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Mr. Christopher Burmeister
District Manager, Division of Health Improvement
New Mexico Department of Health
2040 S. Pacheco
Santa Fe, NM 87505

RE: Public Comment Regarding Draft Regulation 7.30.13

Dear Mr. Burmeister:

I am writing in my capacity as the Director of Santa Fe County's Community Services Department to provide comment on the draft regulations for crisis triage centers, which will be Title 7, Chapter 30, Part 13 of the New Mexico Administrative Code. I will set forth a brief overview of how these regulations will be relevant to Santa Fe County programs and then comment specifically on sections of the proposed regulations.

In May of 2016 Santa Fe County held a Behavioral Health Summit to discuss concerns and gaps in services in behavioral health in Santa Fe County. The overwhelming request of the community was for the County to develop and fund a Behavioral Health Crisis Center (CTC). In November of 2016 the Santa Fe County Board of County Commissioners (BCC) passed a bond providing for \$2.0 million dollars for a building to house a Crisis Center. In June of the same year the BCC voted to support an increase to the Gross Receipts Tax (GRT), which devotes a significant portion to the development and operations of a Crisis Center. Billing of Medicaid and other sources is also expected to support services provided in the Center.

Last fall the County released a Request for Proposals to hire a "Primary Partner" (Managing Partner) to provide core crisis services at the Crisis Center. The core services will include a Mobile Crisis Team, the development of a Living Room Model, on-site pharmacy, assessment, counseling, navigation and other stabilization services. Early in 2018 the County entered into a contractual agreement with New Mexico Solutions, which was chosen to serve as the "Primary Partner" (Managing Partner) to offer such services in our County. Services will be provided at a County owned building located at 2052 Galisteo in Santa Fe, New Mexico, part of which will be leased to NM Solutions.

In addition to the Crisis Triage services being provided by the Primary Provider (Managing Partner), the Center intends to co-locate with other service providers serving Santa Fe County residents. The model includes co-location of the CTC with a detoxification center providing enhanced social detox services and co-location of other intensive navigation programs already being provided in our community. It is the hope of the County that this comprehensive and integrated model will provide individuals experiencing a behavioral health crisis with an array of intensive services designed to mitigate crisis and return individuals to full functioning. The model also emphasizes navigation services which are intended to link clients with long term services and supports, including those related to the social determinants of health.

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The County has received a copy of the regulations that are being promulgated by the Department of Health in partnership with the Human Services Department. While we appreciate the Department's rulemaking efforts, we do have both overarching and specific concerns as detailed below. Overarching concerns include but are not limited to the following:

1. Our model includes the development of a Crisis Triage Center that is co-located with a detoxification center providing enhanced social detox services. Programs are operated independently from one another and by different providers. Does the co-located detox center need to be licensed as a CTC?
2. The Santa Fe County model proposes a non-residential approach with hours of operations less than 24 hours a day/seven days a week and specific to data that indicates when our residents are most likely to experience crisis. The language in the regulations as written is contradictory with regard to hours of operation. Is it the intent of the State to allow for the operations of Crisis Centers who are open for less than 24 hours per day? The Santa Fe County model proposes to begin with hours from 10am to midnight six days per week. All references in the regulations to 24/7 should be reviewed to assure requirements are appropriate to a center's hours of operation.
3. As written the regulations are unclear as to who exactly needs to be licensed. In some cases the regulations specify that the owner of the facility is the licensee. This is problematic because the County owns the building where the CTC will be operated by a Management Company/Primary Partner. In addition, as stated above, it is unclear what co-located services need to be licensed under these regulations given many of the navigation services Santa Fe County's center will co-locate will be part of other existing organizations that are otherwise licensed, certified, or accredited.

These and other issues and suggestions regarding the regulations are summarized below:

1. 7.30.13.7.D Definitions

This section states that the "Applicant" is the legal entity that applies for a license. It further states that the license applicant must be the legal owner of the facility. This poses a problem for Santa Fe County as the "Applicant" should be the service provider (which is the Management Company as defined in the definition) serving as the Primary Partner, not the County, who owns the building. In addition, it creates problems for those CTCs which may be leasing space to operate their facility. We encourage DOH to delete the sentence stating that the license applicant must be the legal owner of the facility, or to otherwise disentangle the requirement that the license applicant also be the legal owner of the facility.

2. 7.30.13.7.R Definitions

This defines the Facility as the physical premises where the CTC services are provided whether owned or leased. This is a problem as stated above because as written it states that the applicant of the license must be the legal owner of the building. In the case of Santa Fe County the applicant would be the Primary Partner (Managing Partner) not the County, who currently owns the building. Again as stated above we request that the State change the language stating that the license applicant must be the legal owner of the facility.

3. 7.30.13.7.AA Definitions

This section refers to the Management Company as the legal entity that manages the facility, and implies this is the entity that will be licensed.

4. 7.30.13.9.A. – General Scope of Services

This section refers to a Crisis Triage Center (CTC) which are "health facilities offering youth and adult outpatient and residential care services." This section is concerning for two reasons:

- a. The section seems to indicate that a Crisis Triage Center will provide “emergency behavioral health triage, evaluation, and admission 24 hours a day, seven days a week.” Other sections of the regulation indicate flexibility in the law for Crisis Centers operating for less than 24 hours (see Section 7.30.13.9.B (1) “a CTC structured for less than 24 hour stays”). Other relevant sections with similar contradictory language include Section 7.30.13.9 B (1), Section 7.30.13.29, Section 7.30.13.6, Section 7.30.13.25 (B) and Section 7.30.13.40. As developed the Santa Fe County model is less than 24 hour.
- b. In other parts of this section and elsewhere in the regulation it seems clear that a CTC could serve youth or adults or could serve both age groups. It is important to insure that language throughout the regulations are consistent with this, as each individual Crisis Center may have differing populations that they will serve on location.

5. Section 7.30.13.9 c(1) Limitations on Scope of Services

This section states that a Crisis Triage Center is limited to serving individuals on a voluntary basis. Subsection C (1) indicates a CTC shall not accepted involuntary commitments of individuals who are not voluntarily seeking treatment. We request the State to clarify what is involuntary in this section of the regulations, specifically with regard to Assisted Outpatient Treatment (AOT). In addition the County seeks guidance on how to deal with individuals who may have treatment guardians or who may be unwilling or unable to sign a written consent to treatment but are cooperating with assessment and/or engagement services.

6. 7.30.13.9 C (3) Limitations on Scope of Services

This subsection states that the CTC shall not provide medical care not related to crisis intervention services beyond basic medical care of first aid and CPR. While Santa Fe County is in agreement that extensive medical services should not be provided, we want to insure that co-located facilities, such as a detox center, may provide medical care when the facility is equipped and staffed to do so (for example high blood pressure, blood sugar levels, Medication Assisted Treatment as required, or asthma treatment) without needing to transport to a more expensive medical facility. In addition, at times medical issues may be concurrent with behavioral health issues, or may exacerbate the situation. We believe the State should allow appropriate medical care to be provided for the person in crisis to manage their immediate needs and/or provide crisis related medical care beyond first aid and CPR, to the extent they are equipped and staffed to do so or as long as they are doing so in collaboration with other qualified practitioners.

7. 7.30.13.9.C: Number 4 is missing.

8. 7.30.13.9.C (5) Limitations on Scope of Services

This subsection requires that residential services not be provided by a CTC in excess of eight days. While the Santa Fe County CTC model is not residential, stabilization may require more than eight days and navigation services to the social determinants of health may require a longer time period. While we expect the length of treatment to be significantly less for most individuals we are recommending that the length of stay limit be extended for up to 14 days.

