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NSMHA Contract Memorandum 2016-002

Date: February 1, 2016

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Donna Konicki, Bridgeways
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Claudia D'Allegri, Sea Mar
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Phil Smith, Volunteers of America
Randy Polidan, Interfaith
Sue Closser, Sunrise Services
Robert Sullivan, Pioneer Human Services
Beratta Gomillion, Center for Human Services

From: Joe Valentine, Executive Director

Subject: Revised policies

***Policy 1707.00 – Crisis System Clinical Dispute Resolution***
This policy has been through the complete review and approval process. The Executive Director signed and approved this policy March 7, 2016.

***Policy 1717.00 – Urgent Contacts & Follow-Up Services***
This policy has been through the complete review and approval process. The Executive Director signed and approved this policy March 7, 2016.

***Policy 1719.00 – Utilization of Crisis Stabilization/Triage Beds for Hospital Discharge Planning***
This policy has been through the complete review and approval process. The Executive Director signed and approved this policy March 7, 2016.

***Policy 1723.00 – Outreach and Involuntary Investigations for Residents of Licensed Residential Care Facilities***
This policy has been through the complete review and approval process. The Executive Director signed and approved this policy March 7, 2016.

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

cc: Cindy Ferraro, Bridgeways
Heather Fennell, Compass Health
Kay Burbidge, Lake Whatcom RTC
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Contract File

Effective Date: 8/27/2012; 1/28/2008; 11/29/2005
Revised Date: 1/28/2016
Review Date: 1/28/2016

# North Sound Behavioral Health Organization

Section 1700 – Crisis Services: Crisis System Clinical Dispute Resolution

Authorizing Source: Per North Sound Behavioral Health Organization and ICRS Management
Cancels: Policy 1507.00
See Also:
Providers must comply with this policy and may develop individualized implementation guidelines as needed
Responsible Staff: Deputy Director

Approved by: Executive Director
Date: 3/7/2016
Signature:

**POLICY #1707.00**

**SUBJECT: CRISIS SYSTEM CLINICAL DISPUTE RESOLUTION**

## PURPOSE

To clarify what happens in the event of professional clinical disagreements in the mental health crisis system and to outline the process by which decisions will be made and disputes resolved.

## DEFINITIONS

**Inter-System Disputes** – Disagreements between Integrated Crisis Response System (ICRS) providers and other service or system providers; other service or system providers may include, but not be limited to: outpatient mental health providers, hospital or medical providers, residential providers, chemical dependency providers, criminal justice system, developmental disabilities system, etc.

**Intra-System Disputes** – Disagreements between ICRS providers; ICRS includes any agency contracted with North Sound Behavioral Health Organization (BHO) to provide emergency crisis services. This includes Volunteers of America Care Crisis Response Services (VOA CCRS), Compass Health*, Snohomish County Human Services*, Pioneer Human Services*, TELECARE.

*****ICRS providers include Designated Mental Health Professionals (DMHPs), Emergency Mental Health Clinicians (EMHCs), Triage Facility staff, Chemical Dependency Professionals (CDP), Certified Peer Counselors (CPC) and Evaluation and Treatment (E&T) Staff (not all agencies identified have all types of ICRS providers).

## POLICY

It is recognized that when concerned, conscientious providers from different systems and perspectives interact with the same individual in crisis, differences of opinion as to what constitutes the best care for the individual will inevitably occur.

The goal of this protocol is to provide rapid and timely resolution of disputes and the ability to use this information to improve services and community relations. The intention is to resolve conflict at the lowest level possible.

During the crisis episode, the emphasis will be on providing the best service possible to the individual. Services will be provided with the minimum amount of delay and will be according to the individual's wishes when possible or with their input before the decision is made.

Complaints by individuals, family members or complaints on behalf of individuals by family members or others will be handled through the Snohomish County Human Services, Behavioral Health Agencies (BHA) and/or North Sound BHO complaint and grievance process and not under this policy. ICRS providers shall ensure involved parties are made aware of the availability of these processes they will apply. These individual complaints/grievances will be handled as expeditiously as the individual's condition requires, which may necessitate an expedited process (See North Sound BHO Policy #1001 for further information related to individual complaint and grievance processes).

