DOH Stakeholder Rules Workshop HB 1394 August 12, 2019
Department of Health-Town Center Campus: 101 Israel Rd SE, Tumwater, WA 98501
NOTES from 8/12/19 Meeting

Breakout Groups

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Meeting Resources:

- [DOH Behavioral Health Agency (BHA) web site](#)
- [DOH Residential Treatment Facility (RTF) web site](#)
- [HB 1394 text](#)
- [Chapter 246-341 WAC for BHAs](#)
- [Chapter 246-337 WAC for RTFs](#)

Intensive Behavioral Health Treatment Facilities (IBHTF)

1) Introductions, overview of why we are here, and the work plan
2) Summary of the legislation and review of specific sections pertaining to IBHTF
3) DOH thoughts and request for feedback on type of facility license required
4) Review existing WAC language that may apply based on facility license requirements
5) Identify gaps that will need to be addressed in DOH rulemaking
6) Use DOH Facility Rules Checklist for reference [See attached PDF]
7) Discuss what we know and what we don’t know about the populations to be served
8) Discuss the eligibility requirements for persons being admitted into these facilities
9) Use WA State Licensed Facilities for Adult Mental Health Services for reference [see attached PDF]
10) Wrap-up, next steps, and build agenda for next meeting

Discussion Notes: What licenses & certifications would be needed for IBHTF?

- Residential Treatment Facility – license
- Behavioral Health Agency – license
- Behavioral Health Agency – certification

If we follow the current licensure path created by DSHS, these facilities would need all three. Would it be possible to take a step towards eliminating one of these layers now? Or is that something that we might better address next year in our bigger Phase Two project?

- What are the pros/cons,
- What are the payment barriers,
- What does the Medicaid State Plan dictate?
- What would be the impact on existing facilities who want to provide this new service?

Outcome: Group agrees it is OK for DOH to do some more research on this.
Discussion Notes on RTF & BHA specific WACS:

Q: We need language related to discharge & transition

RTF rules

a) 246-337-021, 075 Resident rights – Comment: resident rights & ombuds access for IBHTF should be in BHA rules 246-341 rather than RTF 246-337. We will spend a future workshop day focusing on resident rights

b) 246-337-065 Safety and security: 4) may apply when it comes to egress and (5). Not overly prescriptive. If we want something specific about restricted egress, we might want to put it here, or put it in BHA rule. We should be really thoughtful about how we come up with this. This will be a whole workshop – how egress ties in to patient rights.

c) 246-337-080 resident care – some info that overlaps with patient rights. May want to put some language here, or may not need it, may be broad enough

d) 246-337-105 – medication management component in 1394. This wac language is pharmacy language about stocking & disposing & inventory. Some Nurse scope of practice. Non-nurse handling of medications, self-administered medication. Don’t think we need carve-outs here – but these will be helpful for agencies to decide how to manage medications. We will look at BHA medication management rules as well

e) 246-337-110 restraint & seclusion: Q: We think these facilities should have some kind of de-escalation, even just self supported place for a person to step out of milieu. I feel like this should be considered in a future discussion. We don’t know if we have construction requirements for quiet rooms. Q this could be a long, interesting discussion that will require more prep work. Restraint & seclusion isn’t a part of trauma-informed care. Q: we should add training on de-escalation. DOH research other DOH language around trauma-informed care. Might be CARF, quality rules?

BHA rules

a) 246-341-0110 – add as a certification?

b) 246-341-0200 add IBHTF as a definition? May just plunk specific definitions in specific sections if it just relates to one WAC section

c) 246-341-0300s May need tweaks in application, onsite review, plan of correction, if we just require certification and not BHA license.

d) 246-341–0420 (19) complaints & grievances – may want to add some language related to patient rights and access to ombuds.

e) 246-341-0515 agency staff requirements – will come back to this. Supervision from MHP. If there are staffing requirements specific to IBHTF we might be able to capture all of that in a specific section. Q: should we specify staff competency for working with DD and other populations (like TBI at state hospitals)? A: If so, those requirements might just be in IBHTF certification section. Q: Bigger project we could also include training requirements for staff competency for specialized populations.

