23-Hour Crisis Relief Center Rulemaking Workbook: Workshop #3

Initial Draft Language	Comments from Kickoff Meeting and *Info*	Workshop #3 Notes
Walk-in's and drop-off's		
(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;	 EMS Guideline Transport to Mental H  2201044emstranspor toappropriatealternat • What is considered "medically stable"? • RCW 70.168.170: Ambulance services—Work group—Patient transportation—Mental health or chemical dependency services. (wa.gov)	**Workshop participant feedback/questions:** • Are we going to be saying that "only" EMS can deliver people needing behavioral health services to crisis relief centers - and not law enforcement? Does that mean that in crisis situations where only law enforcement is involved, that they, not being medical specialists, will have to take their people in crisis to ERs? What about Crisis Response Teams who may or may not have medically qualified personnel as part of their teams? ○ The definition in statute is that a CRC "accepts all behavioral health crisis walk-ins drop-offs from first responders, and individuals referred through the 988 system regardless of behavioral health acuity." The facilities also have to have a no-refusal policy for law enforcement, so it is not just limited to EMS. • One of the exclusion criteria is "new onset of mental health problems." ○ This can be modified. • Is an EMT able to give a report to another EMT? ○ Yes, the expectation is that in an emergency, EMS transfers to the

		most appropriate location, but nothing in the law speaks to who they report to. One item to keep in mind is that EMTs are not authorized to work in a health care facility unless they have an appropriate credential to do so.
		• Guidelines need to be updated to fix reference to "Designated Mental Health Professional" – now called "Designated Crisis Responder."
		  ○ Department EMS staff have been made aware of this needed update.
		• In addition to state guidelines, are there county-by-county differences (per jurisdiction)?
		  ○ Each Medical Program Director would take the guidelines and make them appropriate for their county. Department guidance is the minimum standard and is written broadly enough, where applicable, that local jurisdictions can tailor to meet local nuances.
		• What is the difference in reimbursement of an ER transport vs a BH/alternate destination transport (CRC)?
		  ○ From Health Care Authority: There is no difference in reimbursement of an ER transport vs a BH/alternate destination transport. 23-hour crisis centers would be included if

		the transport is consistent with RCW 18.73.280 and guidelines. Base rate for reimbursement is $115.34 and $6.86/mile. EMS may also be able to get additional reimbursement from GEMT and QAF funds. • In many places across the nation, EMS is paid differently (less) when transporting to a non-hospital ED which results in very few transports to crisis facilities. Hoping that barrier can be removed in WA for all payers of this important service so individuals in need are connected with the best possible service. • Are there any reimbursement issues experienced by an EMS provider when transporting someone to an alternative destination, such as a Crisis Relief Center, in lieu of a hospital ED? ○ Often the reimbursement is not sufficient to support what EMS is doing. It is not always based on care provided outside of transport. • Local coordination and understanding will be necessary. This seems to allow for that. • This feels like language that informs EMS on when to bring individuals to a CRC, so not sure why it is here. Would prefer to see an expectation that all at the door are welcomed into a CRC which do have 24/7

		medical professionals on site based on the regulation. ○ The bill requires the department to do rulemaking on this point. It is a requirement that EMS must follow, so it is awkward to put it into the BH agency rules, but the department is doing its best to incorporate it in a way that makes sense. There is language in the statute that does encourage the no-wrong door approach. • What if a person does not have insurance? Are all insurances accepted? ○ This would be a question for the Health Care Authority. • Possibly include language to give CRC staff the ability to decline if initial exam is done at drop-off. Option for CRC staff to have a say. • Looping back to our conversation last week about "wound care", when is a wound "medically stable"? When it stops bleeding? Or when there is no sign of infection? ○ The staff with medical credentials who work at the facility will ascertain stability.
(c) Offer walk-in options and drop-off options for first responders and persons referred through the 988	• Clarify “walk in”	• What (c) offers is an open door that might become really difficult to manage. Folks already know of long waits at the

