Behavioral Health Agency Rulemaking Workshop – Notes
August 10, 2021

Notes:
Initial idea of how these can be broken down.

JT - Behavioral health residential and inpatient treatment services – certification standards. We could have a general category for the items listed. Should we combine the first three into SUD services or call out separately? Combining them would be "option 2."

Joan B. - collapse them all into residential.
Becky O. - collapse them.
Linda G. - I like consolidating all residential and can address different treatment requirements separately.
Michael C. - As long as inpatient and residential are differentiated, consolidating makes sense to me.

JT - Anyone disagree?

Pattie M. - agree option 2 can we call it "BH services, including MH and SUD."
Tana R. - What about for facilities that offer both MH/SUD in one residential program...integrated services?
Brooke E. - Option 2 needs to call out "inpatient". Not opposed but need to call that out.

JT – Combine into Residential BH services? Would combine B-E above?

Pattie M. - combine it.
Wendy S.- I think part of the problem is that RTF isn't always the best descriptor. And if you're a boarding home or an assisted living there are already other requirements. I think you have to look at all the moving pieces of the different ways these facilities are already regulated.
Joan B. - Residential BH is more in line w/our future plan of integration. Under that category we can differentiate SUD and MH. Recommend Residential BH Services.

JT - Residential v. Inpatient, we ended up keeping both terms. Hospital = inpatient; RTF = residential. Is there a need to call this out in WAC and create a distinction between residential and inpatient? Sometimes a hospital provides residential type services and can be confusing. I don't' want to prohibit a hospital from providing a service because it's a residential service.

Linda G. - could combine MH and SUD as long as it did not require ALL residential facilities provide mental health.
Wendy S. - I think the expectations of residential MH an SUD are very different.
Mark L. - This is long standing semantic issue. CARF, ASAM and most payers use the term residential. Intensive Inpatient is rarely used outside of WAC.
Ryan R. - Some psychiatric hospitals were getting RTF licenses. The issue is with clarification and distinction due to all the verbiage around E&T, and yes it is very muddy.

JT – In phase three next summer we will look at all the BH chapters (psych, RTF, etc..) to work to remove dual licensure. Maybe we should tackle this then. There may be more options at that time.

Joan B. - ASAM language uses both residential and inpatient and differentiates between them by which employ medical staff or just counseling staff. It's crazy and confusing and I'd love to see just one term.
Becky O. - There is a medical component of an "inpatient" setting that is different than within residential.
Michael Carpenter - Residential and inpatient psychiatric hospitals have different rules, so they should not be combined.
Becky O. - I am in favor of bx health as the category, but the devil is in the details...the model for SUD is very different than for MH.
Pattie M. - I think we are moving to integration, because people we serve do not "neatly" fit into one box or the other. Anything we can do to shift this culture of thinking, would be better in the long run. We are not saying everyone has to do all service options, but rather to make it easier to provide what people need- is that what others are thinking too?
Becky O. - stay away from "ambulatory"!
Brooke E. - Agree, it is definitely muddy. I would like to gather a bit more information - and can send a few ideas to Julie later in week.
Brooke E. - Perhaps we could list both in same line -- "Inpatient and residential"?
Mark L. - ASAM uses level 3.5/3.7 to differentiate this.
Pattie M. - Re: residential vs Inpatient- what is the laymen terms that the public would understand? is it about overnight or short or long term?
Linda G. – Intensive inpatient was used in commercial insurance to distinguish between private and public treatment. Today it is not as relevant because few hospitals now do SUD treatment.
Joan M. - I do think it's challenging to think about inpatient vs residential services without looking also at the facility WACs.
Joan B. - I like something like ambulatory VS non ambulatory to differentiate because it's clear BUT it would be nice to brainstorm to find a more consumer friendly term to describe.
Michael C. - You could "nest" all of these under "Behavioral Health" and then call out inpatient vs residential.
Pattie M. - agree no ambulatory.
Linda G. – Agree on avoiding ambulatory.

JT – If we wanted to nest all of these things but still be able, for data purposes, track what settings these are provided in, they could indicate this on the application.

Becky O. - What if "inpatient" was bundled with the involuntary inpatient and not with residential?

Michael C. - The inpatient facility WACs are quite different from the resi WACs. I agree, I would avoid the term "ambulatory."
Pattie M. - Live -in, overnight services, overnight BH services.

