NORTH SOUND
MENTAL HEALTH ADMINISTRATION

QUALITY MANAGEMENT OVERSIGHT COMMITTEE

MEETING PACKET

August 22, 2012

1. Please join my meeting.
https://www3.gotomeeting.com/join/848365214

2. Use your microphone and speakers (VoIP) - a headset is recommended. Or, call in using your telephone.

Dial +1 (312) 878-3082
Access Code: 848-365-214
Audio PIN: Shown after joining the meeting

Meeting ID: 848-365-214

QMOC GUIDING PRINCIPLES

The QMOC charge is to guide the quality assurance and quality improvement activities of mental health services within the NSRSN region. In assessing the necessary data and making appropriate recommendations, the QMOC members agree to the following:

- **Help create an atmosphere that is SAFE.**
- **Maintain an atmosphere that is OPEN.**
- **Demonstrate RESPECT and speak with RESPECT toward each other at all times.**
- **Practice CANDOR and PATIENCE.**
- **Accept a minimum level of TRUST so we can build on that as we progress.**
- **Be SENSITIVE to each other's role and perspectives.**
- **Promote the TEAM approach toward quality assurance.**
- **Maintain an OPEN DECISION-MAKING PROCESS.**
- **Actively PARTICIPATE at meetings.**
- **Be ACCOUNTABLE for your words and actions.**
- **Keep all stakeholders INFORMED.**

Adopted: 10/27/99
Revised: 1/17/01

NORTH SOUND MENTAL HEALTH ADMINISTRATION
QUALITY MANAGEMENT OVERSIGHT COMMITTEE AGENDA

Date: August 22, 2012 **Time: 1:00-3:00 PM**

Location: NSMHA Conference Room

For information Contact Meeting Facilitator: Greg Long, NSMHA, 360-416-7013

Topic	Objective	ACTION NEEDED	Discussion Leader	Handout available pre-mtg	Handout available at mtg	Tab	Time
Introductions	Welcome guests; presenters and new members		Chair				*5 min*
Review and Approval of Agenda	Ensure agenda is complete and accurate; determine if any adjustments to time estimates are needed. Meeting will start and end on time.	Approve Agenda	Chair	Agenda		**1**	*5 min*
Review and Approval of Summary of Previous Meeting	Ensure meeting summary is complete and accurate.	Approve Meeting Summary	Chair	Summary		**2**	*5 min*
Announcements and Updates							*5 min*
Evaluation forms from last meeting, if any	Discuss feedback, if any.	Inform /discuss	Chair/ Greg				*5 min*
Quality Topics							
Implementation of Customer Satisfaction Survey	Introduction to the 2012 Regional Customer Satisfaction Survey. Present implementation and timeline	Inform/ discuss	Kurt	Committee Discussion Form		**3**	*20 min*
Semi-annual Critical Incident Report	This is the semi-annual report on critical incidents that is presented to QMOC for review and acceptance	Inform/ Discuss/ Approve	Kurt	Committee Discussion Form		**4**	*10 min*
Semi-Annual 2nd Opinion Report	This is the semi-annual report on 2nd Opinions that is presented to QMOC for review and acceptance	Inform/ Discuss/ Approve	Kurt	Committee Discussion Form		**5**	*5 min*
Feedback on proposed NSMHA Training	NSMHA wants feedback on proposed trainings on Motivational Interviewing and Illness Management and Recovery	Inform/ Discuss	Greg	Committee Discussion Form		**6**	*15 min*
ICRS Policy 1707	Approval is being sought for the crisis system dispute policy which has been revised.	Inform/ Discuss/ Approve	Sandy	Committee Discussion Form		**7**	*10 min*
ICRS Crisis Module	Approval is being sought for the training module for clinical staff on the regional crisis system.	Inform/ Discuss/ Approve	Sandy	Committee Discussion Form		**8**	*10 min*
Grievance System Review & Recommendations	This is the semi-annual report on Grievances in the Region and recommendations.	Inform/ Discuss/ Approve	Greg	Committee Discussion Form		**9**	*15 min*
Transferring between NSMHA agencies		Inform/ Discuss	Charissa	Committee Discussion Form		**10**	*5 min*
Requests for Readmission		Inform/ Discuss	Charissa	Committee Discussion Form		**11**	*5 min*
Other issues							
***Review of Meeting**	Were objectives accomplished? How could this meeting be improved? Eval forms						
Date and Agenda for Next Meeting	Ensure meeting date, time and agenda are planned						

Next meeting: September 26, 2012 - 1:00-3:00 PM **Potential Future Agenda Items:**

North Sound Mental Health Administration (NSMHA)
Quality Management Oversight Committee (QMOC)
NSMHA Conference Room
July 25, 2012
1:00 – 3:00 pm
MEETING SUMMARY

PRESENT: Mark McDonald, Candy Trautman, David Kincheloe and Fred Plappert, NSMHA Advisory Board; Mike Manley, Sunrise Services; Larry VanDyke, Pioneer Human Services; Jackie Henderson, Island County; Brad Berry, CVAB; Chuck Davis, ombuds; Heather Fennell, Compass Health; David Small, Sea Mar and Kathy McNaughton, CCS.
BY PHONE: Pam Benjamin, WCPC; Kay Burbidge, LWRTC; Nancy Jones, Snohomish County; Richard Sprague, Interfaith; Susan Ramaglia, NSMHA Advisory Board and Anne Deacon, Whatcom County.
STAFF: Greg Long, Charissa Westergard, Kurt Aemmer, Diana Striplin and Barbara Jacobson.
OTHERS PRESENT: Jeannette Anderson.

TOPIC	DISCUSSION	ACTION
1. **Introductions, Review of Agenda – Chair**	Jackie called the meeting to order at 1:01 pm and introductions are made. She called for additions to agenda and Heather asked to have discussion on the DSM V; which will be added to the end of the agenda	
2. Previous Meeting Summary – Chair	Jackie called for corrections or additions to the meeting summary of May 30, 2012; none are mentioned and the summary was approved as submitted.	Approved
3. Announcements and Updates – All	• Greg noted the work done on identifying special populations mental health consultants and asked Kurt to address the attachment. Kurt thanked all for their input on this and noted that on the chart where it lists willingness confirmed that he had phoned and spoken with each and they have agreed to be contacted. The other columns are alternative suggestions that he was unable to confirm with. They are mental health professionals. David K. noted the absence of any LGBT consultants and it was noted that these populations are identified in the WACs and LGBT is not one of those identified. Mike M noted that the State has referred him to NSMHA for this in the past and Greg noted that it is not part of our contracts but we wanted to create this resource. • Greg stated that the Fund Balance RFP was released yesterday and to please read it carefully for the specifics; we are also looking for proposals that have alternative solutions as well. Anne noted that this did not address all the categories approved by the Board of Directors and also asked what alternatives NSMHA is looking for. We identified areas and put forth programmatic ideas to address them, but providers could suggest other program ideas that they feel would address the identified areas. There were also areas that we wanted to address that are not part of the RFP; housing is one and that will be directed to the counties. Funding for the triage facilities is also not included in the RFP. Anne asked if this addressed all area approved by the board of if another RFP would be released to address any left	Informational

