23-Hour Crisis Relief Center Rulemaking Workbook: Workshop #2

Initial Draft Language	Comments from Workshop #1 and *Info*	Workshop #2 Notes
Disposition		
(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." *Department follow-up comment:* - *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;* *RCW 71.05.050* *(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*	**Department questions/comments:** • Do we need to put a bookend on this amount of time? • For those who need a DCR evaluation, would a bookend of 36 hours be appropriate? **Workshop participant feedback:** • Currently when we call a DCR, they say it could take 24-48 hours before they get there, but they do actually show up within 5-6 hours. • Need to handle the workforce issue. In AZ model, the CRCs are attached to a continuum of care in a single building. Right now, we can't find DCRs to evaluate someone in 12 hours. Will the 36-hour bookend matter if we don't have the staff? • Some facilities would wait until the last moment to call the DCR – that decision should come sooner. • 12 hours past the 23 hours for a DCR to evaluate makes sense. • This makes sense for waiting for a DCR but what happens when detained and no beds available? • This is the risky part for CRCs that don't provide a higher level of care "in-house". Perhaps it could be addressed through

	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 notify the designated crisis responder of the need for evaluation. • 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.	the required agreements or the individual may need to be transferred to a hospital. • 36 hours is a long time to keep someone in MH urgent care. How does a provider get paid if someone is there so long? • This is a question for HCA. They are currently working on a funding model for the CRC. • What would happen if DCR can't get there in time, what happens to the patient? Would the facility end up out of compliance? This is an issue when the patient is suicidal/homicidal and needs an ITA hold, but the DCR doesn't get there in time. • Robust documentation regarding this scenario would be needed and would be considered on a case by case basis. • The exception was written into the bill so that patients can stay past 24 hours and the facility would not have to adhere to the regulatory requirements of an RTF. • Concern about patient staying voluntarily for almost 24 hours and then switching to involuntary and DCR being called at last minute, and then there being nowhere to put the patient after 12 hours. • Draft language of "imminent transition to another setting" is too vague. • If DCR comes and determines ITA criteria is met, DCR should have the patient transported to the ER for medical clearance, removing them from CRC.

		Issue of getting facility is now the DCR's at the ER. • If the "crisis responder evaluation" is a medical evaluation, this points to the need for the first stage to simply be a medical phase, then release the person into the non-medical remaining segment of the facility. • Allowed to place own hold at a 23-hour MH center in LA, which was attached to CSU and subacute. Could we get certain licensed staff LPS designated rather than using DCRs? • Not at the current time. • Intent is for CRCs to be alternative to ED and jail. First and important step to create trauma-informed response. DCRs may need to be co-located at the facilities in urban areas. • Keep the law as is until it is sorted out in real life and then change laws to accommodate reality. These facilities are new and experimental – should not be locked down prematurely into a certain mold. Rules should be revised by a certain date after trials have run which show real need. • Waiting on a DCR (12 hours applies) or making imminent transition. The imminent seems to be "likely to occur at any moment" applied to transition to another setting. DCR notification should occur as early as possible so the patient is "waiting on a DCR".

		• Suggestion to insert "more restrictive" – "imminent transition to another more restrictive setting." • State laws can be fine-tuned as needed. • Have we defined who the professional staff need to be to determine if someone is at imminent risk? I think that would be important when we think of staffing models. • For upcoming discussion **Department questions/comments:** • In RCW 71.05, the responsibility lies with the DCR to make a decision of imminent danger. • The expectation from the legislature is that these facilities can hold someone for up to 12 hours and then the decision is made and the person is transferred to the most appropriate setting (ED, E&T, SWMS). • Most likely, individuals with an involuntary commitment will go from the CRC to an ER for medical clearance and then to SWMS, E&T. • Appears to be that 36 hours is the maximum bookend that participants are comfortable with.
(j) Maintain relationships with entities capable of providing for reasonably anticipated ongoing service needs of clients, unless the	*WAC 246-341-0901 requires:* *(h) Assure communication and coordination with the individual's mental health or substance use treatment provider, if indicated and appropriate;*	Most workshop participants who responded to the poll (93%) said that the existing language in WAC 246-341-0901 was sufficient to support the requirement in new subsection (j).

licensee itself provides sufficient services; and	*(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.*	

(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,
		84% of workshop participants who responded to the poll said that the existing language in WAC 246-341-0901 on documentation requirements was sufficient to support the requirement in new subsection (k).
		