f) 246-341-0600 individual rights for all BHA inpatient/outpatient/long term/short term. Will come back to these. Something to think about. Do we want rights specific to patients in long term settings –should that go here, or in its own section? Will talk about this at a later meeting.

g) 246-341-0605 Complaint process –will come back to this also.

h) 246-341-0610 Clinical assessment. Is this general criteria good, or do we need something specific? RTF has an assessment section as well, so we need to look at this? DOH will go back and do this and Individual Service Plan and bring to the group.
i) 246-341-0712 psych medication & medication support. We can say IBHTF must provide medication in accordance to 0712, they wouldn’t have to have a specific separate certification. Is everyone ok with that? A: Think so. We can come back and look at this to see if there’s anything we want to add. Outpatient Medication Mgt & monitor, indivd treatment, group therapy, peer support, therapeutic psychoeducation. Q: concerned that existing agencies might be impacted – A: don’t worry, we’ll carefully explain what applies to IBHTF so other agencies that provide medication management already aren’t impacted.

j) Q: Can these facilities provide outpatient services? A: Not sure if they can contract with other agencies to provide outpatient services? Q: Concerned with loose staffing in E&Ts. I would advocate that staff are committed to one E&T so staff don’t have a prison mentality. Need social work staff that know how to do discharge planning. Hard for E&Ts to provide good professional models because of scale. Prescribers want to have flexibility to do other work. We have shortages of prescribers so we want to tread carefully. A: One of our workshops will be about the specific services that will be provided in these facilities. Need more discussion on – do these services have to be provided by the facilities or can be provided by contracting out. One idea is that these would be a step-down and people would transition to a lower-level of care, so contracting with an outpatient provider would make good sense. Q: Is there already language about contracting in BHA wac? This seems more like inpatient/triage type service, which is all services provided in the facility. Q: Prescribers using telepsych don’t know WA standards. Contracting needs to be mindful of this. Q: Treatment plan can include these. Need a person-centered approach. Assessment upon arrival – need to discuss this when we talk about services.

k) 246-341-11xx – where we would put in a new WAC for specific IBHTF facility type somewhere between 246-341-1134 and -1138. Drafting of bill seemed to be mental health focused. Is that true? Do we need to expand our thinking on that? Required CDP on staff? Q: WSH is moving towards co-occurring, especially for appropriate assessment, so I think it needs to be a requirement. Q: In DD population, odds are rare that the person has an SUD issue, but may have MH & DD. So requiring a lot of SUD training that’s way outside of the scope of DD focused. Q: What about whole person care model – don’t need a particular dual-diagnosis, whole person health assessment instead of being specific in our WAC. This conversation is tricky since we don’t have COD WACs. Q: I think the workforce shortage would make it tricky to have SUD requirement – would be a barrier to workforce. Agree that assessment is best practice, but BHAs don’t have a lot of SUD CDP work – Need to come back to this when we talk about staffing and services. Q: SUD assessment is key for a voluntary admit for medical necessity.

l) 246-341-1118 – add IBHTF as an inpatient MH service

m) 246-341-1122 – patient rights – we will focus on this at a later meeting.

n) 246-341-1124 – antipsych medication – maybe need to refer to this

Outcome: DOH will draft language and bring back to this group for the next meeting.

Discussion Notes: Populations to be served and eligibility

To start discussion on who is eligible for this service: Patients are 18 yrs and older, not involuntary. IBHTF are a step up from ESF, but step down from E&T. Does that sound correct? What types of things would make a person not-eligible for this facility? Certain level of medical care, age, involuntary, more appropriately served somewhere else?
a) HCA draft proposal document from bill work with legislature: These are hospital discharges, so acute, can’t live independently even with supportive housing. Can’t go to ALTSA facility, even with intensive residential team. Not eligible for ALTSA services. Could use ALTSA help with this.

b) Q: Is this the same as an ARTF? Enhanced Services Facility (ESF) has built in nursing (16 hrs of RN/LPN) they are medically complex; more than just diabetic with insulin needs. Residents need daily living skills. ARTFs aren’t really for that. ESF is medical plus behavioral. Example of ESF is Orchard Highlands in Vancouver ran by Apple Tree. Spokane, and SnoCo Everett has one too.

