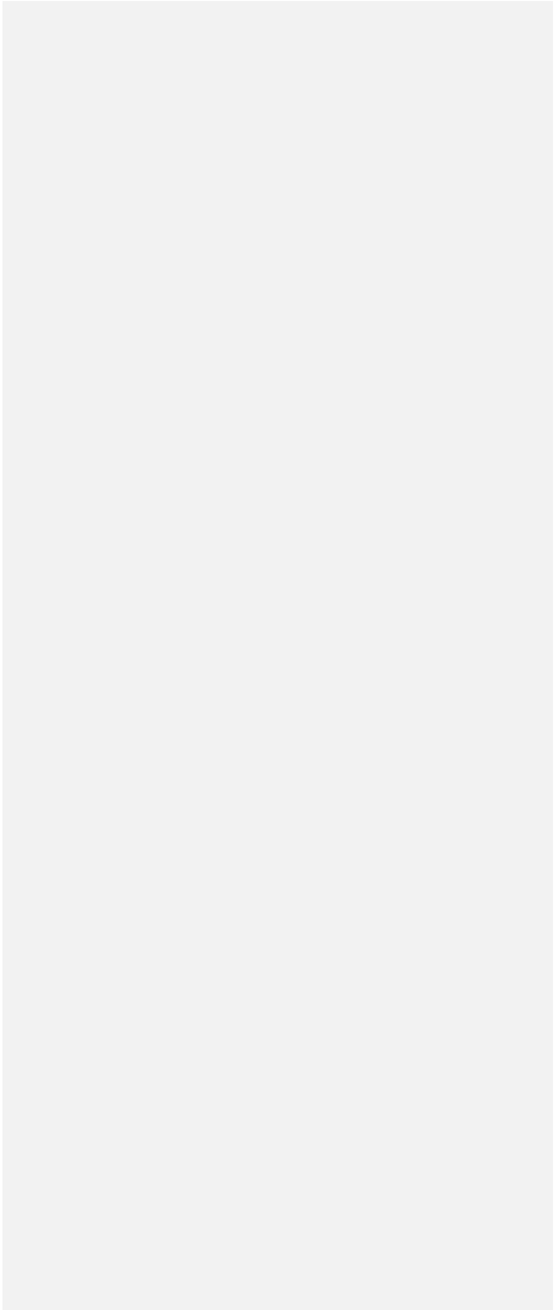
23-Hour Crisis Relief Center Rulemaking Workbook: Workshop #1

Initial Draft Language	Info and Background	Workshop Notes
246-341-0110 **Behavioral health—Available certifications.** (1) A behavioral health agency licensed by the department must hold one or more of the following certifications: (a) Behavioral health information and assistance; (b) Behavioral health support; (c) Mental health peer respite; (d) Clubhouse; (e) Behavioral health outpatient intervention, assessment and treatment; (f) Behavioral health outpatient crisis services~~, observation, and intervention~~; () 23-hour crisis relief center services; (g) Designated crisis responder services; (h) Opioid treatment program; (i) Withdrawal management; (j) Behavioral health residential or inpatient intervention, assessment and treatment;	Propose creating a new and separate certification because this service has many unique requirements that go beyond the standard requirements for general outpatient crisis services. Propose renaming the certification for general outpatient crisis services to make it less of a mouthful. History: this long title was put into rule to capture a 23-hour model before this bill was passed. Now that there will be a unique certification it might be okay to shorten the title back up. Bill language requires consolidating triage and crisis stabilization unit (CSU) into a single certification type.	• The law says that we have to remove the word "triage" – this is non-negotiable. • Triage and crisis stabilization units are regulated the same way and the description of them in the statute is also very similar. Reimbursement is very similar or the same for the two facility types. • The service of triage will not change in any form or fashion. - *Existing triage facilities will continue to operate, but will be called crisis stabilization units. There will be no change in their function or reimbursement rates, only a change in terminology.*