		Workshop participant feedback:
		• Some type of follow-up, even a phone call, could be indicated for all people who present to a 23-hour unit.
		• Recent research has shown that having a "crisis plan" or "safety plan" has no effect. The concern is that clinicians are not going over the plan with the clients.
		• Additional concern is that someone must be held accountable to helping the patient get the follow-up care/referrals,

	follow-up phone call or visit from peer, etc.) • Expectations for discharge planning need to be articulated (social determinants of health, housing status, etc.) *WAC 246-341-0901* *See language above and these documentation requirements:* *(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.*	but there is no billing mechanism to do the follow-up. • Concern about subsection (5)(b), the names of the participants. Can a different identifier be used? • Can consider for future rulemaking as a change would impact more than just CRC services • Staff at these facilities should conduct ongoing scientific research (collect data) for program evaluation and to ascertain the needs and experiences of the participants.
Services		
(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.	**Department questions/comments:** As part of the health screening that will happen when an individual enters the CRC, it is likely that the staff doing the screening will be looking for signs of dementia. Do we need to specifically call dementia out in the rule language?

		Workshop participant feedback: • TBI, autism spectrum disorders and developmental disabilities should also be taken into consideration. • Facility needs to address MH and SUD and screen appropriately to pass individuals on to more appropriate resources. • Health screenings may be more appropriate for conditions like TBI than dementia. • There are often co-occurring diagnoses between MH/SUD and dementia, IDD, TBI that this should be left general for clinicians to figure out. • People need to be screened for dementia so they may be sent to appropriate settings with the right care and services for those issues. Recommend including dementia-specific language.
(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? *Having non-patient specific medications (stock medications) that can be dispensed and administered to individuals. This requires a pharmacy credential or a prescriber who takes responsibility for the stock medications.*	**Department questions/comments:** • The term "dispense" has a specific meaning in this context. The facility will most likely need to procure a Health Care Entity (HCE) license. The options are to either procure stock medications or to have a prescriber that will take responsibility for the stock meds. Many RTFs have an HCE license. • It will be a challenge to limit in the rule what medications are appropriate to this

	• 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.	type of facility – this will need to be the prescriber’s call. **<u>Workshop participant feedback:</u>** • Who will determine what meds are appropriate? The administrator of the building? Can standing orders be used in this facility? • The prescriber would be determining which medication are appropriate. Standing orders can be used in some situations. The nursing commission can help clarify. • In some communities, there are long periods of time (~17 hours) when the pharmacy is not open. Having prescriber access 24/7 does not create pharmacy access. • Getting and maintaining a HCE license is a complicated process and not one easily done by a non-medical entity and especially a smaller BHA. • Keep options for med formulary broad, given the wide range of potential clinical presentations. Great to position CRCs to increase access to medication assisted treatment for SUDs/OUDs, long-acting injectable meds, etc. **<u>Department questions/comments:</u>** “Access” will be up to the determination of the individual facility. It would be wonderful if someone was onsite, but the department

		does not want to restrict this in the rule language. **<u>Workshop participant feedback:</u>** • "Access to a prescriber" allows for a variety of prescriber credentials. • There are shortfalls to telemedicine. It's great for prescribers but not so much for clients/patients. • In the AZ model, there's both telehealth and in-person. Assessments are happening in-person and nurses are on staff 24/7. • In rural communities, there is a heavier reliance on telehealth. **<u>Department questions/comments:</u>** • Do we want to describe what a multi-disciplinary team should include? Call out specific types of professionals? • The role of peers has been emphasized today and previously. • Coming up with any specific ratios would be challenging and the department does not do this for other facility types. **<u>Workshop participant feedback:</u>** • First part of (g) needs to articulate staffing to support and triage BH. • If calling out peers, use current licensing language for that role. • Leave it open for the facilities to be creative based on community need.

