

October 21, 2020

Julie Tomaro, Facilities Program Manager
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**Re: WSHA Comments & Suggested Language for Chapter 246-341 WAC
Behavioral Health Services Administrative Requirements
Department of Health Rules Rewrite Project – Phase I**

Dear Ms. Tomaro,

On behalf of all Washington hospitals, thank you for the opportunity to contribute to the Department of Health's project to rewrite the Behavioral Health Agencies (BHA) regulations (WAC 246-341). This was a significant project with implications on how we increase access to, and improve delivery of, behavioral health services in the state. Washington hospitals and health systems offer a spectrum of behavioral health services in addition to inpatient mental health services, including outpatient services for both mental health and substance use disorder; opioid treatment; recovery support; crisis mental health; and triage. By offering services along the continuum of care, we are uniquely positioned to contribute to this project.

We are proud to have participated in the nearly 50 hours and 17 workshops the Department hosted over nearly five months. You and your team facilitated a comprehensive and collaborative opportunity to review these important regulations and we hope you will refer to and rely on the many comments and recommendations we put forward for nearly every section of the thirteen-part WAC chapter. To that end, in addition to our feedback in each of the workshops and our previous written comments of July 14 and August 6, 2020, please accept the written comments and suggested language on certain key sections contained in the chapter identified below.

In addition, we reiterate our support for some of the Department's broader and ongoing initiatives to improve the licensure and certification process for BHAs such as hospitals. The work done during this first phase of the Department's broader project is an important foundation to future work. We fully agree that there are equally important steps that must come next, including that:

- **The Department will develop guidance for its surveyors** that makes clear the intention behind the new regulations, namely operational flexibility and agency discretion which still maintain the highest possible patient care and safety. The spirit of the improvements developed over the last several months cannot be fulfilled unless surveyors share the same understanding as Department leadership about what is (and is not) permissible under the regulations.
- **The Department will develop guidance for hospitals and other BHAs that set out the specific requirements referenced but not specifically identified in the regulations**, e.g. requirements related to involuntary treatment. We fully support moving away from making the BHA chapter overly prescriptive. At the same time, the provision of behavioral health care is exceedingly complex. The Department can and should serve the important role of helping agencies fulfill their many obligations with developing comprehensive guidance to support patient care.
- **The Department will conduct an analysis of all facility regulations to align the BHA Chapter with the WAC chapters regulating hospitals, freestanding psychiatric hospitals, and residential treatment facilities and professional licensures, among others, where possible and**

appropriate. Over the last several months we have seen firsthand how much variation exists between facility and professional licensure regulations, how little the variation is understood, and how potentially inhibitive of patient care such variation can be. We believe this alignment work must be central to the next phase of the Department's BHA rulemaking to continue to improving access to care by removing operational barriers that arise from overlapping regulations.

- **As part of the alignment work to come, the Department will address its deeming process for hospitals that are also BHAs.** The current deeming process does not work for hospitals, freestanding psychiatric hospitals and general acute care hospitals with inpatient psychiatric units alike. Hospitals currently receive multiple annual surveys from the Department notwithstanding their accredited status and the deeming authority contained in the BHA Chapter. While we appreciate the improvements to the deeming language during this phase of the rulemaking, the benefits will not be available to hospitals until the Department addresses how overlapping licensures and accreditation can be incorporated into the deeming process. Please reach out to me when you begin to review this issue so that I may help identify solutions that reduce the burden associated with multiple, avoidable surveys and still maintain appropriate Department oversight.

Thank you again for facilitating this work and the opportunity to contribute to the development of the Chapter. Please contact me with questions.

Sincerely,

/s/

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Below contains draft language and related comments for the following regulations:

- WAC 246-341-0200 Behavioral health services—Definitions.
- WAC 246-341-0300 Agency licensure and certification—General information.
- WAC 246-341-0310 Agency licensure and certification—Deeming.
- WAC 246-341-0410 Agency administration—Administrator key responsibilities.
- WAC 246-341-0420 Agency Policies and procedures.
- WAC 246-341-0510 Personnel—Agency record requirements.
- WAC 246-341-0420 Agency Policies and procedures.
- WAC 246-341-0600 Clinical—Individual rights.
- WAC 246-341-0640 Clinical record content.
- WAC 246-341-0800 Involuntary and court-ordered—Noncompliance reporting for outpatient court-ordered substance use disorder treatment.
- WAC 246-341-0805 Involuntary and court-ordered—Outpatient Less restrictive alternative (LRA) or conditional release support behavioral health services.
- WAC 246-341-0900 Crisis mental health services—General.

