Workbook for Workshop #5

Draft Language (2)	Outstanding Questions/ Recommendations	Ideas from Arizona Rules	Notes

(g) Be staffed 24 hours a day, seven days a week, with a multidisciplinary team capable of meeting the needs of individuals experiencing all levels of crisis in the community, including peers.	• Should we be more specific?
	• SAMHSA best practices: Be staffed at all times (24/7/365) with a multidisciplinary team capable of meeting the needs of individuals experiencing all levels of crisis in the community; including:
	a. Psychiatrists or psychiatric nurse practitioners (telehealth may be used)
	b. Nurses
	c. Licensed and/or credentialed clinicians capable of completing assessments in the region; and
	d. Peers with lived experience similar to the experience of the population served.
		• AZ model, always a prescriber (MD, ARNP or PA) and a nurse.	**Poll – Should we be more specific?**
			43% - yes
			57% - no
			
			Participant comments/feedback
			• Does this additional language mean that peers will have to be at the facility 24/7? There is concern regarding staffing flexibility.
			• Several workshop participants said that yes, peers should be expected to be there 24/7.
			• Can peers be "on call"?
			  • This is something that can be taken into consideration.
			• Spell out who should be there or on call.
			• Less prescriptive – allow CRCs to determine what is best.
			• Be more specific – like SAMHSA – with the addition of the AZ model language.
			• Can you use a non-psychiatric prescriber in these facilities, for example, primary care or family medicine MD? It would allow for some minor physical healthcare to be provided as well as for flexibility.
			  • SAMHSA best practices call out psychiatric NP but we don't want to

			say that a family practitioner cannot be part of a multi-disciplinary team. • If the only prescriber on site is not psychiatric, they'd need to be comfortable with managing medication. • Rural communities may not be able find a 24/7 psych prescriber. Programs may also focus on SUD stabilization in addition to mental health. • Could have a psych prescriber as part of the team but could use a family med/PCP or psychiatrist on each shift. • Should we not have a social worker who can help the patient, so they are not discharged to nothing? • SAMHSA language is concise and good. I would add "including but not limited to" in the language. It is important that you have knowledgeable staff administering medication. • SAMHSA best practices is a good start for the rule in WA. • Consider mirroring other WACs. There is limited specificity there (articulating need for an MHP but not specifying staffing patterns). • If left vague, services at different facilities may vary too much. • Language should reference not only meeting the needs of the individuals, but possibly include reference to the "number" of individuals – capacity of facility.

			• Agree on less prescriptive. This can create unnecessary hardships for providers in rural communities and during staffing crises. There should be a minimum standard (RNs, etc.).
			• Being too prescriptive is pretty concerning when staffing and circumstances are very different between different communities (rural vs urban).
			• Is there an expectation with, as example, law enforcement/first responder drop off - that guests will need intense intervention similar to E&T admits?
			  • The definition of CRC in statute says that these facilities must take individuals regardless of behavioral health acuity.
			• How is this setting different from a CSU…length of stay and ability to handle involuntary folks only?
			  • In a CSU, you can have an individual stay longer than 24 hours.
			• Staffing levels need to be able to handle high-acuity guests 23 hours a day.
			• Staffing level requirements are important. Does WA have minimum psychiatric staffing levels and is implementing staffing level requirements for the CRC an opportunity?
			  • In previous workshops, we talked about staffing ratios. The department has historically not prescribed staffing ratios. It is difficult to put staffing ratios in rules.

			• The legislature made the decision to call out prescribers but to otherwise allow agencies to staff their teams as flexibly as possible. • Staffing ratios in our current environment would make this model incredible difficult to stand up. • Given the workforce shortage and particularly the challenges facing rural providers, as well as the precedent for keeping staffing models/ratios out of rule, it is important to maintain this flexibility. • I think it would be possible to create rotating teams of peers (maybe partner with local NAMI groups etc.) to do f/u calls to or visits within a 48-72 hour window. Not only to make sure folks are doing okay but also gather feedback and data.
(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 identified and addressed through a nursing assessment ~~addressed without need for medical diagnosis or~~			**Poll – Do you approve of this new language?** 89% - approve 11 – disapprove **Participant comments/feedback** • Most wounds are treated by nurses anyway who often do the assessment. • The word "capacity" is not the best term here. What about "ability" to deliver. • This would likely get us to the same place. The concept is that you need someone there to do these things. • Someone might get hung up on the word "most."

