Workbook for Workshop #4			
Draft Language (2)	**Outstanding Questions/ Recommendations**	**Ideas from Arizona Rules**	**Notes**
(b) 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;	• Consider requirement to provide a bed and/or private space if there beyond 24 hrs. • Workshop comment that the language regarding imminent transition should include to "a more restrictive setting"	• AZ model does not appear to allow for anything beyond 23 hr and 59 min.	**Questions/comments from the department:** • Do we need a bookend? • When is it too long to remain in a facility that is not an inpatient or residential facility? • At previous workshops, it did not sound like people were confident going beyond a 36-hour period. The 36 hours is based on how long someone can be held in a facility, waiting for a DCR to come and do an evaluation, and then be transported/taken to an appropriate facility that can provide involuntary treatment. The statute lists up to 12 hours for that process. • If someone is in a CRC for longer than 24 hours, should there be a private place for them to relax, to sleep? We will discuss this when we talk about construction standards. **Workshop participant comments/feedback:** • 24 hours is a long time for someone to be in a chair/recliner. Encourage assigning a designated bed in a bedroom for anyone there over 24 hours.

			• Would designating a bed and holding an individual for more than 24 hours cause problems with billing? There was concern that the 36 hours would impact reimbursement. In some areas, DCR evaluation exceeds the 12-hour limit.
			• A time limit seems reasonable, but it does not address what happens when a patient isn't safe and another facility is not available. Would this result in transfers to the ED for boarding?
			  ○ If there is no bed available and the facility has to get someone out by 36 hours, the ED would be a place that the individual can be transferred to.
			• There were several comments about allowing these facilities to have an RTF license or a dual license if they are holding individuals for longer than 24 hours, since requirements for RTFs include things like bathroom, food, etc.
			  ○ The statute is specific in allowing CRCs to go over the 24-hour time limit without requiring them to have an RTF license.
			• Consider licensing a unit as a CRC with CSU beds. For example, a total capacity of 20 but beds allow for only 8 people to be there over 24 hours. This flexibility might be necessary for rural communities. Allow for 24 hours of CRC billing and then stabilization services in a bed.

			◦ Facilities will be able to add this service as a complimentary service. It is very likely that most facilities will be dually credentialed. • During the AZ presentation two weeks ago, it was mentioned that the instances in which they must go over the 23 hours, 59 minutes are few. • The difficulties with discharge/transition planning alone makes it much more likely that it is attached to another resource. • If a 23-hr CRC and a CSU were co-located for the reasons above, would there be specific regs needed to allow for shared staffing between these programs? ◦ It would be one agency providing two different services so the staff can be shared. • In most of the country, the CRC facility has a connecting 16 bed unit to support flow as the 24 hours winds down. This is true in all facilities in Maricopa County, AZ. **Questions/comments from the department:** Should there be an addition to the language to state that the imminent transition is to a "more restrictive setting?" **Workshop participant comments/feedback:**

			• There isn't must less restrictive than this setting. Support the "more restrictive" language for clarity.
			• How does the program preserve patient rights when holding in this setting for up to 36 hours pending a DCR evaluation?
			    ○ There is existing statutory language regarding the legalities of holding individuals that would need to be followed.
			• Best practice is to ensure least restrictive care that is still appropriate, so the after-care plan may not necessarily be more restrictive.
			• If crisis resolution requires more time, will this "more restrictive setting" language result in transfers to ERs?
			    ○ Perhaps this is why the language was left broad in the statute. If an individual is there voluntarily and are choosing to stay, maybe the language should be left broad.
			• Would not recommend limiting to only more restrictive settings. If someone is receiving withdrawal management support while at the CRC and needs safe transition to an outside program to continue withdrawal management (non-secure setting), that should remain an option to stay longer while arranging appropriate transfer.
			• Would require evaluation by DCR to determine if more restrictive care was necessary.

