specific rule-making authority in RCW 71.24.037
- Develop a more consistent level of regulation across service types

Goals:

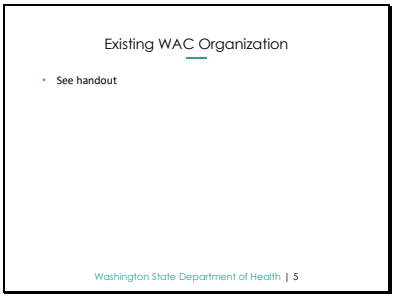
- Finish phase 1 clean-up work

Behavioral Health Agency Rulemaking Workshop – Notes
July 27, 2021

Slide 4

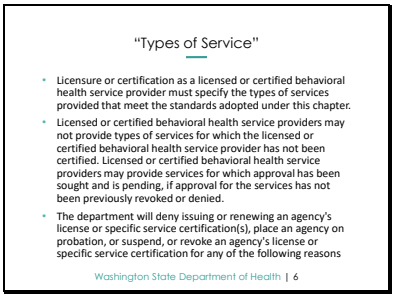
- Support for broadening level of certification.
- Polling identified that most attendees recommended broadening certifications either somewhat or a lot.
- Polling information and thoughts were used as a guide for today's workshop.

Slide 5



- Use existing WAC structure as the starting place and adjust it from there.
- Handout shows how our WAC is currently organized into different services under headers.
- Discuss certifications being granted at the higher "header" level versus the individual service level.

Slide 6



Changing or restructuring certifications will redefine "type of service" for licensing and certification purposes. The language on this slide is directly from the BHA licensing statute Chapter 71.24 RCW.

Currently, the rules imply (not defined) that a type of service is each individual-specific service. If we certify at a broader level, would we be broadening the implied definition of "type of service" to the broader level; making a distinction between type of service and individual/specific service.

What would be changed?

- First bullet point on slide 6; this means that on the license document it specifies the type of services that the agency is approved to provide based on the standards being met. This means that on the licensing document it would list a broader certification versus all of the individual services. If collecting information on all of the individual services is important, we can still collect the information and have it available.
- Second bullet; an agency may not provide types of services unless approval has been sought. Currently, this applies to every individual service (if you are certified for individual treatment and you want to add group therapy you cannot provide it unless you

have submitted a license amendment to add the service. If we broaden the certification level then this would apply at the broader level.

- Third bullet; one of the tools DOH can use for enforcement purposes is to revoke a certification. Currently, this applies to specific individual services but if we broaden certification levels this could look a bit different. For example, if we certify an agency for outpatient services, which include the ability to do individual and group therapy and that certification was revoked then neither service could be provided. Currently, the department could revoke just individual treatment certification or just group therapy certification. If this is problematic then we may need to consider revising this section of WAC as well.

Discussion:
Attendee - One concern I have with doing away with certifying individual types of services is the possible unintended consequence of requirements that currently apply only to one certification having to apply to all. Take outpatient services for example…if an agency only provided peer support, they would have to meet all the requirements of medication management as well.

DOH - There is an algorithm that will help address that.

Attendee - Some that don't provide full scope – by lumping them all together you are moving in a direction that they may not be qualified to do. It may create challenges. If we go to a general set of core services, if there would be the option to designate that a BHA is licensed for moderate to severe that are under our scope of practice.

DOH - We will look at this as well and talk about whether or not we feel that the overarching categories are too broad, and we need to split them out more. There are also some potential assumptions and logistics that we will talk about.

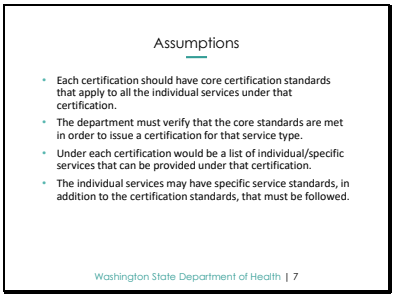
Behavioral Health Agency Rulemaking Workshop – Notes
July 27, 2021

Attendee - We have locations in WA and OR, and the OR licensing model uses the broader categories for agency licensing (Outpatient MH, Outpatient SUD, Intensive Outpatient…etc.) It is much easier to manage as agencies don't have to update licenses unless there are major changes to service types.

Attendee - Agency level v. individual service level. We have to certify every service at every location. There will be a lag in changing services for new locations. It would be nice at the organization level and submit the ADA checklist. Every time we move, it is burdensome to have to do the certifications for every site v. at the organization level.

Attendee - Is this the main site location v. branch site locations? If I'm qualified at site A why recertify at another site if we are still giving the same oversight. Demonstrate that the site meets the minimum standards.