9. 7.30.13.9.C.(6) Limitations on Scope of Services

This provision would prohibit CTCs from providing ongoing outpatient behavioral health treatment or navigation services. While we understand the desire to license these facilitates separately, the State should not prohibit or discourage CTCs with co-located navigation services from providing ongoing services beyond the time period of the crisis. Santa Fe County is looking at providing a

central location where the community has the ability to access multiple services in one location. As individuals work through their service needs, priorities and needs may change, and this service should be made available at the CTC. The CTC should also be a location for caregivers, treatment guardians, family members and the citizens of the county to obtain information and or resources to assist their family members or individuals in their care, at times both resources and navigation services may be provided beyond the scope of the individual's primary treatment at the CTC.

10. 7.30.13.9.D. License Required

This section needs to be revised to consider services that are currently being operated and which may be seen as falling into the definitions proposed in this regulation (e.g., withdrawal management). Nothing in this regulation or in its implementation should result in an existing program which has been operating safely with good outcomes for people and communities, to have to shut down because it is not in a facility or not yet ready to be licensed as a CTC. We applaud the State's proposed use of variances or waivers (Subsections 7.30.13.7.ZZ. and AA.) to provide additional time or an exception to some of the requirements of this proposed regulation. However, the waiver and variance process, the criteria by which a waiver or variance request will be provided, as well as the process for appealing a denial of a waiver or variance request should be described in a more detailed manner.

11. Section 7.30.13.10. E Existing or Renovated Construction

This subsection states that if the proposed facility includes any remodeling, renovations or additions or new construction of any type, the building plans and specifications covering all portions of the proposed work shall be submitted to the Department for review and approval. We are respectfully requesting that the Department outline parameters and timelines for review and response by the State so that costs and timeframes can be managed at the local level.

12. 7.30.13.10.G.(4) Program Description

This section describes the elements of the program description that must be provided by an applicant for a CTC license. It requires proposed 24/seven staffing plans for both residential and non-residential programs. Yet, the earlier subsection 7.30.13.9.B.(1) specifically contemplates a less than 24/seven operation for some CTCs. This subsection should be revised to reflect that programs should provide a staffing plan appropriate to its proposed hours of service.

13. 7.30.13.21 Governing Body

In Santa Fe County, the Applicant, Licensee, Management Company are the same legal entity and not the owner of the Facility. That legal entity does have a governing body, but that governing body is not Santa Fe County.

14. 7.30.13.25 – Client Acceptance, Admission and Discharge Criteria

7.30.13.25.B states that the facility shall admit and discharge 24 hours a day/seven days a week in contradiction to other sections of the regulations which allow for a CTC to operate for less than 24 hours a day and less than seven days a week.

This section as written assumes that all individuals experiencing a crisis will require a residential stay. Individuals should be able to receive services in the CTC without an assumption or need for admission to a residential setting. The regulation should make a distinction between admission and discharge, and presentation for services and release.

The requirement is residential program licensing, and Santa Fe County will focus on a non-residential program with emphasis on client care navigation and a "warm-handoff" with face-to-face connections. The services may be provided via telehealth and or other available resources and should be incorporated into the post-discharge or post-release process. One of the most valuable and most underfunded services for individuals challenged with substance use and/or mental disorders is the navigation or case management services that can provide the immediate service needed. This will prove to be one of the most valuable services in the continuum of care offered by the crisis centers

15. 7.30.13.26 – Program Services

This subsection requires that assessments be provided by independently licensed mental health professionals. Given the nature of the workforce and the availability of professional staff we are recommending that the word "independently" be dropped from the requirement. We agree that assessment should be provided by a licensed mental health professional.

Program services should require appropriate roles for peers and peer-provided and peer-driven services. Studies continue to show and encourage the use of "certified" peer support workers. The CTC should be encouraged and allowed to identify certified peer support workers as the first line of contact when an individual is seeking services. This is a service that should be provided at the crisis center and as a support service after initial contact by the mobile crisis response teams.

16. 7.30.13.29 (a) – Staffing Requirements

This subsection states that the CTC shall have staff onsite 24 hours a day seven days a week, in contradiction to other areas of the regulations that state that CTC's may operate for less than 24 hours per day and less than seven days a week. This staffing section needs to be revised to provide for appropriate staff for services proposed related to the service provider's respective hours of operation.

Flexibility should be given to utilize any licensed professional that is appropriate given the limitations of available workforce. Specifically, the proposed regulations require that both a physician and a psychiatrist be available during all operating hours, in this case 24/7. This requirement seems specifically onerous given the limitations on workforce in Santa Fe County and in rural areas of the State.

Staffing should include a role for a certified peer(s) support staff on-site during operating hours. Workforce issues are difficult in many communities thus implementing services such as telehealth are great options. In subsection A.(5), the regulation should allow for appropriately licensed and trained mental health practitioners other than a psychiatrist who can be available during operating hours in person or through telehealth (e.g., a psychiatric nurse practitioner, a prescribing psychologist, etc.).

The CTC staffing patterns should be addressed by the different Crisis Center providers based on the needs of the community, the population of the region, and most important the needs identified by the respective Counties. Again, hiring and keeping licensed professionals has not only proven challenging in New Mexico and Santa Fe County but also nationwide.

17. 7.30.13.29.B (4) Other Staff Requirements

The regulation requires that all employees are tested for TB prior to direct contact with clients and are retested annually. The DOH has already deleted this requirement from other regulations. If TB tests are required the State should mandate these for residential programs only.

18. 7.30.13.32 – Staff Training

This section should include training on peer delivered services and recovery supports. Training should also include information about available services in the local area served by the CTC.

Also in section B, (3 and 4) it refers to staff training regarding substance use disorders and co existing disorders as well as withdrawal management protocols and procedures, if withdrawal management is provided. But earlier in the regulations, section 7.30.13.9.C (2) it states “the CTC shall not provide acute medical alcohol withdrawal management.” This can be confusing and needs to be clarified.

19. 7.30.13.34 – Nutrition

This subsection should be clarified to apply only to residential programs or to be specific to food provided on a short-term basis for persons at a facility operating less than 24 hours a day/seven days a week.

20. 7.30.13.40 – Business Hours

The CTC shall provide crisis stabilization and admissions 24 hours a day, seven days a week. Hours shall be posted on signage exterior to the building.

This sections should be revised to allow the CTCs in its respective communities to operate as needed to meet the community needs and post such operating hours. If the facility operates less than 24 hours a day, seven days a week, it may complement its services with the use of the mobile crisis response team, or access to NMCAL. These numbers can also be posted on the “hours of operation signage”.

21. 7.30.13.58.B Resident Rooms

Subsection B states that resident rooms may be private or semi-private. It further states that semi-private rooms may not house more than two residents. While this is not problematic for Santa Fe County’s crisis center because it will not be residential in nature, it is problematic for the co-located detox center if they need to meet the same licensing requirements. Currently the detox center operates with an open ward that accommodates 10 in the male unit and 5 in the female. Requiring them to meet this standard is untenable from both a staffing and a safety perspective.

22. Facility Requirements

All facility requirements should be reviewed to assure facilities are only required to have those areas and aspects truly necessary for its hours of operation and its services (e.g., non-residential versus residential). While some parts of the regulations are indicated as specific to residential programs, others appear to apply to all CTCs and may not be necessary for all models. If the State intends to handle this by waiver or variance, it should indicate this specifically. Nothing in these regulations should preclude the use of Living Room or other peer-delivered service models that may be more home-like in nature.

Thank you for the opportunity to comment on the draft regulations. I look forward to participating in the discussion at the public hearing on the draft.

Sincerely,

A handwritten signature in black ink, appearing to read 'Rachel O'Connor', written over a horizontal line.