~~health care prescriber orders,~~			• We are using screening and assessment interchangeably, but there is a WAC definition for assessment that should be kept in mind (246-341-0200 (4))
			• Define "minor wound care" and what staffing would be necessary to provide that care - and would that be 23/7 - - and this goes back to an earlier set of discussions about staff.
			• Understand that premise but maybe we need to be able to track how many people are using the facility and the identification of issues that they have when they come to the facility. Some intakes are just by the nature of their issue and are going to take longer than others. As with everything one needs to have profiles on how long each activity should take.
			• Capacity is more for availability of beds, not ability to provide the wound care.
			• Can the nursing assessment be done by an MA?
			  • The department will double check this with the Nursing Commission. Assumption is that the nursing assessment would be done by an RN or LPN.
			• LPN or RN should do the assessment and delegate to the MA if appropriate.
			• Is “nursing assessment” an actual type of assessment? Or is this in reference to the staff that need to complete it.
			  • Both.

			• I think that "provide care for minor physical or basic health needs that can be identified by an LPN or RN assessment" is clear.
			• Is it actually maintaining capacity or is it that you must be able to?
			  • Being prepared to do it and doing it. For individuals who have minor or basic health needs, the facility must be prepared to provide that level of care.
			• Would basic health needs include things like dental?
			  • There will most likely be immediate dental needs that an individual would have and facilities might be able to provide that level of care if they want to, but the department probably will not require/enforce this.
			• That goes back to my question about allowing the facility to be staffed by either a psychiatric provider or a primary care provider. I might be wrong but I am not sure psych NPs can provide the orders for some basic wound care. Can you clarify if a psych NP can prescribe basic wound care like antibiotics etc.?
			• Family NP with psych training/additional certification is a best-case scenario in my experience.
			• "Provide minor would care for non-life threatening wounds, minor physical care, and basic needs screened by a medical provider."

			• "Facility to maintain knowledgeable staff trained to provide minor wound care." • Feet care, by a nurse, can be very important for those who are or have been homeless. • Suggest eliminating the word "capacity" and rewording more for being able to provide the care vs having a bed to provide the care. • Facilities might want to use this rule for SUD crisis care and a psychiatrist would be overstaffing but a physical health provider is a must.
(i) Screen all individuals for: (i) Suicide risk, using a validated tool, and engage in comprehensive suicide risk assessment and planning when clinically indicated; (ii) Violence risk, using a validated tool, and engage in comprehensive violence risk assessment and	• When is the screening conducted? ○ AZ requires that the medical screening be conducted within 30 minutes of arrival. ○ AZ allows for screening before admission.		**Poll – Should the validated tool language be removed from (ii), violence risk?** 69% - agree 31% - disagree **Participant comments/feedback on validated tool language** • Please remove "validated tool." There are options for suicide risk tools, but violence risk tools that have validity are few and lengthy. • There should be screening for all, not just when "clinically indicated." • The "clinically indicated" is tied to the plan. Should this be reworded to make it clearer? • Validated violence risk tools are challenging. • Can there be a list of available tools somewhere for agencies to use?

planning when clinically indicated; and (iii) Physical health needs, including a cognitive screening for dementia.			**Participant comments/feedback on dementia language** • Dementia is a progressive, neurological disorder. It may initially seem like a person is in psychiatric distress, when in fact they have dementia. • Alzheimer's Association has a few dementia screening tools and the quickest one takes 3 minutes. If the person does not have dementia, it will be apparent very quickly. • Completing the suicide risk, violence risk, physical needs screening as early as possible would seem important relative to development of a plan. D/C is occurring fairly quickly if engagement (warm hand off) will actually occur. • Dementia screening should be left up to the facility. There are tons of medical needs that can present as BH needs that will need to be caught and referred to other appropriate settings. • Cognitive screening for dementia should be at the providers discretion. If a person in crisis is 22 years old with methamphetamine intoxication and psychosis, it doesn't seem clinically indicated. • Screening ALL individuals for dementia seems like overkill. Screening selected individuals for dementia, as clinically indicated, makes sense. • What if a person with dementia has a BH crisis? Would it be appropriate to refer

			them to a facility that can handle both dementia and BH crisis? • If co-occurring, CRCs may be very appropriate for the individual. A person with dementia may be confused and aggressive, which may seem like a BH issue but isn't. • Have dementia screens been validated in populations with active psychiatric symptoms? • If the dementia screening result could rule out admission there are very few other options for immediate care. • Acute substance use could produce psychosis and could not be effectively screened in those cases. • Most facilities aren't great for people with dementia unless they are dementia specific with people trained to handle dementia. • We do not want someone who is diagnosed with or now displaying symptoms of dementia to be prescribed unnecessary psychotropic medications. **<u>Participant comments/feedback on the timing of the screening</u>** • All screenings should be done at the same time and in a distinct/separated room from where guests are after admission. This would include making sure any weapons or weapon like things are secured.

