Workbook for Workshop #7

RCW Requirement:

(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.

(5) The department shall specify physical environment standards for the construction review process that are responsive to the unique characteristics of the types of interventions used to provide care for all levels of acuity in facilities operating under the 23-hour crisis relief center model

Draft Language	Notes
Option 1: General list of requirements. Lacks specificity=open to interpretation. (2) An agency providing 23-hour crisis relief center services must be constructed in such a way to be responsive to the unique characteristics of the types of interventions used to provide care for all levels of behavioral health acuity and accessibility needs including having: () A public walk-in entrance; () A designated area for first responder drop-off; () Private space for screening and delivery of clinical services; () Secure medication storage; () Secure storage for personal belongings of individuals receiving services; () No more than 24 licensed recliners in a single room; () At least four feet of clear floor space between recliners and at least three feet of clear floor space between the recliner and wall;	**<u>Department comments</u>** • One idea that can be explored is limiting the number of recliners per room. 24 is an arbitrary number/a starting point. • For the space between recliners, the department looked at both the AZ model and the Facility Guidelines Institute (FGI) guidelines. • A nourishment area is included in some of the existing standards. • There are several additional construction-related components included in Option 1. These are standards across all facility types that have construction standards. The draft language describes when construction standards would apply. • (6) describes when facilities could temporarily exceed the licensed recliners – only to comply with the no-refusal policy for law enforcement. The local building department would give the facility the maximum occupancy for the number of patients and that number would be the

() At least one toilet and one shower for every eight recliners;
() A station that allows staff observation of the patient care areas;
() A bed in a private space for individuals who are admitted for greater than 24 hours per WAC XXX;
() A room capable of restraint or seclusion that meets the construction standards in WAC 246-337-127;
() A system or systems within the building that give staff awareness of the movements of individuals within the facility. If a door control system is used, it shall not prevent a resident from leaving the licensed space on their own accord, except temporary delays. Such systems include:
(i) Limited egress systems consistent with state building code, such as delayed egress;
(ii) Appropriate staffing levels to address safety and security; and
(iii) Policies and procedures that:
(A) Are consistent with the assessment of the individual's care needs and plan; and
(B) Do not limit the rights of a voluntary individual.
() A nourishment area for individuals receiving services to eat and drink;
() Access to a telephone for individuals receiving services;
() Storage for cleaning supplies;
() A room for holding of soiled linens, supplies, and equipment; and
() A room for storage of clean linen, supplies, and equipment.
	maximum amount that a facility could reach when they temporarily exceed the number of licensed recliners.
	
	<u>Workshop participant comments/feedback</u>
	• How many staff per 24?
	  ○ In the staffing language that has been drafted so far, the department is not prescribing a patient to staff ratio. The language states that there are certain types of staff that need to be available.
	• Noise and privacy in a room like that would be difficult to maintain.
	• Dividers and rooms create issues with monitoring patients.
	• Acuity of patients makes a difference in how many in a room.
	• Is there a room size per 24 recliners?
	  ○ The room size would be determined by the floor space requirements.
	• Limiting the number to 24 restricts the model.
	• A big issue at this time for hospitals or clinics is the number of clients per oversight person(s) - e.g. nurses, etc. - with the current concern being that some providers load on too many patients for each oversight person so that there can't be the time needed to take care of each patients/client's need. Is there going to be some sort of mandate in these facilities that the number of oversight persons need to be on hand to handle so many patients/clients. I bring this up when I see the "no more than 24 licensed recliners in a single room".
	  ○ The patient load that a nurse is able to take on also depends on the nurse's skill level. How a facility is