c) Q: CMS has new code for crisis behavior intervention. ABA has some of this scope. Dangerous to self & others. So we need to be thoughtful that those codes & providers can be enveloped into this language New CPT codes Jan 2019 just regarding behavioral (not DD or age) functional analysis of maladaptive behaviors in specialized settings. Not DD settings. These are the CPT codes that need to be used in those provider settings so we need to keep that in mind. Qualifications to use those codes are ABA. Move towards wraparound services & supports. DOH: Can you send me those codes? Yes.

d) Q: Referring to Matrix document - There are other facility types in DDA system. With this new type of facility there is DD language. So we are also trying to figure out that gap as well. DD clients in BH system aren’t always being served well – trying to marry the systems to serve the whole person. The chart is missing DD population facilities. Jeff Green from DDA can add columns to the matrix, or Betty.

e) Q: Maybe this isn’t a step-up from ESF or maybe instead an equivalent of ESF but no medical component. The Council worked with Rashi & Gov’s office – who is this population that can’t be served anywhere else. But some of these services bleed into each other – ESF, AFH, AL, We have to be able to flex these services & supports to meet complex needs of folks who we serve here. Maybe DOH will pull terminology from those ABA CPT codes and pull ESF language which may be applicable for these facility types as well.

f) Q: What about folks with history of fire starting? When the Council was talking about this with Gov’s office, saw a person with history of arson as the type of person that could be placed here.

g) Q: Is the new level of care intended to be a stepdown from state hosp for those who can’t be placed out? Or do we intend this to be a transitional step? That (transitional) would be one of the differentiation points between ALTSA and MH system. BH expects change, LTC does not necessarily. Ideally, we want this to be a transition step, but take care of individuals who take a very long time to transition. Some just need 30 days, some need 2 years because it takes that long to get to the next step. These facilities are supposed to encompass both sides. Bill identifies in Sec 3(5) skills training are working toward voluntary & independence

Outcome: DOH will draft language and bring back to this group for the next meeting.
90-180 Day Services

1) Introductions, overview of why we are here, and the work plan
2) Summary of the legislation and review of specific sections pertaining to 90-180 day services
3) Review existing WAC language for this service
4) Identify gaps needing to be addressed in DOH rule and/or licensing/certification process
   a) Use DOH Facility Rules Checklist for reference
5) Wrap-up, next steps, and build agenda for next meeting

Discussion Notes: General

WSHA and DSHS not in attendance – need to loop them in to this discussion. It won’t likely take 4 meetings to do this work. But we’ll do at least one more meeting to make sure WSHA & E&Ts can look at our notes.

Q: If we’re looking at short term facilities (E&Ts) providing long term care, we need to talk about ratios and community capacity for open beds (might have a lot of people waiting for placement. Q: That might already be happening – E&Ts are getting paid short term rate, but patient is staying there because there’s no spot in WSH. There’s language in budget bill to talk to community hospitals. When HCA was seeking out facilities this year, HCA asked them to take monthly single bed certification numbers and half that or quarter that and contract for that amount. HCA hasn’t seen an increase in shortage for those beds as far as they know

Discussion Notes: Adjust the administrative process for DOH certification to serve persons on long term stays.
Any thoughts on process to get certified? No concerns from the group.

Outcome: OK for DOH to explore rule changes to make this Exception Long Term certification like other certifications. DOH will bring draft language back to this group. This would mean:
   • 246-341-0110 adding Long Term Certification to the list of certifications
   • 246-341-1136 – just the adult part – Long term certification for adults applies to a facility. For child, it is an individual exception for a person (child). DOH doesn’t think they’ve received requests for child LTC. So for now we would focus on adult language. All requests DOH has received have come from the facility itself. E&T rules in 246-341-1134 apply to LT Exception. Language mostly copies statute. DOH reviewed Long Term exceptions that DSHS previously granted. There aren’t a lot of additional requirements imposed for these facilities. The facilities that provide this services have done a stellar job & they are safe.

Discussion Notes: Requirements for outdoor space – put in DOH rules or HCA report?