Rachel O'Connor
Director of Community Services for Santa Fe County



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Chris Burmeister
District Manager
DHI
NM DOH
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Re. Proposed Crisis Triage Center (7.30.13) regulations

Delivered via email

May 24, 2018

Dear Mr. Burmeister,

Thank you for the opportunity to review and comment. I will also attend the public hearing on the 30th. Comments and notes are appended below:

- Although page 5, item B.1 indicates that an acceptable type of service for CTC is “a CTC structured for less than 24-hour stays...”, there remain numerous lingering references throughout the document to a 24/7 requirement (page 7 G4d, page 15, item B; page 17 item A3,; page 21, item 40) NMS requests these all be deleted or amended by qualifiers to indicate they do not apply if CTC is not structured as a 24/7 program;
- On page 2-3, items D (applicant), R (Facility), and AA (management company) seem to conflict, creating a requirement such that the owner of the building must be the licensed operator. This is not a current DHI requirement in other behavioral health licenses, such as CMHC. NMS requests these be amended to be consistent with CMHC expectations.
- Regulations do not allow or permit deemed status in response to national accreditation. NMS recommends this be added, consistent with best practice and other NMAC facility requirements.
- On page 5, item 6 prohibits “ongoing outpatient behavioral health

treatment.” This language and prohibition is unnecessary and unnecessarily broad. Some patients may have to return to the CTC several times in order to resolve crises, or address gaps in prescriptions or access to stable outpatient services. NMS recommends this language be stricken.

- On page 5, Item C1 restricts involuntary treatment. This precludes CTC services playing a role in Assisted Outpatient Treatment (AOT).
- Page 5, item C3 prohibits medical care in language which is unnecessarily broad and prohibits licensed medical providers from providing services for which they are qualified and licensed.
- On page 7, Item E requires that a program obtain prior approval from DOH/DHI before starting renovations. However, no time frame is given for DHI’s response. This creates a burden on the program and inhibits the development of much-needed services in NM. Given that DHI currently is understaffed, delays in response may be anticipated. This requirement should be amended, given a reasonable timeline for DHI response, or the requirement stricken.
- Page 13, item H, regarding chemical restraint. This language is internally contradictory, and essentially negates a restriction on chemical restraint – by defining a medication used for standard treatment as not being a chemical restraint, this language opens a broad door to use of intramuscular injections of Haldol for instance, a standard treatment for individuals determined to be agitated or out of control. This is indeed the very definition of a chemical restraint.
- Page 11, 7.30.13.21 regarding governing body is complicated by earlier items regarding “facility,” applicant and management company, as it is unclear which of these entities must have the governing body. It is recommended these be made consistent with CMHC regulations.
- Page 15, program services requirement of an independently licensed mental health professional. Given the workforces shortage issues, particularly in independent licensed providers, this requirement places an unnecessary and undue burden on provider. HSD recently revised requirements that only independently licensed clinicians could conduct assessments, allowing them under supervision, consistent with state licensing regulations. It is recommended that DHI incorporate this best practice in their own requirements.
- Page 18, item 4 at top of page, requiring TB screens and annual retesting – this requirement is in conflict with the 2004 repeal of NMAC 7.4.4 and places an unnecessary burden on CTC providers.
- Page 26, item 60, sentence “facilities shall be reward to support laboratory procedures if provided” is a fragment and incomplete requirement.

Thank you for the opportunity to comment.

David J. Ley, Ph.D.
Executive Director
Psychologist #834



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Gary Housepian, Chief Executive Officer

Promoting and Protecting the Rights of Persons with Disabilities

May 24, 2018
Christopher Burmeister
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2040 S. Pacheco
Santa Fe, NM 87505

via e-mail: Christopher.Burmeis@state.nm.us

Re: comments on proposed Crisis Triage Center regulations, 7.30.13 NMAC

Dear Mr. Burmeister:

I write to submit public comments regarding the proposed Crisis Triage Centers (CTC) regulations on behalf of Disability Rights New Mexico (DRNM). DRNM is a private, non-profit organization whose mission is to protect, promote and expand the rights of persons with disabilities. As such, we monitor proposed programs and regulations to advocate for the rights of our constituents who will be affected by them. Our comments, observations and suggestions are below.

Before commenting on individual sections, DRNM is compelled to address two predicate conditions. The enabling legislation states that they are to provide “stabilization of behavioral health crisis and may include residential and nonresidential stabilization.” The legislation does not address whether this stabilization treatment is for voluntary clients only. The proposed regulations say that services are provided on a voluntary basis. *See* proposed regulations at 7.30.13.9(A) and (B) NMAC. Yet, the proposed regulations imply that medications may be given in emergency situations (those situations where medications are used to protect “the safety of the individual and other persons”: proposed 7.30.13.35(B)(2)NMAC). Under both the adult and children’s mental health codes, this means administering medication without consent. NMSA 1978, § 43-1-15(M), 32A-6A-17(L). The regulations also mention guardian participation several times. If the CTC programs are voluntary, only the individual him or herself may consent to treatment. These issues must be addressed before the regulations go into effect. Otherwise, the regulations set the stage for serious legal rights violations.

Second, seclusion is properly and expressly prohibited in these regulations. **Proposed 7.30.13.24(B) NMAC**. Thus, the multiple references to seclusion throughout these regulations must be stricken.

7.30.13.7 Definitions

DRNM believes several more definitions need to be added to this section. First, there appears to be a difference between a *Crisis Intervention Plan* and a *Crisis Stabilization Plan*. It would be helpful to define these initially for ease of reference when reading the regulations.

Definitions for the following would also be helpful:

- “Behavioral health services”
- “Consent” or “Capacity to consent” – this is necessary as Crisis Triage Centers are for those who volunteer to be there, and which should include the right to refuse medication.
- “Crisis Triage Center” – such as the introductory paragraph in the notice
- “Crisis”
- “Emergency Safety Intervention”
- “Guardian”
- “Legal representative” – should include “legal custodian” for children
- “Operating Agreement”
- “Residential treatment or habilitation program” (*See* NMSA 1978, §32A-6A-4(AA) – CTCs that provide residential treatment for youths 14 and older which permit the involuntary emergency administration of psychotropic medication are considered residential treatment or habilitation programs
- “Voluntary” – discussed more fully below, the issue is that only individuals with capacity to consent may volunteer for treatment and legal guardians or legal representatives cannot “volunteer” for an individual

DRNM offers these additional comments regarding this section:

EE. The definition of “physical restraint” should expressly prohibit prone restraint.

P. This definition of “Withdrawal management” is out of alphabetical order and is duplicative of BBB, which is in alphabetical order. “P” should be deleted.

S. “High risk behavior” is defined as behaviors that put the client, staff or others’ health and safety at risk. This implies that there are behaviors for which emergency interventions such as restraint (defined at EE) or perhaps emergency medication, as distinguished from chemical restraint, may be administered. There is no definition of emergency medication and whether it can be administered without the client’s consent. The regulations simply require a CTC to develop policies and procedures to address how to respond to clients who “present with imminent risk to self or others, assaultive and other high-risk behaviors.” *See* proposed regulations at 7.30.13.24(A) NMAC, Risk Assessment. DRNM believes the proper procedures to address use of medications administered for the purpose of “protecting the safety of the

individual and other persons” (proposed 7.30.13.35 NMAC) must be articulated in these regulations rather than be left to each CTC to develop.

Z. “Licensed mental health professional” has as the last clause “with behavioral health training licensed in the state of New Mexico.” Does this last phrase apply to all of the professionals listed, or only an advanced practice registered nurse? Please clarify (*see* NMSA 1978, § 43-1-3(T) as an example).