(3) An agency must obtain construction review approval prior to a certification for 23- hour crisis relief services being granted. The construction standards in this section apply to agencies providing 23-hr crisis relief center services including: (a) New buildings to be certified to provide 23-hr crisis relief center services; (b) Conversion of an existing building or portion of an existing building for providing 23-hr crisis relief center services; (c) Additions to an existing agency providing 23-hr crisis relief center services; (d) Alterations to an existing agency providing 23-hr crisis relief center services; and (e) Buildings or portions of buildings certified to provide 23-hour crisis relief center services and used for providing 23-hour crisis relief center services; (f) Excluding nonpatient care buildings used exclusively for administration functions. (4) The requirements of chapter **246-341** WAC in effect at the time the application and fee are submitted to the department, and project number is assigned by the department, apply for the duration of the construction project. (5) Construction review process. (a) Preconstruction. The applicant or licensee must request and attend a presubmission conference with the department for projects with a construction value of two hundred fifty thousand dollars or more.	run/managed can change staffing ratios and needs. • Has anyone looked at the layout at Unity Center for BH in Portland? I believe their emergency/crisis space has recliners. • It should be driven by community needs, size of the project, organization's standards and procedures. Should be adaptable. • Organization's model should drive the number of chairs. ○ The statute requires the department's rules to include standards for the number of recliner chairs. The department's intent is to write rules that create the most flexibility for an environment capable of providing crisis services, while still having a number attached to it. • Not mandating some ratio is a problem. I have been in dangerous situations due to running with too little staff. Staff hurt, patients hurt. • Ratio of floor/other staff to client is a huge issue. It is something that needs to be addressed and worked through. I am not sure how, but I think there are lot of people in this industry with that exact concern. • It should definitely be driven by community needs. In my experience, busy crisis facilities in AZ have 50-60 recliners. There is a significant community need to meet. The open room for crisis facilities improves the staff ability to monitor. • I have worked in small, medium and larger 23 hr facilities. Small is 14 or lower, medium 26-30 and large up to 60 or more. I find the medium size one works better for the

The presubmission conference shall be scheduled to occur at the end of the design development phase or the beginning of the construction documentation phase of the project.
(b) Construction document review. The applicant or licensee must submit accurate and complete construction documents for proposed new construction to the department for review within ten days of submission to the local authorities. The construction documents must include:
(i) A written functional program outlining the types of services provided, types of residents to be served, and how the needs of the residents will be met including a narrative description of:
(A) Program goals;
(B) Staffing and health care to be provided, as applicable;
(C) Room functions;
(D) Safety and security efforts;
(E) Restraint and seclusion;
(F) Medication storage; and
(G) Housekeeping.
(ii) Drawings prepared, stamped, and signed by an architect or engineer licensed by the state of Washington under chapter **18.08** RCW. The services of a consulting engineer licensed by the state of Washington may be used for the various branches of the work, if appropriate;
(iii) Drawings with coordinated architectural, mechanical, and electrical work drawn to scale showing complete details for construction;
	community as well as being able to keep the milieu therapeutic.
	• In the larger facilities, how are privacy concerns addressed?
	  ○ Participant response – There are consult rooms on the unit.
	  ○ Participant response – Patients are interviewed in a private room for their assessments.
	• Perhaps there may be no other way to "ensure" a safe ratio of clients to caregiver than to "mandate" a number - I believe caregivers would give evidence that for-profit behavioral healthcare providers will "always" be looking to "squeeze" as much as possible out of its caregivers - sorry, just considering real-life realities vrs. hoped for outcomes. The HCA sets the certification requirements - not the providers!
	• Will there be a limit for storage for stuff brought with them?
	• We anticipate that some people will come into the facility with weapons and need to plan for that.
	• Outdoor pods might be helpful to implement at some point. There are lots of people who keep most of their personal possessions on them, or near them stashed somewhere close.
	• Illicit substances – may need to account for disposal vs storage.
	• Some will come in with illegal substances, need to prepare for that as well.
	• Any concerns for hidden objects? Any need for metal detection, for example?
	• Animals?

(iv) Specifications that describe with specificity the workmanship and finishes; (v) Shop drawings and related equipment specifications; (vi) An interim life safety measures plan to ensure the health and safety of occupants during construction and renovation; and (vii) An infection control risk assessment indicating appropriate infection control measures, including keeping the surrounding occupied area free of dust and fumes during construction, and ensuring rooms or areas are well ventilated, unoccupied, and unavailable for use until free of volatile fumes and odors. (c) Resubmittals. The licensee shall respond in writing when the department requests additional or corrected construction documents. (d) Construction. The licensee or applicant shall comply with the following requirements during the construction phase: (i) Assure conformance to the approved plans during construction; (ii) Submit addenda, change orders, construction change directives or any other deviation from the approved plans to the department prior to their installation; and (iii) Allow any necessary inspections for the verification of compliance with the construction documents, addenda, and modifications. (e) Project closeout. The licensee or applicant shall not use any new or remodeled areas until:	• Unfortunately, belongings also may have bed bugs, lice, etc. so a separate space to address that. • Cleaning supplies need to be secured as well.