Conversation about persons staying long term in a facility built for short term stays. Many feel residents need to have access to fresh air. Would the barriers be too high if DOH requires therapeutic spaces (outdoor) availability? Is there a consensus that we should move forward with some sort of requirement in one way or the other? DOH can explore writing this into rule with this project. Bill 1394 doesn’ require DOH to do rulemaking at this time for 90-180 day stays. HCA has a report - make
recommendations & provide info to the legislature. Concerns could go into this report rather than DOH rules at this time and leave it up to the legislature and the legislative process.

a) Q: Can hospitals do this or just RTFs?
b) Q: I think it’s a non-negotiable to have outdoor spaces. I know of E&Ts with not good outdoor spaces or none. Some do it well. E&Ts designed for very short term so may not have contemplated this.
c) Q: When we opened we didn’t have this requirement and we’d need extra funding – it’s beneficial for the client & we’d like to have it, but I don’t know if it should be a requirement.
d) Q: Can the state give money to help – finding some way to encourage if it’s going to be mandatory for brand new facilities?
e) Q: If someone is on a level 5 at WSH, they might be able to check in and check out of the hospital. Some of this population might qualify.
f) Q: I think the HCA report is more appropriate. Commerce might fit in to this conversation. Could there be grant funding or something like that? There have been several rounds of funding so far for remodeling or revamping (not sure if it’s for fresh air).
g) Q: Fresh air is a good de-escalation tool as well.
h) Q: We would be hesitant to move forward without E&Ts and WSHA being at the table. Might be premature without them.
i) Q: What about bringing a green space inside? Plants/windows.
j) Q: We need to look at including a requirement for outdoor spaces.
k) Q: Concerned about Level Five – at WSH they did walk off sometimes.
l) Q: I think outdoor space is something we need for long term stays and I agree with concern of people walking off.

Outcome: Group consensus is that language regarding outdoor spaces is needed, but that the cost of this requirement may decrease interest in providing this service and therefore negatively impact access to care. The best option at this time may be to put this information and these concerns in the HCA report to legislature rather than this DOH rules project at this time. Also include the concern about ratios - having current short-term beds disproportionately filled with long-term residents, creating a new shortage in short-term beds.
Mental Health Peer Respite Centers

1) Introductions, overview of why we are here, and the work plan
2) Summary of the legislation and review of specific sections pertaining to MHPRC
3) DOH thoughts and request for feedback on type of facility license required
4) Review existing WAC language that may apply based on facility license requirements
5) Identify gaps that will need to be addressed in DOH rulemaking
   a) Use DOH Facility Rules Checklist for reference
6) Discuss staffing requirements for these facilities
7) Wrap-up, next steps, and build agenda for next meeting

Discussion Notes: What licenses & certifications would be needed for MHPRC?

For discussion purposes, what does the group think of not having MHPRC being licensed as an RTF and licensing them as a Behavioral Health Agency?

a) Q: There are some BHA requirements that should not apply to MHPRC.
   b) Q: I’m wondering about calling it treatment at all, since it’s not treatment. Medicaid needs it to be under a “treatment” umbrella, so we’ll just be careful with terminology.
   c) Q: I support not having RTF license since there’s so many things that would be obstacles. So what are the options?
   d) Q: What is the licensing for homeless shelters? A: DOH may have some language around licensing shelters, but we don’t license them. For the purposes of this conversation, homeless shelters aren’t licensed.
   e) Q: can they be licensed under DSHS like youth respite shelters? A: No, because the bill requires DOH to license these facilities.
   f) Q: For peer respites to run how they should, it wouldn’t be tied to Medicaid requirements. We shouldn’t build them to be Medicaid funded if there’s opportunities to be grant funded or other kinds of funding. A: Behavioral Health Agency license is only required if the peer respite center wants to receive Medicaid reimbursement. If the peer respite center is private pay only then it wouldn’t be subject to the agency rules driven by Medicaid standards, however, they would be unregulated without a behavioral health agency license.
   g) Q: Medicaid is a mixed blessing. Over the last 10 years it’s been difficult to get the same non-Medicaid resources to support community BH services. Medicaid brings 50-90 percent match federal dollars. We need to be very thoughtful about whether we’re willing to step away from that in the interest of having more flexibility to support a really important model. If we were to have separate licensing structures for programs that do accept Medicaid or don’t – adds to potential confusion for facilities and public. Puts Medicaid funded provider at a competitive disadvantage. How we strike that balance between flexibility and standard community safety regulatory quality protections as we’re putting in place new facilities. This question gets complicated. I want us to be really thoughtful about it.
   h) Q: If it is funded by Medicaid, is there a requirement for a clinician? A: provided by or under supervision of MHP for Medicaid services. So if it was Medicaid we think it must be under the supervision of MHP.
Q: Would there have to be clinical diagnosis for ICD code? HCA will get back to us on that. If the service provided in MHPRC is the current BHA certification for Peer Support, it is supervised by MHP, requires documentation, and a treatment plan, but HCA will research.