system, without a requirement for medical clearance for these individuals;	• Note: Definition of first responder: "First responders" includes ambulance, fire, mobile rapid response crisis team, coresponder team, designated crisis responder, fire department mobile integrated health team, community assistance referral and education services program under RCW 35.21.930, and law enforcement personnel.	ED (hours and hours) and given that reality they may inappropriately walk into this setting.
		• If 988 can do some preliminary screening and make a "true" referral, then that might be helpful.
		• In some cases families are transporting. How does this impact those situations?
		  ○ CRCs are required to accept walk-ins, which would include individuals transported by family members.
		• Can we include liability protection for BH providers, if we are not requiring medical clearance? Some BH crises are a symptom of a physiological illness (syphilis can cause mania, psychosis and delirium).
		  ○ The department will take this into consideration.
		• If there are minimal medical standards there needs to be a way to address drops that aren't stable. For example, LE can't do a BP check, but the facility can, so if it is outside parameters than what?
		• What happens if the person being dropped off is unstable to the point they are not able to be managed or cared for?
		• Dr. Nathaniel Schlicher, in coordination with WA State Hospital Association, created a Medical Clearance Guidelines that were signed off on by all of the

		Emergency Department Medical Directors state-wide. It narrowed the need for unnecessary labs and tests. **Department comment:** Medical clearance is something that the statute talks about when referencing an individual that is under involuntary commitment and that is being transported to the facility for treatment under involuntary commitment. Pertaining to the reference to medical clearance here, the understanding is that there are facility types that first responders can take individuals to currently, but the facilities require medical clearance. The intent of this legislation was to eliminate that barrier so that first responders are able to take individuals to CRCs without clearance first. Not all BH crises have a medical component to them.
(e) Have a no-refusal policy for law enforcement;	• Clarification around "no-refusal policy" • Need for specifying tribal LE? • How does this work if the CRC is at capacity?	• Please specify tribal LE. We regularly run into state agency staff who interpret the law narrowly and will exclude them unless specified. • So the officer waits until nursing does a quick assessment and re-routes them to the ED? Or they call an ambulance or what? • So if an officer drops off and then leaves because they need to go back into service now EMS is being called to transport and is that creating a burden to EMS as police can just drop off?

		• It is good to keep in mind that for the AZ facilities (last week's presentation), their rate of follow-up medical care needed (that couldn't be handled by the crisis facility) was only 6% of cases. • Do transfers only happen between equal levels of care (CRC to CRC?) Going to a hospital is not a transfer. In order to be discharged you need to be admitted. Accepted vs. admitted, process of admittance and discharge needs to be clarified. **Department comment:** During last week's workshop, we heard from a representative of several CRCs in Arizona. They said that if there are any questions regarding medical complications overriding BH complications, the individual will be transported to an ED. If the police drops someone off and their medical complications are too great, then an ambulance service will be called. There is a question of who does the transportation and who pays for it, and a lot of this will be driven by reimbursement and be dependent on the level of transport needed.
(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	• Does full capacity mean fully staffed and therefore all beds open/for use? Capacity could go down if centers are not fully staffed which would impact the ability for the CRCs to function as intended.	• There needs to be a definition of "admission" and "full capacity." • What happens if someone walks into a CRC and the provider doesn't admit them?

for the declines tracked and made available to the department;	• 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?	• Can this be clarified to say "eligible admissions"? ○ Perhaps the facility can document the declined admission as not being an eligible admission and why. Would these two data points be sufficient? • Facilities may do their own tracking – acceptances, what the individual came in for, how long they stayed. • A CRC may publicize that they have a 16-bed capacity, but then if law enforcement comes, they have to take the individual anyway, which makes things extremely difficult due to staffing. • It is more likely that a facility would hold slots below full capacity for mandated drops, rather than go over capacity. In our current struggles to staff all behavioral health programs it is unlikely that you would have staff waiting to be called in to staff at higher census. • How can you track things and not get into the various HIPAA expectation of chapter 246-341 WAC? • At what point do they become a client? What happens if someone just leaves because they don't like how the facility looks? At what point do they become an entry in the Electronic Health Record? How do you reimburse someone who has not been admitted?

		• What data is required by the law to gather?
		  ○ There are no specific data points required.
		• Can CRCs go on divert?
		  ○ This is a question for the EMS experts.
		• If these facilities are similar to an ER, you obtain basic demographic information and screen for immediate needs.
		• Would there ever be a scenario where we'd be declining service via telephone? Still wondering about gathering data.
		• Do the records requirements in WAC 246-341-0640: apply? If not, the exception has to be called out in this section.
		  ○ The proposed certification would exempt them from the requirements in WAC 246-341-0640.