Slide 7



DOH - Assumptions: If we certify at the broader "umbrella" level, each certification should have core standards that apply to all the individual services under that certification. The core standards should be the primary way the department assures patient safety. We could refer to these as the certification standards. Under each certification there would be a list of individual services that can be provided under that certification. The individual services may have specific service standards, in addition to the certification standards, that must be followed. The individual service standards would include minimum requirements that aim at assuring the service is provided in a consistent manner.

For some services there may be some specific language that we may want to keep in WAC to ensure that there is a standard for that service.

Example of this: Psychiatric Med mgt fell under an outpatient certification. There are core standards for outpatient services. If you choose to provide psych med mgt – there may be some additional language in the WAC that sets requirements for that individual services – store mediations, document medication administration a certain way. The individual service has additional requirements attached to it that don't

necessarily apply to example – individual mental health treatment.

Any objections to these assumptions or other ideas?

Discussion:
Attendee - Could you comment on how similar or different these are from the standards for hospitals? Mindful that hospitals are also nationally certified. Barring that difference.

DOH - Hospital licensing structure can be found in Chapter 246-320 WAC. There are sections for specific services, such as surgical services, emergency services, etc... For each of the services, there will be language that says something like "for each of the services provided hospitals must…." And then list the standards that must be met.

Attendee - I think there is an assumption here that those core certification standards would result in therapeutic outcomes. It would be good to acknowledge because until we can be assessed based on whether or not our services are effective, we are following regulations that assume if we do something a certain way, it will result in the people we serve getting better and those core standards are not always evidence and research-based. So approaches that should take precedence over anecdotal industry norms that are considered "best practice" but not proven to result in better outcomes. Does that make sense?

DOH - The goal is to look at if we have the appropriate level of regulation for each of the services. Reason is that under the authority for Chapter 71.24 RCW there is a subsection that says as part of rulemaking the department would need to put in the intended result of each service. We need to talk through that and what that means and what that looks like in rule.

Attendee - Is it possible when we discuss deeming, if they are nationally certified, that their experience is more like what hospitals have? It has a different

regulatory approach. Accredited organizations are more streamlined with regulations.

DOH - We will have more discussion on deeming. Once we establish the general standard then we can compare how the new approach will fit with the deeming conversation. Feel free to keep sharing deeming concerns so we can address them later. Feel free to keep sharing deeming concerns so we can address them later.

Attendee - I feel that we may end up with several "specific standards" in nearly all services. Could we consider just making reference to the other WAC or RCW's that pertain to the specific service OR are you saying we will write in additional language under each?

DOH - We did work last summer on requirements and WAC clean up. We will not redo that work but instead will take existing work and shift to accommodate the certification reorganization. We don't have time to go back and re-write the requirements. If some are missing or should be removed we can look at that.

Attendee - Hospital standards. What about outpatient primary care certifications?

Attendee - What about primary care clinics?

DOH - Envision that a primary care clinic would take advantage of whatever certification fits their model. We wouldn't be incorporating physical health standards into outpatient BH standards at this time but it is an interesting concept. Arizona example – they address both and don't silo either. For now, we will keep it specific to behavioral health.

Attendee - We want it more accessible – behavioral health more like primary care. We are more regulated and is problematic that there is no acknowledgement around that and billing codes. State has put zero effort in putting behavioral health in primary care. Primary care is unregulated in this way and there is a double standard. They have less documentation in primary care settings providing BH services because they don't have

to have a behavioral health license to provide services in primary care.

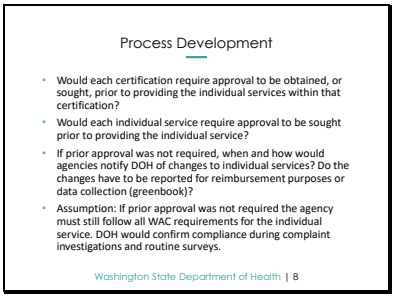
DOH - We have authority to license behavioral health agencies, but we don't have the same authority for primary care.

DOH - Even though we are trying to do that with this multiphase project – how can we make it easier and closer to a primary care model.

Attendee - Would it be fair to say that this proposed approach to certification would make it less time consuming/cumbersome for agencies to pivot and offer other services under that certification? We would not have to "add the additional service to our license."

DOH - This would help with that, but we need to work through how much it will help. Core standards is what would make the state comfortable to help ensure that agencies are providing safe care. Requirements attached to services are aimed at consistent care as the core standards ensure patient safety. Potentially we would allow flexibility to adjust the individual services without the administrative burden.
Ideal vision for the certification process.