(i) The department has approved construction documents; (ii) The local jurisdictions have completed all required inspections and approvals, when applicable or given approval to occupy; and (iii) The licensee or applicant notifies the department when construction is completed and includes: (A) A copy of the local jurisdiction's approval for occupancy; (B) The completion date; (C) The actual construction cost; and (D) Additional information as required by the department. (6) An agency may temporarily exceed the number of licensed recliners only to comply with the no-refusal policy for law enforcement, up to the maximum occupancy allowed by the local building department for patient care spaces within the licensed unit. (7) For the purposes of this section, a recliner means a piece of equipment used by individuals receiving crisis services that can be in a sitting position and fully reclined.	
Option 2: Use draft above but add specificity. Will take significant amount of time.	**Department comments** • There is risk to having a laundry list such as in Option 1 without adding specificity, because that would leave a lot of room for interpretation. For example, one surveyor might mean a lockbox while another means a room. Or the architect helping you with the build could interpret a

	requirement one way, but the department may have a different interpretation. **<u>Workshop participant comments/feedback</u>** • Better now to have the rules before someone dies. • I think that the more details you add, the more you are accountable to those details. All reviews/audit are on some level subjective to the person doing the review and their interpretation. Having general standards and clear policies/procedures on how you meet those is program management and operational. • Long ago in the SUD world we had a WAC implementation guide (WIG) that helped lay out the specifics of how to interpret the WACS without having to have too much specificity in the rules. • When I worked at DBHR on the Licensing and Cert team, we had long convos about "if you need interpretive guidelines then you need to write the WAC better." • The WIG was so helpful! ○ The department wants to provide as many resources as possible, such as implementation guides, but we have to be mindful because guides should not replace requirements that should be in rule. • Other areas of DOH are problematic due to unclear WACs. • It occurs to me, that with one large room, there might need to be some indication of lighting expectations...lighting that allows some restful time, but that facilitates the work necessary in the setting as well.
Option 3: Reference existing national standard with ability to exempt or amend certain requirements.	**<u>Department comments</u>**

An agency certified to provide 23-hour crisis relief center services must be constructed in such a way to be responsive to the unique characteristics of the types of interventions used to provide care for all levels of behavioral health acuity and accessibility needs. These rules are not retroactive and are intended to be applied as outlined below.
(1) These regulations apply to agencies providing 23-hr crisis relief center services including:
(a) New buildings to be certified to provide 23-hr crisis relief center services;
(b) Conversion of an existing building or portion of an existing building for providing 23-hr crisis relief center services;
(c) Additions to an existing agency providing 23-hr crisis relief center services;
(d) Alterations to an existing agency providing 23-hr crisis relief center services; and
(e) Buildings or portions of buildings certified to provide 23-hour crisis relief center services and used for providing 23-hour crisis relief center services;
(f) Excluding nonpatient care buildings used exclusively for administration functions.
(2) The requirements of chapter **246-341** WAC in effect at the time the application and fee are submitted to the department, and project number is assigned by the department, apply for the duration of the construction project.
(3) Standards for design and construction.
	• This option would entail using an existing tool that already has the specificity in it.
	• The FGI standards mentioned here are guidelines for the construction and design of hospitals and while hospitals may open CRCs we could adopt the standards that do apply to standalone CRCs and then call out the ones that should be exempt because they are not applicable to non-hospital facilities.
	• SAMHSA guidelines are too broad to be able to provide the level of oversight needed.
	
	Workshop participant comments/feedback
	• Do we have the use the same names? Why is it called a nourishment room if we are not committing to providing a meal?
	  ○ If we reference the FGI standards then we wouldn't need to call out this specific language in the WAC.
	• Are there examples of a facility that has been running for a while in other states? If so, we might be able to save a lot of time with trying to come up with a design.
	  ○ The department has been looking at the AZ rules. We could copy/paste them, but we cannot directly reference another state's rules like we can with the FGI standards.
	• You indicated that there are already observation units being built, is the expectation they just follow the FGI guidelines? It would be costly to make changes later.
	  ○ The observation units are being built based on an agreement to use the FGI standards. Part of the reason for choosing FGI for that facility is that the likelihood of us coming up with standards that are