			• As much as can be done at the beginning as possible but it will take astute staff to figure out what is happening. Concern about the level of complications that people might bring in. 30 minutes should be flexible. • People will be coming in with law enforcement, EMS and through 988 system. There has to be a process to listen to them and ask why they are there. • We also need to think about implications for Medicaid billing in terms of sequencing triage and what constitutes an intake. Insurance revenue shouldn't trump clinical best practice but is relevant. • It is important to screen their immediate needs/imminent risks and determine the nature of the crisis. • Some level of screening needs to happen quickly so that all in the facility are safe. Allowing individuals space who are in crisis is understandable but balancing that with ensuring safety for all is important as well. • I would have a range of time 30-45 min. • We could say within 30 minutes whenever possible? • Initial triage and then complete eval within an hour is an opportunity. • It really needs to happen to ensure safety. • I think setting minimum requirements in WAC and allow the provider to determine the timeline. Otherwise, they would not

			be able to meet timelines if they had 3 individuals show up at the same time? • Screening is different than evaluation - medical screening can be a quick review of systems, vital signs, observation - like triage. • This specificity is not applied to other facilities. • Like adding “when possible.” • Time frame is important for safety of clients and staff as well as accomplishing the purpose of the facility. Within 60 minutes seems reasonable. • Some patients will need time to sleep and take care of other things rather than wanting to participate in an intake immediately. • The time frame is typically utilized for quality insurance quality date information. • Completed within an hour seems more reasonable- most facilities probably won't have more than one provider on at a time. • What happens if there is a strictly prescribed timeframe and it isn't met? • Could there be an implementation frame around the time limits? After a year, adjust time based on reality. • This would require additional rulemaking. Once it is in the rules, it becomes difficult to modify and we would need good data to back up a change. But the more flexible we are,

			the harder it gets for the department to regulate. • I believe WA crisis stabilization screening window is within 3 hours. • Suggest 45 minutes to 1 hour. • Reasonable amount of time is too vague. Suggest saying "30 minutes, no more than an hour." • Could have 30 minute expectation but not use "required" so there is some flexibility. • Screening, for suicide risk, violence potential, and physical is really essential for these facilities. If this isn't done, increased risk and liability are a significant potential.
(c) A disposition including any referrals for services and individualized follow-up plan;	Note: This is existing language in WAC that would be referenced	• AZ discharge language: ○ Before a patient is discharged from the designated area for behavioral health observation/stabilization services, a medical practitioner determines whether the patient will be: a. If the behavioral health observation/stabilization services are provided in a health care institution that also provides	**<u>Poll – Should this language be more specific, like the AZ discharge language, or less specific?</u>** The poll feature was not working so participants were asked to put their answers in the chat. 20 participants said less specific 3 participants said more specific **<u>Participant comments/feedback</u>** • Enough so DRW can advocate. • Be more concise in some of the wording. • Since they are presenting in crisis, wouldn't some sort of crisis planning be a part of the discharge planning expectations? • Background info needed – quality measures from a patient perspective; is

		inpatient services and is capable of meeting the patient's needs, admitted to the health care institution as an inpatient; b. Transferred to another health care institution capable of meeting the patient's needs; c. Provided a referral to another entity capable of meeting the patient's needs; or d. Discharged and provided patient follow-up instructions • AZ discharge documentation: o If a patient is not being admitted as an inpatient to a health care institution, before discharging the patient from a designated area for behavioral health observation/stabilizati	this lived-experience led; where is the recovery orientation? • We need to get very specific because we know that if the patient shows up at the doorstep, we are sending people out the door as if they can handle their specific scenario. We do not have anyone assigned to work with the people when they leave. We all know that people need the extra push to help people. Want more meaningful language.

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

		on services, a personnel member: a. Provides the patient with discharge information that includes: i. The identified specific needs of the patient after discharge, and ii. Resources that may be available for the patient; and b. Contacts any resources identified as required in subsection (A)(13)(b);	
() The facility must be structured to accept admissions 90 percent of the time when the facility is not at its full capacity; () Instances of declined admissions and the reasons for the declines must be tracked and made available to the department;	• How does DOH regulate this requirement? Require daily census and daily declines? • When is someone "admitted" to the facility? • Need to define "full capacity". Recliners full vs staffing capacity?	• AZ rule regarding assessment upon admission: ○ When a patient is admitted to a designated area for behavioral health observation/stabilization services, an assessment of the patient includes the	**Department comments/questions** • What does it mean to be structured? Enough recliners? Enough staff? • Contact at HCA for questions about funding model: Michele.wilsie@hca.wa.gov. • How would the department regulate whether the facility is accepting 90% of admissions when not at full capacity? The department has to be mindful of what we are requiring facilities to report. How can we do this in the least burdensome way? **Participant comments/feedback**