- NEW WAC 246-341-1060 General requirements for mental health and substance use disorder inpatient and residential services providing services under chapters 71.05 or 71.34 RCW
- WAC 246-341-1124 Mental health inpatient services—Rights related to antipsychotic medication.
- WAC 246-341-1134 Mental health inpatient services—Evaluation and treatment services.

SECTION TWO—BEHAVIORAL HEALTH SERVICES—DEFINITIONS

WAC 246-341-0200 Behavioral health services—Definitions.

In general, we support a definition of clinical supervision that makes clear that this requirement refers to the day-to-day supervision of providers while offering services generally, as distinct from clinical supervision for purposes of licensure. The latter type of supervision is distinct, and a matter addressed by the numerous health professions licensed under Title 18 RCW. As much is made clear in the Department’s language below—and we agree with this approach. To better achieve this objective, we ask that this language be more broadly stated, and not make specific reference to certain professions. The current language is underinclusive and therefore invites confusion as to whether other professions’ clinical supervision for purposes of licensure are captured or excluded by the definition and the requirements related to it under the Chapter.

WSHA requested language:

“Clinical supervision” means regular and periodic activities performed by a mental health professional, co-occurring disorder specialist, or substance use disorder professional licensed, certified, or registered under Title 18 RCW practicing within their scope of practice . Clinical supervision includes review of assessment, diagnostic formulation, treatment planning, progress toward completion of care, identification of barriers to care, continuation of services, authorization of care, and the direct observation of the delivery of clinical care. In the context of this chapter, clinical supervision is separate from clinical supervision required for ~~mental health counselor associates and substance use disorder professional trainees~~ purposes of obtaining supervised hours toward ~~full~~ fulfilling requirements related to professional licensure under Title 18 RCW.

SECTION THREE—BEHAVIORAL HEALTH SERVICES—AGENCY LICENSURE AND CERTIFICATION

WAC 246-341-0300 Agency licensure and certification—General information.

In general, we support the Department’s redesign of the licensure and certification sections towards a combined section that contains a more streamlined set of requirements for facilities looking to open, expand, renew, or modify the types of behavioral health services they offer. We especially support removing requirements that increase administrative burden without corresponding patient benefit, e.g. removing the requirement that agencies that add a branch site submit the same policies and protocols of the main branch and removing the requirement that those with an ownership interest provide background check information in addition to the agency’s administrator.

We do see three important areas of improvement that are consistent with the Department's new approach, and which more appropriately recognize the diversity of facility and license structures employed by behavioral health agencies.

First, under subsection (2), we ask that the regulations enable the Department to issue a single agency license for multiple buildings on the same campus "or on multiple campuses all under a single facility license." This will mean that an agency with multiple campuses may be recognized as a single operating entity, albeit with an additional campus where services are offered. For instance, one health system may have multiple campuses operating under a single hospital license. In that case, the fact of the single hospital license should permit the hospital to obtain a single main site BHA license so that when services are added to one campus, the health system or hospital needn't seek an additional main site license. This would create the administrative redundancy the re-write project seeks to reduce; add non-patient care oriented costs to the operation of facility, and increase administrative burden as different and additional sets of policies and procedures would be required for one campus.

Second, under subsection 3(a), addressing licensing of a branch site, we ask that you add the phrase "if applicable" to reflect that branch sites may not need to revise policies and procedures to accommodate any differences in business and clinical practices at the site relative to the main site.

Finally, under section (4), under license renewal, we request that there be a provision added that recognizes that the Department "shall grant the renewal" automatically if the requirements for renewal are met before the expiration date of the agency's current license. This is to address the fact that agencies can submit license renewals and follow the requirements for renewal within the prescribed timeframe and not receive their renewal prior to the expiry of their license. The result is that it appears as though the agency's license has lapsed—but it is through no fault of their own.

We strongly encourage the Department to review their renewal process to facilitate timely renewals of agency licensures. We ask now for regulatory language acknowledging and supporting that important process improvement.