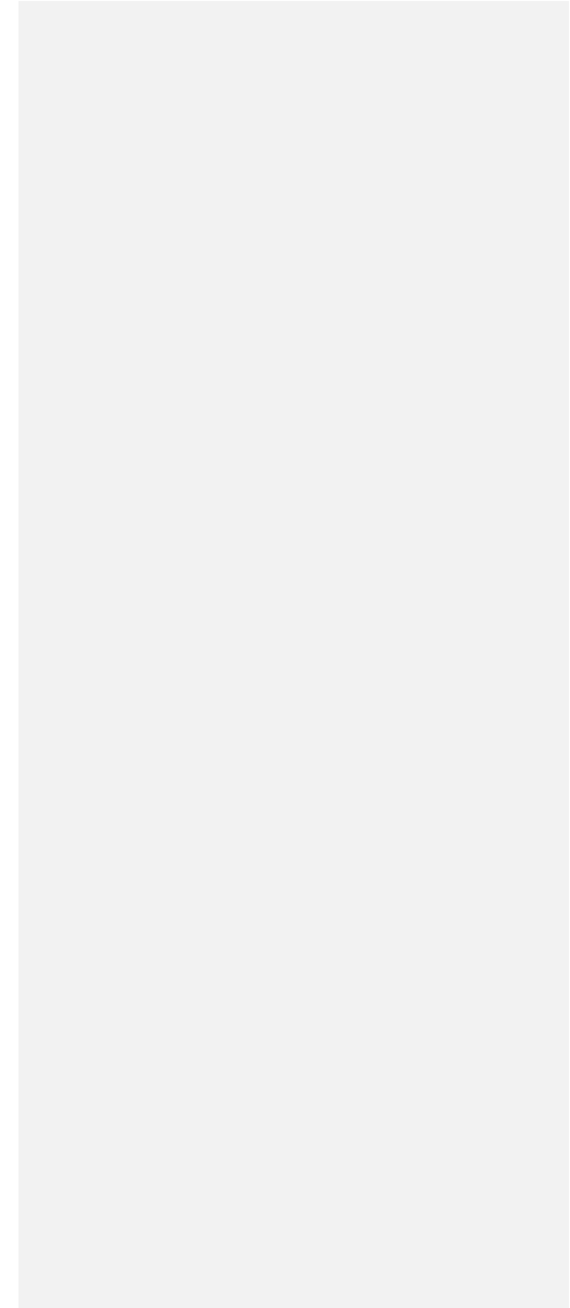
(k) Involuntary behavioral health residential or inpatient; (l) Intensive behavioral health treatment; (m) Crisis stabilization unit ~~and triage~~; (n) Competency restoration; (o) Problem gambling and gambling disorder; or (p) Applied behavior analysis. (2) The type of certification(s) held by the agency determines which behavioral health services the agency is approved to provide.		
246-341-0200 **Behavioral health—Definitions.** "23-hour crisis relief center" means the same as defined in RCW 71.24.025.	Propose adding a definition of CRC that references the statute definition.	
246-341-0901 **Behavioral health outpatient crisis ~~outreach, observation and intervention~~ services—Certification standards.** (1) Agencies certified for outpatient behavioral health crisis ~~outreach,~~	Updated to reflect the shorter certification title for general outpatient crisis services.	

~~observation and intervention~~ services provide face-to-face and other means of services to stabilize an individual in crisis to prevent further deterioration, <u>and</u> provide immediate treatment or intervention in the least restrictive environment at a location best suited to meet the needs of the individual which may be in the community, a behavioral health agency, or other setting. (2) An agency certified for outpatient behavioral health crisis ~~outreach, observation and intervention~~ services does not need to meet the requirements in WAC **246-341-0640**. (3) An agency providing outpatient behavioral health crisis ~~outreach, observation and intervention~~ services for substance use disorder must ensure a professional appropriately credentialed to provide substance use disorder treatment is available or on staff 24 hours a day, seven days a week. (4) An agency providing any outpatient behavioral health crisis ~~outreach, observation and intervention~~ services must: (a) Provide crisis telephone support in accordance with WAC **246-341-0670**;		

(b) For mental health crisis, ensure face-to-face outreach services are provided by a mental health professional or department-credentialed staff person with documented training in crisis response; (c) For a substance use disorder crisis, ensure face-to-face outreach services are provided by a professional appropriately credentialed to provide substance use disorder treatment, or individual who has completed training that covers substance use disorders; (d) Develop and implement policies and procedures for training staff to identify and assist individuals in crisis before assigning the staff member unsupervised duties; (e) Resolve the crisis in the least restrictive manner possible; (f) Require that trained staff remain with the individual in crisis in order to provide stabilization and support until the crisis is resolved or referral to another service is accomplished; (g) Determine if an individual has a crisis plan and request a copy if available; (h) Assure communication and coordination with the individual's mental		