	out. Greg noted that there is not another RFP coming out at this point. • The outpatient services RFQ is going forward and will be released in October and there is a draft on our website that you may review.	
4. Evaluation Forms from Last Meeting – Chair/Greg	Jackie reviewed the feedback on the forms received last meeting and noted that there were four responses and item C was low in ranking.	Informational
5. Clinical Forums	Greg noted that this is follow up to the recommendation from ombuds to address recurring issues in the grievance process by addressing them in a clinical forum. Ombuds would be willing to give suggestions and dialog on how best to handle some of these issues from their perspective. A second issue is how to deal with consumers who are very angry or consistently uncooperative; and third how the system can deal with those consumers who are actively psychotic. Dr Brown may be willing to come and discuss this. Greg also thought perhaps Hank Balderama could come and talk about the Fair Hearing process. Chuck d discussed the angry clients and how hard they are to work with and hard to get them needed help. Mike M stated that he would like to clarify what the RSN expectation of providers is in the complaint process to accommodate the client. Greg suggested that we begin with meeting on complaint and grievance process and next seek creative ideas on how to handle the difficult consumers. Chuck and Greg will arrange this first meeting for 90 minutes and agencies can choose who to send.	Informational Greg and Chuck will set up this meeting
6. Children's Mental Health Class Action	Charrisa noted this resulted from a class action lawsuit that was filed in November 2009 called the TR lawsuit to address deficiencies in services to children and youth. There is an interim agreement that has been reached with system reforms and contract language coming in September around this. We expect the most impact to us will be in intensive services; with one implementation piece being child and family teams. There is a lot unanswered at this time and we will update things as we learn more. David K asked how many NSMHA kids are in our system and of those how many will this impact and Greg noted this is targeted at high needs kids and he is not sure of the number. It is a limited number and not clear; perhaps 100-800 in this region. Kathy N noted it would be helpful to know the number of high intensity slots there are in the region now; and Greg stated about 120. He will ask Julie to get the information on the numbers to him to send out.	Informational Greg will send out information on high intensity slots.
7. Healthy Options	Greg noted that the Healthy Options program has been opened up to five managed care plans in our region; with a limited mental health benefit attached. NSMHA has met with the plans and developed MOUs to guide us in our interactions with them. We are also working on regional agreements about data sharing which is an HCA requirement. Greg noted that United Healthcare approached NSMHA to manage their mental health program; though after researching this we declined; Greater Columbia also declined to do this. We felt there were legal and	Greg will update all on when a meeting may take place.

	conflict of interest reasons for not doing it. We will have ongoing meetings with them to work on things like access between the two benefits. A meeting may occur around the access issue that providers and VOA may want to attend to discuss. We will keep all updated as changes are known.	
8. Critical Incidents	Kurt noted that the state updates the critical incident program every few years and there was a short timeline this time. Greg sent out an email to providers with a draft of the form for all to follow as the changes took effect on July 1st. Kurt reviewed the changes that started July 1and noted that most of the change occurred on the NSMHA end of the program. There are three additional categories that were added and the categories are divided into two categories and the third category is elopement which is not reportable but is still there as we track here at NSMHA. Category I items are instantly reportable; category II are within one working day. Kurt will clarify the reporting procedure and timelines in the policy draft at the request of the committee. David K asked if there were consumers on the CIRC committee and Greg noted that there is PHI so consumers are not included. David K asked if the critical incident goes into the client file and there was discussion on what goes into a client file when an incident occurs. There are two levels of documents; one is a quality improvement document that has protection from discoverability in a lawsuit and is for the provider's quality of care review. The documentation that goes into the client file is about the client and its impact on them. Kurt will update the policy as noted.	Informational Kurt will send out documents when updated for review.
9. General Contract Changes	Greg noted that we received amendments to the state contracts that went into effect July 1, thought we just received them at the end of June. They will be incorporated into the contracts in October when more updates are expected. Attached are the changes and the amendments so that you can be aware. There was brief discussion on some of the changes.	Informational
10. Customer Satisfaction Survey	Kurt noted we are going to do the survey again the last two weeks of October and we will have the questionnaires distributed to providers by end of August. The same procedure will be used as last time. NSMHA is hoping to improve in participation 15% over our initial survey last year; which had an overall 45% participation rate. David K asked about the training provided to the front line staff and where the survey came from. Kurt noted that it is a national survey and a draft of questionnaire will be out next month. David K noted that it may be helpful to have some choices on the non-participation sheet for reasons not to participate. Mark M asked of the cost of this project and Greg noted it was around $3000; the cost of the surveys and the process that goes into it.	Informational
11. UR Results	Charissa noted this is an annual review; to see if the type and amount of service received is appropriate. The reviews were done February through	Remedial action letters

	April this year and around 415 charts were reviewed in the region. The attached report shows the results with the items highlighted are those that fell below 90% in 2012 and in 2010 and/or 2011. Charissa noted that remedial action will occur on those items. NSMHA will be sending out the remedial action letter in the next couple weeks. The tool is not expected to change for the next review at this time which is planned for January through March 2013. Charissa asked if there were any items that providers would like to discuss on this tool; which can happen at a later QMOC meeting, just let her know.	to be sent out
12. Open Forum	Jackie asked for other items for next month's agenda. Kurt will have the CIRC Report and the Second Opinion report, the customer satisfaction survey and updates on the CIRC policy and procedure. Heather noted that she would like to have the CIRC policy and procedures changes not wait for the next meeting she would like updates sent out by email. Kurt will send out by the end of the week with the changes suggested. **DSM-V** Heather F noted Compass went to recent trainings by Jack Klott of PESI and that it was a good training and they recommend the DVD PESI has for sale on this. Larry V stated he has the form for this and can forward to NSMHA. David Small noted that he is retiring from Sea Mar and will let us know who his replacement will be.	Discussion
13. Date and Agenda for Next Meeting	The meeting was adjourned at 2:55pm. The next meeting is August 22, 2012.	

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: 2012 NSMHA Customer Satisfaction Survey Implementation Plan

PRESENTER: Kurt Aemmer

COMMITTEE ACTION: Action Item () FYI & Discussion (x) FYI only ()

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:

1) Please implement plan ASAP, and be sure all locations are oriented by Friday, October 12
2) Survey will again this year be conducted during the last 2 full weeks of October (10/15 - 10/26).
3) Distribution & explanation of :
    a. The Implementation Plan (with Script)
    b. Adequate numbers of the 6 types of questionnaires for each provider location
    c. Two non-participation sheets for each provider location (to be reproduced on site)
    d. Self-addressed stamped envelopes for return of completed and unused questionnaires after 10/26/12

CONCLUSIONS/RECOMMENDATIONS: When providers reorient designated staff to the survey process, please stress the importance of the use of the Script (page 4 of the plan), and the goal of increasing the overall participation rate by at least 15%.

TIMELINES: 10/15/12 - 10/26/12

ATTACHMENTS: 2012 NSMHA Customer Satisfaction Survey Implementation Plan

2012 NSMHA
Customer Satisfaction Survey
Implementation Outline

August 22, 2012

Overview:

The North Sound Mental Health Administration (NSMHA) and our providers conduct a wide variety of quality improvement initiatives to try to constantly improve services. Prior to 2011, a missing piece of this effort has been regional consumer satisfaction studies for a number of years.

NSMHA is therefore conducting a simple 15 question survey using questions from two widely used national surveys to collect consumer satisfaction data. This initiative is modeled after one that has been conducted in Clark County RSN for several years, and the 2011 NSMHA Survey.

Implementation Strategy

1. At the 7/25/12 QMOC meeting NSMHA will orient the provider Quality Managers to the survey process.
2. At the 8/22/12 QMOC meeting:
    a. Enough survey questionnaires, for each age group, in separate packets for each provider agency.
        1) Age groups include:
            a) Adults (21+)
            b) Youth (13-20)
            c) Parents/Caregivers (for children up to and including 12)
    b. One self-addressed, oversized manila envelopes for each site.
    c. At least two non-participation sheets, for each age group, for each site. **NOTE**: These should be reproduced at each provider location in numbers sufficient enough to allow for utilization with every consumer who indicates they do not want to participate in the survey.
    d. Each Provider Quality Manager will estimate how many questionnaires each of their outpatient sites will need, and distribute them with the envelopes and non-participation sheets accordingly.
3. Between Wednesday 8/22/12 & Friday 10/12/12 the Quality Manager for each agency will:
    a. distribute the packets to each of their respective outpatient sites
    b. orient all staff at their outpatient sites to the survey process

1) **NOTE:** Orientation to ***all*** receptionists and outreach staff will be critical, as they will be the individuals whose role will be to offer the questionnaires to the people who will be filling them out, and retrieve the forms once they are completed.