WSHA requested language:

The department licenses behavioral health agencies and certifies them to provide behavioral health treatment services. To obtain and maintain licensure and certification, an applicant must meet the requirements of this chapter, applicable local and state rules, and state and federal statutes. In addition, the applicant must meet the applicable specific program requirements for all behavioral health services certified by the department.

(2) The department may issue a single agency license to include two or more buildings on the same campus or multiple campuses all under a single facility license if the applicant operates the multiple buildings or multiple campuses as a single integrated system with governance by a single authority or body over all staff and buildings.

(3) Initial licensure of a behavioral health agency – branch site. To add a branch site, an existing behavioral health agency, shall meet the application requirements in subsection (1)(a) through (d) and submit:

(a) A written declaration that a current copy of applicable agency policies and procedures that address all of the applicable requirements of this chapter are accessible

to the branch site and that the policies and procedures have been revised to accommodate the differences in business and clinical practices at that site, if applicable;

(b) A copy of policies and procedures for any behavioral health service that is unique to the branch site location, if applicable; and

(c) A copy of the disclosure statement and report of findings from a background check of the administrator completed within the previous three months of the application date, if the administrator of the branch site is different than the administrator of the main site location.

(4) License renewal. (a) To renew a main site or branch site license and certification, an agency shall submit a renewal request signed by the agency's designated official. The renewal request must:

(i) Be received by the department before the expiration date of the agency's current license; and

(ii) Include payment of the specific renewal fee.

(b) The department shall renew an agency's main site or branch site license, if all the requirements for renewal are met and the renewal request is received before the expiration date of the agency's current license.

WAC 246-341-0310 Agency licensure and certification—Deeming.

We appreciate the Department's attention to the deeming regulations contained in the Chapter. While we generally support the proposed changes below for introducing important efficiencies in the deeming process, we strongly encourage the Department to take steps towards evaluating the deeming process on a more global level, namely for facilities like hospitals that hold multiple licenses and which receive accreditation under the other licenses (such as hospital). Presently, it seems that dual license entities, particularly those offering involuntary treatment services, such as hospitals, are not granted deemed status even though they meet the requirements for doing so.

As we identified during the workshops, the result of this is that hospitals receive numerous *additional* surveys notwithstanding their following the deeming process outlined by the Department. Surveys are time and labor intensive for both the hospital and the Department. It is disruptive to operations and distracts from patient care. The current public health emergency demonstrates how reduced regulatory burden enables more efficient, swift and innovative models of care like telemedicine. This duplicative survey practice goes in the other direction and is counterproductive. It also creates reputational issues for a hospital in that one issue may result in multiple publicly available reports. The result can create a false impression of more systemic issues than may exist.

In the next phase of this rulemaking, we urge the Department to conduct the gap analysis it proposed in the workshops between BHA and other facility requirements, federal requirements, and accrediting organization standards; and share the results of that analysis with stakeholders including WSHA so that we can identify a solution. The regulations contemplate a deeming process and all facilities meeting the requirements should be able to access that efficiency—to the betterment of facility operations, more efficient use of limited Department resources and patient care alike.

For present purposes, we request that you add the word "relevant" to subsection 7 below. Not every communication regarding accreditation may be relevant.

WSHA requested language:

(7) A deemed main site agency or branch site must submit to the department a copy of any relevant reports regarding accreditation from the accrediting organization.

SECTION FOUR—BEHAVIORAL HEALTH SERVICES—AGENCY ADMINISTRATION

WAC 246-341-0410 Agency administration—Administrator key responsibilities.

In general, we support the Department’s revisions to this section that result in a less prescriptive, but still appropriate, set of requirements for an agency’s administrator. We ask the Department to make four additional changes, all of which we believe are consistent with the Department’s proposed changes and which will better reflect how agencies functionally fulfill the requirements of this section.

First, following subsection (1) and before subsection (2), we ask the Department to include a section explicitly authorizing an administrator to designate the responsibilities assigned to them to appropriate staff. This reflects a common practice, especially among larger organizations, to ensure responsibilities such as compliance, training and supervision are managed by someone with greater day-to-day oversight and special expertise on these areas are responsible for these areas rather than an administrator who may be more removed from these aspects of an agency’s operation. Relatedly, we ask the Department to then include the phrase “or designee” elsewhere in the section. We also ask the Department to consider if such language may be appropriate elsewhere in the Chapter.