		• Do not specifically call out peers. Draft language doesn't say that - it is implied. • Point out medical professionals needed in these facilities – there must be at least a psychiatric NP on hand so that they can make at least an initial guess/diagnosis of the person entering the facility. • Flexibility within the space better supports success when there are tremendous limitations in access to vital parts of the workforce. • If you're being specific on the services that need to be provided, give flexibility except for the inclusion of peers. • If there are expectations for specific provider types, that needs to be specified in the WAC. • Nurse roles are hard to find, but if prescribing is part of the intervention, they can take a verbal order while other roles cannot. • This is a stabilization process, not an ACT process and we need to be able to utilize all disciplines at any given time. • From SAMHSA National Guidelines: 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. **Department questions/comments:** -0901 references the need to collaborate with other health care providers. Is this enough? **Workshop participant feedback:** • If someone comes into the CRC in an actively psychotic state, they will not be able to say who they have been treated by before.

(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.
		Department questions/comments:
		• Do we need clarification on "deliver minor wound care"?
		• What is the distinction between providing first aid and emergent care? Facilities can probably do more than just first aid because of having access to prescribers.
		
		Workshop participant feedback:
		• Can we say, apply first aid unless the scope of practice of the practitioner allows more sophisticated care?
		• Possibly.
		• Medical piece should be there but not be the foundation. Aside from actual physical, medical needs, treatment should not be medical in these short-term facilities.
		• RTFs require orders for most things. Given that this is an outpatient service,

		what is our latitude to provide wound care and address other issues without orders? • The rule/RCW points to the type of care which would not need orders or diagnosis which should define the scope of available treatment. • What about medical diagnostic capabilities – lab work, EKG? Wound can look superficially minor but may be more complicated if labs show infection, etc. • Not enough nurses to staff these facilities. Perhaps people should go to urgent care for medical care and then go to crisis respite if they can function in normal consciousness and are not in need of more acute care. • Nursing assessment should help us determine if it is something that we could handle and if not, we get them to ER. • Word "minor" is critical. People who are using Tranq are losing their limbs. • In AZ, typically address wounds if it requires no more than once daily dressing changes. • Wouldn't minor wound care fall in the scope of practice of nurses? Makes sense to specify minor/basic needs without need for full-scope medical care. • Emergent care only works if there is a way for the facility to have a good feel for what they see how the client "presents", but have **quick** access to the medical

		history of the individual needing crisis care. • Wound care should be treated as a signal for needing additional services or to engage the client in a conversation. • RNs have decision making ability during the nursing assessment. • Will consider this as a way to describe the level of care that can be provided without a diagnosis. **Department questions/comments:** The nursing assessment is a very reasonable baseline. It is not a medical diagnosis, but nurses can determine if a higher level of care is needed.
(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.	Discussion of this subsection was moved to the next workshop as we ran out of time.
(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.		

Questions/comments for EMS special guests at next weeks workshop:

- What are the potential reimbursement or regulatory issues that limit EMS transport to a crisis facility?
- What resources would EMS expect if they drop an individual off at this sort of facility?
- EMS decision making algorithm or "gray area" of how to choose where they refer the individual.
- EMS will need to understand what the CRC's are limited to with staffing and allowable services, in order to define what is medically stable for a facility like the CRC.

General comments/questions:

- It sounds like a complex infrastructure needs to be in place to support a 24-hour crisis reception facility (i.e. if there are no drug de-tox facilities available for the # of people nearing or in the middle of overdosing that piece breaks down, and if there is no public housing available for the large # of homeless people who're seeking a micro-apartment that piece breaks down also). I see the problem as a very complex mainly social problem with some medical aspects to it, but it is primarily a social problem and in the US the social piece is extremely weak compared to the amount of medical industry built up.
- There are housing options in AZ that do not exist in WA's infrastructure.
- In rural areas, there are not sufficient resources to build a CRC this robust.
    - This may turn into an equity issue – catering towards urban centers.
- Need to increase outpatient services, peer respite, housing options, etc.
- Maybe CRCs need to be located in more than one place – some in hospitals, some in other locations, and people are brought or transferred to most suitable place according to category of crisis.
- In Tacoma, both police and fire/EMS transport to crisis stabilization units for voluntary placement, they transport to the ER for involuntary placements for med clearance prior to placement in an E&T.
- Who will be responsible for the cost of the transportation from the 23-hour facility to the hospital?
- Reimbursement is handled through the Health Care Authority and they are currently working on a reimbursement model. In other such cases, the fiscal responsibility is not on the facility.
- There should also be drop-in facilities that prevent people from going into a crisis state in the first place; this effort could be connected to the crisis centers and be a different kind of approach.