Slide 8



Bullet 1 - Poll:
Would each certification require approval to be obtained prior to providing the individual services within that certification?

Yes – 88%
No – 4%
Other – 10%

Attendee - "Approval to be obtained" is a bit confusing. Are you saying that it would be applied for, or approved before providing service?

DOH - With the approval – yes – you would submit to the department for approval. I would need some legal advice but there seems to be wiggle room regarding

when they sought approval and when they can provide services.

Bullet 2 – Poll:
Would you want each individual service to require approval to be sought prior to providing that individual service?
Yes – 35%
No – 53%
Other – 12%

Attendee - Last week we discussed the possibility of adding a service, with notification, and changing certification at annual review, is that memory correct?

DOH - Yes – we did discuss that.

Attendee - I'm ok with certifying each service, so long as each service doesn't have to be certified at each site; not if it falls under the core services of that certification. That is the thinking behind my no vote.

Attendee - An example of why unable to say yes or no to the poll would be SUD outpatient services. No need for prior approval if adding LOC 1.0 to an already 2.1...

Bullet 3- Hospitals provide info during their annual update. Would this impact your ability to get reimbursement even if the individual services were considered “pre-approved” based on your certification. Greenbook hasn’t been updated since 2019.

Attendee - If prior approval was not required for individual services, when and how would it be appropriate to notify the department? Right away, six months, or during the annual renewal?

DOH - Upon annual renewal.

Attendee - In the scenario you describe, notification at the annual renewal would be reasonably timely and promote flexibility for agencies.

Attendee - Prior to providing that service, I would assume we could ask for a "notice of intention and understanding of requirements" then review of those services at annual review. I think creating a simple process that includes some planning, then a progress report at annual renewal.

Attendee - The agency can give the department a head's up that they are adding the service and attesting that they are meeting requirements and then the department would officially approve at the annual renewal. Is this the idea?

DOH – Yes. This would follow hospital methodology.

Attendee - Can anyone provide examples of an outpatient BH/SUD agency that would not have a reasonable amount of time to notify the department of additional services? I just don't see why an agency couldn't do this promptly.
There is a difference between a notification – the renewal is a review process. Is it too burdensome to expect a head's up to the department?

Attendee - I manage 8-10 locations and changes are always happening. That is when it becomes burdensome. Different sites are on different timelines. If it's part of an annual renewal seems like a good time to notify. I wouldn't see a need for approval for individual services if we are approved for broader categories.

DOH - There's a greater impact on those multi-campus agencies.

Attendee - It sounds like the more granular services would not be certified but then DOH would still be tracking, approving, and overseeing those as individual service types rather than as the umbrella service category?

DOH - Good question – we need to clarify. A full approval process at the certification level for the broad categories.

DOH - My vision would be for individual services and not a full approval process. We would assume that agencies meeting the core standards could provide those services safely. When the department does a routine survey, they would check that WAC requirements are being met. We would be able to regulate at an individual service level but not have to apply and obtain approval first. If we were to get a complaint, the department would be able to use the WAC to apply those requirements at that time.
I think the heads up also allows DOH to prepare for the annual review.

DOH - Hospital example – survey pulls their credentialing file. If they have reported changes they will know. They only have to do it once a year and they go to the hospital and have them tell the department what services they are providing. A head's up helps prepare the survey team but there are other examples about how the department adapts on the spot.

Attendee - I think an easy online form to complete and submit to the department saying "intention" to add additional services and estimated date would be good and could do quite quickly. I mean agencies DO plan ahead when adding services.

Attendee - The need is to inform at the time of our yearly recertification, so that the surveys could be completed appropriately.

Attendee - If agencies are approved for the broader categories, notification of the granular service types seems unnecessary. I recommend the specific service types are reviewed only during audits or if there is a complaint or other reason to review.

Attendee - It is the approval process that is burdensome, but I think DOH has the obligation to know what services are being provided at which agencies, doesn't that tie into the licensure of provider types who are hired by those agencies. This would be a good example of how WAC would have to apply and be adhered to. Consumers should be able to depend on

Behavioral Health Agency Rulemaking Workshop – Notes
July 27, 2021

DOH to know what's happening in each certified agency. seems like it allows for oversight and flexibility.

Attendee - Will we need to include NON pre-approved services in our "informed consent" and what happens to clients if the department pulls our approval?

ACTION – May address the previous question in more depth. We would work with the agency if a certification got revoked.

Attendee - The survey team is already asking us which certifications we have prior to the survey.