JT – are there inpatient or hospitals that want to provide long-term residential? Would we be taking away the hospital's ability to offer that level of care?

Ryan R. - Yes it would take away if they wanted to provide.
Becky O. - The staffing and structure are more similar between vol and invol than between inpatient and residential.
Brooke E. - Yes to what Julie just noted. We have quite a bit of voluntary provided in hospitals as well.
Mark L. - That gets dicey. The 24 nursing language in 3.7 makes this language difficult. You could have a full time MD but not have 24-hour nursing and ASAM would say that is non-medical.
Becky O. - When we discuss "medical" and "non-medical" we are creating a false barrier...just moving the barrier from between SUD and MH.
Michael C. - Agree with those two.
Ryan R. - Julie is 100% Right and those are the issues as well!
Brooke E. - Absolutely. Good point. It gets very confusing, very quickly. Agree, would like to investigate this more as well!
Mary S. - Is there any risk that combining/integrating services in WACs will cause provider organizations to be held accountable for compliance with all areas? For example, if SUD and MH tx were combined in WAC, would the provider be required to complete both or all types of assessments, etc., and comply with all regulatory requirements, even if the facility was SUD only or MH tx only?

JT – It would allow agencies to choose. Not held to SUD requirements if you weren't providing the SUD version of that service. How can we make sure we know which version of the service the agency is providing? Not seeing a big policy shift in making agencies provide both services.

Ryan R. - We provide involuntary ITA. We have to pay for separate licensures that mix with residential.

JT – We may need an interim solution but we will keep all of these thoughts and ideas and talk about this next summer.

Pattie M. - inpatient has 24/7 monitoring vs residential has more autonomy and does not include expectation of 24-hour medical monitor.
Mary S. - I agree that we may need more information.
Becky O. - what/who is currently doing "intensive bx health treatment services"?

JT – Not at this time. Commerce is providing funding but none are open.

Pattie M. - re: Mary comment -- I hope NOT!
Pattie M. - and wouldn't there be an initial Plan for which services they want to start with?
Ryan R. - How does that work with dual diagnosis. There is usually a mixture of both.

JT - Would need to follow requirements for both MH and SUD.

JT – Initial BH treatment services – these were added by the legislature with specific requirements. Need to do more thinking to see if this can be included or pulled out to be a stand-alone service.

JT – Similarities between triage and CSU but the difference is that there can be a voluntary only triage. Can there be a voluntary version of CSU?

Becky O. - Intensive seems to like just beneath a free-standing E&T along a continuum. As such, it should maybe be called out as its own.
Becky O. - CSU=voluntary.
Wendy S. – yes.
Melanie G. – Our local CSU is voluntary only.
Remi Smith. - There can definitely be voluntary CSU.

JT – What I would do is include voluntary CSU.

JT – Should withdrawal Management be called out as it's own certification v. lumped in with general residential and inpatient treatment services?

G'Nell A. - Separate Cert for WM.
Wendy S - Yes, withdrawal management has some very specific requirements that are very different.
Linda Grant - WM is very different and should be alone.
Joan B. - I think w/d management can be listed under residential/medical based while MAT or ambulatory detox could be included outpatient category.
Mark - Here is one for you....you can meet all the WAC requirements for WDM, but cannot bill for it because the SERI requires 24 nursing but the WAC does not.

JT – When we talk about withdrawal management, we are talking about ASAM 3.7, but you could provide ASAM 4 as well. There are no RTFs that provide level 4, only in hospitals. Payers may not allow it. Do we want to keep withdrawal management as 3.7 and above or capture medical?

Joan B. - Withdrawal is medical.

Linda G. - WM 3.7 has many requirements not identified at a single place. 3.2 is non-medical and can blend into a residential setting more easily. I would like to see 3.2 and 3.7 separated as they need to be funded differently too.
Joan B. - Also, there ARE SUD residentials who provide w/d management using MAT
Linda G. - 3.2 might fit into residential but 3.7 requires HCE license and lots of pharmacy reqs.
Becky O. - This brings us to a philosophical place...WAC and ASAM and SERI...
Becky O. - The sources of info aren't consistent and so what role do they fill?

JT - Separate out existing categories?

Linda G. – yes.

JT – Separating withdrawal management as its own certification has caused barriers, but if we allow nesting it may take care of the issue.

JT – If 3.7 needs to be a different certification then maybe we should call this medically monitored medication management?