**PROCEDURE**

A. INTER-SYSTEM DISPUTES (between ICRS providers and other service or system providers)

1. When involved, the CCRS Triage Clinician mediates conflicts between other service or system providers and ICRS providers and informs those parties of the next day follow up procedure. In the event the dispute cannot be resolved at the time, the following shall occur:

   The CCRS Program Manager will follow up on the next working day and inform the appropriate Crisis Services Manager or their designee of the situation.

2. When an issue comes to the attention of Crisis Services Managers, they will contact the other service or system provider by the next working day. If notification of the issue did not come from VOA CCRS, the Crisis Services Manager may inform the CCRS Program Manager of the issue.
3. If the dispute cannot be resolved, information may be brought to a case review. Venues for this case review can include staff meetings, local oversight committees and the Regional ICRS Committee. All relevant information will be gathered and reviewed to determine if the dispute arose from a systems issue, problem with customer service, extraordinary occurrence, training issue, or other reason. When the reason for the dispute is ascertained, appropriate measures will be taken to address the cause.
4. Disputes will be reported to the Regional ICRS Committee for monitoring and quality improvement purposes.

B. INTRA-SYSTEM DISPUTES (between ICRS providers)

1. When clinical disputes arise between ICRS providers, the CCRS Triage Clinician will have the final determination as to what service will be provided at that time.
2. Information on the incident will be brought to the appropriate ICRS Program Managers the next business day. Managers will connect and come to a resolution informally whenever possible.
3. Managers may also bring the incident to staff meetings, local crisis oversight committees and/or the Regional ICRS Committee for review, discussion and resolution. If the dispute cannot be resolved, information may be brought to a case review, as noted in A(3).

C. Issues related to system functioning/resolution of disputes will be shared with the Regional ICRS Committee and, if needed, at the North Sound BHO Quality Management Oversight Committee (QMOC).

**ATTACHMENTS**

None

Effective Date: 1/25/2013; 11/8/2007; 6/25/2004
Revised Date: 2/25/2016
Review Date: 2/25/2016

# North Sound Behavioral Health Organization

Section 1700 – ICRS: Urgent Contacts & Follow-Up Services

Authorizing Source: WACs 388-877A-0230, 0240, 0260, and 0270 and Contract
Cancels: Policy 1514.00
See Also:
Providers must comply with this policy and individualized implementation guidelines may be developed as needed
Responsible Staff: Deputy Director

Approved by: Executive Director
Signature:

Date: 3/7/2016

**POLICY #1717.00**

**SUBJECT: ICRS – URGENT CONTACTS & FOLLOW-UP SERVICES**

## PURPOSE

To define urgent and follow up individual contacts and services within the Integrated Crisis Response Services (ICRS) system; to clarify the process for triaging and providing individuals with urgent contacts and follow-up services when indicated.

## POLICY

For individuals calling Volunteers of America (VOA) Care Crisis Response Services (CCRS) in crisis, CCRS Clinicians determine the urgency of the caller's crisis and initiate the crisis services contact with North Sound Behavioral Health Organization (BHO) providers. There are three (3) levels of face-to-face responses available in the ICRS system:

A. Emergent Contact: Calls in this category require a response within two (2) hours of the dispatch of outreach staff by the VOA CCRS Clinician (see North Sound BHO Policy 1702, ICRS Outreach Screening, Crisis Line Pre- and Post-Dispatch, for additional policy and procedures related to Emergent contacts).
B. Urgent Contact: Calls in this category shall provide individuals in crisis with timely access to face-to-face mental health evaluation/intervention services when needed, to prevent the individual's situation from deteriorating to the point that Emergent care is necessary. These calls require a response by the North Sound BHO provider within 24 hours of the VOA CCRS Clinician's notification.
C. Follow-up Services: Follow-up appointments are offered when the caller does not require "Emergent" or "Urgent" intervention but there is an indication that without prompt assessment/intervention further decompensation is likely. This appointment may be initiated at the request of the VOA CCRS Clinician or by any other Clinician within the ICRS system. Follow-up services may also be offered to non-enrolled individuals needing follow-up contact while awaiting transition into ongoing care.