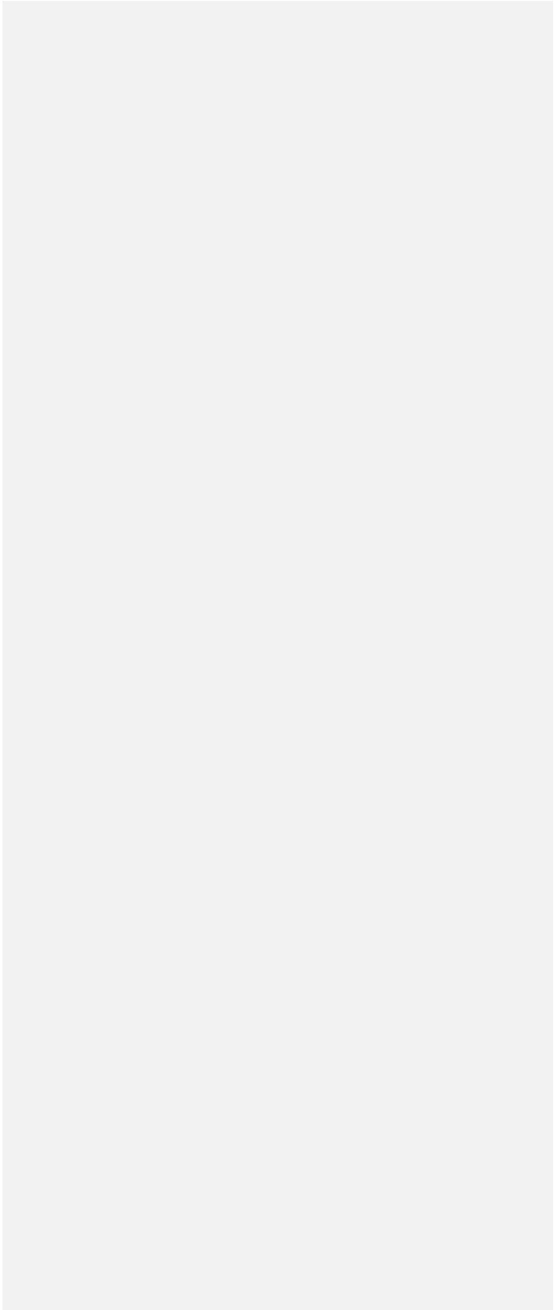


health or substance use treatment provider, if indicated and appropriate; (i) As appropriate, refer individuals to voluntary or involuntary treatment facilities for admission on a seven day a week, 24 hour a day basis, including arrangements for contacting the designated crisis responder; (j) Maintain a current list of local resources for referrals, legal, employment, education, interpreter and social and health services; (k) Transport or arrange for transport of an individual in a safe and timely manner, when necessary; (l) Be available 24 hours a day, seven days a week; and (m) Include family members, significant others, and other relevant treatment providers, as necessary, to provide support to the individual in crisis. (5) Documentation of a crisis service must include the following: (a) A brief summary of each crisis service encounter, including the: (i) Date; (ii) Time, including time elapsed from initial contact to face-to-face contact, if applicable; and		



(iii) Nature and duration of the encounter. (b) The names of the participants; (c) A disposition including any referrals for services and individualized follow-up plan; (d) Whether the individual has a crisis plan and any request to obtain the crisis plan; and (e) The name and credential, if applicable, of the staff person providing the service. (6) An agency utilizing certified peer counselors to provide crisis outreach services must: (a) Ensure services are provided by a person recognized by the health care authority as a peer counselor, as defined in WAC **246-341-0200**; (b) Ensure services provided by a peer counselor are within the scope of the peer counselor's training and credential; (c) Ensure peer counselors receive annual training that is relevant to their unique working environment. (7) When services are provided in a private home or nonpublic setting, the agency must:		