The definitions leave some confusion regarding the various licensed mental health professionals, as some are defined (physician, physician’s assistant, advanced practice registered nurse) but others are not (psychologist, social worker, psychiatrist, practical nurse, social worker). It would be helpful if all are defined, and perhaps distinguish between psychologists who can prescribe medications and those who cannot.

7.30.13.9 Scope of Services

A. General Scope of Services: DRNM agrees that these services be offered on a voluntary basis. It is necessary to clarify who is “volunteering” the individual for admission, as the right to consent to treatment belongs to the individual alone. Only the person receiving the treatment can volunteer for it. This includes youths 14 years of age or older as they are given the right to consent to treatment under the Children’s Mental Health and Developmental Disabilities Act (“Children’s Act”) NMSA 1978, §32A-6A-15(A).

C. Limitations on Scope of Services: Subsection (5) says residential services may not be longer than eight days. We suggest stating this is eight **calendar** days.

7.30.13.10 Initial License Procedures

G(4)(e). This subsection requires that CTCs have operating agreements with various treatment facilities, including “behavioral health agencies for follow-up appointments for individuals discharged from the licensed facility.” Please define “operating agreement.” If this means there is an agreement that individuals discharged from the CTC are to have follow up appointments made at the facilities/agencies with which there are operating agreements, and that they are guaranteed services if the individual wishes to have them, the definition should state that.

7.30.13.20 Reporting of Incidents

It would be helpful to provide citations of the statutes and regulations that govern serious incident reporting.

7.30.11.22 Policies and Procedures

T. Client Rights: It would be helpful to reference the section of the regulation that lists the client’s rights (proposed 7.30.13.27 NMAC).

7.30.13.24 Risk Assessment

DRNM appreciates that the restraint guidelines in the Risk Assessment section include steps required when restraining a youth. NMSA 1978, §32A-6A-10. We believe these steps provide a thoughtful and thorough approach to the use of restraint and appreciate that DOH is requiring that these steps be used for adults as well as youth.

A. This section requires a facility to develop policies governing their response to clients who present an imminent risk, are assaultive or engage in other high risk behaviors. DRNM believes it is the Department that should issue the guidelines for these policies in these regulations rather than leave it to each facility to develop their own. This is critically important, particularly to address whether emergency medications may be administered. Compliance with the process for administering emergency medication in both mental health codes must be ensured. DRNM believes that would include transferring a person to an evaluation facility for possible emergency admission.

B. This section describes the parameters for the use of restraint. We suggest that it also include the provision from the Children’s Mental Health Code which says that those applying a restraint use “only the reasonable force necessary to protect the individual or other person from imminent and serious physical harm.” NMSA 1978, §32A-6A-10 I.

E. Physical restraint “*are*” should be physical restraint “*is*”. Prone restraint must be expressly prohibited.

H. This subsection prohibits chemical restraint, which DRNM agrees with. It does not address whether CTC clinicians may administer emergency medication, and if yes, whether they may do so without the client’s consent. If the emergency medication administration is considered permissible, it must be done in a manner consistent with the mental health statutes. NMSA 1978, § 43-1-15(M), § 32A6A-17(L).

J. This subsection requires a debriefing immediately following an incident of physical restraint. It does not make clear whether the individual him/herself participates in the debriefing, or if this is with staff only. If it is with staff only, the restraint should be discussed with the individual as soon as feasible. NMSA 1978, §32A-6A-10(G).

L(2). This is one of several places that references seclusion. However, **seclusion is expressly prohibited** in these regulations. *See proposed 7.30.13.24(B) NMAC.* Please go through the regulations and remove references to seclusion except for the specific prohibition. *Id.*

M. We wonder whether it is purposeful that “restraint/clinician” contains a vertical slash. It is written that way in other parts of the regulation as well.

M(4)(d). In referencing the need to document the “emergency safety intervention” used, it would be helpful to define this term.

N. Subsection (4) specifically references that a medical and “psychiatry” provider conduct the evaluation for suicide risk interventions. Is the “psychiatry” evaluation to be conducted only by a psychiatrist, or can it be conducted by any of the “licensed mental health professionals” listed in proposed 7.30.13.17(Z) NMAC?

7.30.13.25 Client Acceptance, Admission and Discharge Criteria

E. This requires that materials related to the CTC services must be provided at admission and that they must be understandable to the client and legal guardians. It is not clear under what circumstances a legal guardian would be involved. If the client is an adult with a legal guardian, there would need to be a process to determine if the individual had the right to consent voluntarily to mental health treatment. This would require an examination of the guardianship order or the letters of guardianship. Unless the guardianship order specifically grants mental health decision making to the guardian, the individual retains that decision making authority. NMSA 1978, § 45-5-312 (2009, amended and adopted by S.B. 19, 53rd Leg., 2nd Reg. Sess. (N.M. 2018)).

The Adult Mental Health and Developmental Disabilities Code (“Adult Code”) prohibits a guardian or other surrogate decision maker from consenting to admission to a facility of the individual/proposed client. All a guardian may do is present an adult to a facility for an evaluation for possible admission. NMSA 1978, § 43-1-14(B). Assuming the individual retains the authority to consent to mental health care, there is no role for a guardian here. If the guardian has been granted specific authority to make decisions about mental health treatment, the person lacks capacity to consent to participate in a voluntary program. *Id.* The only option would be to have the individual evaluated at a facility for possible admission as an inpatient.

The rule for children 14 and older is similar, though not identical to the law governing adult treatment. Children 14 and older are presumed to have the capacity to consent to treatment. NMSA 1978, §32A-6A-15(A). A child age 14 or older may be admitted to a residential facility when both the child and their legal custodian consent to admission. NMSA 1978, §32A-6A-21(B). (Legal custodian is defined at NMSA 1978, §32A-6A-4(N).)

Children age 14 and older may consent to outpatient verbal therapies and psychotropic medication without the consent of that child’s legal custodian. NMSA 1978, §32A-6A-15 A and B.

Given the differences of the requirements for adults and children, for residential care and the special rules for children as outpatients, it would be clearer to articulate acceptance and admission criteria separately for adults and children age 14 and older.

H. DRNM wonders why inspection of clients for contraband and weapons is limited to admission to residential care only. Certainly a person could have contraband and weapons when an outpatient as well.

J. This subpart references a client’s legal guardian. Again, it is unclear what capacity a legal guardian serves as admission to a CTC is voluntary; a guardian cannot “volunteer” a person for care. NMSA 1978, §43-1-14(B).

K(3). This subsection gives the individual “recommendations for continued care and appointment times...” It is not clear how this part fits with the requirement that the CTC have “operating agreements” with outpatient providers. Proposed 7.30.13.10(G)(4)(e) NMAC. When would a CTC refer a person to an outpatient provider with whom they have “operating agreements” and when might a referral be made to another provider? Also, it is not clear whether “appointment times” means that an appointment has been made for the individual in advance of the discharge or that a person has been given information about numbers to call upon discharge. Please clarify.

7.30.13.26 Program Services

B. Crisis Stabilization Plan: This appears to be the actual treatment plan, which is the core component of crisis stabilization services. It would be helpful to place a brief description in the definition section.

B(1)(g). The plan must “evidence the involvement by the client and **legal guardian...**” (emphasis added). Again, it is unclear to me how a legal guardian would take part in a CTC admission if this is a voluntary service requiring consent of the individual served. *See* comments regarding proposed 7.30.13.25(E) NMAC, *supra*.

7.30.13.27 Client Rights

DRNM suggests mirroring the Adult Mental Health Code by including that individuals are entitled to a “nourishing, well balanced, varied and appetizing diet.” NMSA 1978, § 43-1-6(F).