Survey Steps: 10/15/12 – 10/26/12

I. Receptionists
   A. All customer satisfaction questionnaires, non-participation sheets, and NSMHA self-addressed envelopes will be kept at the reception desk, at each outpatient site.
   B. When each individual arrives for their outpatient session, the receptionist will inform them (or their caregiver) that a customer satisfaction survey is being conducted throughout the region, and they will be asked to participate, anonymously.
   C. The receptionist will give a questionnaire, appropriate to the participant's age and language groups, to each consumer and ask them to complete it while they are waiting for their session to begin.
      1. The receptionist should inform the individual that there are only 15 questions, and it can be completed in a very few minutes. (*See attached SCRIPT)
   D. If the individual refuses to participate, the receptionist will place an age group appropriate non-participation sheet in the NSMHA self-addressed envelope, and return the unused questionnaires to the stack of unused questionnaires at the reception desk.
   E. When the individual completes the questionnaire, the receptionist will thank the individual for their participation, and place the completed questionnaire in the NSMHA self-addressed envelope.

II. Outreach Staff
   A. Each day, before embarking on routine outpatient outreach session(s), the outreach staff person will stop by the receptionist's desk and pick up an appropriate number of age/language appropriate questionnaires and non-participation sheets for that day.
   B. At each visit, the outreach staff person will ask the consumer to take a few minutes to complete a questionnaire. (*See attached SCRIPT)
   C. If the individual refuses to participate, the outreach staff person will utilize a non-participation sheet.
   D. On returning to the office, the outreach staff person will hand over all questionnaires and non-participation sheets to the receptionist, who will place the completed questionnaires and non-participation sheets in the

NSMHA self-addressed envelope, and return any unused questionnaires to the stack of unused questionnaires at the reception desk.

III. Receptionists

A. By Thursday 11/1/12 the receptionist will seal the NSMHA self-addressed envelope, containing all of the completed and unused questionnaires, along with the used non-participation sheets, and mail them to:
Kurt Aemmer, Quality Specialist
North Sound Mental Health Administration
117 North 1st Street
Mount Vernon, WA 98273-2858

IV. Other Considerations

A. Each site will likely need more than the two non-participation sheets provided. Please feel free to make more photocopies of the non-participation sheets as needed.
    1. These sheets are necessary for NSMHA to calculate participation rates, so please use them whenever appropriate
    2. They hold no copyrights, so make and use as many copies as you need to
    3. The originals have color-coded titles, but the colors were primarily used to aid initial collating and distribution. Please feel free to use black & white copies when the colored ones run out.
    4. If the receptionists find that the site is running short of questionnaires, they should follow the steps below:
        a. Call the reception desk of a sister site and request the they share extra copies
        b. If the sister site is also running low and cannot provide extra copies, photocopy the needed number of questionnaires.
        NOTE: Because of copyright obligations pertaining to the questionnaires, please only use photocopies when absolutely necessary.

ATTACHMENT: Receptionist/Outreach Staff Script

2012 NSMHA Customer Satisfaction Receptionist/Outreach Staff Script

1. We are conducting a customer satisfaction survey.
2. We would appreciate your feedback on the level of satisfaction with the services you have received here.
3. Would you please complete this brief questionnaire while you are waiting for your session to begin?
4. There are 15 questions, and additional room to write any comments you may choose to share with us.
5. Please do not write your name on the questionnaire, as we would like all responses to be anonymous.
6. When you have completed the questionnaire, please return it to me and I will place it in a sealed envelope with all other completed questionnaires and return them to the Regional Support Network for analysis.
7. Thank you for your cooperation in helping us better understand your level of satisfaction with the services we provide.

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: 1st & 2nd Quarter Semi-annual CIRC Report

PRESENTER: Kurt Aemmer

COMMITTEE ACTION: Action Item () FYI & Discussion () FYI only (x)

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:

1) Sixteen CI were reported to NSMHA in 1st half of 2012. Two were screened out.
2) Fourteen (14) were reported to DBHR and were investigated by CIRC. Dispositions were determined for eleven (11), and 3 remained open at the end of the 2nd quarter.
3) Seven (7) of the fourteen (14) actual critical incidents (50%) fell within the "incidents or crimes reported by, or having potential to be reported in the media" categories.

CONCLUSIONS/RECOMMENDATIONS: None

TIMELINES: NA

ATTACHMENTS: 1st & 2nd Quarter Semi-annual CIRC Report

NSMHA Semi-Annual CIRC Report

January – June 2012

PURPOSE: To inform NSMHA Board of Directors, Executive Director, County Coordinators, the Critical Incident Review Committee (CIRC), the Quality Management Oversight Committee (QMOC), and other stakeholders in the region interested in critical incident (CI) data and activities on a semi-annual basis.

HIGHLIGHTS OF CI DATA FROM JANUARY – JUNE 2012

CIRC screened sixteen (16) reported CI in the 1st half of 2012. Two (2) of the reported CI were determined to not meet the formal definition of a CI, so fourteen (14) were reported to Division of Behavioral Health & Recovery (DBHR) and investigated by CIRC (APPENDIX I & II). Seven (7) of the fourteen 14 actual critical incidents (50%) fell within the "incidents or crimes reported by, or having potential to be reported in, the media" categories. This finding demonstrates the further movement toward a risk management focus of the CIRC process in the last two, and upcoming iteration(s) of the DBHR critical incident reporting and investigating process, the most recent to be implemented July 1, 2012.

CIRC INVOLVEMENT IN REGION-WIDE QUALITY IMPROVEMENT ACTIVITIES

Preventing elopements from E&Ts: Gains have been held in the quality improvement efforts to prevent elopements from E&Ts. Since the relatively large number of elopements (8) in 2005 and subsequent quality improvement efforts, there have been no more than 2 elopements in any quarter. There were 2 in the 2nd Quarter of 2007. Other than that quarter, there has been zero or one elopement per quarter. There was only 1 reported in all of 2008, and none in 2009, 2010, 2011 and 2012 year-to-date. *NSMHA recognizes the continued excellent work of E&T staff in addressing this issue!*

Attachments: APPENDIX I: Table Showing # of Reported Critical Incidents by County, by Quarter, January – March 2012 (1st Quarter)
APPENDIX II: Table Showing # of Reported Critical Incidents by County, by Quarter, April – June 2012 (2nd Quarter)

APPENDIX I: Table Showing # of Reported Critical Incidents by County, by Quarter January – March 2012

County of Incident	Unauthorized leave by a non-offender from an E & T	Death or serious injury of a consumer, staff or public citizen on DSHS owned, licensed or contracted property	Unauthorized leave by an offender from an E & T	Alleged consumer abuse or neglect	Assault of a consumer by a staff	Assault of a staff by a consumer resulting in hospitalization	Suicide attempt on DSHS owned, licensed or contracted by DSHS requiring medical care	Violent act perpetrated by a consumer	Alleged financial exploitation involving a consumer, agency or other	Incident involving a consumer reported by the media, or having potential for media interest	Crime involving a consumer reported by the media, or having potential for media interest	Natural disaster presenting substantial threat to facility operation or consumer safety	Breach of consumer information	Totals
San Juan	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Island	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Skagit	0	0	0	0	0	0	0	0	0	2	0	0	0	2
Whatcom	0	1	0	0	0	0	0	0	0	0	0	0	0	1
Snohomish	0	1	0	0	0	0	0	3	0	2	0	0	0	6
Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0
1st QUARTER TOTALS	0	2	0	0	0	0	0	3	0	4	0	0	0	9

APPENDIX II: Table Showing # of Reported Critical Incidents by County, by Quarter April – June 2012 (2nd Quarter)

County of Incident	Unauthorized leave by a non-offender from an E & T	Death or serious injury of a consumer, staff or public citizen on DSHS owned, licensed or contracted property	Unauthorized leave by an offender from an E & T	Alleged consumer abuse or neglect	Assault of a consumer by a staff	Assault of a staff by a consumer resulting in hospitalization	Suicide attempt on DSHS owned, licensed or contracted by DSHS requiring medical care	Violent act perpetrated by a consumer	Alleged financial exploitation involving a consumer, agency or other	Incident involving a consumer reported by the media, or having potential for media interest	Crime involving a consumer reported by the media, or having potential for media interest	Natural disaster presenting substantial threat to facility operation or consumer safety	Breach of consumer information	Totals
San Juan	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Island	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Skagit	0	0	0	0	0	0	0	1	0	0	1	0	0	2
Whatcom	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Snohomish	0	0	0	0	0	0	0	1	0	1	1	0	0	3
Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2nd QUARTER TOTALS	0	0	0	0	0	0	0	2	0	1	2	0	0	5

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: 1st & 2nd Quarter Semi-annual Second Opinion Report

PRESENTER: Kurt Aemmer

COMMITTEE ACTION: Action Item () FYI & Discussion () FYI only (x)

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:

1. There was only 1request for a 2nd opinion in each of the 1st two quarters of 2012 (APPENDIX I).
2. Both were completed within the required 30-day window.