(a) Have a written plan for training, staff back-up, information sharing, and communication for staff members who respond to a crisis in an individual's personal residence or in a nonpublic location; (b) Ensure that a staff member responding to a crisis is able to be accompanied by a second trained individual when services are provided in the individual's personal residence or other nonpublic location; (c) Ensure that any staff member who engages in home visits is provided access, by their employer, to a wireless telephone or comparable device, for the purpose of emergency communication; (d) Provide staff members who are sent to a personal residence or other nonpublic location to evaluate an individual in crisis prompt access to information about any history of dangerousness or potential dangerousness on the individual they are being sent to evaluate, that is documented in a crisis plan(s) or commitment record(s). This information must be made available without unduly delaying the crisis response. (8) If utilizing peer counselors for crisis outreach response:		



(a) Ensure that a peer counselor responding to an initial crisis visit is accompanied by a mental health professional or individual appropriately credentialed to provide substance use disorder treatment as appropriate to the crisis; (b) Develop and implement policies and procedures for determining when peer counselors may provide follow-up crisis outreach services without being accompanied by a mental health professional or individual appropriately credentialed to provide substance use disorder treatment as appropriate.		
NEW SECTION WAC 246-341-XXXX **23-hour Crisis relief center services - Certification standards** (1) An agency certified for 23-hour crisis relief center services must: () Follow requirements for outpatient crisis services in WAC 246-341-0901;	Propose that CRCs follow the WAC for general outpatient crisis services. WAC 246-341-0901 (see language in above in left column) modifies assessment and documentation requirements in a way that is appropriate for crisis services. Question: Are there any requirements in -0901 that would not make sense for CRCs?	

(a) Provide services to address mental health and substance use crisis issues;		• Dementia crises need to be taken into consideration – they can look like a mental health crisis.

(b) Limit patient stays to a maximum of 23 hours and 59 minutes except for patients waiting on a designated crisis responder evaluation or making an imminent transition to another setting as part of an established aftercare plan;		• There needs to be greater clarification on the word "imminent."
		  ○ Given issues with transportation options and other settings, "imminent" may take a while.
		  ○ "Imminent" is defined in RCW 71.05, but the term in this statute is likely to be different, so maybe a different word can be used here, or a definition?
		• What does emergency custody mean? Who can place someone into emergency custody? What if the individual refuses to stay?
		• Need to spend considerable amount of time discussing voluntary vs involuntary, the expectations of the CRC and the impacts to the rest of the system.
		• CRCs will not be able to put someone into an Involuntary Treatment Act (ITA) situation. ITAs go through a specific process.
		• A Peace Officer can take someone from the community into emergency custody (if they are not willing to go by themselves) and deliver them to a 23-hour crisis facility. They can then be held at the CRC until the Designated Crisis Responder (DCR) is able to respond and do the evaluation. If the DCR determines the individual needs involuntary detention, then the ITA process will start. For example, the individual may be moved to an

		Evaluation & Treatment facility that can provide that ITA service. - *Law enforcement has the authority to take a person into custody and deliver to a Crisis Relief Center (CRC). The facility then has the ability determine whether to involuntarily hold the person no longer than 12 hours from the time the professional staff notify the DCR and not including time prior to medical clearance (as it is defined in 71.05 which says something like a medical provider has determined the person is stable and ready for evaluation by the DCR).* • DCR evaluations have their own time limits. The timeframes and legality for involuntary and voluntary detention and ITA are very clearly spelled out in the law. This will be clarified as we move forward, perhaps by drawing a connection to the existing language in the law. • The department can see what resources may already exist or be created to support the crisis system in understanding what the process looks like, for example, through technical assistance. • Interested party concern about moving patients in the middle of the night vs moving them in the daylight. Since this is a facility meant to be running 24 hours a day, it is likely that transfer may happen not during daylight hours. • So, will the facility be required to have seclusion/restraint licensure then if they can

Commented [EK(1]: Dan, can you check this for accuracy?
Someone also asked:
Will the facility be required to have seclusion/restraint licensure then if they can hold the person who refuses to stay voluntarily?