			• Legislative intent was to not transfer during the hold (ideally).
			• It may not be more restrictive in all cases. There are circumstances in which individuals require specialized placements upon discharge.
			• Not every crisis would fall in the need for DCR or involuntary treatment.
			• When would a patient be transferred to the ED and how? In ERs and other BH settings, individuals often become upset and combative, and it can turn into more of a crisis.
			    ○ In the definition of CRC in statute, it says that these facilities are required to accept individuals regardless of BH acuity. They may be transferred due to their physical health – physical health needs that cannot be taken care of in the CRC. The language does not specify how they are transferred. The rules would leave it up to the agency to determine how the transportation would work.
			• How are these facilities licensed as an E&T for detention if a DCR detains under RCW 71.05?
			    ○ DCRs can do evaluations in non-E&T settings. The individual would be transported to an E&T based on the DCR evaluation.

			Decision/poll The department asked, via poll, whether the "more restrictive setting" language should be added. 61% disapproved 39% approved **Department follow-up needed** Verify with the Health Care Authority (HCA) how 36-hour timeframe would impact reimbursement. ○ Reimbursement model is still pending. Most likely will support reimbursement.
(c) 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;	• Need to define "walk-in"? ○ Walk-in includes individuals who arrive on their own accord or with the assistance of another person who is not a first responder. ○ Drop-off includes first responder personnel transporting the individual to the CRC, including those willingly being transported and those who were taken into emergency custody by LE.		**Questions/comments from the department:** • Do we need to define walk-in? • The language includes both walk-in and drop-off options, so it should cover everyone. **Workshop participant comments/feedback:** • Is referral from 988 considered a walk-in or drop-off? ○ It can probably be either one. • Can a person walk in at any time? 24/7? ○ Yes, the CRC is meant to be open 24/7. • How will this roll out if there is any level of medical acuity? Walk-ins and drop-offs are frequently redirected to the ER if there is any level of medical acuity.

			- The CRCs are required to provide minor wound care, general first aid. Previously, we had discussed that this would be limited to care that can be provided via a nursing assessment. - Is the intent that if someone needs help, they can come in on their own accord or be dropped off? - Yes. - When an individual shows up, CRC staff would assess the immediate level of care and choose the level of care appropriate to meet immediate needs? - Yes. - When someone walks in, how is it handled in terms of COVID testing before the client is attended to? - This would be up to the agency. - How about dealing with substances on board? - This would be up to the agency. - Will there be a requirement concerning medical clearance for a DCR placement? DCR placement requires medical clearances with labs, etc. If not, this will require a hospital transfer before detainment. **<u>Decision/poll</u>** The department asked, via poll if "walk-in" should be defined. 67% no

			33% yes

() If a crisis receiving center is at full capacity, the center may go on divert status to alert emergency medical services that it is unable to accept admissions.	• Can CRCs go on "divert"?
	  • Answer from EMS SMEs was "yes" but recommend having standard language regarding when they can go on divert.
			Questions/comments from the department: The statute says that CRCs are required to take all police officer drop-offs, but it does not specify EMS drop-offs. After the previous workshop, the department asked our EMS experts if only hospitals can go on divert. They responded that other facilities could go on divert status as well. Advised that we should put something in rule that standardizes when a CRC goes on divert.
			
			Workshop participant comments/feedback:
			• Does full capacity include when there are unfilled beds, but not staffing for those beds?
			• Almost every facility can stop/delay incoming clients/patients. It seems that this should be true here. Why do we need to have language in the WAC to allow this when it is not in other settings?
			• Is there going to be a real-time "search system" which folks planning for a drop-off would be able to access and know "immediately" what kind of reception status a planned destination facility is in at that moment?
			  ○ Not at this time.
			• We should track this data when they go on this type of hold. Should be rare.
			• Who monitors the divert and if these facilities just stay on divert?

			• Transferring to an ED for all ITAs prior to E&T seems cumbersome and low yield. Can regulations address that direct CRC to E&T admission is allowable with stable vitals, rule out red flag symptoms, nursing eval, psychiatrist/NP eval, +/- basic labs? • Diversion is very rare given CRCs are continuously working on flow, so they are ready to say yes to the next referral. It's very important to avoid diversion if at all possible. We typically go several months between going on a couple of hours of hospital ED diversion. • These situations will be more rare than common. Each entity that chooses to pursue this type of facility will create Policies & Procedures to meet their community needs. • If they are full and someone walks in clearly needing help, how does the facility respond? Is that defined in the program development? • ED diversion is only for EMS. It doesn't apply to walk-in or law enforcement drop-offs. CRCs would operate similarly. • No diversion for walk-ins. Those individuals are all served. Diversion impacts hospital Eds that are told to hold on sending individuals until they can be served in the site. **<u>Questions/comments from the department:</u>**