	When a facility is not at full capacity it states they can still decline admissions 10% of the time. What would be the reasons for declining if it isn't because of full capacity?
	○ What if full capacity means all recliners are filled, but the 10% variance could allow for times the CRC may not be fully staffed to operate all recliners?
		interval for monitoring the patient based on the patient's medical condition, behavior, suspected drug or alcohol abuse, and medication status to ensure the health and safety of the patient
		• AZ rule regarding requirements when declining admissions:
		○ If an individual is not admitted for behavioral health observation/stabilization services because there is not an observation chair available for the individual's use, a personnel member provides support to the individual to access the services or resources necessary for the individual's health and safety, which may include:
			• The language says, "structured to have the capacity…when not at full capacity." That makes it more confusing.
			• Sounds like a staffing thing to me.
			• This is tricky because empty beds often lead to less staff.
			• Sounds like must have policies in place.
			• Probably about policies and staffing patterns. Full capacity as determined by the facility and published as part of a description of the program.
			• Capacity Definition & Meaning - Merriam-Webster
			• Isn't it a licensing issue? Won't we be licensed for a specific capacity?
			  • The statute requires the department to determine the maximum number of recliners to be licensed. Determining capacity strictly on the number of recliners is easier than determining it based on the number of staffed recliners.
			• I thought, because 23-hour is "outpatient" then the 16 bed IMD rule was not applicable, (as for RTF). Knowing maximum capacity (recliner chairs) will be important to know as soon as possible.
			  • IMD does not apply so it is not limited to 16 beds. However, there are ways to be creative with this. For example, saying "limited to this many recliners per sq footage."

		a. Admitting the individual to the outpatient treatment center to provide behavioral health services other than behavioral health observation/stabilization services; b. Establishing a method to notify the individual when there is an observation chair available; c. Referring or providing transportation to the individual to another health care institution; d. Assisting the individual to contact the individual's support system; and e. If the individual is enrolled with a Regional Behavioral Health Authority, contacting the appropriate person to request assistance for the individual;	• It would be great for declines to be shared as part of quality assurance for peers who can choose sites. Data shared with patients/peers so peer choice can take place. • "Acuity" would make the definition of capacity completely impossible to define. • The statute is clear that the facility must be ready to accept all levels of BH acuity. • Focus is on creating a meaningful service but one has to build the efficient infrastructure so that the systems work for the best quality for the people and their families who are walking in the door.

		• AZ rules regarding documenting declined admissions: ○ Personnel members establish a log of individuals who were not admitted because there was not an observation chair available and document the individual's name, actions taken to provide support to the individual to access the services or resources necessary for the individual's health and safety, and date and time the actions were taken; • The log required in subsection (A)(19) is maintained for at least 12 months	

Vision Setting Exercise

This workshop began with an exercise in which participants were led through a series of questions regarding their vision for how an individual would receive services at a CRC.

1) What happens when an individual first arrives at the facility?

- Person is greeted by a nurse.
- Greeted by a peer.
- Welcomed with a smile.
- You have to assess their safety and reason for coming.
- Greeted and asked how we can help.
- Someone with lived experience greets them.
- The person is welcomed and given a seat.
- Person is greeted by medical and/peer staff.
- Individual is greeted/welcomed by a peer counselor. Immediate needs such as restroom/food attended to. Give the individual time to get acclimated.
- The nurse will have to attend to the client and see if the client is tested for COVID. In other words, the client is tested for COVID and then assessment starts.
- At Smokey Point they had a TV room and they were allowed to sit there and wait until they got to see the nurse and provide the intake process
- The person is given somewhere comfortable to sit before they are given a recliner. People can be sitting together, but not in a cramped environment.
- It will also depend how the individual person is presenting somewhat. I hope it will be welcoming in appearance & decor and the way staff are dressed.
- Very brief health/safety needs screening.
- Quiet areas as well as TV room.
- Ask how we can help.
- Ask their needs, will help with next step.
- If accepted, then they fill out the forms.
- What if the person is contaminated with body fluids or other and needs clean clothes/shower etc.?
- Determine appropriateness for service.