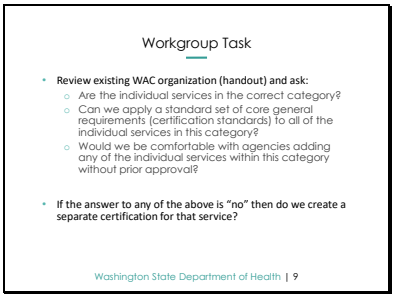
DOH - We will be implementing a new licensing system that is more outward facing that may be able to track services.

Attendee - Will non department approved services cause problems with insurance reimbursement?

DOH - We reached out to MCOs and they haven't said anything yet but if they are on the line – please speak up.

ACTION – Julie will continue to get a firm answer on whether or not department approved services will cause problems with insurance reimbursement.

Slide 9



DOH - For our work project we are going to run the different types of service through an algorithm to see if we can't use it as a template for how we organize certifications and individual services. We most likely will not get through all of this during this meeting, so it might be a two-parter.

Category: outpatient
People haven't always liked that term, since some of these can be provided in inpatient/residential settings. We can re-label if we can come up with a better term.

Recommendation to combine individual mental health; brief mental health; group mental health; family therapy mental health; rehabilitative case management mental health services.

Behavioral Health Agency Rulemaking Workshop – Notes
July 27, 2021

DOH - Most of these are bundled the majority of the time.
Are there commonalities that exist?

Attendee - Does the department regulate them differently from each other?

Attendee - Can Peer Support services be a core service option for all certifications (if those agencies want to offer Peer Services)?

Attendee - I would add peer counseling to that top list. Peer support programs fit into recovery whereas peer support services (certified peer counseling) is certainly a part of treatment rather than just recovery.

DOH - We had similar questions about psychiatric medication management and Medication monitoring. Similar to peer counseling – regardless of what you are certified to do, you can do general requirements.

DOH - Like RTF – any RTF can provide medication management. So, it kind of gets pulled out and is this general allowance for all BH agencies. Same with peer counseling. They can be provided in any of these certifications. So maybe we can pull it out and call it a general, so it's not attached to any specific certification. Outpatient & recovery support are broken out because there are some requirements for outpatient that don't apply to recovery support.

DOH - Peer counseling – you could put general management. Can be provided under any certifications. What if we made it a general for all BHAs? If you choose to use peer counselors, you need to follow certain parameters.

DOH - Many agencies want to do Peer services, but not all recovery supports. Just because you have a certification, doesn't mean to have to provide all. You can choose which services you provide. Example would be recovery support – choose just peer services.

Attendee - I made the comment because it is listed only under recovery support and I believe it solidly lives under outpatient in practice.

DOH - They are broken out separately, outpatient has different requirements than agencies that only provide recovery support services.

Attendee - I guess the reason I am asking for us to consider it to be a choice in all certifications, is to also encourage agencies to include in all practices. I understand why recovery supports needs a separate certification- need that for peer run organizations, but also want to ensure ease for clinical settings to do peer services.

DOH - Anything in the list that doesn't fit or fits better under another category?

Attendee - I'm not sure that an "assessment only" designation for SUD makes sense in the current models/practice.
Suggest broad category for outpatient SUD that include intervention, assessment & treatment. That way it can cover anything SUD NOT hospital or residential.

Attendee - Worth acknowledging co-occurring as its own service. Reason being that we are still struggling to integrate regulation-wise.

DOH - This is one of the things we want to look at – how do we support?

Attendee - I wonder if Alcohol and Drug Information School and "information" fit here...maybe more in recovery support?

Attendee - Court-ordered service. For individuals under a court order. Move under outpatient court ordered services?

Attendee - SUD information and crisis services is similar to telephone crisis services under mental health crisis certification level.

Behavioral Health Agency Rulemaking Workshop – Notes
July 27, 2021

DOH - Mental health component – anything that doesn't belong under outpatient services? When these are being provided, individuals are getting an assessment and/or therapy. Then there is prescribing and managing medications. These are slightly different. Do you consider medication services to fit under Treatment or do you think it's more of a support service?

Attendee - All MH components seem to make sense...they are direct treatment services to address a diagnosable MH condition.

Attendee - Yes, I think medication services fit under the broad Outpatient category.

Attendee - I agree that psychiatric med management and medication monitoring may be grouped separate from the top 4 outpatient service types.

Attendee - I think if it is not there, it would limit choice and provider coordination for individuals. I like the broad definition Joan gave. Integration should be a priority. Separating MH and SUD seems outdated in today's models- probably a giant leap for us right now, but worth considering any move that helps us see the vision of integration.

Attendee - Big T (Treatment) and Assessment and intervention – big picture – can we certify agencies for that and leave the weeds (services provided and how) to the professional services side? Example - becoming a BHA – we provided xx services, then it's carried out under their individual provider credential and regulated there, and the facility just stays specific to the facility.