			The divert status is specifically a notification to EMS. We could modify this language to state that the CRC should have a process for notifying EMS.
(e) Have a no-refusal policy for law enforcement, including tribal law enforcement			There were no comments/concerns about this addition.
(f) Accept admissions 90 percent of the time when the facility is not at its full capacity with instances of declined admissions and the reasons for the declines tracked and made available to the department;	• When is someone "admitted" to the facility? ○ AZ model has a screening process before admission. The screening is for physical health needs. Once screened they can be admitted to the CRC, if the CRC is capable, or transferred to an entity that can take care of immediate physical needs. Screening must take place within 30 min. of arrival. ○ Need to define "full capacity". Recliners full vs staffing capacity? When a facility is not at full capacity it states they can still decline	• AZ rule regarding assessment upon admission: ○ When a patient is admitted to a designated area for behavioral health observation/stabilization services, an assessment of the patient includes the interval for monitoring the patient based on the patient's medical condition, behavior, suspected drug or alcohol abuse, and medication status to ensure the health and safety of the patient	**Workshop participant comments/feedback:** • In some facilities in AZ, there is no "screening." Individuals get a physical health assessment within the first 30 minutes to determine care needs. But in these cases, the individual is first admitted – EMS and LE are not waiting for an "admission." • A lot of AZ facilities do operate with a screening process. Individuals are screened and triaged immediately. Then assessments are done. With screening and triage, they are still entered into the system. Preliminary information is obtained, and they are monitored. Not all individuals meet criteria for admission into the Crisis/Obs unit. • What about admission and then clearing the scene? Is there a direct admit process for EMS? • Want to be sure it supports the no refusal of LE drop-off and the only "refusal" is for physical health acuity reasons.

	admissions 10% of the time. What would be the reasons for declining if it isn't because of full capacity? ○ What if full capacity means all recliners are filled, but the 10% variance could allow for times the CRC may not be fully staffed to operate all recliners? • Won't facilities leave recliners open to take mandatory LE drop-off's? ○ Could we consider having LE designated recliners that are not counted as part of the general recliner capacity?	• AZ rule regarding requirements when declining admissions: ○ If an individual is not admitted for behavioral health observation/stabilization services because there is not an observation chair available for the individual's use, a personnel member provides support to the individual to access the services or resources necessary for the individual's health and safety, which may include: a. Admitting the individual to the outpatient treatment center to provide behavioral health services other than behavioral health observation/stabilization services;	• Would the consent to treat have to be completed before assessment? • Could a person be considered "admitted" upon completing their intake paperwork and signing a consent for the CRC to treat? • The semantics of calling something an admission or screening before admission might become relevant when it comes to being able to bill for services. • One component of an "admission" being important is EMS has to be able to document transfer of care to a facility. If the patient isn't going to be admitted, EMS/LE can't technically clear the scene. • Billing, liability, EHR, HIPAA concerns, etc. are all attached to the idea of "admission." • One attendee indicated preference to the model where a person is admitted and then the medical screen happens afterwards. • Another attendee indicated a preference to screen before admission so they do not have to discharge to somewhere else. • Screen first to determine need. • How did the legislature come up with 90%? What would the other 10% declined look like? Perhaps this is wiggle room related to staffing, acuity? • 90% expectation comes directly from the SAMHSA National Guidelines for