Since CTCs are voluntary programs, it would be appropriate to say individuals have a right to leave treatment, unless the individual meets the criteria for issuing a certificate of evaluation for transportation as described in the Adult Mental Health Code. NMSA 1978, § 43-1-10. In addition, it is not clear whether someone can come and go during a period of treatment, whether outpatient or inpatient. If this is a voluntary program, a person should have the right to come and go as the individual chooses.

DRNM suggests amending D(10) to include a representative from the state’s designated protection and advocacy system. 42 U.S.C. § 10805(a)(3), 42 C.F.R. §§ 51.31(d)(1) and 51.42.

D(12)(i). Individuals “have the right to refuse treatment and to be free from unnecessary or excessive medication...” This implies that medication would not be administered in an emergency without consent. As stated in the regulations, individuals have the right to refuse medication. Proposed 7.30.13.35(C)(3) NMAC. If it is contemplated that medication could be administered without consent, it should be expressly required that it be done as proscribed by both Mental Health Codes. NMSA 1978, §43-1-15(M) and §32A-6A-17(L). In addition, DRNM advocates that in such circumstances, arrangements be made for emergency transfer to a facility for evaluation for possible admission.

DRNM suggests adding a provision similar to that in the Children’s Code: individuals shall have access to the state’s protection and advocacy system and access to an attorney of the individual’s choice. *See* NMSA 1978, §32A-6A-12(A)(2).

7.30.13.28 Client clinical record

Seclusion is prohibited by these regulations, thus the reference to it at subsection J should be removed. *See* **proposed 7.30.13.24(B) NMAC**.

7.30.13.29 Staffing Requirements

B(1)(c). DRNM suggests amending this subpart to read “experienced and competent in the profession for which they are licensed.”

7.30.13.35 Pharmaceutical Services

B(2). By saying that medications may be used for “protecting the safety of the individual or other persons” this subsection implies that emergency medications may be administered at CTCs. As stated above, DRNM believes that no medication may be administered without the individual’s proper consent. If the Department is authorizing administration of emergency medication, it must have a regulation describing how that is done and that it be done according to procedures in both the adult and children’s Mental Health Codes. NMSA 1978, §43-1-15(M), § 32A-6A-17(L).

7.30.13.19 Client Transfers

B. DRNM wonders about the reason authorization for transfer may be issued only by physicians or advance practice nurses. We suggest that this authority be given to any of the licensed mental health professionals. *See* proposed 7.30.13.7(Z) NMAC. In addition, it seems appropriate to specifically identify circumstances in which transfer must be initiated, such as when emergency medication is administered to a child as an outpatient (NMSA 1978, §32A-6A-17(L)). Also, the client must be informed that a transfer to a higher level of care means that the evaluation facility will determine whether admission is necessary; as a matter of law it is not guaranteed.

7.30.13.47 Custodial Closets

Please specify that these closets must be locked.

7.30.13.58 Resident Rooms

There may need to be a provision to address how bed space will be made available by gender. For example, if a woman presents for admission, and the only bed remaining is one in a semi-private room which a male occupies, what happens?

7.30.13.60 Collection/Draw/Lab Area

The first line says “Facilities shall be *reward* to support...”. Perhaps the word “*reward*” should be “*required*”?

7.30.13.61 Nutrition

If a residential CTC provides services to both adults and youth, DRNM recommends that the mealtimes for the two populations be separate.

7.30.13.79 Additional requirements for facilities serving youth

DRNM agrees there needs to be a separate section addressing the legal requirements of youth who may receive treatment in a CTC. We suggest amending the second sentence of this section to say “For facilities serving youth, the additional requirements of sections 7.30.13.79 NMAC through 7.30.13.85 NMAC must also be met.”

7.30.13.80 Risk Assessment

I. It is necessary to add two more provisions from the Children’s Code: After an incident of restraint, a debriefing must be conducted with the child, and the treatment team needs to meet and review the restraint incident to revise the plan to reduce the possibility that a restraint will again be necessary. NMSA 1978, § 32A-6A-10(F) and (G).

DRNM appreciates the opportunity to provide comments and suggestions on the proposed Crisis Triage Centers regulations. We hope these suggestions will be considered and adopted before final publication of the regulations.

On behalf of Disability Rights New Mexico,



Nancy Koenigsberg
Senior Attorney

Cc: Gary Housepian, Chief Executive Officer

May 24, 2018

Christopher Burmeister
District Manager, Division of Health Improvement
New Mexico Department of Health
2040 S. Pacheco
Santa Fe, NM 87505

Dear Mr. Burmeister,

I would like to submit the following public comment with respect to the draft Crisis Triage Center regulations (NMAC 7.30.13).

The Santa Fe Recovery Center is an adult substance use disorder treatment program rendering a wide array of services to more than 700 clients a year throughout New Mexico. We have been in operation since 2005 and offer social detoxification, residential treatment, medication assisted treatment, regular and intensive outpatient treatment, and sober living.

We have been interested, for some time, in providing a higher level of detoxification that includes dual diagnosis assessment and treatment as well as medical screening, clearance, medication assisted treatment, treatment, and stabilization that I believe would fall under the crisis triage center regulations. It is with the intention of transitioning our social detoxification program into a crisis triage center that I comment on the draft regulations today.

COMMENTS:

7.30.13.7.A With respect to the definition of Acute Medical Alcohol Detoxification in this section, there are a list of 8 symptoms. And while it is true that certain of these symptoms are of the severity level to require hospital based detoxification such as autonomic hyper-activity, vomiting, hallucinations, and seizures, there are several symptoms that would not meet criteria for a hospital based detoxification. For example, a combination of nausea and insomnia or anxiety and hand tremor would not be sufficient to meet hospitalization criteria and yet, based on this definition, would exempt the individual from detoxification in the crisis triage center. I would suggest that something be added to the language that the combination of the two or more symptoms must be severe enough to meet criteria for a hospital based or medically managed detoxification.

7.30.13.7.D With respect to this section where it reads that “The License applicant must be the legal owner of the facility”. I would like to request that the language allow for leasing of space such that the applicant have control of the facility rather than having to be the legal owner.

7.30.13.9.C. With respect to this section titled Limitations on scope of services. Number 3 states that a CTC shall not provide medical care not related to crisis triage intervention services beyond basic medical care of first aid and CPR. When the physician is on site, it is within their scope of practice to address medical conditions such as prescription of asthma medication or high blood pressure medication and other low level medical interventions that would de-incentivize individuals from unnecessarily going to urgent care or the emergency room for these basic medical interventions. So long as it is within the physician's scope of practice, examination and treatment of non-emergent medical conditions should be allowed.

7.30.13.9.C. Within this same section, there is no number 4 in the list of limitations. Number 5 stipulates that the CTC shall not provide residential services in excess of eight days. A more significant medically supervised or medically monitored detoxification of benzodiazapines, for example, may require up to 14 days for stabilization. The wording on this limitation should add "unless symptoms requiring medical monitoring or supervision persist, in which case residential services shall not exceed 14 days".

7.30.13.9.C. Within this same section, number 7 states that the CTC shall not exceed 16 beds. Federal guidelines in the state SUD waiver allow for up to 15 days of residential treatment for facilities with more than 16 beds. Therefore, limiting residential services in the CTC to 16 beds seems to unnecessarily restricts access to care and limits New Mexico's ability to provide network adequacy for this service.

7.30.13.9.D.2. Under the next section I would request a point of clarification. The section reads that "Any facility providing the services described under these regulations on the effective date of these regulations shall apply for a CTC license within 180 days". Is the intent of this standard to require all residential detoxification facilities to be licensed as CTC's?