DOH – We are interested in exploring this. After phase 1 some services are just a definition without requirements – does it need to be certified as a service? We may move in that direction.

Attendee - Does the info & crisis mean the phone recovery line? Also, who does "emergency service patrol" in our state and what exactly is it?

DOH - Licensing data showed at least one agency certified for crisis telephone service and SUD. Only one emergency service patrol in King County. I would like to get rid of it – it's a transportation service but the legislature has it in statute that we have to license it and have rules. It may belong under a different category.

Attendee - Keep in mind that despite integration, there are still agencies that are SUD only and do NOT provide mental health.

Attendee - I think Outpatient as a category could be as simple as Individual, Group, Family, Psychiatric medication...no MH or SUD specification.

Attendee - I would guess service patrol would be a Peer Role? is that a provider type under that service? Also, with the new 988 line and some of the recovery teams who are supporting law enforcement, this may be a service description that fits the new teams being formed.

Attendee - HB 1310 may affect emergency service patrol too.

Attendee - I agree with the comment about letting individual provider's credentials guide specific services provided within the generic category.

DOH - Day support MH – should this be under recovery support? Talks about supporting individuals and it can include therapy. Doesn't have to include therapy. Does it really belong under the outpatient treatment focused header or more appropriate under recovery support?

Attendee - Yes, I was wondering the same thing. Day support is really like a club house model.
Attendee - Day support seems to be in Recovery support...it's a leftover day treatment category.

DOH - Anyone disagree with moving it under recovery support?

Attendee - The challenge with recovery support is that those words imply "post-treatment". Many of those things are during treatment.

DOH - Maybe we need to think about how we label that category.

Attendee - What about Ancillary services to replace Recovery?

Attendee - Recovery support doesn't mean post treatment.

Attendee - We should think about terminology.

Attendee - Description of the certification to ensure that it makes sense.

Attendee - I would say OP MH treatment. This is something DESC utilizes and we provide Peer drop-in services + OP MH + SUD services in coordination with day support.

Attendee - I don't think the term "recovery support" indicates it is after treatment, recovery is an ongoing process. I think it was called that for a reason. "Ancillary" kind of diminishes the meaning and importance of incorporating recovery concepts.

ACTION – make note and look at existing description of recovery support – is it clear?

DOH - Problem Gambling and Gambling Disorder – outpatient and could also be provided in residential programs. If you had an agency with OP certification and they provided PG services, would we be comfortable with them adding one of the other services without prior approval? Or should it be its own certification?

Behavioral Health Agency Rulemaking Workshop – Notes
July 27, 2021

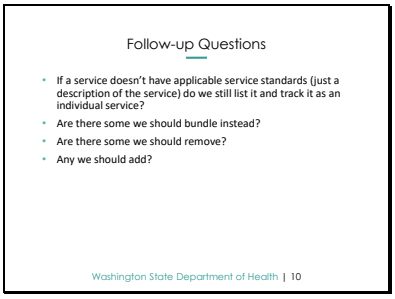
ACTION – Michelle to reach out to Roxane Waldron at HCA to get input.

Attendee - Problem gambling, in my experience, often comes up as a secondary diagnosis, so should be included at any level of care.

Attendee - I agree with the comments around recovery and believe it is best practice to address and reinforce recovery throughout treatment. That said, clinically, in diagnostic terms, recovery is a stage of treatment. So I believe a discussion of terminology there would be helpful.

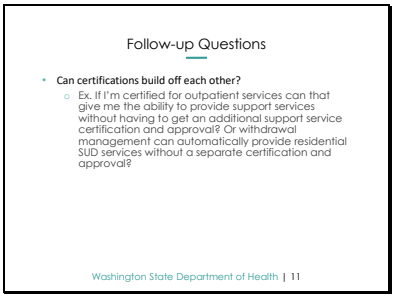
ACTION – Julie to organize what this may look like in WAC. If we like it we will continue with other certification categories.

Slide 10

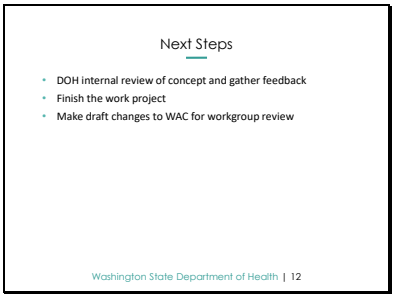


These are additional questions we will tackle at our next meeting.

Slide 11



Slide 12



Behavioral Health Agency Rulemaking Workshop – Notes
July 27, 2021

Slide 13

Slide 14