		b. Establishing a method to notify the individual when there is an observation chair available; c. Referring or providing transportation to the individual to another health care institution; d. Assisting the individual to contact the individual's support system; and e. If the individual is enrolled with a Regional Behavioral Health Authority, contacting the appropriate person to request assistance for the individual; • AZ rules regarding documenting declined admissions: ○ Personnel members establish a log of	Behavioral Health Crisis Care – A Best Practice Toolkit. Intent is more around capacity design than operations – shouldn't turn anyone away. From SAMHSA – "Be structured in a manner that offers capacity to accept all referrals at least 90% of the time with a no rejection policy for first responders." • Clarification on "full capacity" – does it mean space, staffing, or licensed capacity? In anticipation of future needs we may build a bigger place then we need currently, but will staff based on present need. Likewise with "licensed" capacity, we might be licensed for X beds but if on a particular day we might be staffed for something less than licensed capacity. • "b" sounds like a "waiting list" is being created. • Does a chair's "unavailability" include if there is insufficient staff to safely monitor/support the individual who would occupy it? • Staffing is always a challenge. Agencies should not be punished for the 90% requirement due to the staffing crisis. • There needs to be an allowance for staffing levels to dictate capacity. Safety would be a major concern. • The Crisis Care Centers model we're working on standing up in King County includes 24/7 urgent care, 23-hour obs, and up to 14-day CSU all as part of a single program. The urgent care

		individuals who were not admitted because there was not an observation chair available and document the individual's name, actions taken to provide support to the individual to access the services or resources necessary for the individual's health and safety, and date and time the actions were taken; The log required in subsection (A)(19) is maintained for at least 12 months	(outpatient license) at the front end allows for an intake eval to then triage to 23-hr obs only if needing that higher intensity level of care. The CSU on the back end addresses the bed issues discussed earlier. • Tracking and having any reliable data requires a clear denominator. Chair availability is a better marker than staffing. • What if the client is shelter seeking, not requiring urgent care, is that a decline? You would not know this until you evaluate the individual. • Capacity is reference to census capacity and that 10% be the variation of census capacity be due to staff capacity. Will help with the denominator and budgeting for staffing in the future, other planning, etc. • What would the negative impact be of not meeting the 90% acceptance? ○ If a facility was in violation of this and the department came across it, it would start with a citation and the facility would have to come up with a Plan of Correction. If multiple complaints were received, the department may direct a Plan of Correction. • If it's staff capacity, what would the consistency factors be for knowing when and how declines were occurring. Is there concern around the potential that first responders may use other services to

			transport if there is concern about services not being adequately provided if capacity is inconsistent. • If the facility does not accept all referrals from first responders, they will go where they know they can drop the person off – hospital EDs or the justice system. • If staff are aware of patients inbound from law enforcement, they might decline an admission to make sure a recliner is available for impending admit. • A carve out for LE doesn't make practical sense. • Capacity should reflect who you can safely and effectively serve. I don't know how you separate those numbers out. • If there are LE designated chairs shouldn't there be designated walk-in chairs? Otherwise it seems like we are prioritizing LE as a way to get access rather than going to the CRC directly. • EMS and LE need a 15 minute drop-off or they will go to the ED. If daily admissions are unpredictable, EMS/LE will most likely avoid the diversion. • Are there requirements for LE to use the CRCs in comparison to Fire/EMS? ○ No, it is not required. It is just another option for them. • It is more appropriate to fill beds for any individual needs vs "holding out" for LE. **<u>Department follow-up needed</u>**

			The department will follow-up with HCA on screening vs admission. ○ The reimbursement model is still pending. Most likely won't matter since crisis services don't require intake.
(g) 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 peers.	• Should we be more specific? ○ SAMHSA best practices: Be staffed at all times (24/7/365) with a multidisciplinary team capable of meeting the needs of individuals experiencing all levels of crisis in the community; including: a. Psychiatrists or psychiatric nurse practitioners (telehealth may be used) b. Nurses c. Licensed and/or credentialed clinicians capable of completing assessments in the region; and d. Peers with lived experience similar to the experience of the population served.	• AZ model, always a prescriber (MD, ARNP or PA) and a nurse.	We did not have time to discuss this during workshop #4.
(h) Maintain capacity to deliver minor wound			We did not have time to discuss this during workshop #4.