Second, under subsection 3(g), we ask the Department to broaden the types of plans referenced for purposes of addressing clinical supervision, clinical training and monitoring compliance. Specifically, we ask that this section acknowledge that a “human resources plan or similarly specialize plan” be included to reflect the fact that these areas are not traditionally or necessarily associated with quality improvement—as the existing language suggests. Referencing these plans will not change the level of oversight required of this section but it will ensure that agencies are not inadvertently and unintentionally required to restructure their existing plans related to clinical supervision, clinical training and compliance to be contained within a quality improvement structure.

Finally, under the same subsection under (iii), we recommend that the Department add additional language expanding the reference to cultural competency so that agencies have a better understanding of what that work entails. The phrase cultural competency may be difficult to scope and execute against if agencies do not know how to frame their initiatives. Our recommended language will help agencies to design their programs to the communities they serve and may serve in the future.

WSHA requested language:

- (1) The agency administrator is responsible for the day-to-day operation of the agency's provision of certified behavioral health treatment services, including:
- (a) All administrative matters;
 - (b) Individual care services; and
 - (c) Meeting all applicable rules, policies, and ethical standards.

(1) The administrator may designate the responsibilities assigned to them under this section to appropriate staff.

(2) The administrator must delegate to a staff person the duty and responsibility to act in the administrator's behalf when the administrator is not on duty or on call

(3) The administrator or their designee, as appropriate, must ensure:

(a) Administrative, personnel, and clinical policies and procedures are adhered to and compliant kept current to be in compliance with the rules in this chapter, as applicable;

(b) There is sufficient qualified personnel to provide adequate treatment services and facility security;

(c) All persons providing clinical services are appropriately credentialed for the clinical services they provide;

(d) Clinical supervision of all clinical services;

(e) There is an up-to-date personnel file for each employee, trainee, student, volunteer, and for each contracted staff person who provides or supervises an individual's care; and

(f) Personnel records document that Washington state patrol background checks consistent with chapter 43.43 RCW have been completed for each employee in contact with individuals receiving services.

(g) A written internal quality management plan written, human resources plan or similarly specialized plan, as appropriate, is developed and maintained that:

(i) Addresses the clinical supervision and training of clinical staff;

(ii) Monitors compliance with the rules in this chapter, and other state and federal rules and laws that govern agency licensing and certification requirements; and

(iii) Continuously improves the quality of care in all of the following:

(A) Cultural competency commensurate with the agency's local community and individuals the agency serves or may serve;

(B) Use of evidence based and promising practices; and

(C) In response to critical incidents and substantiated complaints.

WAC 246-341-0420 Agency Policies and procedures.

In general, we support the Department's revisions to this section, specifically the effort to align the critical incident reporting requirements with other similar reporting requirements across different regulations. However, to achieve the alignment for hospitals, a further revision is required.

Under subsection (13), we ask the Department to recognize that if a "critical incident" under this Chapter also constitutes an "adverse event" under Chapter 246-302 WAC, which applies to hospitals, then the reporting follow the adverse event reporting processes and timelines set out in that chapter.

This is necessary because the Department's current proposed language referencing that critical incidents be reported within 48 hours is different from the reporting timelines set out in Chapter 342-402 WAC and could result in hospitals having two separate reporting structures and timelines for the same single event. Double reporting invites conflicting and competing reports, duplicative review by the Department (and corresponding duplicative use of limited Department resources) and does not create corresponding patient safety and quality benefits. In addition, the reports triggered by an adverse event compared to a

critical incident report are different and require different levels of detail. There is concern that the existing critical incident form and process presumes a level of detail that may not be available at the time specified. This may be a process issue for the Department to work through. In the meantime, this language should help align the reporting structures without shielding Department oversight.

Our suggested language is intended to maintain the Department's oversight of these events while allowing hospitals to follow one set of reporting timelines and processes. If the Department has concerns with this language, please contact me to discuss alternatives.

In addition, under subsection (14), we recommend the Department include reference to agency smoking policy as following county ordinances. This is recommended to help flag for agencies that they need to be aware of the county-specific requirements related to these policies. Alternatively, the Department's guidance document could also address this.

