North Sound Mental Health Administration

Regional Support Network for Island, San Juan, Skagit, Snohomish, and Whatcom Counties

Improving the mental health and well being of individuals and families in our communities

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NSMHA Contract Memorandum 2014-003

Date: March 28, 2014

To: Tom Sebastian, Compass Health
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Dean Wight, Whatcom Counseling and Psychiatric Center
Kathy McNaughton, Catholic Community Services Northwest
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Ken Stark, Snohomish County Human Services Director
Phil Smith, Volunteers of America
Cindy Paffumi, Interfaith
Sue Closser, Sunrise Services
Mitch Lykins, Pioneer Human Services

From: Joe Valentine, Executive Director

Subject: Revised Policies

Policy 1550.00 – Early Periodic Screening and Diagnostic Treatment (EPSDT)
This policy has been through the complete review and approval process. The Executive Director signed and approved this policy March 28, 2013.

Policy 1704.00 – Crisis Services – General Policy
This policy has been through the complete review and approval process. The Executive Director signed and approved this policy March 28, 2013.

Policy 1720.00 – Administration of the ITA
This policy has been through the complete review and approval process. The Executive Director signed and approved this policy March 28, 2013.

Policy 1725.00 – Mobile Outreach Team (MOT)
This policy has been through the complete review and approval process. The Executive Director signed and approved this policy March 28, 2013.

Full implementation of these policies should occur no later than 60 days after this memo.

cc: Cindy Ferraro, Bridgeways
Heather Fennell, Compass Health
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Contract File

Effective Date: 3/28/2014; 10/4/2010; 6/17/2010; 11/29/2005, 7/3/2007
Revised Date: 12/16/2013
Review Date: 3/26/2014

North Sound Mental Health Administration

Section 1500 – Clinical: Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services

Authorizing Source: DSHS Contract;
Cancels:
See Also:
Providers must have a policy "consistent with" this policy — Approved by: Executive Director — Date:
Responsible Staff:: Deputy Director — Signature:

POLICY #1550.00

SUBJECT: EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) SERVICES

PURPOSE

To ensure the North Sound Mental Health Administration (NSMHA) providers assess and provide appropriate levels of mental health services to individuals referred through the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program and to ensure ongoing coordination of care.

DEFINITIONS

EPSDT Program is a preventive health care benefit for individuals with Medicaid under 21 years of age. The program is intended to identify, through periodic screening, any existing physical and/or mental health issues and ensure appropriate referrals and treatment for identified issues. In the context of the NSMHA system, individuals are identified as being in the EPSDT Program when they have been referred to a NSMHA Provider by a Primary Care Provider (PCP).).

Primary Care Provider (PCP) is defined as the following providers eligible to perform EPSDT screens:

A. EPSDT clinics;
B. Physicians;
C. Naturopathic Physicians;
D. Advanced registered nurse practitioners (ARNPs);
E. Physician Assistants (PAs) working under the guidance and MAA provider number of a physician;
F. Registered nurses working under the guidance of a physician or ARNP may also preform EPSDT screenings. However, only physicians, PA's and ARNP's can diagnose and treat problems found in screenings.

EPSDT Referral – NSMHA considers the following an EPSDT referral:

A. Written referral in any format from the PCP
B. Verbal referral directly from the PCP
C. Verbal referral by the PCP as reported by the consumer

POLICY

NSMHA believes the early screening and detection of mental health issues in individuals and coordination of care with health care providers are core components of quality mental health services. Mental health services will be provided following the requirements of the EPSDT Program.

The individual's PCP performs the EPSDT screening, which includes a full physical examination at an interval prescribed by the treating PCP but not to exceed two years. The examination may result in referral to mental health services.

EPSDT service must be structured in ways that are culturally and age appropriate, involve the family and/or caregiver and include a full assessment of the family's needs.

PROCEDURE

NSMHA Providers are responsible for:

A. Responding to EPSDT referrals that originate from PCPs. The referral may be a written referral in any format or verbal referral from the PCP office or consumer.

   i. When mental health services are requested with an EPSDT referral, a written response must be provided to the Physician, ARNP, Physician Assistant, trained public health nurse or RN who made the EPSDT referral. This notice must include at least the date of intake and the diagnosis.
   ii. Contacting the individual/guardian within 10 working days of all EPSDT referrals to confirm if services are being requested by the individual/guardian. Documentation of this effort shall be maintained for one year after the completion of the contract period, to confirm if the individual/guardian requests, declines or does not respond to efforts within 10 working days.
   iii. In the event an enrollee's referral to mental health services **did not** originate from a PCP, the individual is not considered an EPSDT referral.