		hold the person who refuses to stay voluntarily? • This is a question we want to bring back for the group to provide discussion and feedback on. Our understanding is that models in other states do have rooms capable of restraint or seclusion. - *There is not a definition of imminent in the statute that was amended by the bill. There is a definition in Chapter 71.05 RCW that we can discuss in a future workshop.* - *RCW 71.05.020: Definitions.* *(28) "Imminent" means the state or condition of being likely to occur at any moment or near at hand, rather than distant or remote;*
(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;		• How will an individual get to the CRC if they are referred by 988? • We may want to pull in people from the 988 system/process when we get to that point. • Need to clarify "walk-in" and "medical clearance." - Walk in is a voluntary admission upon one's own volition. The need for additional clarification can be discussed as a group - Sec. 3. RCW 71.05.020 and 2022 c 210 s 1 are each amended to read as follows: (37) "Medical clearance" means a physician or other health care provider has determined that a person is medically stable and ready for referral to the designated crisis responder; • The term 'medically stable' is used in the bill and needs discussion

(d) May only accept emergency medical services drop-offs of individuals determined to be medically stable by emergency medical services in accordance with department guidelines developed per RCW 70.168.170;	Bill language: "The rules, at a minimum, must develop standards for determining medical stability before an emergency medical services drop-off." Thoughts: These standards would be applied to EMS because the determination is made prior to an individual being delivered to a CRC. Previous legislation required DOH and EMS partners to develop guidelines for EMS protocols related to determining appropriateness of delivery to a behavioral health facility vs a hospital. To support the work that has already been done and meet the rulemaking requirement in the legislation we'd like to consider language that references the guidelines. The guidelines can be updated as needed. EMS Guideline Transport to Mental H	• Need to clarify "medically stable." Who determines this? • The department plans to invite EMS experts to an upcoming workshop where we will dig into the details of this subsection. • We will explain what is in the guidelines and how they came to be. • Question regarding whether the legislature needs to make changes to the guidelines for EMS to truly have no medical clearance so folks do not have to go through the ED first? • If medical stability is only tied to EMS drop-offs, is the intent to not have any medical stability standards for law enforcement drop-offs? Can a facility have medical parameters of their own to measure the individual against once they are dropped off?

(e) Have a no-refusal policy for law enforcement;		• The no-refusal policy needs to be defined. • What if the facility is at capacity and there is a law enforcement drop-off? *-The RCW requires the following:* *-(4) The rules must include standards for the number of recliner chairs that may be licensed or certified in a 23-hour crisis relief center and the appropriate variance for temporarily exceeding that number in order to provide the no-refusal policy for law enforcement.* • *This matter is one we will be discussing when we discuss construction standards.* • There needs to be a no-refusal policy for tribal law enforcement.
(f) Accept admissions 90 percent of the time when the facility is not at its full capacity with instances of declined admission and the reasons for the declines tracked and made available to the department;		• How will this interact with the Unavailable Detention Facilities reporting (if an individual is held, meets criteria, and a bed is unable to be secured)? • There needs to be clarity about the points of data collection for this requirement (is it calling to inquire about bed availability or making a formal referral?) • What happens if the facility is at full capacity?
(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, which includes access to a prescriber, the ability to dispense medications appropriate for 23-hour crisis relief center clients;		• What is an appropriate medication for a 23-hour CRC? • What does “dispense” mean in this context? • Does “access to a prescriber” mean that telehealth is allowable and they don’t have to be onsite? • It will be important to collaborate with other health care entities who have been prescribers with patients before they enter the CRC.

		• This entire subsection can be pulled out for discussion/analysis during a workshop. There is much to discuss!

(h) Maintain capacity to deliver minor wound care for nonlife-threatening wounds, and provide care for most minor physical or basic health needs that can be addressed without need for medical diagnosis or health care prescriber orders, with an identified pathway to transfer the person to more medically appropriate services if needed;		• What is defined as minor wound care?
		  ○ Wound care is a complicated issue that requires evaluation by someone appropriately credentialed and trained.
		  ○ Is it appropriate to not have a medical diagnosis and still provide wound care and basic health care needs?
		• What is defined as a basic health need?
		• There needs to be a discussion of transfer vs discharge.
		• There needs to be collaboration with existing health systems that have been working with these patients.