- The BHCM may talk to the client and assess the needs of the client and see if the client needs further treatment than the facility can afford.
- Reassuring the person they are safe. Asking either "what happened to bring you here" and/or "what would be most helpful for you right now."
- After the greeting, the person needs to feel comfortable. There should be a non-threatening conversation which would incorporate the screening and the persons understanding the purpose of the screening and an acknowledgement of their COVID status.
- Primarily addressing the individual, but if they are not alone, we should engage whomever is with them as well.
- The individual is met at the door by a PEER counselor and asked if he/she/them wants to sit down in a comfy chair that's placed nearby - and then sits and chats with the visitor.

2) What is the next step after the brief screening?

- If identified that they have a physical health issue, get them to the appropriate care.

3) If the facility can meet their needs, what happens next?

- Greetings - Safety Screening- do they have any their vitals taken - ask if they are comfortable with a short minimal medical triage.
- I think we should allow time in between steps.
- Determine a plan of action that the person is onboard with.
- Registration - collection of basic information.
- Seems like they are accepted then screened to be a no wrong door.
- The intake process begins with the forms, and a more intensive health screening as well as whether they have eaten ect.
- Explain program to them, complete intake, give them a tour, offer food and drink.
- Client is assisted and reassured that client is at the right place for whatever client would looking up to.
- This could be a time when a drop in center environment can be supportive as they decide what needs they have.
- Try to provide an estimate of when full assessment will take place.
- During the discussion there should be an understanding between the patient and the facility of whether they can meet their needs. Then together they discuss the next steps forward. Every step of the intake process should be explained to the patient so that they are working together. Understanding and acceptance of what the plan of action should be.
- Once they are accepted as appropriate for intake/admit then a peer or other staff who can and will STAY with them there for a time. SAME person is important.

- Client is given something to eat and drink, if client is in need of taking a shower, client is given the opportunity to do so.
- I think steps should be explained and allow time. Approach/time should be unique to each person based on what their level of comfort is. When I ran CSC, if a person was super exhausted, hungry, we had the RN do a screening, had the client sign informed consent forms, and then let them rest. All the other paperwork etc can be done later.
- Client is seen by different staff depending on the service the client is there for.
- Assign a peer and recliner. Medical assessment.
- Client is kept at the center for the period of 23 hrs, 59 mins while getting the necessary help they need.

4) What happens if there is no recliner available at the moment?

- Opportunity to look at developing another component. Another waiting location, like an entryway of a peer respite. The individual would be engaged with peers while waiting.
- Getting bounced around between different staff can be scary and frustrating.
- Check when a space will be available.
- Once an individual arrives, they should be welcomed and even if no recliners/space, they should be accommodated and efforts made to find an alternative resource.
- In Arizona, some crisis facilities have lobbies where individuals can wait safely until a chair is available or be transferred to another facility if appropriate.
- I would think a maximum waiting room time might need to exist given the 23H 59M rule. If for some reason, space isn't opening up need to consider how to meet someone's needs. Up-staffing? Transfer?
- The colors at the waiting room area should be warm, comforting and not look like an ER arrival area.

5) What are the expectations once someone is moved to a recliner? Is there a standard level of service?

- Ask if they are comfortable. Ask for their needs first.
- Minimal interruptions if they are sleeping.
- Offer to LISTEN to the best of what it is that has brought them here tonight.
- Providing an overview of what to expect, explain expectations (i.e. you are in a safe space, if you are feeling SI, contact staff immediately, stay in your space to support safety, explain who is working and who to contact if needed, where the bathrooms/snacks are, etc.)

- Once a recliner is assigned, it seems that all expectations under WAC are now at play…consent, clinician disclosures, assessments and planning, etc.
- Provide orientation to unit. Will reduce anxiety if oriented to unit.
- Listening to them is as important as asking them questions. Or more.

6) What should be included in the discharge?

- Follow-up care.
- Referrals.
- Once again ask them what they need.
- Housing.
- Discharge should mention where the person is going.
- Next steps, contact information, crisis numbers, medications, referrals, what to do if the crisis restarts.
- Resources.
- Medication if necessary.
- Transportation.
- Don't discharge to homelessness (the street). Ask them if they know where they will go to accomplish the discharge instructions.
- If the client is going back to his/her home, client will be given resources to lay on when they get into crisis again
- Will there be staff or volunteers to follow up on or with this person?
- Also, the client is told that they can come back at any time they get into crisis.
- Quality paper used for discharge paperwork.
- Transitioning with clean and dry clothing, hygiene supplies, and maybe even a cell phone would make transitions smoother.
- Ascertain whether a higher level of care is desired and or needed. Some individuals may be open to a longer term stay at Crisis Stabilization Center.