B. Assisting individuals/families, who do not have a PCP, in locating and connecting with a PCP. The following information may be used to assist the individual in locating a provider.

   Toll Free Number: 1-800-562-3022
   Web site: http://hrsa.dshs.wa.gov/applehealth

C. Developing, in coordination with the individual/family, other health care providers, and related allied systems, a Recovery and Resiliency Plan (RRP; aka Individual Service Plan) that addresses the individual/family's needs per NSMHA policies on RRPs and coordination of care (NSMHA Policies 1517, 1546, 1551, etc.).

   i. The RRP must contain clarification of roles and responsibilities of all health care providers involved in serving the youth.
   ii. In the event the other health care providers and/or allied systems choose not to jointly create a coordination plan, the NSMHA provider must develop a plan that addresses how they will interact with the other external providers in order to address the individual/family needs.

Through routine review of NSMHA provider records, NSMHA will ensure providers have:

A. Responded to EPSDT referrals.
B. Assisted in locating and connecting to a PCP.
C. Coordinated development of RRPs.

ATTACHMENTS

None

Effective Date: 3/28/2014; 8/28/2009; 5/30/2007; 11/29/2005
Revised Date: 11/26/2013
Review Date: 11/26/2013

North Sound Mental Health Administration

Section 1700 – Crisis Services – General Policy

Authorizing Source: WAC 388-877A-0200, 0230, 0240 and 0260; NSMHA/ICRS Management agreement
Cancels:
See Also:
Providers contracted for Crisis Services must have a "policy consistent with" NSMHA policy
Responsible Staff: Deputy Director Approved by: Executive Director Date:

Signature:

POLICY #1704.00

SUBJECT: CRISIS SERVICES – GENERAL POLICY

PURPOSE

To provide an integrated, coordinated and seamless crisis response system for the North Sound Mental Health Administration (NSMHA) and its member counties: Island, San Juan, Skagit, Snohomish and Whatcom ("NSMHA Service Area").

POLICY

Crisis Services are an integrated system of voluntary and involuntary short-term emergency mental health services provided by professional crisis responders, available 24-hours a day/7 days a week to anyone in the North Sound Region by calling 1-800-584-3578. Crisis Services are aimed at resolving crises rapidly using the least restrictive setting that assures individual, family/natural supports, staff and public safety.

PROCEDURE

I. NSMHA intends Integrated Crisis Response Services (ICRS) will be delivered in accordance with WAC 388-877A-0200, 0240, NSMHA contract, and the following Substance Abuse and Mental Health Administration (SAMHSA) principles:

   a. ICRS will deliver timely access to supports and services throughout NSMHA/PHP for children and adults
   b. ICRS will have the capacity to provide outreach when an individual cannot come to a traditional service site
   c. A crisis is self-defined or a situation where an individual is acutely mentally ill, or experiencing serious disruption in cognitive, volitional, psychological, and/or neurophysiologic functioning
   d. Individuals experiencing a psychiatric crisis will be stabilized in the least restrictive manner and setting, preserving the individual's connectedness to his or her world
   e. Adequate time will be spent with the individual and families to assist in resolution of the crisis
   f. ICRS will develop strength based plans with the individual and natural supports in resolution of the crisis
   g. Interventions will consider the whole context of the individual's plan of services
   h. ICRS services will be performed in a culturally competent manner.
   i. Rights are respected
   j. ICRS services are trauma informed
   k. Helping the individual regain a sense of control is a priority
   l. When peer support is available (directly or via referral), offering opportunity for contact with others whose personal experiences with mental health crisis allow an ability to convey a sense of hopefulness

m. ICRS will be prepared to refer to a variety of services and supports.
n. Delivery of services will be seamless and consistent throughout the region.
o. Recognition that recurring crises are signaling problems in assessment, engagement, or care
p. Meaningful measures will be taken to reduce the likelihood of future crises

II. Any individual is eligible for ICRS who is currently located in NSMHA Service Area, regardless of age, county of residence, enrollment status with another RSN, funding source, and/or ability to pay.