    - Advocacy to bring that from leg to reality is needed.
- Will the sites be staffed by psychiatrist 24/7 like an ED?
- A prescriber must be accessible.
- Will 23-hour facilities be implemented in existing behavioral health facilities, or will all of them be brand new facilities?
- There is currently no plans to restrict or prescribe where the CRC may be located.
- 23-hour CRC and other "redesigns" are all over right now: Reinventing the E.R. for America's Mental-Health Crisis | The New Yorker
- We should see this as more of an opportunity, rather than a burden, to change the course/process of BH care occurrences.
- Need to emphasize trauma-informed training.
- There needs to be greater clarity on what this type of facility needs to be. What is the difference between CRC and CSU?
- The CRC is outpatient where the CSU is residential and the CRC must have a no refusal law enforcement drop off.
- In AZ, all of our crisis receiving centers do have 16 bed subacute units that help with flow... we use this structure in many but not all states in which we operate based on regulations. Possible flexibility to allow crisis relief center and crisis stabilization services to exist in the same space might support access in rural communities and also maximize the impact of the workforce.
    - Allowing flexibilities for shared staffing between CRCs other co-located units like CSUs or outpatient will be important to make staffing possible, given workforce shortages and the need for 23-hour units to accommodate fluxes in patient capacity.

Dr. Chris Carson Presentation

- ER psychiatrist who was worked in crisis for over 30 years.
- Brought out to Maricopa County, AZ in 2004 to help look at problems in the crisis system there. There was a general dissatisfaction with outcomes on all sides.
- Individuals used to sit in the back of police cruisers for 1.5 hours in 115-degree heat. Goal was to decrease the time to six minutes.
- A lot of people ended up in jail, which was easier than taking them to the ER. They wanted people to be re-directed to treatment instead of jail.
- All of the planning for this type of facility needs to be from the perspective of the patient. Who is the person coming in? What do you need to do to safely take police drop-offs?
- Have to be ready to take people in an acutely psychotic state, as well as administer medications immediately. Wanted to have a Pyxis machine to avoid delays.
- Created guidelines appropriate to them regarding when an individual might need stitches, have medical issues, etc. If so, they need to be taken to the ER. Arrange transport to ED 3 % of the time.
- Able to treat diabetes, high blood pressure. Created guidelines for vital signs, blood alcohol levels. The goal is to successfully monitor the patient once they arrive.
- Peers would meet patients at the back door – key piece of the multidisciplinary team.

- In a 23-hour observation unit, there are incredibly volatile volumes. If you go on divert or get too full, the system comes undone.
- Added subacute beds to help with the flow issue, in case people need something else after the 23 hours.
- The AZ system has been under intense management and transformation over the last 2 decades.
- Disposition and discharge planning starts at minute 1. Need to create a multi-factorial discharge plan. Inpatient numbers somewhere around 30-35%. Patients need a wide variety of community-based services. Also have a transitions program that serves as a bridge into the community.
- Follow staffing guidelines. As volumes rise and fall, the staffing changes as a unit. It is driven by acuity and the population being served.
- People may appear at the back door with a serious injury like a gunshot wound, but the police would never bring someone with a gunshot wound to the facility. The police are very good at following the established guidelines.
- There are times when police encounter a person with an altered mental status due to dehydration/heat and they bring the person to the CRC. A physical is conducted (nursing assessment) and then the person is transported to the ER.
- The number one principle is that you should never turn people who are in high acuity away.