7.30.13.26 With regard to this section titled Program Services. This section states that an independently licensed mental health professional must assess each individual. Many behavioral health facilities within the state including CMHC's, FQHC's, and facilities with an approved Supervisory Protocol can have non-independently licensed mental health professionals, under the supervision of an independently licensed mental health professional, render assessments. Due to workforce shortages and staffing costs as well as established practice, this language should allow for assessment by a non-independently licensed mental health professional, under the supervision of an independently licensed mental health professional.

7.30.13.29 (4 and 5) Under the section Staffing Requirements, the program is required to have an on-call physician AND psychiatrist 24hrs a day, 7 days a week. It is cost prohibitive to require the program to retain an on-call physician 24/7. To also require an on-call psychiatrists is an exorbitant cost for the facility. There are also workforce shortages in the state that would make this virtually impossible. I would suggest that the facility be required to have a psychiatrist available for consult but not require that this be 24/7.

7.30.13.29.B.4 Under this section there is a requirement that the CTC ensure that all employees are tested for tuberculosis at hire and annually. In 2004, the department of health stopped requiring TB testing for employees, and even when it was required, it did not need to be repeated annually. I would like to request that there be consideration of removing this stipulation.

7.30.13.52.B Under this section I would like clarification as to whether a pharmacy grade locked medication cart would be sufficient to meet the standard. This is allowed by pharmacy regulations and, as a space saving measure, is preferable to requiring a medication closet or room.

7.30.13.58.B. Under this section there is a requirement that residential CTC's have private or semi-private rooms. I would like to strenuously object to this standard. This standard is neither a best practice, as it hampers supervision and line of sight of clients, nor is it a requirement that most detoxification center statewide would be able to meet. The safest way to provide medically supervised/monitored detoxification is with dormitory style sleeping arrangements that allow direct care staff to see all clients at all times. Earlier this year, our medical technician saved the life of a client by being able to witness the client collapsing and losing vital signs. Due to that immediate observation, the medical technician was able to successfully administer CPR until paramedics could arrive. Semi-private room requirements would severely limit the ability of most residential facilities statewide to be licensed as CTCs. Client dignity and comfort can be ensured through privacy curtains and other methods.

7.30.13.62.A Under this section it reads that "the facility shall have either contracted food preparation or prepare food on site". This provision does not allow for a facility to prepare food off site and transport it to the CTC. There is environment department catering licenses that allow for this type of food service, and as such, it should be an allowed method of food service for CTC's. The Santa Fe Recovery Center has a commercial kitchen in its residential facility and currently prepares food at that location and transports it to the detoxification facility. This is allowed per our catering environment department certification.

In addition to the section comments listed above, I have two general comments about the regulations. The first is that facilities that are federally accredited through CARF, Joint Commission, or COA should have deemed status with respect to certain of these standards including, but not limited to, policies and procedures, health and safety standards, and quality assurance plans. This would reduce the burden on facilities to report to and show evidence of these standards to multiple regulatory bodies and would save DHI time and money related to certification and licensing of these facilities. If not for initial licensing, perhaps ongoing accreditation of the facility could assist with ongoing licensure to reduce administrative burden related to that process.

The second general comment is that there are incongruences within the regulations related to residential versus outpatient or non-residential CTC's. In the definition of the service, the language allows for non-residential and less than 24 hour crisis services, but then throughout the remainder of the document it lists

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requirements in multiple sections related to 24 hour operations without stipulating that these requirements would only apply to residential facilities providing 24/7 operations.

Thank you so much for your consideration of these comments. Please feel free to reach out to me with questions or comments should you so desire.

A handwritten signature in blue ink that reads "S Barela". The signature is written in a cursive style with a large initial "S".

Sylvia Barela, MBA
Chief Executive Officer
Santa Fe Recovery Center



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May 25, 2018

Written Public Comment on Proposed Rule 7.30.13 NMAC

Thank you for the opportunity to provide comments on this proposed Rule governing Crisis Triage Centers. I am writing as the Chief Mental Health Officer of Hidalgo Medical Services, with primary responsibility for the operation of Tu Casa – a 24/7 facility designed to provide Social Detox services in a full spectrum facility designed to provide a continuum of care for substance abuse for the four-county area in the Southwest corner of New Mexico. We anticipate a start date in the summer of 2018, and are very interested in expanding those services to include Mental Health crises as this would fill another service gap in our rural and frontier portion of the state.

Since Tu Casa is designed for a maximum stay of 23 hours, we are grateful for the revision of the CTC legislation, and this rule to permit that level of care. However, I found many locations in the Proposed Rule where that specification is not clear, and would suggest an expansion of the language present at the beginning of Section 7.30.13.58 could be expanded to other portions of the Proposed Rule beyond 7.30.13.62. Those would include 7.30.13.63 LAUNDRY SERVICES, which includes the language “separate from the resident units” which logically would not apply to a non-residential facility. Similarly, 7.30.13.34 NUTRITION would not appear to address the nutrition needs of a facility not providing residential services. Also, 7.30.13.9 SCOPE OF SERVICES, part A defines a CTC as providing “stabilization in a residential, rather than institutional setting.” This would appear to contradict the inclusion of 7.30.13.9 B indicating “a CTC structured for less than 24-hour stays.”

Thus, we request the Department review and revise the entire Proposed Rule to eliminate language that would imply or require residential facilities in contradiction of 7.30.13.9 B (1).

A second area of concern for us has to do with what appears to be an unduly restrictive limitation on services offered in a CTC, appearing to undermine the integration of medical and behavioral health services in a single facility.

In 7.30.13.9 SCOPE OF SERVICES C(3) there is a prohibition on the provision of “medical care not related to crisis triage intervention services beyond basic medical care of first aid and CPR.” It is not clear how to reconcile this with 7.30.13.27 D (12e) which requires “prompt and adequate

medical attention for physical ailments.” This would also appear to undermine the provision of Social Detox in a facility that also provides crisis triage services. It is difficult to find a justification for this in a resource challenged rural and frontier community.

Similarly, 7.30.13.9 C(6) prohibits “ongoing outpatient behavioral health treatment,” disallowing the benefits of an integrated, ‘one-stop’ treatment facility allowing a rural community to leverage an appropriate facility to maximize access and ease of services for those with ongoing needs for treatment. Also, 7.30.13.9 D (3) would appear to prohibit the provision of any services beyond those contemplated in this rule, regardless of patient and community needs. Section 7.30.13.7 (DD) specifically excludes ongoing behavioral health services while failing to distinguish outpatient crisis stabilization services from the overwhelmingly accepted definition of outpatient services which does include ongoing treatment. The impact of this regulation would be to increase costs of treatment, and provide a barrier to access.

The overall intent of this rule seems to be to require a CTC to be a stand-alone facility that would be unable to provide continuity of care, instead requiring referrals to other facilities. Thus, we request the Department revise the rule to permit multiple licensures for a CTC facility - allowing the benefits of integrated and ongoing services in a single facility.

A third area of concern has to do with over prescription of licensure types allowed to provide particular services in a CTC.

For example, 7.30.13.7 Z “Licensed Mental Health Professional” includes providers who are primary care providers (physician, physician assistant, registered nurse) who may well have extremely limited training in the provision of behavioral health services, but excludes Licensed Professional Counselors (LMHC and LPCC) and Licensed Substance Abuse Counselors (LADAC), thus potentially suggesting both a more expensive and less than optimal staffing pattern for a CTC.

Further, 7.30.13.24 RISK ASSESSMENT includes elements that unduly restrict which staff can provide needed services. 7.30.13.24 N (1) and (2) both require a physician or advanced practice nurse to initiate or remove suicide restrictions. It is not at all clear why other independently licensed mental health professionals could not handle this, thus reducing both delays in responding to a crisis (neither of those credentials are required 24/7) and increased costs for the facility.