Linda B. - I would nest 3.2 under residential treatment to encourage blending. I would make 3.7 separate.
Joan M. - I don't know about anyone else, but it seems confusing to separate ASAM levels into different certifications??
Linda G. - Yes. 3.7 is medically monitored. 4.0 WM is medically managed. 3.2 is Clinically managed.
Becky O. - If we stick with what needs certification, with withdrawal, it seems that the difference is about how much medical monitoring and intervention is needed...if clinical intervention only, then it's just residential.
Mark L. - For example, you can have a ASAM certified 3.5 program with a full time MD who does WDM and it is medical but does not have 24 nursing. This is WDM but does not meet SERI or ASAM 3.7. There should be a place for this service and the ability to bill for it.
Linda G. - 3.7 is a community alternative to hospitalization. It is nothing like residential. I agree on 3.7 and above separated.
Michael C. - I agree. It would be 3.7 and above for Withdrawal management.
Alicia F. - I think we should certify specific elements of services rather than ASAM levels of care.
Remi S. - WE have 3.7 withdrawal mgmt. program, but we also have a 3.2 LOC for moderate withdrawals aka 3.2 sub-acute.
Linda G. - Mark has a good point re 3.5 residential adding WM.
Joan B. - Back to my original thought... Can't we place w/d management under either residential/medical or outpatient with prescribing powers. There are agencies with both currently.

JT – Should we broaden that to MH medication management? This might get to the components of the service which is the medication management piece of it.

Pattie M. - Is there any WAC or RCW work going on to align the conflicting statues or rules? I am guessing this is the first step, just wondering if we are tracking all the possible conflicts in RCW, WAC, or even SERI. Also rules and insurance billing conflicts is something that we can address through state plan or policy changes, maybe?

ACTION: JT – Worked on that last summer. We can pull up some of that information once we get the next draft and discuss any of the conflicts.

Wendy S. – concerns about mental health and SUD. MH medications – specialized. Concerned about average doc taking over pysch medications. MAT and SUD prescribing is so small and have concerns about combining and creating potential barriers to access to cover that complexity. Current system is not broken.

JT – If we combined, would it be possible to have core requirements to apply to MH and SUD?

Joan B. - I'll admit I am not a fan of ASAM but we should not be concerned about USING ASAM language as long as we understand the concept of the LOC's.
Pattie M. - Wendy has a great point! we see this happening already... maybe it is a larger issue about training and education for Primary care providers (off topic, but a challenge that is very real.
Alicia F. - I think the challenge there can be addressed with a qualifier of "within provider's scope of practice" rather than trying to regulate the weeds.
Joan B. - A little history- The whole point of MAT is for licensed prescribers to be able to assist SUD clients on an outpatient basis (OBOT) with withdrawal management. MAT can be used in both residential and outpatient settings. The goal is for MAT specialists to disappear and allow any DEA licensed prescriber to offer these meds as needed.

JT – Certification for involuntary inpatients and residential BH crisis and treatment services. Once you add an involuntary component, there would be a significant change in how the facility is built. This is the reason why this may not be possible to nest it in with the general inpatient services. This would include involuntary CSU, involuntary triage, evaluation and treatment (and CLIP), and secure withdrawal management and stabilization.

Mary S. - Using Scope of Practice terminology has been problematic in the past, but I agree with the concept of identifying the need for expertise in the area of prescribing psychotropic medication.
Linda G. - Just remember that WM is also physical health care at 3.7 and above; it is not just medication management.

Joan B. - What about IT and court ordered being placed under category such as "legally mandated BH services"?

JT - Is everyone ok with the thinking on the Involuntary inpatient and residential BH crisis and treatment services section?

Kelli M. - If there is a general; "legally mandated section" does that include all LRA requirements then?
Linda G. - Re Involuntary, what is the programmatic difference? Locks on the doors should not be the only difference.

JT – The major difference is that they have to follow all the requirements in chapter 71.05 and 71.34 RCW.

Wendy S. - Legally mandated has a lot of issues. A court can order an individual to access treatment that is not related to ITA.
David M. – Least restrictive alternative? 71.05 RCW.
Ryan R. - I'm having to pay for multiple certifications and licensures then for all of the different items. I feel paying the certs multiple times for the same beds frustrating.

JT – We will work on that.

Becky O. - historically, the difference in physical plant has been about seclusion capabilities. These programs also require more robust staffing and a breadth of staffing. It seems helpful to keep these together and not bundle with OP (court ordered or not).
Joan B. - I would think involuntary inpatient, LRA, AOT, DUI mandates could all be under legally mandated BH services.