WSHA requested language:

Each agency licensed by the department to provide any behavioral health service must develop, implement, and maintain policies and procedures that address all of the applicable licensing and certification requirements of this chapter including administrative and personnel policies and procedures. Administrative policies and procedures must demonstrate the following, as applicable:

(13) Reporting critical incidents. A description of how the agency directs staff to report to the department within forty-eight hours any critical incident that occurs involving an individual, and actions taken as a result of the incident. Provided that a critical incident which is also an adverse event under Chapter 346-302 shall follow the reporting processes under Chapter 346-302 and be reported under the timelines established in WAC 246-302-020. A critical incident is a serious or undesirable outcome that occurs in the facility including:

- (a) Allegations of abuse;
- (b) Death including death by suicide;
- (c) Injuries resulting in an inpatient hospital stay.

(14) A smoking policy. Documentation that a smoking policy consistent with chapter 70.160 RCW (smoking in public places) and in compliance with applicable county ordinances, is in effect.

SECTION FIVE—BEHAVIORAL HEALTH SERVICES—PERSONNEL

WAC 246-341-0510 Personnel—Agency record requirements.

In general, we support the Department's revisions to this section. We reiterate our recommendation to add language better describing the parameters of "cultural competency" as identified under 246-341-0410 (above). In addition, under subsection (1)(e), we also recommend additional language clarifying the two options for completely workplace violence training.

WSHA Requested language:

Each agency must maintain a personnel record for each person employed by the agency.

(1) The personnel record must contain all of the following:

...

(e) A record of violence prevention training on the safety and violence prevention topics described in RCW 49.19.030; such training may be completed annually for employees working directly with clients receiving mental health services per RCW 71.05.720 or according to the agency's workplace violence plan required per RCW 49.19.020, as applicable.

WAC 246-341-0515 Personnel—Agency staff requirements.

We support the language as drafted below about clinical supervision. It states broad principles and expectations that will be addressed appropriately on an individual agency level. Licensure requirements, scope of practice, oversight and attention vary broadly and change regularly, as the Washington legislature continues to look for new ways to improve the diversity and size of our behavioral health workplace. The language below contemplates flexibility and agency discretion which are necessary to keep pace with legislative changes and foster the type of creative solutions our current workforce challenges call for.

We ask the Department to make sure these expectations is well understood by surveyors. Clear guidance about operationalizing this section will be required to ensure there are no inconsistent survey practices and presumptions placed on facilities who operate responsibly and in keeping with their workforce's skillset.

We question the inclusion of section (3) which refers to special supervision requirements for mental health services without corresponding requirements specific to substance use disorder. However, we do not encourage creating separate requirements for these services, which are so often intertwined. Instead, we recommend more general language that reflect the more holistic language of behavioral health, such as "professional person with the appropriate credential and experience to provide clinical supervision."

WSHA Requested language:

Each agency must ensure that all of the following staff requirements are met:

(1) All clinical staff are appropriately credentialed for the services they provide, which may include a co-occurring disorder specialist enhancement.

(2) All clinical staff receive clinical supervision;

(3) All clinical staff providing mental health services have access to consultation with a ~~psychiatrist, physician, physician assistant, advanced registered nurse practitioner (ARNP), or psychologist who has at least one year's experience in the direct treatment of individuals who~~

have a mental or emotional disorder “professional person with the appropriate credential and experience to provide clinical supervision.”

(4) An agency providing group counseling or group therapy must have a staff ratio of at least one staff member to every sixteen individuals.

(5) An agency providing problem gambling and gambling disorder treatment services must ensure staffing in accordance with WAC 246-341-0754.

SECTION SIX—BEHAVIORAL HEALTH SERVICES—CLINICAL

WAC 246-341-0600 Clinical—Individual rights.

Protecting an individual’s rights in providing them behavioral health care services, some or all of which may be provided involuntarily, is fundamental. To fulfil this obligation, agencies must manage complicated and overlapping requirements. If agencies struggle to determine which rights are owed under voluntary or involuntary treatment, there is the potential for patients to be confused about what they do (and do not) have a right to as part of receiving these critical services. To that end, we request that you add our proposed language in subsection (1) which helps to differentiate the list of rights detailed in that section as compared to the rights set out in statutes regarding involuntary treatment. This is because several requirements contained in this section’s list of rights are duplicative of the rights identified in statute but use different language. For instance, references to an individual service plan and the right to practice one’s religion of choice. As drafted, we are concerned that the regulation contemplates providing a person the same but differently worded rights—and that this may inhibit rather than encourage a person’s ability to exercise those rights meaningfully.