## PROCEDURES

### A. Urgent Contacts

1. Individuals with an open outpatient episode:

   a) During typical business hours, individuals who are currently enrolled with a North Sound Behavioral Health Agency (BHA) shall be seen, whenever possible, by their Behavioral Health Care Provider (BHCP)/team. If the BHCP is unavailable, the program supervisor will be contacted to determine if another member of the treatment team can see the individual. In those rare circumstances where support through the treatment team is unavailable, ICRS staff may be dispatched by VOA CCRS Clinician.
   b) When the BHCP will be unavailable to the VOA CCRS Clinician within 24 hours of the identified need for contact (e.g., the need is identified on a Friday evening), the ICRS staff shall be contacted, briefed and requested to respond via face-to-face intervention within 24 hours.

2. Individuals without an open outpatient episode:

    a) Designated ICRS Providers shall maintain a Monday through Friday schedule of available appointment times and shall make this schedule available to VOA CCRS Clinicians.
    b) VOA CCRS Clinicians shall schedule an available Urgent Appointment for callers, within 24 hours of the call to VOA.
    c) VOA CCRS Clinicians shall notify the BHA as soon as possible regarding the scheduled contact and shall provide summarized clinical information in a standard format.
    d) When an appointment is not available within 24 hours (e.g., the need is identified on a Friday evening), the ICRS staff shall be contacted, briefed and requested to respond via face-to-face intervention within 24 hours. Disposition will follow the ICRS process.

**B. <u>Follow-Up Services</u>**

1. Individuals with an open outpatient episode:

    a) Follow-up services for these individuals shall be provided by the BHCP or another member of the clinical team. ICRS is not responsible for providing follow-up services to enrolled individuals.
    b) The VOA CCRS Clinician or Emergency Services (ES) staff referring an enrolled individual for follow-up services shall notify the BHA as soon as possible and shall provide summarized information in a standard format.

2. Individuals without an open outpatient episode:

    a) VOA CCRS Clinicians shall notify the Designated ICRS providers regarding the referral and shall provide summarized clinical information in a standard format. Disposition will follow the ICRS process.

        During this period of ICRS emergency follow-up services, ES staff shall communicate directly with the individual regarding scheduling appointments, etc., as needed.

    b) ES staff is responsible for providing clinically necessary follow-up services to non-enrolled individuals in crisis when needed, until the crisis is stabilized and/or until the referral to ongoing services is complete.

**ATTACHMENTS**

None

Effective Date: 9/30/2014; 9/9/11; 11/8/2007
Revised Date: 2/25/2016
Reviewed Date: 2/25/2016

# North Sound Behavioral Health Organization

Section 1700 – ICRS: Utilization of Crisis Stabilization/Triage Beds for Hospital Discharge Planning

Authorizing Source: WAC 388-865-0800 through 0880, WAC 388-877A-0260
Cancels:
See Also:
Providers must comply with this policy and may develop individualized implementation guidelines as needed
Approved by: Executive Director
Date: 3/7/2016
Responsible Staff: Deputy Director
Signature:

**POLICY #1719.00**

**SUBJECT: UTILIZATION OF CRISIS STABILIZATION/TRIAGE BEDS FOR HOSPITAL DISCHARGE PLANNING**

## PURPOSE

To identify a coordinated discharge procedure between hospitals and contracted community crisis stabilization/triage programs in the North Sound Behavioral Health Organization (BHO) region to ensure rapid and safe discharges from hospitals to less restrictive options.

## POLICY

Crisis stabilization/triage beds will be utilized to provide a temporary step-down placement for those individuals who are anticipating discharge from the hospital setting but continue to need stabilization services prior to their return to community living. The intent of this service is to improve the transition for the individual into the community, reducing the risk for re-hospitalization.

Priority will be given to those individuals who are ready for discharge from Western State Hospital (WSH). The use of the stabilization program is also available to the Evaluation and Treatment (E&T) Centers and community hospitals on a case-by-case basis.