JT – Could you nest LRA services under cert standards? WAC 246-341-1060 talks about following all requirements, which would cover the LRA piece in a residential setting.

Becky O. – Clarify LR – court has to designate a BH entity. Could be in Residential or their apartment. I can be the person noted as providing oversight. Court ordered outpatient treatment needs to be totally separate. They are so different and what they mean for individuals.

JT – Agree but was trying to figure out how to acknowledge that LRA can be provided in a residential setting as well. Where would we acknowledge that?

JT – The core concepts are noted. Will work to incorporate comments from today into a draft WAC for future review.

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246-341-0000

Behavioral health residential and inpatient treatment services—Certification Standards.

(1) Agencies certified for residential and inpatient treatment services provide individualized intervention, assessment and treatment for mental health, substance use, or co-occurring disorders in a licensed residential treatment facility or hospital. An agency may choose to provide any of the following individual behavioral health services under this certification:

Option 1:

(a) Intensive inpatient services;
(b) Low intensity (recovery house) residential treatment services;
(c) Long-term residential treatment services
(d) Residential MH
(e) Intensive behavioral health treatment services;
(f) Voluntary triage

Option 2:

(a) Residential MH services
(b) Residential SUD services
(c) Intensive BH services
(d) Voluntary triage

(2) Agencies providing residential and inpatient treatment services must follow the general requirements as described in WAC sections 246-341-1050.

(3) Agencies must follow individual service requirements in WAC sections 246-341-XXXX through XXXX as applicable to the individual service being provided.

(4) Agencies certified for residential and inpatient treatment services may also choose to provide information, assistance and referral, behavioral health support, intervention, assessment, and treatment, and outpatient crisis services without additional certification.

Commented [TJ(1]: Should these be combined similar to what we did with the outpatient BH services? See option 2.

Commented [TJ(2]: This would be new and has been requested multiple times. Kind of a version of Outpatient MH in an inpatient setting.

Commented [TJ(3]: Separate this out?

Commented [TJ(4]: Is there such a thing as voluntary only CSU? RCW is only clear about triage.

Commented [TJ(5]: Combine into Residential BH services? Would combine B-E above.

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Withdrawal management- Certification Standards

(1) Agencies certified for withdrawal management provide... An agency may choose to provide any of the involuntary crisis and treatment services under this certification:
   (a) Medically managed
   (b) Medically monitored
   (c) Clinically managed
(2) Agencies certified to provide withdrawal management services must follow the general requirements in WACs 246-341-1060 and 246-341-1070.
(3) Agencies must follow the individual service requirements in WAC 246-341-1100.
(4) Agencies certified for withdrawal management services may also choose to provide information, assistance and referral, behavioral health support, intervention, assessment, and treatment, outpatient crisis services, and inpatient and residential treatment services without additional certification.

Commented [TJ(6]: Should WM be separate from residential/inpatient BH treatment services?

Commented [TJ(7]: DOH currently uses this to certify ASAM level 3.7 and 4. It is not broken down acute and sub-acute or further.

Commented [TJ(8]: Do any RTFs do this? Is it allowed by payors? Technically RTF rules would not prohibit this.

246-341-0000

Involuntary inpatient and residential behavioral health crisis and treatment services—Certification Standards

(1) Agencies certified for involuntary inpatient and residential behavioral health crisis and treatment provide residential and inpatient BH intervention, assessment, and treatment services to individuals receiving services under Chapters 71.05 and 71.34 RCW. An agency may choose to provide any of the involuntary crisis and treatment services under this certification:
   (a) Crisis stabilization unit
   (b) Involuntary triage
   (c) Evaluation and treatment (including CLIP)
   (d) Secure withdrawal management and stabilization

(5) Agencies certified to provide involuntary crisis and treatment services must follow the general requirements in WAC 246-341-1060.
(6) Agencies must follow individual service requirements in WAC sections 246-341-XXXX through XXXX as applicable to the individual service being provided.
(7) Agencies certified for residential and inpatient treatment services may also choose to provide information, assistance and referral, behavioral health support, intervention, assessment, and treatment, outpatient crisis services, and inpatient and residential treatment services without additional certification.

Commented [TJ(9]: This is different than what we did with outpatient; however, they have different construction standards which would require approval from Construction Review Services before being provided.

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