Facilities constructed and intended for use under this chapter shall comply with:
(a) The following sections of the 2022 edition of the *Guidelines for Design and Construction of Hospitals* as developed by the Facilities Guidelines Institute and published by the Facility Guidelines Institute, 9750 Fall Ridge Trail, St. Louis, MO as amended in WAC **246-341 (allows us to add things we want and remove things we don't)**:
(i) 1.1 Introduction
(ii) 1.2 Planning, Design, Construction, and Commissioning
(iii) 2.1 Common Elements for Hospitals
(iv) 2.2 -3.2 Specific Requirements for General Hospitals, Behavioral Health Crisis unit;
(v) Part 4: Ventilation of Health Care Facilities; and
 	
(b) The following specific requirements:
 	
(i) A public walk-in entrance;
(ii) A designated area for first responder drop-off;
(iii) A bed in a private space for individuals who are admitted for greater than 24 hours per WAC XXX;
(iv) A system or systems within the building that give staff awareness of the movements of individuals within the facility. If a door control system is used, it shall not prevent a resident from leaving the licensed space on their own accord, except temporary delays. Such systems include:
	more prescriptive than FGI is not likely. When a facility is built and it becomes licensed prior to the rules going into effect, retroactive requirements do not apply.
	• Where is this facility being built currently?
	  ○ Kirland.
	• It seems that if you organize and mimic some of the RTF expectations in 246-336 that it would ease confusion later.
	• It seems that using an existing standard that is so complicated to access may not be in the best interest of our community members and their advocates (thinking about lack of transparency). For example, if an advocate thinks that a facility is acting inappropriately in some way, it would be reasonable for them to access the regulations related to the facility to decide whether or not there is a problem. You can read the RCWs or WACs and choose whether there is a concern.
	  ○ The facilities themselves and architects are very familiar with FGI standards, for all facility types.
	  ○ Construction requirements are not referenced in detail in facility rules.
	
	Poll
	Which direction for construction related rulemaking should we go? 1. Use the generic list with risk of varying interpretation. 2. Use the list, but take time to add in specificity. 3. Reference the FGI or another standard if available.
	
	23% - option 1
	
	36% - option 2

Commented [JW1]: This is where the meat of the requirements are.

Commented [JT2R1]: Standards covered include:
Means for visual observation of the unit
Exam/treatment room
Square footage per person
Space around recliners
Hand washing station
Toilet
Shower
Quiet room
Secure holding room- where provided
Medication safety zone
Outdoor area- Where provided
Nurse station
Intake/consultation room
Nourishment room
Clean workroom/supply
Soiled workroom/holding
Equipment/Supply storage
Environmental service room
Staff support area
Visitor/family lounge

Commented [TJ(3]: Are any of the requirements below already covered in the FGI referenced?

(A) Limited egress systems consistent with state building code, such as delayed egress; (B) Appropriate staffing levels to address safety and security; and (C) Policies and procedures that are consistent with the assessment of the individual's care needs and plan and do not limit the rights of a voluntary individual. (v) Access to a telephone for individuals receiving services. (4) Construction review process. (a) Preconstruction. The applicant or licensee must request and attend a presubmission conference with the department for projects with a construction value of two hundred fifty thousand dollars or more. The presubmission conference shall be scheduled to occur at the end of the design development phase or the beginning of the construction documentation phase of the project. (b) Construction document review. The applicant or licensee must submit accurate and complete construction documents for proposed new construction to the department for review within ten days of submission to the local authorities. The construction documents must include: (i) A written functional program outlining the types of services provided, types of residents to be served, and how the needs of the residents will be met including a narrative description of: (A) Program goals;	41% - option 3 **<u>Workshop participant comments/feedback</u>** A workshop participant indicated that they did not feel comfortable voting before they had an opportunity to review this document, as well as the FGI guidelines. • Can you clarify if Option 2 is a feasible option, given Julie's presentation and the timeline? ○ If this was the option that the majority of participants preferred, the department would need to consult with leadership regarding how it would impact our timeline.