CONCLUSIONS/RECOMMENDATIONS:

1. Second Opinions are being managed by NSMHA in a systematic, timely and appropriate manner.
2. *NSMHA providers, across the board, have been extremely supportive insuring that high quality 2nd opinion consults are getting scheduled and completed.

TIMELINES: NA

ATTACHMENTS: 1st & 2nd Quarter Semi-annual Second Opinion Report

NORTH SOUND MENTAL HEALTH ADMINISTRATION
SEMI-ANNUAL SECOND OPINION REPORT
July 31, 2012

Introduction

At any time during the course of outpatient mental health treatment, the principals to treatment (e.g., consumer, custodial parents of children and adolescents, others with legal custody, NSMHA, a NSMHA-contracted Community Mental Health Agency [CMHA], or primary Mental Health Care Provider [MHCP]) may submit a request for a second opinion regarding any outpatient clinical decision to NSMHA either verbally or in writing. If other parties (family member, primary medical health provider) desire a second opinion, the request is made through the MHCP. NSMHA-contracted CMHA staff and Ombuds are available to assist consumers, custodial parents and legal guardians in accessing a timely second opinion.

Second opinions may be requested for many reasons, including situations in which:

1. There is a question regarding medical necessity;
2. There is a question regarding the reasonableness or necessity of recommended interventions and/or medications;
3. There is a question regarding a diagnosis or plan of care;
4. The clinical indications for a diagnosis are not clear or a diagnosis is in doubt due to conflicting test results;
5. The treatment interventions in progress are not improving the condition of the consumer within an appropriate period of time given the diagnosis and plan of care.

In accordance with the 2012 NSMHA Comprehensive Work Plan, this is the semi-annual reports that is due on July 31.

Historic Findings

NSMHA has been monitoring the requests for and provision of 2nd Opinions since September of 2004. Prior to this report, frequency of 2nd Opinion requests was reported annually during EQRO Surveys. (APPENDIX I).

1. In recent years the annual average number of 2nd opinion requests per quarter increased from 2.0 to 5.8, with only 2009 showing a decrease from 4.0 in 2008 to 3.5 in 2009. It then rose to 5.0 in 2010, and then to 5.8 in 2011. During the first half of 2012 the year-to-date average number of requests dropped significantly to 1 per quarter (APPENDIX I).

1st & 2nd Quarter 2012 Findings

1) There was 1 request in the 1st Quarter & 1 in the 2nd, a sudden decrease of annual averages following increases in each of the previous 2 years (APPENDIX I).
2) Second Quarter 2012 marks the 9th quarter in a row where all appropriate 2nd opinion requests resulted in the consult being scheduled and completed within the 30 day window required in WAC 388-865-0355 (APPENDIX II) .

Conclusions

1) The numbers of 2nd Opinion requests (1 in each of the first 2 Quarters) in the first half of 2012 is are lowest since the 2th Quarter of 2007 when there were 0.
2) Both consultations were completed within 30 days of the date they were requested.

Recommendations

1. Continue with current process.

Attachments:

APPENDIX I: Table Showing Requests History October 1, 2004 - June 30, 2012

APPENDIX II: Bar Chart Showing Rate of Consults Completed in 30 days October 1, 2004 - June 30, 2012

APPENDIX I

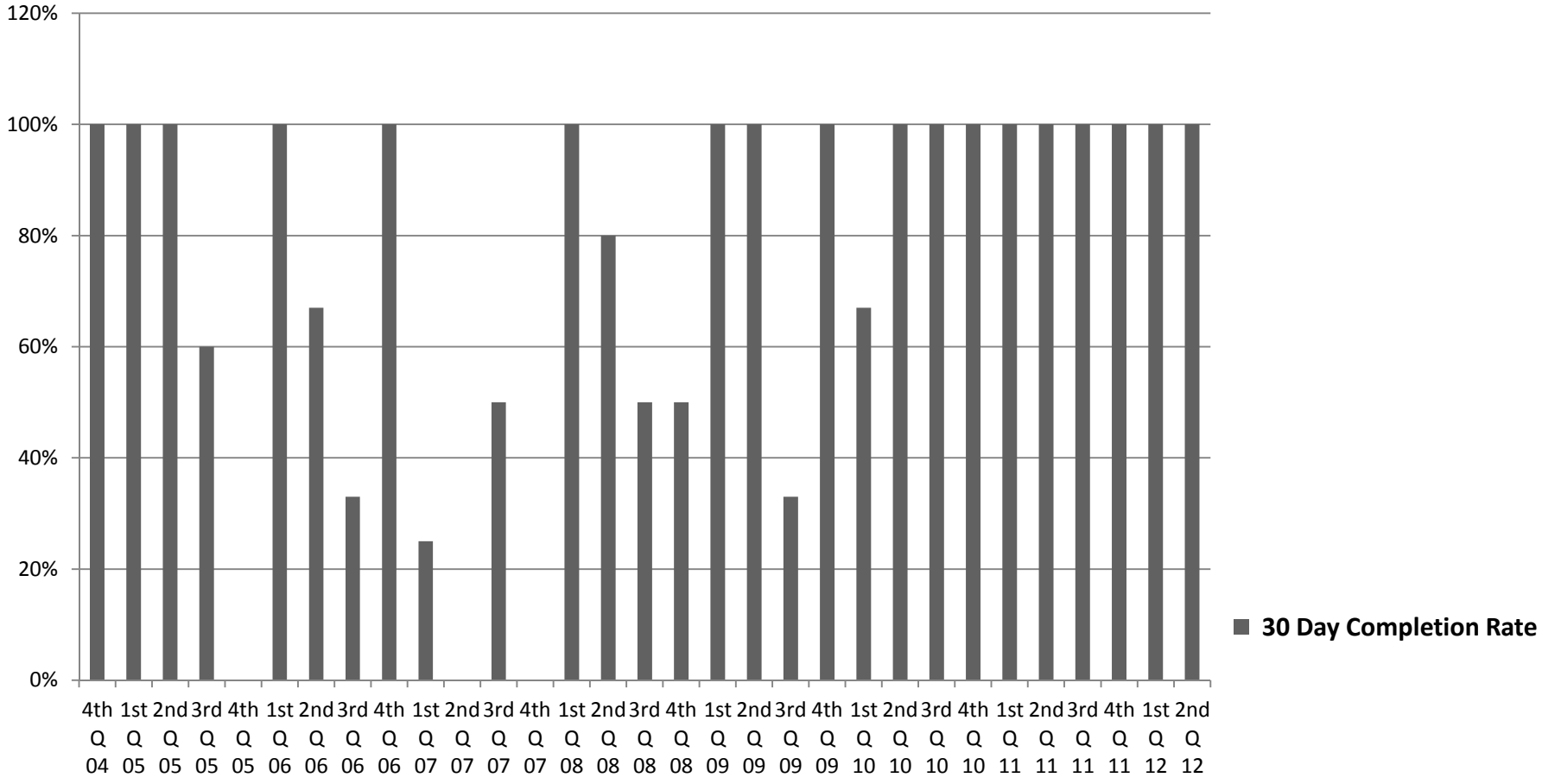
Table Showing Requests History October 1, 2004 - June 30, 2012