Cont. Discussion on Services		

• (i) Screen all individuals for:
  • (i) Suicide risk and engage in comprehensive suicide risk assessment and planning when clinically indicated;
  • (ii) Violence risk and engage in
	• What are the criteria for someone being too much of a violence or suicide risk?	• The language is purposely left loose. Can we reference a list of recognized screening guidelines?
		• This ties in to whether someone is admitted or screened for admission. At what point does this expectation kick in? Other than that, vague is probably better.
		• Can consider using "a validated tool for suicide risk screening."
		• Screening is not evaluation.

comprehensive violence risk assessment and planning when clinically indicated; and • (iii) Physical health needs.		• 2 votes to leave the WAC vague to give facilities more autonomy. • Are the terms "screening" and "evaluation" defined in statute? ○ These terms are not defined in either RCW 71.24.025 or 71.05.020.

General comments/questions

- There was considerable concern regarding youth experiencing behavioral health crisis and questions about why these rules that are in development will not include services for youth. Department staff explained that the bill that instructs the department to do rulemaking for CRCs defines CRCs in this way: *"23-hour crisis relief center" means a community-based facility or portion of a facility serving adults, which is licensed or certified by the department of health and open 24 hours a day, seven days a week, offering access to mental health and substance use care for no more than 23 hours and 59 minutes at a time per patient, and which accepts all behavioral health crisis walk-ins drop-offs from first responders, and individuals referred through the 988 system regardless of behavioral health acuity, and meets the requirements under section 2 of this act.*
- Are there going to be minimum standards for these facilities? There are some subpar facilities that at times cause more harm than help.
  - The rules that are being developed will set the minimum standards for this facility type.
- We need more triage centers outside of or inside of facilities.
- DCRs are so backed up they struggle to keep up with timely attention to clients.
- Suggestion to explore the 10-year plan for dismantling poverty in WA when designing the rules: Poverty Reduction Work Group | Dismantle Poverty in Washington.

EMS presentation

- Catie Holstein, EMS Director, and Dawn Felt, EMS Education and Training Consultant, both from the Department of Health presented on the EMS guidelines (see attachments).
- In 2015, SHB 1721 was passed. It directed the department to collaborate with DSHS and HCA to convene a workgroup to establish guidelines for procedures, protocols and training to transport to BH facilities instead of ERs.
- The workgroup developed a state guideline that is used as a minimum standard for how these transports occur. It is common for the department to develop guidelines for certain activities.

- The EMS system across the state is regionalized so councils are tasked with developing and maintaining a regional plan that includes strategies to meet various needs. The counties narrow the guidance down and the Medical Program Directors (MPDs) develop protocols.
- Local areas can personalize the guidance and EMS is required to adhere to protocols, operating procedures, etc.
- Every EMS service must follow the regional plan. An example of this is a regional Patient Care Procedure.
- County Operating Procedures will say, for example, what facilities accept what types of patients and specify how and when to transfer them.
- EMS providers also follow written protocols and consult with online medical direction. The MPD protocols have to align with guidance.
- The workgroup considered what patient conditions would require them to be transferred to an ER vs to a BH facility and developed exclusion/inclusion criteria. The department can work with interested parties to amend the criteria accordingly.
- Appendix A lists specific kinds of MH complaints/concerns, age ranges, vital sign recommendations. Facility exclusion criteria are listed.
- The last section of the guidelines lists the education that the law required as suggested minimum content for EMS providers that are participating in the transport to these facilities.
- Lessons learned include that EMS is doing a good job screening the patients (MPDs conduct 100% QA). An additional lesson is that there are not enough facilities for EMS to transport people to. Finally, if there are similar types of facilities with different acceptance criteria, it is confusing to EMS, because it is difficult for EMS to know the nuances between facilities.
- EMS would expect that for this new type of facility, they would come in and do a timely transfer. Delays at patient drop-off often result in EMS inability to go into service, which results in lack of emergency services for the public. They also expect that there will be someone to give the report to. They do not want to drop off a patient without having someone receive the patient (consensual turnover). It would be nice for someone to take a report over the phone and for there to be a place for EMS to finish writing their report, use restroom, wash hands, etc.
- If a person has special needs (maybe they have a medical device they use everyday w/out medical monitoring), there needs to be support for that.
- Clinical guidance is typically not in the rules because it can change, so it is preferable to not prescribe specifical clinical screenings in rule.