In addition, with respect to the Department’s proposed changes to “reasonable searches” under section 1(d), we ask the Department to make two changes to better address the fact that searches are a critical activity to ensure the safety of the individual, other patients and staff. First, searches should be allowed to “address the risk of harm to the patient or others” in addition to preventing possession or use of contraband. This is consistent with other references and assessments regarding risk of harm elsewhere in the Chapter and it is an important allowance to ensure everyone’s safety regardless of concern about contraband.

Second, the definition of “reasonable” needs to contemplate an invasive search “upon the initial intake process” or if there is reasonable suspicion of “other risk” beyond possession of contraband that can be used to cause harm to self or others. As is, the definition of reasonable is unduly narrow and will inhibit appropriate practices that assure safety and security for the individual, other patients and agency staff. Our requested language is intended to permit searches only in these narrow but crucially important circumstances.

WSHA requested language:

(1) Each agency must develop a statement of individual participant rights applicable to the services agency is certified to provide, to ensure an individual's rights are protected in compliance with chapters 71.05, 71.12, and 71.34 RCW. To the extent that the rights set out in

those chapters do not specifically address the rights in this subsection and the aforementioned chapters are not applicable to all of the agency's services.~~In addition~~, the agency must further develop a general statement of individual participant rights that incorporates at a minimum the following statements. "You have the right to:"

- (a) Receive services without regard to race, creed, national origin, religion, gender, sexual orientation, age or disability;
- (b) Practice the religion of choice as long as the practice does not infringe on the rights and treatment of others or the treatment service. Individual participants have the right to refuse participation in any religious practice;
- (c) Be reasonably accommodated in case of sensory or physical disability, limited ability to communicate, limited-English proficiency, and cultural differences;
- (d) Be treated with respect, dignity and privacy, except that staff may conduct reasonable searches to detect and prevent possession or use of contraband on the premises or to address risk of harm to the patient or others. Reasonable is defined as minimally invasive searches to detect contraband or invasive searches only upon the initial intake process or if there is reasonable suspicion of possession of contraband or the presence of other risk that could be used to cause harm to self or others;

WAC 246-341-0640 Clinical record content.

In general, we support the Department's proposed changes to this section. We agree that referencing an assessment and individual service plan within this section, as apart to stand alone sections, is a welcome efficiency to the Chapter. That said, we recommend that the definitions of assessment and individual service plan are also included in the definition sections, 246-341-0200, for clarity, comprehension, and ease of access. Alternatively, the Department could include additional detail to the title of the section to indicate that these components of a clinical record are laid out in this section.

In addition, we recommend that the reference to a referral to emergency or crisis services be revised to better align with the language and structure of the section.

WSHA requested language:

(1) The clinical record must include:

- ...
- (c) An assessment; An assessment is an age-appropriate, strengths-based psychosocial assessment that considers current needs and the individual's relevant history according to best practices, completed by a person appropriately credentialed or qualified to provide the type assessment pertaining to the service(s) being sought, which includes:
 - (i) Presenting issue(s);
 - (ii) An assessment of any risk of harm to self and others, including suicide, homicide, and a history of self-harm and if the assessment indicates there is such a risk, a referral for provision of emergency/crisis services must be made if indicated in the risk assessment;
 - (iii) Treatment recommendations or recommendations for additional program-specific assessment; and
 - (iv) A diagnostic assessment statement, including sufficient information to determine a diagnosis supported by the current and applicable Diagnostic and Statistical Manual of Mental Disorders (DSM-5) or a placement decision, using

ASAM criteria dimensions, when the assessment indicates the individual is in need of substance use disorder services

SECTION EIGHT—INVOLUNTARY AND COURT-ORDERED OUTPATIENT TREATMENT

WAC 246-341-0800 Involuntary and court-ordered—Noncompliance reporting for outpatient court-ordered substance use disorder treatment.

We request that the requirements associated for reporting noncompliance for court-ordered services under each of the applicable statutes be discussed in the Department’s future guidance document. This is an area where there are implications for people’s due process rights, and their access to necessary medical treatment. It is important that reporting requirements are accessible and well understood.