Q: I have other funding - WA grant funding – what if we have a general ICD code just for anyone (maybe 4320 or another) for anyone receiving services if some people want to avoid the system. HCA will help us with getting reimbursement answers.

Q: Maybe use “adjustment disorders” code?

Q: Could it be a structure like homeless shelter, with a program that came in during the day that was provided by Medicaid, supervising MHP etc. Would cover sleeping over under one license (or non license) but have constructive activities during the day. A: that might be the model we will try to follow. We can get close to that with the BHA certification without having RTF license or an additional license. So we’re certifying peer services, not overnight.

Q: What about a Bed & Breakfast facility model? A: do we need to license the overnight stay? What would be the benefit – it would cost, be regulated more like hotel-motel B&B. But they’d have to have both the B&B license (Transient accommodation license?) and BHA license. Would the benefits outweigh the barriers to that? Oxford house are not licensed. The issue there is they can’t bill Medicaid. But day treatment services that came in during the day could be provided.

Q: This makes a lot of sense. Medicaid does not pay for room & board in RTFs or E&Ts so that would not be covered in any case. So we don’t need to limit our thinking to capture Medicaid resources for that service. This kind of flexibility with some licensed components and some not is very interesting.

Q: Respite would have intake 24 hrs a day, that might be a problem.

Q: A DCR is an MHP, so they can send a person appropriately to the MHPRC and will have the DCRs assessment. Q: Will everyone be coming through DCR? No. Ideally anyone could come for a “tune up”.

Q: “intake” is not terminology I like – could it be more “interview”?

Q: There is a concern if someone receives BHA services with a provider and they believe they receive peer support from another agency. There might be confusion about reports of unprofessionalism, where would it fall? DOH doesn’t have grounds to look at it, unless it was Agency Affiliated Counselor, which is how most peers are certified & held accountable, and so MHPRC would need to be licensed as a BHA. BH professionals who do not work for a licensed BHA are regulated by their professional license. But Peers who don’t have a professional license through DOH and are a Certified Peer Counselor through HCA – HCA cannot withdraw a Certified Peer Counselor certification if something goes wrong. A: Because the legislation does not specify that you must be licensed in order to operate a MHPRC, DOH couldn’t go after anyone for unlicensed practice. Same as BHA licensure – nothing in statute that says you must be licensed as a BHA to provide BH services, just need BHA licensure to bill Medicaid.

Q: Peer respite that is not licensed might have a board or some sort of protocol?

Q: Is anyone from downtown emergency services in the room/on the phone? No: Ann Christian, WA BH Council would like to check with them since their crisis solution center helped advocate for this legislation – they operate as a homeless shelter & BHA. Council will contact them before letting us know if they are comfortable with this direction.

Q: I’m all for it not being an RTF.