Quarter	# of Requested	Ave. # of Requests Per Year	# Completed in 30 days	# Rescinded or 30-day window waved by consumer	#30-Day Completion Rate
4th Q 04	4	4.0	2	2	100%
1st Q 05	1	2.5	1	0	100%
2nd Q 05	0	2.5	0	0	100%
3rd Q 05	6	2.5	3	1	60%
4th Q 05	3	2.5	0	1	0%
1st Q 06	3	2.5	2	1	100%
2nd Q 06	3	2.5	2	0	67%
3rd Q 06	3	2.5	1	0	33%
4th Q 06	1	2.5	1	0	100%
1st Q 07	4	2.0	1	0	25%
2nd Q 07	0	2.0	0	0	0%
3rd Q 07	2	2.0	1	0	50%
4th Q 07	2	2.0	0	0	0%
1st Q 08	2	4.0	1	1	100%
2nd Q 08	8	4.0	5	3	100%
3rd Q 08	3	4.0	1	1	50%
4th Q 08	3	4.0	1	1	50%
1st Q 09	4	3.5	1	3	100%
2nd Q 09	3	3.5	2	1	100%
3rd Q 09	3	3.5	1	0	33%
4th Q 09	4	3.5	2	2	100%
1st Q 10	3	5.0	2	0	67%
2nd Q 10	5	5.0	2	3	100%
3rd Q 10	8	5.0	5	3	100%
4th Q 10	4	5.0	3	1	100%
1st Q 11	6	5.8	2	4	100%
2nd Q 11	3	5.8	2	2	100%
3rd Q 11	8	5.8	2	6	100%
4th Q 11	6	5.8	1	5	100%
1st Q 12	1	1.0	1	0	100%
2nd Q 12	1	1.0	1	0	100%

APPENDIX II

Bar Chart Showing Rate of 2nd Opinion Consultations Completed in 30 Days

October 1, 2012 - June 30, 2012



NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: Training on Motivation Interviewing and Illness Management and Recovery

PRESENTER: Greg Long

COMMITTEE ACTION: **Action Item () FYI & Discussion (x) FYI only ()**

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:
NSMHA is considering providing additional training on evidence-based practices, specifically Motivational Interviewing and Illness Management and Recovery (IMR). NSMHA wants to clarify the demand for these trainings by direct service staff so this training can have maximum benefit for individual consumers, clinicians, and the Regional system of care.

NSMHA proposes the following regional trainings on motivational interviewing:
4 – Basic MI trainings (25 Participants per session/100 total participants)
4 – Advanced MI trainings (25 participants per session/100 total participants)
1 – MI booster session (open to anyone having gone through advanced) (25 participants)
1 – MI booster session for supervisors (25 participants)
2 – Six hour webinars on various MI Topics (25 participants/50 total participants)

NSMHA proposes the following regional training on IMR for intensive outpatient, PACT and residential programs:

1. A "kick-off" training for all staff working with clients in the settings which are interested in providing IMR.
2. 2 day training on IMR
3. Follow-up consultation calls from consultant for 6 months.

CONCLUSIONS/RECOMMENDATIONS:
NSMHA is requesting feedback from the provider agencies on the readiness of direct service staff and programs for these trainings. Please talk with your intensive programs about the IMR Training and their interest/readiness for it.

TIMELINES:
These trainings will occur this fall.

ATTACHMENTS:
None

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: ICRS policy 1707 Clinical Dispute

PRESENTER: Sandy Whitcutt

COMMITTEE ACTION: **Action Item (x) FYI & Discussion () FYI only ()**

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:

When providers from different systems and perspectives interact with the same individual in crisis, sometimes there are differences of opinion as to what constitutes the best care for the individual.

This policy provides guidance to 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 should be on providing the best service possible to the individual.

This policy has gone through many revisions and track changes, making the track change policy difficult to read. The clean version has been attached.

Definitions have been further clarified, inter-system disputes (disagreements between ICRS and other service or system providers) and intra-system (disagreements between ICRS providers) sections have been revised.

CONCLUSIONS/RECOMMENDATIONS: Recommendation is to pass this revised policy

TIMELINES: If approved, this policy will go into effect 60 days following the numbered memo

ATTACHMENTS: Policy 1707

Effective Date: 1/28/2008; 11/29/2005
Revised Date: 5/3/2012
Review Date: 7/26/2012

North Sound Mental Health Administration

Section 1700 – Crisis Services: Crisis System Clinical Dispute Resolution

Authorizing Source: Per NSMHA and ICRS Management
Cancels: Policy 1507.00
See Also: ICRS Providers must comply with this policy and may develop individualized implementation guidelines as needed
Approved by: Executive Director
Date:
Responsible Staff: Deputy Director
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; Integrated Crisis Response System (ICRS) includes any agency contracted with North Sound Mental Health Administration (NSMHA) 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*, and Whatcom Counseling & Psychiatric Clinic*.

*****ICRS providers include Designated Mental Health Professionals (DMHPs), Emergency Mental Health Clinicians (EMHCs), Triage Facility staff, and/or Mobile Outreach Teams (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 should be on providing the best service possible to the individual. Services should be provided with the minimum amount of delay and should 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 Community Mental Health Agency (CMHA) and/or NSMHA complaint and grievance process and not under this policy. ICRS providers shall ensure involved parties are made aware of the availability of these processes should they apply. These individual complaints/grievances will be handled as expeditiously as the individual's condition requires, which may necessitate an expedited process (see NSMHA Policy #1001 for further information related to consumer 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:

    a. 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 should 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 NSMHA Quality Management Oversight Committee.

ATTACHMENTS

None

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: Crisis Module

PRESENTER: Sandy Whitcutt

COMMITTEE ACTION: **Action Item (x) FYI & Discussion () FYI only ()**

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:
The module has been significantly revised by ICRS. It provides an overview for new clinicians to introduce the principles of the Integrated Crisis Response System (ICRS) and make them aware of tools available for managing mental health crises.

There are specific training objectives that will orient clinicians to the mental health crisis system's processes, resources and requirements, educate clinicians regarding voluntary and involuntary hospitalization, educate clinicians regarding involuntary treatment laws and processes and provide guidance regarding the completion of an affidavit for initial detention or petition to revoke.

CONCLUSIONS/RECOMMENDATIONS:
Approval of the module.

TIMELINES:
A numbered memorandum will be sent, the revisions will go into place 60 days after the memo has been sent.

ATTACHMENTS:
Revised crisis module

North Sound Mental Health Administration
Regional Support Network for Island, San Juan, Skagit, Snohomish, and Whatcom Counties
117 North First Street, Suite 8 • Mount Vernon, WA 98273 • 360.416.7013
800.684.3555 • Fax 360.416.7017 • TTY 360.419.9008 • Email nsrsn@nsrsn.org • Web Site http://nsmha.org

NORTH SOUND MENTAL HEALTH ADMINISTRATION

INTEGRATED CRISIS RESPONSE SYSTEM TRAINING MODULE

TABLE OF CONTENTS

TRAINING OBJECTIVES:

1. Orient clinicians to the mental health crisis system's processes, resources and requirements.
2. Educate clinicians regarding voluntary and involuntary hospitalization.
3. Educate clinicians regarding involuntary treatment laws and processes.
4. Provide guidance regarding the completion of an affidavit for initial detention or petition to revoke.

INTRODUCTION

Crisis Services are one of the major components of public mental health services. Crisis services are available to all individuals and families physically located in the North Sound region's five counties, regardless of enrollment status with service providers, ability to pay, or funding source. Services are available on a 24 hour basis for those who are in a self-defined state of crisis (a turning point in the course of anything decisive or critical; a time, a stage or an event of great danger or trouble, whose outcome decides whether possible bad consequences will follow).

Crisis Services include a broad array of services: telephone-based crisis assessment and support, outreach, crisis triage centers and involuntary treatment assessments. Crisis services are intended to stabilize the individual in crisis in the least restrictive community setting possible. Services are matched to the individual's need and severity of the crisis. An individual in crisis is served from a non-stigmatizing, person-oriented approach, including responsive listening and respectful attention.[1] Crisis Services staff actively involve and collaborate with family members and other natural supports during a crisis as appropriate and within limits of confidentiality. **Note:** Triage Centers in the North Sound Region may have some restrictions to admission for Chemical Dependency services based upon county of residence of the referred individual.