(B) Staffing and health care to be provided, as applicable; (C) Room functions; (D) Safety and security efforts; (E) Restraint and seclusion; (F) Medication storage; and (G) Housekeeping. (ii) Drawings prepared, stamped, and signed by an architect or engineer licensed by the state of Washington under chapter **18.08** RCW. The services of a consulting engineer licensed by the state of Washington may be used for the various branches of the work, if appropriate; (iii) Drawings with coordinated architectural, mechanical, and electrical work drawn to scale showing complete details for construction; (iv) Specifications that describe with specificity the workmanship and finishes; (v) Shop drawings and related equipment specifications; (vi) An interim life safety measures plan to ensure the health and safety of occupants during construction and renovation; and (vii) An infection control risk assessment indicating appropriate infection control measures, including keeping the surrounding occupied area free of dust and fumes during construction, and ensuring rooms or areas are well ventilated, unoccupied, and unavailable for use until free of volatile fumes and odors.	

(c) Resubmittals. The licensee shall respond in writing when the department requests additional or corrected construction documents. (d) Construction. The licensee or applicant shall comply with the following requirements during the construction phase: (i) Assure conformance to the approved plans during construction; (ii) Submit addenda, change orders, construction change directives or any other deviation from the approved plans to the department prior to their installation; and (iii) Allow any necessary inspections for the verification of compliance with the construction documents, addenda, and modifications. (e) Project closeout. The licensee or applicant shall not use any new or remodeled areas until: (i) The department has approved construction documents; (ii) The local jurisdictions have completed all required inspections and approvals, when applicable or given approval to occupy; and (iii) The licensee or applicant notifies the department when construction is completed and includes: (A) A copy of the local jurisdiction's approval for occupancy; (B) The completion date; (C) The actual construction cost; and (D) Additional information as required by the department.	

(5) An agency may temporarily exceed the number of licensed recliners only to comply with the no-refusal policy for law enforcement, up to the maximum occupancy allowed by the local building department for patient care spaces within the licensed unit. (6) For the purposes of this section, a recliner means a piece of equipment used by individuals receiving crisis services that can be in a sitting position and fully reclined.	
RCW Requirement: (7) The department shall coordinate with the authority to establish rules that prohibit a hospital that is licensed under chapter 70.41 RCW from discharging or transferring a patient to a 23-hour crisis relief center unless the hospital has a formal relationship with the 23-hour crisis relief center.	
Draft Language	**Notes**
Proposed rule in WAC 246-320 (acute care hospital standards): A hospital must have a documented formal relationship, such as an agreement or memorandum of understanding, with a 23-hour crisis relief center as defined in chapter 71.24 RCW in order to discharge or transfer an individual to the center.	**Department comments** • If this is something that the department will be regulating, it would be helpful to have more of a description of what constitutes a formal relationship. **Workshop participant comments/feedback** • First thoughts that come to mind is what is the different "pathways" or difference between "discharging" or "transferring" a patient to a 23-hour CRC. ○ Typically, transferring happens from one hospital to another hospital. Can transfer happen from one hospital to another hospital-based CRC? Discharge happens if the patient is discharged to the community or someplace like a nursing home. Discharge indicates that the patient is technically

	no longer in the system – it is a severance of a relationship between the patient and the hospital. • I am not sure why a hospital would transfer a patient from their inpatient to a 23hr level of care. It is a lower level of care. In Arizona the only reason we would transfer is if the patient became involuntary and a petition was completed. In Arizona the obs units are screening and evaluation agency who assess patients to see if they are appropriate for court order evaluation. • I'm wondering if we might want to add language about being part of the same system or having the same owner as the hospital. So that they wouldn't need a formal MOU. Because they are the same entity already. • I interpret "discharged" to mean a person was admitted to inpatient level of care, and no longer requires inpatient. "transferred" to be more ambiguous - could be from the emergency dept. for example. • It's been a bit, but I'm thinking that for billing, the ambulance cost would be covered dependent on the plan. Otherwise, a discharge is a discharge with a plan. If that makes sense. • Seems like payment might be tricky with a discharge. • I do think that this language will be helpful. Inpatient facilities (speaking generally) often discharge these sorts of patients to the street. In this new scenario, they wouldn't easily be able to do this, and direct folks to the CRC as a walk-in. They would be encouraged to work with their community partners as a system of care. • Regarding a "documented formal relationship" is that intended to be ambiguous or are there terms of

	agreement standards for such relationships that may already exist? o The department does not know that the legislature's intent was in using the term "formal relationship." There does not appear to be a definition in statute for "formal relationship."