III. ICRS SERVICE COMPONENTS-Crisis response services include both voluntary and involuntary options and are available 24 hours a day/7 days a week. These services are provided by the various members of ICRS, in coordination with the outpatient mental health providers to ensure continuity of care. An array of services available based on medical necessity is provided with the goal of serving the individual in the least restrictive environment possible to effectively and safely resolve the crisis.

a. Twenty-four hour telephone triage support.
b. During business hours, enrolled individuals' needs shall be addressed initially by primary treaters and supported, as needed, by emergency outreach and stabilization services.
c. Investigation for Involuntary Detention for mental disorders.
d. Outreach Services.
e. Peer Support Services.
f. 24-hour/7 day a week Access to Crisis Plans.
g. Emergency Walk-In Services during business hours.
h. Urgent Appointments.
i. Follow Up Contact.
j. Coordination and consultation with other service providers.
k. Coordination with Family and Other Natural Supports.
l. Crisis Triage and Stabilization (for adults only).
m. Referrals to Psychiatric and Emergency Medical Services.
n. Cross-System Coordination.
o. Cross-RSN Coordination.
p. Interpreter Services.
q. Protocol for referrals of an individual to a voluntary or involuntary treatment facility.
r. Protocol for arrangements for transportation to a voluntary or involuntary inpatient treatment facility.

IV. NSMHA shall maintain and staff the ICRS Committee in accordance with NSMHA Quality Management Oversight Committee charter. This committee shall consist of ICRS management staff from county-specific mental health crisis response, community mental health systems, NSMHA and Volunteers of America (VOA). Additional representatives from other service systems and agencies may be invited to participate in this committee on an as needed basis.

V. The Regional ICRS Committee is responsible for establishing policies and procedures, including a documentation protocol that will be used by Contractors to ensure documentation of referral information, as well as information detailing the services provided, to include transportation arrangements, and the outcome of the intervention.

VI. Voluntary Crisis Services and ITA Services are provided in accordance with federal and state laws including the 1915(b) waiver, state administrative codes, Division of Behavioral Health and Recovery (DBHR) Contracts, NSMHA Contracts, attachments and policies established by the Regional ICRS Management Team.

ATTACHMENTS

None

Effective Date: 3/28/2014; 7/14/2010; 8/30/2007
Revised Date: 1/6/14
Reviewed Date: 3/27/2014

North Sound Mental Health Administration

Section 1700 – ICRS: Administration of the Involuntary Treatment Program

Authorizing Source: NSMHA contract, DMHP protocols, WAC 388-877-02,200 through280, (except 230) ; RCW 71.05, 71.34, 10.77
Cancels:
See Also: Approved by: Executive Director Date:
Provider must have a "policy consistent with NSMHA policies"
Responsible Staff: Deputy Director Signature:

POLICY #1720.00

SUBJECT: ADMINISTRATION OF THE INVOLUNTARY TREATMENT PROGRAM

PURPOSE

The purpose of this policy is to ensure that Involuntary Treatment Services are provided by Designated Mental Health Professionals (DMHP) to evaluate an individual in crisis and determine if involuntary services are required.

POLICY

North Sound Mental Health Administration (NSMHA) or its member counties will designate DMHPs to perform the duties of involuntary investigation and detention in accordance with the requirements of RCW Chapters 71.05, 71.34, current Washington Administrative Codes(WAC), and current DMHP protocols (see website at: www.dshs.wa.gov/dbhr/mhcdmhp.shtml). This will be done in consultation between the Integrated Crisis Response Services (ICRS) Service Providers, the counties and NSMHA.

RCW 71.05 provides for persons suffering from mental disorders to be involuntarily committed for treatment and sets forth that procedures and services be integrated with Chapter 71.24 RCW.

RCW 71.34 establishes mental health services for minors, protects minors against needless hospitalization, enables treatment decisions to be made with sound professional judgment and ensures minors' parents/guardians are given an opportunity to participate in treatment decisions

PROCEDURE

Definitions

DMHP means a mental health professional designated by the county or other authority authorized in rule to perform the duties specified in these chapters.

"**Detention**" or "**Detain**" means the lawful confinement of a person, under the provisions of these chapters.

1. NSMHA will have agreements in place with ICRS Service Providers, Snohomish, Skagit, Island Whatcom and San Juan Counties to provide services in accordance with the designation noted above.
2. Mental Health Professionals designated to perform these duties will have the necessary training to perform these duties.
3. NSMHA will monitor this designation practice through the auditing process.