Crisis Services are provided by the following agencies in the following counties:

County	Voluntary Crisis Services	Involuntary Investigations	Triage Centers	Mobile Outreach Team
Island	Compass Health	Compass Health	Island County residents may access triage if transportation can be arranged	Not available in Island County
San Juan	Compass Health	Compass Health	San Juan County residents may access triage if transportation can be arranged	Not available in San Juan County
Skagit	Compass Health	Compass Health	Pioneer Human Services	Pioneer Human Services
Snohomish	Compass Health	Snohomish County Human Services	Compass Health	Not available in Snohomish County
Whatcom	Whatcom Counseling and Psychiatric Clinic (WCPC)	WCPC	WCPC	WCPC

[1] See Journal of Psychiatric Practice, Vol. 9, No. 1: *Individuals' Wants and Needs During a Psychiatric Emergency*

WHAT ARE THE PRINCIPLES OF THE ICRS?

1. Crisis services include voluntary and involuntary service options.
2. Crisis services are delivered across social service systems in a fully integrated, seamless and consistent manner.
3. An individual in crisis is treated as a whole person, rather than focusing on categorical problems.
4. A crisis is self-defined, rather than needing to meet categorical criteria.
5. An individual in crisis will have easy and timely access to appropriate intervention and care.
6. Clinicians involved in crisis response intervention will be able to refer to a complete continuum of care in order to respond to a variety of needs.
7. Individuals experiencing a behavioral health crisis will be stabilized in the least restrictive setting, in the individual's home or in any in vivo setting, and will be referred to the least restrictive resource available to manage the crisis.
8. Crisis response services are community-based.
9. Crisis response services are available to both adults and children.
10. Crisis services and information will be available 24 hours a day, 365 days a year throughout the Region.
11. Crisis services will be fully integrated and coordinated at both the local and regional level.
12. All crisis services will be culturally competent and responsive.
13. Standards of care will be adhered to throughout the region.
14. Crisis services will be provided in a manner recognizing the uniqueness of each individual.
15. The integrated crisis system will utilize a flexible array of services and supports, formal and informal, which fit the needs of the individual.

WHAT TOOLS ARE AVAILABLE FOR MANAGING CRISES?

CRISIS PLANS

The crisis plan is a document that the outpatient clinician develops in collaboration with the North Sound Mental Health Administration (NSMHA) enrolled individual and his/her family and/or other natural supports. The plan is intended to help both the clinician and individual in the event that he/she experiences a crisis during treatment. Working together, the outpatient clinician and individual anticipate potential problems that might create a crisis. The outpatient clinician helps the individual identify his/her specific triggers, "red flags", or early warning signs, and alert him/her that trouble may be developing. The outpatient clinician and individual make a plan for what to do when the individual sees these early warning signs. The plan starts with low intensity interventions that the individual can probably accomplish on his/her own, then progresses to interventions of increasing intensity that include family, natural supports and possibly professional staff. A copy of the crisis plan is kept in the individual's chart, given to the individual, and given to the identified family or natural supports with the individual's approval.

If the individual or a family member/natural support calls the Crisis Line during a crisis, the Crisis Line staff can provide assistance based on the information in the crisis plan. When responding to a crisis, clinicians, CCRS, and crisis services workers will continue to work with family members and other natural supports to best support the individual within limits of confidentiality. Crisis plans shall be reviewed at least every 180 days, updated to reflect any changes in the individual's needs,

or as requested by the individual, their parent, or other legal representative. This shall include any known safety concerns. See NSMHA Policy 1551 for additional requirements related to crisis plans.

CRISIS ALERTS

Crisis alerts contain important up-to-date information about individuals who are likely to require crisis services within the next 10 days. Crisis alerts are created by clinicians and contain information pertinent to the current crisis situation, in contrast to crisis plans, which contain long-term strategies. CCRS receives, stores, and utilizes this time-sensitive information, and makes it available to Mobile Outreach Teams (MOT), Emergency Mental Health Clinicians (EMHC) and Designated Mental Health Professional (DMHP) staff to assess risk and effectively intervene in a crisis. Crisis alerts are kept on file for 10 days and can be renewed if clinically warranted.

MENTAL HEALTH ADVANCE DIRECTIVES

A Mental Health Advance Directive is a written document, consistent with the provisions of RCW (Revised Code of Washington) 71.32, in which a person makes a declaration of instructions or preferences and/or appoints an agent to make decisions on her/his behalf regarding that individual's mental health treatment during times when he/she is incapacitated by a mental disorder and cannot give informed consent. If the clinician has received an individual's advance directive, it will become part of the individual's medical record and the clinician will be considered to have actual knowledge of its contents. More information regarding compliance and conditions for noncompliance can be found in RCW 71.32.150, RCW 7.70.40 and in NSMHA Policy 1518.

WELLNESS RECOVERY ACTION PLAN (WRAP)

WRAP® is an Evidenced Based self-management and recovery system designed by Mary Ellen Copeland and developed by a group of people who had mental health difficulties and were struggling to incorporate wellness tools and strategies into their lives. WRAP is designed to:

1. Decrease and prevent intrusive or troubling feelings and behaviors;
2. Increase personal empowerment;
3. Improve quality of life; and
4. Assist people in achieving their own life goals and dreams.

WRAP is a structured system to monitor uncomfortable and distressing feelings and behaviors and, through planned responses, reduce, modify or eliminate them. It also includes plans for responses from others when individuals cannot make decisions, take care of themselves or keep safe.

**The clinician may ask if an individual has a crisis plan, mental health advance directive or WRAP, but he/she may have chosen not to create these plans. The mental health advance directive and WRAP are not available through VOA.*

WHAT IS THE ROLE OF VOA CARE CRISIS RESPONSE SERVICES (CCRS)?

CRISIS LINE

CCRS provides 24-hour a day, 7 day a week, professionally staffed crisis line system. When someone is in distress and is seeking assistance with a crisis situation, he/she should call the Crisis Line at 1-800-584-3578. They provide a range of support and referral services including:

A. Making requested mental health referrals to the community;
B. Having access to language bank interpreters and TDD equipment;
C. Assuring referral to age and culturally appropriate services and specialists;
D. Scheduling crisis appointments;
E. Providing telephone stabilization and intervention services for individuals with non-acute issues;
F. Assuring timely and consistent crisis response;
G. Providing telephone consultation, intervention and stabilization for individuals and/or family members/natural supports as appropriate and within limits of confidentiality;
H. Determining when face-to-face services are needed, both voluntary and involuntary, and dispatching a DMHP, MOT or EMHC;
I. Tracking the outcome of face-to-face services and seeing if further services are warranted;
J. Deciding when cross-system services are needed;
K. Working closely with law enforcement when appropriate;
L. Consulting with detoxification providers, licensed care facilities, hospitals and other community providers;
M. Troubleshooting cross-system referrals in which there is a difference of opinion of appropriate services or system response; and
N. Providing telephone follow-up with individuals after-hours as part of an individual crisis plan.

TRIAGE SERVICES

VOA CCRS Triage Clinicians are Masters-level mental health professionals. When a professional wishes to speak with someone at the Crisis Line, they can contact the CCRS Triage Clinician directly at 1-800-747-8654.

The CCRS Triage Clinician will have the responsibility of deciding when face-to-face evaluation and/or stabilization services are needed and dispatch the MOT, EMHC, and/or DMHP staff to a community location outside of the provider's office. The MOT, EMHC, or DMHP may not decline a referral for face-to-face services, but decides if backup or other provisions are needed to mitigate risk.

Outreach services shall be provided within two (2) hours of dispatch by the CCRS Triage Clinician.

MOT, EMHC, and DMHP will report the disposition of the case back to the CCRS Triage Clinician by phone or fax within one (1) hour of the completion of the case and to law enforcement when requested.

WHAT FACE-TO-FACE SERVICES ARE AVAILABLE?

CRISIS SERVICES APPOINTMENTS

Urgent and follow-up appointments are available for adults and children who are not currently enrolled in the public mental health system, are determined to be in need of face-to-face evaluation or intervention, and who meet certain criteria. Appointments are available at provider agencies in each county, and are scheduled by VOA CCRS staff. Crisis Services appointments provide brief treatment on a voluntary basis, generally for persons at risk of harm to self or others, at risk of hospitalization, and/or who may be in need of a referral for an emergency medication evaluation. Enrolled individuals' urgent needs will be addressed by their outpatient clinician, treatment team or backup as appropriate.