Q: This legislation is to reduce barriers. Glad group is considering options other than RTF. Hope that is to make it easier to establish these. Since they are being run by peers, from a patient’s perspective, we want to make sure this is not a barrier for peer counselors who have an interest in serving the community. There needs to be supports built in for Peer Counselors to provide this services. If BHA is a better option than RTF, how can we make sure that peer counselors will be
able to establish a center in a way that doesn’t make it very difficult. A: What we may end up having is “non-ideal current state” but then work to fix barriers (like State Plan) at the next opportunity. But we should still think “pie in the sky” for now.

w) Q: We would like to create a new license for these. I’m interested in carve outs like Individual Service Plan – could those be carved out “if needed”.

x) Q: If we license MHPRC it would clinicalize people’s experience, fit them into a box that they don’t fit into.

y) Q: Other states have changed their regulations regarding peer support and maybe it’s time for WA to do this. HCA: State Plan changes can be looked at but we’re cautious to do it because CMS can look at anything on the pages that we submit to them. Which they did recently. Legislature has to give HCA authority to change Medicaid State Plan. We have to spend state dollars to draw down federal dollars.

**Outcome:** DOH does not need to license these as RTFs. DOH does have to license them as BHA in order for the facility to receive Medicaid funding.

**Discussion Notes on BHA specific WACS:**

a) 246-341-0110 List of certifications. MHPRC would need to be added.
b) 246-341-0200 add definition of MHPRC, maybe other definitions.
c) 246-341-0305 Q: facility is not personal residence? Is it is possible for the peer counselor trying to establish this peer-run service have it be in their personal residence? A: A BHA can be a residence, but not an individual person’s house. The peer counselor cannot live in the facility.
d) 246-341-0365 Fee. We will need to discuss this before the end. This is unique. The fee schedule for inpatient services is a per-bed fee rather than service hours. But MHPRC is not inpatient and not service hours because it is 24/7. So we’ll have to come up with a fair fee structure. Towards end of workshop series, we will do this.
e) 246-341-0410 administrator doesn’t have to have a particular license (there is nothing preventing administrator from being a peer)
f) 246-341-0425 all BHAs need individual client records. Assume we need this for MHPRC for Medicaid purposes.
g) 246-341-0515 we will look at this and create carve-outs where we can. Likely come back to this section and make amendments.
h) 246-341-0600s – do some carveouts with this whole section of WACs.
i) 246-341-0610 need carveouts
j) 246-341-0620 ISP need carveouts
k) 246-341-0700 – if it’s outpatient, we’ll put it on this list.
l) 246-341-0718 – Recovery support services. This is where peer support services are listed. Do peer support rules cover a lot of programming for these facilities?
m) 246-341-0920 don’t think the crisis peer applies because bills says these services are for people who are not in crisis.

Thought – MHPRC would be either outpatient or entirely different section. Or do we want to pull out all peer related and put them together – either now or during Phase 2?

**Discussion Notes: Physical plant requirements:**

a) Other than the fact that these can’t be a personal residence, and ADA requirements, what requirements should there be? The bill says “physical plant requirements”. Do we need other things than these 2? Like fire extinguishers? Or not?
b) Q: concerns: Water temperature is too hot, individual scalds themselves. Issues: linens &
bedbugs, lice, scabies.
c) Q: Space requirements – each resident should have their own private place to go, shouldn’t have
to share a room.
d) Q: If it’s not spelled out, security can be compromised.
e) Q: Need medication lockup.
f) Q: Adult foster homes have living quarters separate from patient areas.
g) Q: Do we need kitchen requirements for people to bring their own food & store it. Facility is not
providing the food, it’s up to the individual. So wouldn’t the house have to have a refrigerator Is
that something we need to put in rule? Maybe: “Adequate storage for perishable and non-
perishable food items”
h) Do we need Laundry services? Look at RTF and maybe talk about expectations. Maybe: Agency
provides the linens, residents don’t need to bring.