Also, 7.30.13.39 B requires a physician or advance practice nurse manage client transfers. This is likely to reduce timeliness and increase costs for transfers that may need to occur in the middle of the night, when an RN and Independently Licensed Mental Health Professional will be on site and capable of handling this.

We also note the lack of provision for services provided by Certified Peer Support Specialists.

Thus, we request the Department to revise the rule to permit appropriately licensed professional within CTC facilities.

A fourth area of concern has to do with administrative structures for a CTC.

To begin, 7.30.13.7 D requires that the license applicant be the legal owner of the facility. In our case, and likely other potential CTCs, the owner of the facility is a local government entity while management of the facility is entrusted to HMS as an FQHC and CMHC, while 7.30.13.7 B clearly indicates it is the administrator that is responsible to all management, control, and operation of the facility. It appears this would be the more logical applicant for licensure.

Similarly, 7.30.13.7 NN “Quality committee” appears not to contemplate that the CTC may be managed by a larger organization that already maintains (and is required to maintain) Quality Improvement committees that would, under existing regulations be responsible for Quality Improvement in the CTC. (Also, 7.30.13.7 OO appears to restrict the QI committee to improvements related to stabilization of crises, while operation of such a facility would surely require a much broader application of QI processes.)

Also, 7.30.13.21 appears to require a separate governing body for the CTC, which could result in FQHCs and other Federally funded entities from providing these services, since a separate governing body would be in violation of Federal Regulations for the administration of such entities.

Finally, 7.30.13.31 C indicates that employee records must be retained at the facility, thus potentially leading to violations of regulations governing HR records for multi-site providers of CTC service, such as HMS.

We request the Department revise the Rule to allow for multi-site and more flexible administrative structures.

Finally, we note that 7.30.13.15 D (1) appears to require a violation of 42CF Part 2 as revised in 2018.

Thank you for your consideration of these comments.

Respectfully submitted,

Neal A. Bowen, PhD



County of Bernalillo

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May 24, 2018

Mr. Christopher Burmeister
District Manager, Division of Health Improvement
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Dear Mr. Burmeister:

Thank you and the New Mexico Department of Health for this opportunity to comment on proposed new rule 7.30.13 NMAC, "Crisis Triage Centers." This letter provides comments on the proposed new rule from Bernalillo County. It is important to note at the outset that Bernalillo County is in the process of developing plans and approaches for an array of crisis services for persons with substance use and/or mental illness. Bernalillo County is currently providing and may want to provide or fund withdrawal management and/or crisis stabilization services for those with mental illness or other behavioral health needs in a variety of locations and for a variety of hours throughout the day. Bernalillo County and other counties within New Mexico need the most flexibility possible to arrange such services to meet the unique needs of residents, to make the most of available resources and facilities, and to enhance collaborative efforts underway or developing throughout the county, all to provide alternatives to hospitalization or incarceration and to assist individuals and their families to receive the help they need effectively and safely. While we applaud the State's release of draft regulatory guidance to assure the best possible care, we also request the State to consider ways to provide the flexibility Bernalillo County and other New Mexico counties need to achieve our common goals.

1. Section 7.30.13.7 – We would recommend that "organization" and "owner" be added to and defined in the definitions section of the regulations. It appears that an organization or owner is the entity that would administer the CRC and not necessarily the entity that owns a building that houses a CRC. Organizations and owners then could be hospitals, FQHCs, IHS facilities, other clinics, the State, counties or municipalities. This would clarify the regulations in terms what organizations or owners are responsible for as opposed to owners of real estate or buildings that might house an RTC.

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Julie Morgan Baca

2. Section 7.30.13.9.A. – This section refers to a crisis triage center (CTC) which are “health facilities offering youth and adult outpatient *and* residential care services.” [Emphasis added] This section also indicates the CTC provides emergency behavioral health triage, evaluation, and admission 24 hours a day, seven days a week . . . “ In other parts of this section and elsewhere in the regulation, it seems clear that a CTC could serve youth OR adults or could serve both age groups. It also seems clear and the law requires a CTC is able to provide services less than 24 hours a day and can provide outpatient and/OR residential services. It will be important to make sure all references to services and all descriptions of a CTC are consistent about these options.
3. Section 7.30.13.9.C.(1) – Section A. above indicates a CTC serves individuals on a voluntary basis. Subsection C.(1) indicates a CTC shall not accept involuntary commitments or individuals who are not voluntarily seeking treatment. While we agree with CTCs not generally providing services in a locked environment for those who are involuntarily committed, we request the State to clarify what is involuntary in this context. For example, may a person on an assisted outpatient treatment (AOT) court order who is brought to the CTC by a case manager or other provider be provided services? (7.30.13.25.F. would imply such an individual will not be considered to be involuntary for CTC purposes.) May a person who is not able to voluntarily consent be provided triage and evaluation services or recovery support or peer engagement services? May a person on a temporary hold pending appointment of a treatment guardian or pending a civil commitment order be provided care and services until he or she can be transported to another appropriate facility? It would be counterproductive to set up a situation in which a CTC may not provide immediate triage and engagement services which might help prevent an involuntary treatment order. And it would be counterproductive to have an individual required to be transported to a jail or emergency department simply because a treatment guardian is in the process of being appointed or a court order is in the process of being obtained. We urge the State to clarify what can and cannot be provided in the CTC context to prevent unnecessary transport or institutionalization, especially when the provision of triage and engagement services might actually be able to help prevent the hospitalization or incarceration we are all trying to avoid and which is likely to be less productive for meeting an individual’s care and treatment needs.
4. Section 7.30.13.9.C. (2) – This subsection indicates that a CTC “shall not provide acute medical alcohol withdrawal management.” This may be too restrictive. While we understand that these regulations seek to differentiate services provided by a CTC and services provided by an alcohol detoxification program, it is possible, even likely, that individuals entering a CTC may also need to detoxify from recent alcohol use. Perhaps this section can be clarified.
5. Section 7.30.13.9.C.(3) – This subsection indicates the CTC shall not provided medical care not related to crisis triage intervention services beyond basic medical care of first aid and CPR. While we understand and agree that medical care should only be provided by facilities equipped to do so and by practitioners licensed to do so, we want to assure that the State does not inadvertently prohibit a CTC from being co-located with a medical facility, sharing staff with such a facility, and providing medical care beyond first aid and CPR when the facility is equipped and staffed to do so, to allow medical needs identified within the CTC (e.g., high and unattended blood pressure, asthma causing immediate discomfort or difficulty breathing,

medications prescribed and needed immediately but unavailable to the individual when they arrive, medical care needed associated with a suicide attempt that is beyond first aid or CPR, etc.) to be addressed if they can be addressed safely by appropriately licensed practitioners. This would limit the need to transport an individual to a more expensive and perhaps less accessible facility such as an emergency room, where similarly trained and licensed practitioners would then have to be informed and understand the mental health or addiction issue being attended to by the CTC. At times, it is the medical issues that are causing or exacerbating the behavioral health crisis situation. We believe the State should allow appropriate medical care to be provided for the person in crisis to manage their immediate needs, and/or provide crisis-related medical care beyond first aid and CPR, so long as they are equipped and staffed to do so or can do so safely in collaboration with other practitioners or facilities. This will encourage collaborations to address the whole person and not just the immediate behavioral health crisis. Some of the attendant medical conditions may have impacts on the behavioral health condition of the individual receiving crisis stabilization and may help the individual and his/her family or caretakers understand how to prevent a crisis situation in the future.