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 ~~addressed without need for medical diagnosis or health care prescriber orders,~~			
(i) Screen all individuals for: (i) Suicide risk, using a validated tool, and engage in comprehensive suicide risk assessment and planning when clinically indicated; (ii) Violence risk, using a validated tool, and engage in comprehensive	• When is the screening conducted? ○ AZ requires that the medical screening be conducted within 30 minutes of arrival. ○ AZ allows for screening before admission.		We did not have time to discuss this during workshop #4.

violence risk assessment and planning when clinically indicated; and (iii) Physical health needs, including a cognitive screening for dementia.			
(c) A disposition including any referrals for services and individualized follow-up plan;	Note: This is existing language in WAC that would be referenced	• AZ discharge language: ○ Before a patient is discharged from the designated area for behavioral health observation/stabilization services, a medical practitioner determines whether the patient will be: a. If the behavioral health observation/stabilization services are provided in a health care institution that also provides inpatient services and is capable of meeting the patient's needs, admitted to the	We did not have time to discuss this during workshop #4.

		health care institution as an inpatient; b. Transferred to another health care institution capable of meeting the patient's needs; c. Provided a referral to another entity capable of meeting the patient's needs; or d. Discharged and provided patient follow-up instructions • AZ discharge documentation: ○ If a patient is not being admitted as an inpatient to a health care institution, before discharging the patient from a designated area for behavioral health observation/stabilization services, a personnel member: a. Identifies the specific needs of the	

		patient after discharge necessary to assist the patient to function independently; b. Identifies any resources, including family members, community social services, peer support services, and Regional Behavioral Health Agency staff, that may be available to assist the patient; and c. Documents the information in subsection (A)(13)(a) and the resources in subsection (A)(13)(b) in the patient's medical record; When a patient is discharged from a designated area for behavioral health observation/stabilization services, a personnel member: a. Provides the patient with	

		discharge information that includes: i. The identified specific needs of the patient after discharge, and ii. Resources that may be available for the patient; and b. Contacts any resources identified as required in subsection (A)(13)(b);	
Pending: ○ Looking into liability protections for staff			

General questions and comments:

- These rules will be going into the BH Chapter – Chapter 246-341 WAC. Agencies can be deemed if they are accredited. Because of this, deeming standard will apply, so the department will have to take a close look at the accrediting organizations.
  - Reference from CARF keynote presentation 2023 on BH Crisis Systems: https://www.crisisroadmap.com/
  - Joint Commission also accredits crisis facilities.
- For the EMS guidelines that were discussed last week, will legislative action be needed to make the changes or is it too soon to know?
  - No legislative action or rulemaking is needed. The guidelines are enforceable on the EMS side and they can be modified without going through rulemaking or legislation.
- Are there liabilities issues?
  - This was brought up previously. The department will do further research/get legal guidance on what currently exists, what needs to be added and how.
  - Is HCA working on something related to liability protections for crisis services?

    - HB 1134 included liability protections for 988/911 and crisis mobile teams. Could do something similar for CRCs and EMS transport if needed.
- Who or what unit at HCA is working on billing-related issues for CRCs?
    - Answer is pending.
- The Continuum of Care starts with supporting the individual in their home community and there are services in place (Crisis Connections/Faith based services/mobile outreach/etc.)
- What types of resources are AZ utilizing to keep the patient under 23 hours? From recent experience, the wait times for an inpatient behavioral health bed is much longer in WA than AZ.
- Currently LE and EMS are often redirected from crisis stabilization units and E&Ts in Tacoma back to the ER due to medical acuity.
- There was legislation passed last year that allows "diversion centers" to employ EMT's as an Emergency Supervisory Services Organization (ESSO). We (Whatcom Co.) would like to see these CRC's centers to be positioned the same as "diversion centers" that could employ EMT's for the 23-hour centers. This would greatly help those "warm handoff's" as well as further transportation needs in the EMS system. This can help create integrated systems for SUD and MH Diversions. In addition, this will help with finding people to work in the centers as there is a serious shortage of workers for these types of centers. EMT's can be given specialized training for the work and provide a level of safety in the facilities for emergencies. Experienced EMT's can help determine medical acuity.
    - Department to find out whether CRCs are designated as a diversion center.
- We do want to see the mobile crisis teams include EMS staff when possible, (which does help on medical and transport). We do require that the EMS participate in formal behavioral health training before joining the crisis teams that are seeking certification to respond to 988 calls. It does seem like they could be a good addition to this crisis relief centers too especially with additional behavioral training.