(i) Screen all individuals for:		• What are the criteria for someone being too much of a violence or suicide risk? • The issue of risk circles back to DCR involvement. We may be able to get some lessons learned and examples from the AZ model. • Screening is a standard expectation for a BHA. The tough part is if there is no resource to discharge to.
(i) Suicide risk and engage in comprehensive suicide risk assessment and planning when clinically indicated;		
(ii) Violence risk and engage in comprehensive violence risk assessment and planning when clinically indicated; and		

(iii) Physical health needs.		
(j) Maintain relationships with entities capable of providing for reasonably anticipated ongoing service needs of clients, unless the licensee itself provides sufficient services; and		

(k) When appropriate, coordinate connection to ongoing care.		• There was substantial discussion regarding this point.
		  ○ When would coordination of ongoing care not be appropriate?
		  ○ If there is a resolution to the crisis, will a person need ongoing care? Perhaps if there is no ongoing SUD or mental health need, then their crisis has been resolved.
		  ○ Ongoing care needs to be mandated.
		  ○ If a person reaches a point in their mental health to need to go to CRC, at least one "follow-up" should be included (1:1 therapy, med management appointment, follow-up phone call or visit from peer, etc.)
		• Expectations for discharge planning need to be articulated (social determinants of health, housing status, etc.)

Additional comments/questions not mentioned above:

Questions/Comments	Answers
To what degree will the department be focused on advertising these services? Does outreach and engagement fall under DOH purview, or no?	The process of people calling 988 and having the no wrong door policy should help move this forward. We also have a BHA directory on the doh.wa.gov website, in different formats – there is a PDF

	version of a catalogue of different BHAs and the services they provide. There is also an interactive map on our webpage and an Excel spreadsheet online where people can sort by service, county, etc.
There were multiple questions and comments around recliners: • Is the reference to recliner literal? Can the facility have actual beds that the person occupies for the 23 hours? It would be more efficient for the currently operating facilities to use their beds, rather than purchase recliners. • Can we say "23-hour bed" rather than "recliner"? • Recliners are more challenging to clean. • The facility in AZ that legislators toured last year had actual recliners. • What about hospital grade bariatric reclining chairs? • They need to meet ADA requirements. • SAMHSA may have guidelines regarding recliners. • Is there a maximum number of recliners per CRC approved by the department? • Will there be any variance on this capacity in order to meet the no-refusal policy for law enforcement?	The word "bed" has a connotation of more than 23 hours 59 minutes. The department may have to get legal advice on whether we can redefine what a recliner is. When there is no definition in statute, we usually refer to the dictionary definition of, for example, what a recliner is. At this time, we do not know how much flexibility we have in modifying what a recliner is. The statute directs the department to develop, in the rules, standards for the number of recliner chairs and the appropriate variance for temporarily exceeding that number to provide the no-refusal policy for law enforcement. The number is something we have to discuss at a future workshop. The RCW requires the following: (4) The rules must include standards for the number of recliner chairs that may be licensed or certified in a 23-hour crisis relief center and the appropriate variance for temporarily exceeding that number in order to provide the no-refusal policy for law enforcement.
What about the impacts of having this model in a hospital-based area rather than a standalone center in the community?	The department does not want to exclude hospitals from being able to provide this service. The definition in the statute is "a community-based facility or portion of a facility…" There should not be a limit on where the facilities should be, unless there is a good reason for it. We will review the definition again.
Will there be collaboration with tribes, coordinating with tribal BH services for tribal members, for example during discharge?	Yes, the department intends to make every effort to collaborate with tribes.
Do IMD criteria get triggered?	IMD status is for inpatient rather than outpatient care. If we are dealing with an outpatient service, it should not trigger anything at all.
Will there be penalties on providers if there is no bed available for transfer?	The department issues citations when someone is in violation of a requirement. This is a question of what is the department's requirement to hold agencies to the language in the bill? If an