6. Section 7.30.13.9.C.(5)¹ – This subsection requires that residential services not be provided by a CTC in excess of eight days. We respectfully request the State to increase the potential length of time for stabilization in a CTC residential setting. Stabilization often requires more than eight days and arranging for alternative settings for treatment or housing to prevent another crisis after stabilization may require additional time. While we agree that it may be appropriate to move an individual to a longer term or more intensive treatment setting if stabilization cannot be achieved in the CTC, and while we agree the CTC should not be utilized as a location for a person to “stay” simply because aggressive efforts to find treatment placements or housing have not been attempted, it would not be a good outcome for an individual to be moved to an inpatient or jail setting simply because a post-CTC treatment setting or housing situation will not be available for another day or two. It also would not be a good outcome for an individual to leave the CTC because they are required to, then have another immediate crisis situation, and be readmitted to the CTC for another eight days. While many stays will be less, we recommend the length of stay limit be extended to up to 14 days to allow more time for stabilization and more time for post-stay arrangements to be made to prevent another crisis from developing.
7. 7.30.13.9.C.(6) – This subsection would prohibit CTCs from providing ongoing outpatient behavioral health treatment. While we understand the desire to license these facilities separately, the State should not do anything that will prohibit or discourage co-location of CTCs with FQHCs, hospitals, or any other behavioral health service delivery setting. The ability for the community to be able to go to a central or common location for multiple services, and the ability of providers to co-locate to share staff or otherwise gain efficiencies will not only be good for service users but for the State funding mechanisms as well.
8. 7.30.13.9.C.(7) – This subsection indicates a CTC shall not exceed 16 short-term residential beds in a “single licensed provider.” We recognize the State is probably attempting to avoid a CTC from being considered an IMD so as to prevent services delivered therein to be precluded

¹ NOTE: The numbering in this section goes from (3) to (5) and hence is missing a subsection (4).

from billing Medicaid. However, given the State's recent waiver request to CMS, especially for residential programs for substance use disorders, and CMS' willingness to be more lenient regarding the determination of what is or is not an IMD and what is or is not precluded from billing Medicaid, we recommend the State reconsider how this subsection is written. A single provider, even a single provider at the same location, may be able to provide services at bed numbers higher than 16 in some situations. If the intent is to say that each individual CTC must not be over 16 beds (even if operated by the same provider or if located on the same parcel of land), there may be a better way to say this than as currently written. We encourage the State to consider what is the best way to indicate this limitation without precluding the flexibility needed to provide the best care options for a given community or program. We also presume this limitation can be waived for a program not interested in billing Medicaid for residential services provided. We request the State to clarify this issue.

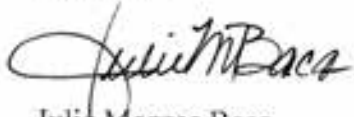
9. 7.30.13.9.D – This section needs to be revised to consider those services (such as sobering or detox services) which are currently operating and may be seen as falling into the definitions proposed in this regulation (e.g., withdrawal management). Nothing in this regulation or in its implementation should result in an existing program which has been operating safely with good outcomes for people and communities, to have to shut down because it is not in a facility or not yet ready to be licensed as a CTC. We applaud the State's contemplation of the use of variances or waivers (Subsections 7.30.13.7.ZZ. and AA.) to provide additional time or an exception to some of the requirements of this proposed regulation. However, the waiver and variance process, the criteria by which a waiver or variance request will be provided, as well as the process for appealing a denial of a waiver or variance request should be described, if not in these regulations, then in any written instructions for making such a request.
10. 7.30.13.10.G.(4) – This section describes the elements of the program description that must be provided by an applicant for a CTC license. It requires proposed 24/seven staffing plans for both residential and non-residential programs. Yet, the earlier subsection 7.30.13.9.B.(1) specifically contemplates a less than 24/seven operation for some CTCs. This subsection should be revised to reflect that programs should provide a staffing plan appropriate to its proposed hours of service.
11. 7.30.13.21 – This section concerns the governing body of the licensed CTC. To the extent a jurisdiction such as a county or city operates the CTC, the governing board requirements or duties should be able to be delegated to appropriate jurisdiction functionaries. That is, a jurisdiction's commission or council does not often approve the hiring of administrators of programs. That function is often delegated to a county or city managing official. Similarly, the evaluation of such administrator's performance is generally left to that jurisdiction's managing official. 7.30.13.22 should also recognize that these jurisdictions may not have a "governing body," but may have a jurisdiction's managing official.
12. 7.30.13.25.F – It is our understanding that some zoning requirements don't allow certain individuals on court ordered release to be in certain areas. If a CTC were to open in one of these areas they might, the, be unable to admit such a client. This may require additional research to clarify.

13. 7.30.13.25.K. – The discharge plan and process should include a “warm handoff” (usually defined as a face-to-face or at least telephonic discussion between the individual served and the provider/practitioner who will be serving that individual after release) to and with the provider who will be doing follow-up care after the individual leaves the CTC, especially for individuals served in the residential part of a CTC.
14. Staffing Requirements – Anywhere the staffing requirements include a psychiatrist or advanced nurse practitioner, a licensed psychologist – or as necessary a licensed psychologist with prescribing privileges – should be included as an option for this leadership. Similarly, in Section 7.30.13.29, staffing requirements should not have to be 24 hours a day, seven days a week for programs that offer less than those hours. Rather, staffing requirements should be for the hours the program is open and providing services. Available consultation should be able to be done not just by a psychiatrist, but by any professional licensed to provide such consultation. Workforce is a big issue, so flexibility to utilize any appropriate professionally licensed person should be provided to the extent practicable. Similarly, an RN should be required to be either present or on-call within a reasonable period of time, depending on the program’s hours and the needs of the individuals being seen. Finally, appropriately trained and certified peer workers should be required to be part of the staffing available for individuals served and their families as needed. RN present should be reflected in hours of operation that are not 24/7 in 7.340.13.29 also and throughout the regulations. Lastly, CTC’s should be able to employ not-fully-licensed individuals who have completed their course work and are performing their internship as required to become licensed as long as these individuals are working under the authority of a fully-licensed proctor/practitioner.
15. 7.30.13.32 – Staff training should include training regarding recovery supports and the value of peer-delivered services for persons recovering from addiction or experiencing mental illness. Training should also include information about available services in the local area served by the CTC.
16. 7.30.13.34 – This subsection should be clarified to apply only to residential programs or to be specific to food provided on a short-term basis for persons at a facility less than 24 hours.
17. 7.30.13.40 – This subsection should be revised to indicate CTCs shall provide crisis stabilization and admissions for the hours it is licensed to provide services. If the facility operates less than 24 hours a day, seven days a week, the State may want to require the posted signage about hours to indicate where or how an individual may receive emergency or crisis services when the CTC is closed. For example, a mobile crisis team number or NMCAL number might be posted along with information about when the CTC is open.
18. Facility Requirements – All facility requirements should be reviewed to assure facilities are only required to have those areas and aspects truly necessary for its hours of operation and its services (e.g., non-residential versus residential). While some parts of the regulations are indicated as specific to residential programs, others appear to apply to all CTCs and may not be necessary for all models. If the State intends to handle this by waiver or variance, it should indicate this specifically. Nothing in these regulations should preclude the use of Living Room or other peer-delivered service models that may be more home-like in nature.

19. It should be made clear what current similar programs operating in the state would not be governed by these regulations (for example: appropriately un-licensed detox and public inebriate programs).

Again, thank you for the opportunity to comment. Please let us know if you have any questions.

Sincerely,

A handwritten signature in black ink, appearing to read "Julio Morgas Baca". The signature is fluid and cursive, with the first name being the most prominent.

Julio Morgas Baca
Bernalillo County Manager

cc: Greg Perez, Director of Public Safety
Katrina Hotrum-Lopez, Behavioral Health Director