WAC 246-341-0805 Involuntary and court-ordered—Outpatient Less restrictive alternative (LRA) or conditional release support behavioral health services.

In general, we support the Department’s proposed changes to this section. We recommend that the Department incorporate our proposed language below with respect to agencies ensuring an individual is “provided everything their rights afford them to, and protect them from” under the applicable statutes. This language better articulates that agencies are responsible for doing and not doing certain things related to the rights identified in statute. It is a small but important distinction from the existing language.

WSHA requested language:

- (3) Ensure the individual is provided everything their rights afford them to, and protect them from, under chapter 71.05 or 71.34 RCW, as applicable.

SECTION NINE—CRISIS OUTPATIENT MENTAL HEALTH SERVICES

WAC 246-341-0900 Crisis mental health services—General.

In general, we support the Department’s proposed changes to this section. We ask the Department to include language in three places that each provide for increased operational flexibility. These changes each recognize that patient circumstances—and agency response to those circumstances—can and do differ more than the current language contemplates. For instance, a patient may not have a crisis plan or may present to an agency offering crisis mental health services in a way that prevents the time or applicability of requesting one. As such, we ask the Department to include the phrase “if appropriate and available” to the requirement in subsection 3(b) requiring an agency to request a crisis plan.

Similarly, a patient may not have a follow-up plan if the result of their crisis services is to be transferred to a facility for inpatient services. As such, we ask the Department to include the phrase “or disposition, as appropriate” to the requirement in subsection 4(c) requiring documentation of a follow-up plan. This contemplates a more comprehensive array of results following the provision of crisis services.

In addition, we also ask the Department to modify its reference to transportation under subsection 3(d) to acknowledge that the agency may not be the one to provide the transportation but will facilitate it when the circumstances call for it. As currently written, that section imputes an obligation on the agency's part to do the physical transport—which conflicts with current practice and contracting arrangements related to reimbursement. It also raises separate issues of patient safety. We believe our proposed language captures the spirit of the requirement.

WSHA requested language:

- (3) An agency providing any crisis mental health service must:
- (a) Require that trained staff remain, in person or on the phone, with the individual in crisis in order to provide stabilization and support until the crisis is resolved or referral to another service is accomplished.
 - (b) Request a copy of an individual's crisis plan, if appropriate and available.
 - (c) As appropriate, refer individuals to voluntary or involuntary treatment facilities for admission on a seven-day-a-week, twenty-four-hour-a-day basis, including arrangements for contacting the designated crisis responder;
 - (d) Arrange for the transport of an individual in a safe and timely manner, when necessary;
 - (e) Be available twenty-four hours a day, seven days a week, unless providing only crisis stabilization services; and
 - (f) Include family members, significant others, and other relevant treatment providers, as necessary, to provide support to the individual in crisis
- (4) Documentation of a crisis service must include the following, as applicable to the crisis service provided:
- (a) A brief summary of each crisis service encounter, including the date, time, and duration of the encounter;
 - (b) The names of the participants;
 - (c) A follow-up plan or disposition, as appropriate, including any referrals for services, including emergency medical services;
 - (d) Whether the person has a crisis plan and any request to obtain the crisis plan; and
 - (e) The name and credential of the staff person providing the service.

SECTION ELEVEN—WITHDRAWAL MANAGEMENT, RESIDENTIAL SUBSTANCE USE DISORDER, AND MENTAL HEALTH INPATIENT SERVICES

We support the Department's bold redesign of the inpatient regulations. We believe that the restructuring achieves three important objectives: first, it helps break down the historical siloes of mental health and substance use disorder (SUD) as distinct treatment modalities, when in fact, they are often co-occurring; second, it provides a more accessible framework for identifying which requirements apply across all inpatient settings and which apply in the provision of involuntary services and then those specific to the very circumscribed rules related to SUD-related treatment; and third, it references statutes rather than specific requirements to identify additional applicable requirements. This last point is especially important considering how complex and evolving the involuntary treatment statutes are, and the potential for requirements described in regulation to conflict, be inconsistent, or create confusion with the statutory requirements when they change from one year to the next.