	individual is at the facility for longer than 23 hours and 59 minutes, if there is no bed to transfer to, the department will need to explain what the different options are and what might happen in this circumstance. Additionally, reimbursement issues may feel like a financial penalty.
How will pricing work?	The Health Care Authority is working on a model for how this will be reimbursed. Trying to get it worked out by December.
What about the construction standards?	We will discuss construction standards once we have a better understanding of what these facilities will be expected to do, so construction standards can be designed around that.
If a person is admitted within the 23-hour 59-minute timeframe and needed to go to an appointment (doctor, etc) can they be "readmitted" or is that a discharge? It must be clear that if one leaves and returns it is either a new 23 hour 59 minutes or is it cumulative from the last one?	This question is forwarded to future workshops for discussion.
Is there a timeline for opening these centers?	
Will these rules be implemented in the crisis facility being built in Kirland?	
RCW addresses the DCR response time requirements to an ED, will there be a DCR response time expectation for CRC? How long can someone stay at the facility waiting for an E&T bed if the person is ITA'd?	Sec. 5. RCW 71.05.050 and 2020 c 302 s are each amended to read as follows: (4) If a person is brought to or accepted at a 23-hour crisis relief center and thereafter refuses to stay voluntarily, and the professional staff of the 23-hour crisis relief center regard the person as presenting as a result of a behavioral health disorder an imminent likelihood of serious harm, or presenting as an imminent danger because of grave disability, they may detain the person for sufficient time to enable the designated crisis responder to complete an evaluation, and, if involuntary commitment criteria are met, authorize the person being further held in custody or transported to a hospital emergency department, evaluation and treatment center, secure withdrawal management and stabilization facility, or approved substance use disorder treatment program pursuant to the provisions of this chapter, but which time shall be no more than 12 hours from the time the professional staff

How will this interact with the Unavailable Detention Facilities reporting (if an individual is held, meets criteria, and a bed is unable to be secured)?	This is a question for the Health Care Authority. RCW 71.05.750 Report—No bed available for person who meets detention criteria. (1) A designated crisis responder shall make a report to the authority when he or she determines a person meets detention criteria under RCW 71.05.150, 71.05.153, 71.34.700, or 71.34.710 and there are not any beds available at an evaluation and treatment facility, the person has not been provisionally accepted for admission by a facility, and the person cannot be served on a single bed certification or less restrictive alternative. Starting at the time when the designated crisis responder determines a person meets detention criteria and the investigation has been completed, the designated crisis responder has twenty-four hours to submit a completed report to the authority.
Is there a time limit that the CRC can detain for a DCR evaluation?	Law enforcement has the authority to take a person into custody and deliver to a Crisis Relief Center (CRC). The facility then has the ability determine whether to involuntarily hold the person no longer than 12 hours from the time the professional staff notify the DCR and not including time prior to medical clearance (as it is defined in 71.05 which says something like a medical provider has determined the person is stable and ready for evaluation by the DCR).
Does that the legislature need to make changes to those guidelines to EMS to truly have a no medical clearance so folks do not have to go through the ED first?	RCW 71.05.020 37) "Medical clearance " means a physician or other health care provider has determined that a person is medically stable and ready for referral to the designated crisis responder; Please note, "…or other health care provider" RCW 70.02.010 (19) "Health care provider" means a person who is licensed, certified, registered, or otherwise authorized by the law of this state to provide health care in the ordinary course of business or practice of a profession.
If the data for admission acceptance is important enough to be in WAC, we should be more clear about the definition of the points of collection. E.G. if I call to enquire about bed availability or if I make a formal referral.	Data will be an important piece for all concerned to be able to demonstrate viability, success, remaining issues, etc. This WAC, however, is related to the CRC and other data collection from other sources would be in those related WACs..

"""When appropriate"" under K?	The current interpretation is that care cannot be forced with the exception of ITA individuals. An individual has the right to refuse future services and the facility needs the flexibility to allow for that.
If someone is dropped off by law enforcement but they don't want to stay, will they be forced to stay and be evaluated?	It would depend on the staffs assessment of the individuals possible DTO/DTS/GD which would require DCR evaluation.
Is the reference to recliner literal? Can the facility have acutal beds that the person occupies for the 23 hours? It would be more efficient for currently operating facilities to use their beds, rather than purchase recliners Hospital grade bariatric reclining chairs have been used. They need to meet ADA expectations The bill uses language: behavioral health bed types and recliner chairs maybe just use "23 hour bed" rather than recliner FYI, the Arizona CRC legislators last year toured has actual recliners. recliners will be more challenging to clean	Questions related to the definition of “recliner” can be discussed at a future workshop.
Will there be collaboration wtih tribes, coordinating with tribal BH services for tribal members, for example during discharge	yes