ATTACHMENTS

None

Effective Date: 3/28/2014; 4/23/2012; 11/29/2011
Revised Date: 2/23/14
Review Date: 2/23/14

North Sound Mental Health Administration

Section 1700 – Crisis Services – Mobile Outreach Team (MOT)

Authorizing Source: NSMHA contract, WACs 388-877A-0200 through270
Cancels:
See Also: Approved by: Executive Director Date:
Providers must "comply with" this policy
Responsible Staff: Deputy Director Signature:

POLICY #1725.00

SUBJECT: MOBILE OUTREACH TEAM (MOT)

PURPOSE

To define the role of MOT which is intended to provide more outreach to individuals in the community to prevent mental health crises, as well as, prevent unnecessary emergency department admissions and inpatient psychiatric hospitalizations.

POLICY

The MOT program is part of an integrated, coordinated and seamless crisis response system for the North Sound Mental Health Administration (NSMHA) and its member counties: Island, San Juan, Skagit, Snohomish and Whatcom ("NSMHA Service Area"). These teams are established in Skagit and Whatcom counties.

The program is intended to provide early intervention to assess, engage, provide temporary support and make appropriate referrals to community resources for individuals who are not currently enrolled in the outpatient public mental health system. The MOTs shall respond to non-emergent mental health situations (i.e., the severity and/or acuity of the individual's behavior/situation does not meet criteria for either emergency services or an involuntary treatment investigation). Non-emergent mental health situations are defined as those situations where the level of stress has overwhelmed the individual's ability to cope and earlier support/intervention may alleviate the effects of the stressful situation.

The MOTs are intended to prevent crises so that:

I. People are stable and safe living in the community;
II. People do not have to go to emergency departments to prevent crises;
III. The number of people needing admission into inpatient psychiatric services can be reduced.

These teams shall respond to direct calls from the community and calls dispatched by the Volunteers of America (VOA) Care Crisis Line. These teams will coordinate as necessary with existing Emergency Services and Involuntary Treatment Investigation Services. As indicated above, these teams are not intended to respond to emergent mental health crises.

PROCEDURES

I. MOT Responsibilities:

Each team will:

A. Provide community outreach as defined below;
B. Be comprised of two members, a Mental Health Professional and peer counselor;
C. Be available Monday through Friday between the hours of 1 pm to 9 pm;
D. Be stationed at their assigned place of work when not out in the community;

E. Take referrals from calls to the Care Crisis Line and direct access calls from the community;
F. Respond to pages from VOA Care Crisis within 10 minutes;
G. Respond to calls dispatched by VOA as rapidly as possible, complete a safety screen, when able, with VOA Care Crisis (see ICRS policy 1702.00) and attempt to make phone or face-to-face contact with the individual or concerned caller by the next business day. Attempts to contact the individual or concerned caller should be documented by the MOT;
H. Utilize family, community and other natural supports to support the recovery plan;
I. Provide stabilization services that can last up to 4 hours (average per contact), and provide up to 10 hours (average), per individual, of direct services within a 30 day time period;
J. Integrate services with existing Emergency Services system and involved treatment providers as appropriate; and
K. Report these services into the Mental Health Consumer Information System as Crisis Services.

II. MOT Community Outreach expectations:

At a minimum, 75% of MOT services will be provided in the home and in community settings.

Community outreach is considered to be at the person's home, place of work, school, community centers, or other community setting (e.g., restaurant). It does not include hospitals, Emergency Departments, or Community Mental Health Agency (CMHA) offices. Teams will:

A. Assess the situation.
B. Provide support to the individual and other involved parties.
C. Work to engage the individual and/or stabilize the situation.
D. Develop a recovery-oriented stabilization/disposition plan with the individual and available supports.
E. Make referrals and connect individuals to appropriate resources.

   Transition resources can include crisis triage centers, coordination with existing Community Mental Health providers and other service providers.

F. Provide coordination of care with care providers.
G. Contacting VOA Care Crisis Line to ascertain any available information and/or to request a WATCH. VOA Care Crisis Line will open an episode as a consult to document this activity.
H. Contact VOA Care Crisis with a stabilization/disposition plan upon completion of the initial contact.
I. Provide necessary follow up to the family or other identified caregivers and supports to include phone calls and outreach.
J. Follow-up to facilitate engagement into services.

ATTACHMENTS

None