EMERGENCY PSYCHIATRIC SERVICES

Emergency psychiatric medication evaluations are available for those individuals who have been assessed by an EMHC or DMHP and deemed at risk of hospitalization. Access to these psychiatric appointments is through the EMHC or DMHP. This process varies from county to county. Follow up psychiatric consultations are available when clinically indicated by the prescriber. Generally this service is used for non-enrolled individuals.

OUTREACH

Outreach is the provision of face-to-face evaluation and/or intervention services (voluntary or involuntary) in community locations. The expectation is that emergency outreach clinicians providing crisis response services will provide services to the individual in the community. Outreach services are an important and available service, both when necessary to support the person in crisis and to provide services in the least restrictive, appropriate manner, with the use of family and natural supports within limits of confidentiality. The intent, however, is never to promote outreach at the expense of anyone's safety – including individual, staff, family/natural support, and the public.

EMHCs/DMHPs must respond to pages from the VOA within 10 minutes. Once dispatched, the EMHC and DMHP must be on-site with the person in crisis within 2 hours. Within 1 hour following the completion of any outreach, the EMHC and DMHP calls the CCRS Triage Clinician to relay the disposition of the case back to the CCRS Triage Clinician and, when appropriate, the referral source, to include the individual's clinician. If EMHC or DMHP is unable to arrive to the dispatch location within two hours due high volume, inclement weather, etc., they will document the reason for the delay.

MOBILE OUTREACH TEAM (MOT)

Mobile Outreach is a community service available in Skagit and Whatcom counties for individuals and families not currently enrolled in Medicaid outpatient services. These teams are intended to respond to non-emergent mental health situations, defined as situations where the level of stress has overwhelmed the individual's ability to cope. The teams are available to provide early intervention to assess, engage, and provide temporary support and make referrals to community resources. These teams can be accessed by calling the VOA Care Crisis Line or directly contacting the provider. The teams are designed to integrate with the existing Emergency Services and Involuntary Treatment Investigation Services.

INVOLUNTARY INVESTIGATION SERVICES

Involuntary investigations are another crisis service available in all five counties and performed by the DMHPs. These individuals have specialized training in performing mental health investigations, and are designated by their counties. Their role is to assess for danger to self, others, property and/or grave disability as a result of an acute mental disorder. They work closely with the voluntary teams, hospitals, triage facilities, and other allied systems. Their specific role and investigation procedures are further detailed later in this module.

WHAT SERVICES ARE AVAILABLE FOR ADULTS ENROLLED WITH THE DIVISION OF DEVELOPMENTAL DISABILITIES (DDD)?

For adults (18 or older) who are enrolled with the DDD, there are additional services that are available during times of crisis. These services are based on an urgent, not emergent, model and rely upon referral from the DDD Case Manager during business hours.

The EMHC/DMHP can check on an individual's enrollment status by calling the Care Crisis Line. An assessment for stabilization services can be arranged through the DDD Mental Health/ Developmental Disability Resource Manager, if criteria are met (enrolled with DDD, not currently enrolled with the RSN, and at risk of hospitalization or loss of placement).

Region 2-North DDD also has access to one Hospital Diversion bed located in North Seattle. Referrals for hospital diversion bed services should be made to the DDD Mental Health/ Developmental Disability Resource Manager.

WHAT RESIDENTIALLY BASED CRISIS SERVICES EXIST IN THE REGION?

Crisis stabilization/triage facilities for adults are located in Whatcom, Skagit, and Snohomish counties. These programs typically provide short-term support (up to 5 days) in a staffed facility for adults who are in or at high risk of experiencing a mental health crisis. The programs in Skagit and Whatcom Counties provide sub-acute detoxification and the program in Snohomish County provides (non-medical) sobering services for chemically abusing or dependent individuals. When an outpatient clinician believes that an individual would benefit from crisis stabilization/triage, they may call the facility directly to make the referral or call the Care Crisis Line and speak to a CCRS Triage Clinician to make the referral. Staff at each facility is trained to review the presenting information and establish whether placement is appropriate.

WHATCOM COUNTY BEHAVIORAL HEALTH TRIAGE CENTER (WCBHTC)

Pioneer Human Services and Whatcom Counseling and Psychiatric Clinic have a cooperative agreement to provide crisis services and sub acute detoxification services at the WCBHTC. Pioneer Human Services has started a suboxone program on site and has a physician who runs a suboxone clinic several times a week.

WCBHTC is licensed for 13 beds, 8 beds are designated for detoxification and 5 beds are designated for crisis stabilization. The residential services are 24/7 and the usual length of stay in both programs is between 3 to 5 days. This is a less restrictive option to hospitalization. The services offered at WCBHTC are voluntary. Referral sources include, but are not limited to, hospital staff and social workers, case managers, law enforcement, correctional officers and jail staff.

There are DMHPs housed at the site who can assist with crises that may need their expertise. A Physician Assistant is available to assist residents in stabilization beds with their basic medical needs, as well as, being available to staff for medical consultations. A strong and developing part of

WCBHTC is the utilization of Certified Peer Counselors who provide supportive services to those in residence. WCBHTC also provides access to the Behavioral Health Access Program (BHAP) that provides mental health and chemical dependency treatment for residents who have no source of funding. BHAP workers regularly interview their individuals on site.

SKAGIT COUNTY CRISIS CENTER (SCCC)

Pioneer Human Services operates the Skagit County Crisis Center (SCCC) in Burlington, WA. The SCCC provides short-term stabilization services for individuals who are experiencing a mental health crisis or are experiencing the effects of intoxicants and require sub-acute detoxification services. SCCC will provide supportive care 24 hours a day, 7 days a week, for individuals while they stabilize from a mental health crisis or withdraw from the transitory effects of intoxication. SCCC is a non-medical, community based program that offers a less-restrictive placement option to inpatient hospitalization, or acute detoxification. This facility is a voluntary unit and does not use restraints or seclusion.

SCCC services are based on a Strength-based Recovery model and utilize SAMHSA Principles of Recovery. Staffing includes Chemical Dependency Professionals, Mental Health Professionals (MHP), Certified Peer Counselors, as well as, other professional staff. Referrals can be made by community professional staff, to include case managers, chemical dependency providers, mental health clinicians, hospital social workers and discharge planning staff and law enforcement.

SCCC is a combined facility providing integrated care for individuals who are experiencing mental health and/or chemical dependency issues. It is unable to accept individuals who are leveled sex offenders, violent, assaultive or have a history of fire setting.

1. <u>Sub-acute detoxification referrals</u>:

    a. Sub-acute detoxification placement is offered at SCCC. As with other non-medical, detoxification service facilities, SCCC is unable to accept individuals who are detoxing from benzodiazepines or barbiturates.
    b. Face-to-face assessment may be necessary and completed by medical personnel to determine the appropriateness of placement in a non-medical setting for unknown persons or those with known history of severe withdrawal symptoms. Referrals will also be accepted from community providers using the Community Professional/Case Manager Screening Form.
    c. The referral source will contact the SCCC regarding the availability and the appropriateness (review inclusion/exclusion criteria) of the placement.

If the placement is appropriate and the SCCC agrees to accept the individual, the referral source or SCCC staff will arrange for appropriate transportation.

SNOHOMISH COUNTY TRIAGE CENTER (SCTC)

Compass Health operates the SCTC in Everett. This facility provides short-term stabilization services for individuals experiencing a behavioral health crisis, which might include mental health or chemical abuse/dependency symptoms. The program does not provide detoxification services, but does provide support to those who are sobering.

SCTC services are based on a Recovery Model, and staffing includes Certified Peer Counselors, as well as, other professional staff. Referrals can be made by a wide range of professional staff to include case managers, chemical dependency providers, mental health clinicians, hospital social work and discharge planning staff, and others. Additionally, this facility is "locked", and accepts direct referrals from any Snohomish County Law Enforcement officer as a diversion from jail or hospital emergency departments.