Crisis stabilization/triage programs do not need to reserve beds for people potentially being discharged from hospitals. However, use of these beds as an aid to transitioning people out of inpatient care is an important function for these programs. Crisis stabilization/triage staff shall work collaboratively with WSH Liaisons and E&T/community hospital discharge planners to coordinate rapid discharge from inpatient facilities.

The preference is to provide crisis stabilization/triage bed placement for individuals living in the county where the crisis stabilization/triage program is located, but consideration will be given to individuals from other counties in the North Sound BHO region requiring crisis stabilization/triage bed placement who meet the other conditions outlined in this policy. Exceptions to the use of the beds will be considered on a case-by-case basis, after review by the Crisis Stabilization/Triage Program Manager or designee.

## PROCEDURE

### I. Admission Criteria:

A. WSH Liaisons and E&T/community hospital personnel will complete comprehensive discharge planning prior to contacting the crisis stabilization/triage program in the individual's county of residence.

1. The discharge plan will include a housing plan, which addresses proposed living arrangements and the funding arrangements for the proposed housing and ongoing living costs.

2. The discharge plan will address relapse prevention/intervention strategies including assessment of Less Restrictive/Assisted Outpatient Treatment/Conditional Release (LR/AOT/CR) needs and hospital readmission protocol for the individual.

B. The individual must have a source of funding that addresses basic needs including the ability to obtain any prescribed medications and other medical equipment.
C. The individual must have an open outpatient episode or a scheduled assessment for outpatient services with a North Sound BHO contracted provider within seven (7) calendar days of inpatient discharge, prior to their admission to crisis stabilization/triage beds for step-down from a hospital.
D. WSH Liaisons and E&T/community hospital personnel will coordinate with the Crisis Stabilization/Triage Program Manager or designee to address the needs of the individual and the rationale for the use of the crisis stabilization/triage bed.
E. Crisis stabilization/triage admissions will meet the inclusionary criteria defined in North Sound BHO Policy #1701.
F. Crisis stabilization triage bed placements after discharge from an inpatient setting are a transitional placement. Crisis stabilization triage beds used for the purpose of step-down from inpatient will initially be given up to five (5) calendar days. Anything beyond five (5) calendar days is considered an extension, which shall be utilized only on a very limited basis.

1. Crisis stabilization/triage staff shall maintain a log of all extensions.

   The log must include the name of the individual, the dates of admission, extension and discharge, and the name of the crisis stabilization/triage staff making the determination to extend the stay.

2. The clinical justification for any extensions must be documented in the crisis stabilization/triage facility clinical record.
3. Crisis stabilization/triage facilities shall provide a monthly report and/or log of extensions to North Sound BHO. North Sound BHO shall perform periodic utilization reviews on those individuals requiring extensions to ensure that extensions for crisis stabilization beds used as step down from inpatient are being used when clinically appropriate.

**II. Exclusionary Criteria:**

A. Individuals who appear to have housing needs that are expected to exceed 14 calendar days to resolve would not be considered for this program.
B. Exclusionary criteria, as defined in North Sound BHO Policy #1701, apply in this policy.

**III. Stabilization/Triage Services:**

Individuals in this program shall receive all services defined in North Sound BHO Policy 1701.

**ATTACHMENTS**

None

Effective Date: 4/30/2012
Revised Date: 2/25/2016
Reviewed Date: 2/25/2016

# North Sound Behavioral Health Organization

Section 1700 – ICRS: Outreach and Involuntary Investigations for Residents of Licensed Residential Care Facilities

Authorizing Source: 2 CFR 488.3 Subpart A; RCWs 18.20.185; 18.51.190; 70.129.110; 74.39A.060; 74.42.450(7)4; and 71.05, WACs 388-877 0240, 0260, 0270 and 0280; North Sound Behavioral Health Organization ICRS

Cancels:

See Also:

ICRS providers must comply with this policy and individualized implementation guidelines may be developed as needed

Approved by: Executive Director

Date: 3/7/2016

Responsible Staff: Deputy Director

Signature:

**POLICY #1723.00**

**SUBJECT: OUTREACH AND INVOLUNTARY INVESTIGATIONS FOR RESIDENTS OF LICENSED RESIDENTIAL CARE FACILITIES**

## PURPOSE

The purpose of this policy is to ensure that Emergency Mental Health Clinicians (EMHC)/Designated Mental Health Professionals (DMHP) performing crisis outreach or involuntary investigations to residents of licensed residential care facilities coordinate care with these facilities and exhaust less restrictive (LR) options available to the residents. Additionally, this policy offers procedural guidance to the EMHC/DMHP if an individual from a licensed residential facility is evaluated at an Emergency Department (ED).

## POLICY

The public mental health system is committed to supporting individuals in the most independent living situation that meets their needs. Crisis outreach mental health services should be requested by licensed residential care facilities early in a crisis, to prevent risk of discharge from the facility or referral to an ED. Licensed residential care facilities include adult family homes (AFH), boarding homes and nursing homes.

If there is evidence that an individual is experiencing a mental health concern and may pose a danger to self, others, or is gravely disabled, the EMHC/DMHP will attempt to coordinate with the care facilities to assess whether the facility can safely be a less restrictive alternative (LRA) to hospitalization, whether the needs of the resident can be met and if the safety of other residents can be protected through reasonable changes in the facility's practices or the provision of additional services.

## PROCEDURE

I. Licensed residential care facilities should contact Care Crisis Response Services (CCRS) Triage Clinicians by calling Volunteers of America (VOA) Care Crisis Line at 1-800-747-8654. The CCRS Triage Clinician will conduct a preliminary nursing home screening with the Nursing Home Screening tool (available at: http://nsmha.org/Forms/index.asp), prior to CCRS consulting with or dispatching the EMHC/DMHP.

II. The preliminary screening will assist the Triage Clinician with dispatch information for the crisis outreach worker or in making recommendations to the licensed care facility regarding available resources and supports that are an appropriate alternative to dispatching the crisis outreach worker.

III. The following considerations will assist the EMHC/DMHP in the coordination and assessment of the resident's needs:

A. Whenever possible, the EMHC/DMHP shall evaluate the individual at the licensed residential care facility rather than an ED so that situational, staffing and other factors can be observed. If the individual is referred to the ED from a licensed care facility, the EMHC/DMHP will review the information provided to determine if LR options have been exhausted at the licensed care facility and made the appropriate referrals needed.
B. The EMHC/DMHP should confer with and obtain information from the facility on the reason for the referral, the level of safety threat to residents and alternatives that may have been considered to maintain the individual at the facility. When appropriate, available and consistent with confidentiality provisions, the EMHC/DMHP should also obtain information from a variety of sources such as: the resident, family members of the resident, guardians, facility staff, attending physician, the resident's file, the resident's caseworker or mental health provider and/or the ombudsperson.

   Alternative strategies could include: changes in care approaches, consultations with mental health professionals/specialists and/or clinical specialists, reduction of environmental or situational stressors and/or medical evaluations of treatable conditions that could cause aggression or significant decline in functioning.

C. For those outreaches and investigations where hospitalization can be diverted, the EMHC/DMHP shall provide recommendations and resources, including recommendations for possible follow-up services to the facility staff and others for any remaining mental health concerns the individual may have.
D. In those circumstances where a resident has been evaluated at an ED and hospitalization can be diverted, the resident may have re-admission rights to the licensed care facility.

   If the EMHC/DMHP has concerns about facility refusal to re-admit the resident, the EMHC/DMHP should notify the Residential Care Services Complaint Resolution Unit (CRU) Hotline at 1-800-562-6078, **TTY** 1-800-737-7931.

E. If during the course of the outreach/investigation, the EMHC/DMHP has concerns about mental health or other services provided by the facility, the EMHC/DMHP should notify the Residential Care Services CRU Hotline for follow-up at 1-800-562-6078 or Adult Protective Services (APS). The website to report AFH abuse is: www.adsa.dshs.wa.gov/APS.

**ATTACHMENTS**

None