At the same time, we request that the Department pay particular attention to the inpatient requirements in its forthcoming guidance document, especially with respect to the requirements for providing involuntary treatment services. These rules are exceedingly difficult to understand and support from the Department in understanding and fulfilling the obligations contained in statute will be especially helpful to agencies and ensuring patients receive the best possible care in the difficult circumstances necessitating their acute inpatient care.

NEW WAC 246-341-1060 General requirements for mental health and substance use disorder inpatient and residential services providing services under chapters 71.05 or 71.34 RCW

In section 1(b)(ii), we ask the Department to adopt our language regarding visual monitoring so that it refers to “regulator monitoring, as appropriate to the individual,” rather than refer to line of sight or camera monitoring. First, because these specific references create a higher degree of monitoring than may be necessary for a particular patient—and which invite potentially significant implications for access to care as a result of workforce limitations without corresponding benefit for patient care and safety. Hospitals and other agencies that serve involuntary patients are best equipped on an individual basis to determine which type of visual monitoring is needed for a particular patient. In addition, the Centers for Medicare and Medicaid sets out several requirements and guidance on this topic so there is no concern that hospitals and other agencies will be without direction about how visual monitoring should be done for a particular patient.

In addition, we also ask the Department to remove new subsection (2) which would require hospitals to inform potentially two separate DCR offices about a patient’s discharge. We have concerns that this requirement creates added administrative burden without corresponding patient care benefits. We also have concerns that this may conflict with applicable privacy laws given that there is no direct tie to involuntary treatment, emergency conditions or similarly applicable rule permitting the sharing of such information. We also wonder about the utility about this requirement. Is it intended to encourage DCRs to do follow up in the community? That is outside the scope of involuntary treatment services as regulated under this section. Is it to inform potential future investigations for involuntary treatment? It may stigmatize, if not prejudice the patient unnecessarily. We note this language was not stakeholdered during the workshops and we ask the Department to remove this language in full.

WSHA requested language:

This section applies to agencies providing secure withdrawal management, evaluation and treatment, involuntary crisis stabilization unit, and involuntary triage services.

- (1) An agency providing services under chapter 71.05 or 71.34 RCW must:
 - (a) Follow the applicable statutory requirements in 71.05 or 71.34 RCW;
 - (b) Ensure that services are provided in a secure environment. "Secure" means having:
 - (i) All doors and windows leading to the outside locked at all times;
 - (ii) **Regular** visual monitoring, ~~either by line of sight or camera~~ as appropriate to the individual;
 - (iii) A space to separate persons who are violent or may become violent from others when necessary to maintain safety of the individual and others.
 - (iv) The means to contact law enforcement immediately in the event of an elopement from the facility; and

(v) Adequate numbers of staff present at all times that are trained in facility security measures.

~~(2) Upon discharge of the individual the agency shall provide notification to the designated crisis responder office responsible for the initial commitment, which may be a federally recognized Indian tribe or other Indian health care provider if the designated crisis responder is appointed by the health care authority, and the designated crisis responder office that serves the county in which the person is expected to reside.~~

WAC 246-341-1124 Mental health inpatient services—Rights related to antipsychotic medication.

We ask the Department to strike this section from the Chapter. As was acknowledged by the Department during the workshop process, the rights of patients in relation to antipsychotic medication is under the jurisdiction of the Health Care Authority. Further, the Authority currently has rulemaking open on the topic. See [WSR 20-09-130](#). Apart from the duplication, these rules are especially complex and it is problematic to have these rules remain as is here, without appropriate workshopping and development, especially in light of recent changes under SB 5720 (2020).

WAC 246-341-1134 Mental health inpatient services—Evaluation and treatment services.

We ask the Department to update the language in this section to accurately reflect that evaluation and treatment services include initial detention as well as short-term and long-term commitments. This is an important clarification to help improve access to evaluation and treatment services, especially in recognition of the longer detention period effective January 1, 2021.

WSHA Requested language:

Evaluation and treatment services are provided for individuals who are detained or on fourteen, ninety, or one hundred eighty-day civil commitment orders according to chapter 71.05 RCW. An agency providing evaluation and treatment services may choose to serve individuals who are held for one hundred twenty hour detention or on short-term commitment orders (fourteen-day), long-term commitment orders (ninety-day and one hundred eighty-day), or all three both. Agencies providing evaluation and treatment services may also provide services for individuals who are not detained or committed.