Discussion Notes: Staffing

a) Q: is there a section that tells how these are run? Can we say they are 51% peers on the board so
there’s more of a chance that they will stay peer run. Maybe governing board section or into
section for peer respite.
b) Q: Regarding peer counselors billing for Medicaid: MHP role being present in peer center – I think
that’s a barrier, a huge one, to hire (none available) and start a peer center. Most peers don’t
have MH professional environment.
c) Q: What is the definition of MHP? HCA: The definition lives in the State Plan. WAC must copy
State Plan. Statute is less specific, says DOH will explain in rule. DOH rules have specifics. Is there
wiggle room with MHP definition? Maybe is there room for how MHP applies to these services?
HCA: if you want Medicaid money, you must have MHP.
d) Q: There will be a lot of overlap with existing peer services certification. The assessment is a
clinical assessment – I don’t think MHPRC are intended to provide clinical services, so why do they
need assessments.
e) Q: I’m confused about the people using the term “referrals”. People who use MHPRC are self-
referred. Maybe someone tells them about it, but they aren’t referred. That will help MHPRC that
it’s the right fit for the person & they aren’t forced to go. That’s a huge piece of this. In other
models, the residents could be self-referred, referred by family, LEO, Hospital EDs.
f) Q: What if we require the MHP to be a peer? A: Good idea. Is that difficult? Q: MHP have to have
a master’s degree & 2 years of experience. So it’s possible that there are MHPs with peer
counselor certificate, but it’s much easier to become a certified peer counselor than MHP. Being
an MHP would be a significant barrier to be a peer. Q: There would be 3 additional trainings,
maybe that can be incorporated in the rules - maybe BHA rules, maybe somewhere else. A: We
can look into. Q: Need to check with Peer community – they may feel strongly with MHP being a
peer. Q: Financially, it’s hard to sustain an MHP masters-level in a peer run center. MHPS tend to
join agencies that provide them with lots of benefits.
g) Q: Peers giving assessments makes a power dynamic that I’m not comfortable with.
h) Even though we need to have this staffing discussion, part of this will be dependent on BHA
requirements to do an assessment. So we will have to look at this for staffing model – need an
MHP. How can we make the most of this situation, given what this is. HCA: For Medicaid funding,
each person has to have an intake assessment. If the person has an open assessment with peer
services on their treatment plan, that’s ok. It’s just new to services that might be a barrier. So you
could encourage everyone to put it on everyone’s treatment plan. Q: For MCOs, it depends on what region – in some regions anyone can receive care, not just medicaid.

i) Q: There are a limited number of state plan services that can be done before intake eval is completed. Could people new to the system receive peer respite before intake has happened? HCA: probably would require a state plan amendment to make that change. Q: That might be a less threatening change than the other ones we’ve been talking about.

j) The intent is for MHPRCs to provide a different service than outpatient. MHP brings this closer to outpat/inpat model. The intent is to build up a new niche that supplements our current/existing outpat/inpat services. This is a statement in support of last suggestion to not have intake be a requirement.

k) Q: The ICD code for adjustment disorder unspecified and ICD code 309.0 for unspecified adjustment reaction. 43.20 for adjustment disorder unspecified.

l) We assume that these are staffed 24/7. Would that also mean intakes 24/7 or do we leave that up to the facility to decide? Q: for this model to be successful it has to serve around the clock– limiting 8-5 would hurt. Challenging time is after 5 when all agencies close the doors.

m) Q: Are people referred to this service? A: Combination – They can be referred, show up, family members, other outpatient services can inform. Q: But has that been decided, because that is not the peer respite model. Only the person can call & say they want to come. No one can drop them off. They must be voluntary, not even family member can bring them (coercion). If they are just dropped off, they aren’t necessarily doing it under their own will. Referrals are not done for Peer Respite. Maybe we need to make this clear in rules if needed. People shouldn’t be dropped off. Q: LEO often has no options. But no one should be forced. Need to put clarification in rule about this. Q: If there aren’t rules then the agency can write their own P&P. Even voluntary can be problematic, very clear language that identifies who and what is accepted will be needed. Coercion will always be a factor.

**Outcome:** DOH will research definitions of MHP in different places for future consideration. Will research what flexibility is out there for MHPRC requirements. We may be constricted in this project, but draft rules as close to ideal as possible - how can we make the most of this project with what it is – think about the future, too. Ideas from the group to consider for MHPRC rule draft:

- idea of percentage of peers on governing board in rule to keep this peer-run
- Consensus is that we should have MHP supervisors be certified peers.
- 1 MHP for facility supervision, more if need to provide assessments
- Assume that these are staffed 24/7. Either require intakes 24/7 or leave that up to the facility to decide
- Clarify how people come for services (strictly no referrals? Or multiple ways to arrive at MHPRC?)