Duration of stay averages three to four days, but may be as short as one day or as long as five with the need for continued stay based on clinical criteria to include presentation and strength of discharge planning.

1. Referral Process:

    a. For Mental Health Clinicians or Case Managers, referral to any of this program can be accomplished by calling the program directly. Program staff will complete a screening questionnaire during the call, and will evaluate the referral to determine whether any exclusionary criteria are present. Generally an answer to the referral can be made during this initial call but sometimes some internal consultation is necessary. Program staff is committed to providing an answer to the referral as quickly as possible.
    b. For Mental Health Clinicians or Case Managers, it is generally expected that the individual being referred has been seen recently and evaluated as being in need of this level of care.
    c. Once accepted, it is the responsibility of the referring Mental Health Clinician or Case Manager to ensure safe transportation to the facility and to assist with all details related to admission. These details may include obtaining medications, communicating with other supports/systems, assisting with obtaining releases to facilitate discharge planning, etc.

2. Length of Stay/Discharge Planning:

    a. The length of stay is limited; up to 5 days but extensions are available if clinically warranted.
    b. The discharge planning will begin at the time of initial placement at the facility.

WHAT IS THE PROCESS FOR PSYCHIATRIC HOSPITALIZATION?

VOLUNTARY HOSPITALIZATION

The clinician evaluates whether a less restrictive option such as increased outpatient services, staying with family or natural supports, a crisis triage center stay, might be sufficient to stabilize the individual. If all less restrictive options are ruled out (i.e., have been tried unsuccessfully, are inappropriate for some clear and documentable reason), the clinician may proceed with the voluntary hospitalization process.

The VOA Inpatient Utilization Management Team conducts the authorization process for voluntary psychiatric hospitalization for all Medicaid and Medicaid-eligible residents of the North Sound region. The program is available 24 hours per day, 7 days per week. When a clinician feels that the individual they have assessed requires psychiatric hospitalization they must do the following:

1. Contact a psychiatric hospital and secure a bed.
2. After a bed has been identified, but before admission, the clinician must call VOA at 1-800-707-4656 and request the authorization.

    a. The clinician will have to provide clinical and demographic information;
    b. Discuss and justify the reasons, including specific symptoms and behaviors, requiring inpatient hospital care;
    c. Describe what less restrictive options have been attempted.

3. VOA consults with a psychiatrist on all requests for hospitalization of children/youth and on any requests for which medical necessity is in question.
4. If the individual meets medical necessity criteria the hospitalization episode will be authorized. For those requests that are denied, the consumer has the right to appeal or grieve and the admitting psychiatric facility has the right to appeal (see NSMHA policies 1001-1004 and 1020).
5. The outpatient clinician may then make the final arrangements for admission (e.g., contacting the hospital to notify of authorization or denial, transportation, etc). In those instances where a denial has been issued and an admission will not occur, the outpatient clinician is responsible for developing an alternative plan with the individual to address the individual's needs.

ASSESSMENTS FOR INVOLUNTARY TREATMENT

Persons who are alleged to be a danger to themselves, others or property or are gravely disabled (unable to meet their basic needs of health and safety) as the result of an acute mental disorder may be assessed for involuntary treatment.

Note: Individuals, who are developmentally disabled, impaired by chronic alcoholism or drug abuse, or suffering from dementia shall not be detained solely by reason of that condition. The detention may be appropriate if said condition meets the definition of an acute mental disorder as defined in RCW 71.05 and detention grounds are met.

In Washington State, DMHPs conduct all assessments for involuntary treatment. In assessing whether or not a person should be detained against their will to an inpatient psychiatric unit DMHPs focus their evaluations on the following questions:

1. Is the person suffering from an acute mental disorder? RCW 71.05 defines mental disorder as "any organic, mental or emotional disorder which has substantial adverse effects on an individual's cognitive and volitional functions."
2. Is there evidence that the person, as the result of mental disorder:

    a. Presents a likelihood of serious harm to him or herself, other persons, or the property of others; or
    b. May be gravely disabled?

3. Does imminent danger exist?

    a. A DMHP should take a person into emergency custody only when the person presents an **imminent** likelihood of serious harm or is in imminent danger because they are gravely disabled.

b. Before filing the petition, the DMHP must personally interview the person, unless the person refuses an interview, and determine whether the person will voluntarily receive appropriate evaluation and treatment at an evaluation and treatment facility.

4. Does the person present, as a result of a mental disorder, likelihood of serious harm, or grave disability, but without imminent danger?

    a. If the person does meet criteria for detention, but no imminent danger exists, then the DMHP may initiate a non-emergent detention by petitioning the superior court for an order to detain. There are variances between counties on this. **Note:** Imminent danger is not required for the emergency detention of minors.

5. What appropriate alternatives to involuntary hospitalization exist? Will the person voluntarily accept appropriate, available, less restrictive treatment options?

In evaluating a person for involuntary treatment, DMHPs investigate not only the immediate circumstances around the request for the evaluation, but also must consider reasonably available history. This includes reviewing reasonably available records and/or databases in order to obtain the person's background and history prior to interviewing the person to be investigated. If family members are available and deemed credible, the DMHP will interview them to obtain further information and may request a written statement. The DMHP reviews, if available, at a minimum, a person's history of violent acts, suicide attempts and prior detentions/commitments.

This information should always be considered in light of the intent to provide prompt evaluation, as well as, timely and appropriate treatment.

WHAT HAPPENS AFTER AN INVOLUNTARY ADMISSION TAKES PLACE?

When a person is detained, he or she is entitled to a court hearing within 72 hours of the initial detention. This is called a probable cause hearing. Weekends and holidays are excluded in the calculation of the initial 72 hours. The treating psychiatrist/physician or psychiatric Advanced Registered Nurse Practitioner (ARNP) may discharge any patient at any time during a commitment if, in their opinion, the criteria for involuntary treatment are no longer being met. The focus of the probable cause hearing is to determine if the person continues to require involuntary treatment. In the hearing, it will be determined whether the initial commitment was appropriate and, if so, does the person still present a danger to themselves, others or property or is gravely disabled as the result of an acute mental disorder. Family member/natural support input is generally encouraged in preparation for these hearings. The judge has the option of continuing the detention, discharging the individual back home on a voluntary basis (dismissal of petition), or releasing the person on a Less Restrictive Order (LRO or LR). An LR contains a number of requirements. These are called the "conditions" of the LR. Examples include taking medications as prescribed, attending scheduled appointments, not using non-prescribed drugs or alcohol, refraining from threats or acts of harm toward themselves or others, and not having access to weapons.

COURT ORDERS (LESS RESTRICTIVE ORDER AND CONDITIONAL RELEASE)

When a person is released on an LR, they receive a written notice containing the conditions of their release. Caregivers, including those providing residential supports and the mental health system, are expected to support the individual in meeting these conditions. This includes getting the person

to appointments, and working closely together as service providers to address problems in a proactive manner. Family members/natural supports can also help the individual adhere to the conditions especially if the individual resides with them.

There is another type of court order called a Conditional Release (CR). When an individual is committed to the hospital for 14 days or 90 days (this is called the More Restrictive Order (MRO)) the treating physician can decide to discharge the person on a CR. He/she must have an accepting outpatient provider to follow up on the CR. The physician writes a document outlining the conditions the person agrees to follow. This document is given to the receiving outpatient provider, the individual on the CR and is filed with the court without a hearing taking place.

Sometimes, however, people either do not follow through on the conditions of their LR/CR or experience substantial deterioration in their functioning even when following the conditions. Under these circumstances, a DMHP may file a petition for revocation which places the individual back in the hospital for up to five days (including holidays & weekends) pending a revocation hearing. This hearing is held in order to determine whether the individual needs to be returned to inpatient status ("revoked") for up to however many days are left on the order. Whenever possible, the person will be stabilized and released back to where they were living, often on the same LR/CR. The facility may choose to release the person on the existing LR/CR without requesting a court hearing.

When a DMHP receives notice that an individual has violated the conditions of their LR/CR and/or is experiencing substantial deterioration that requires inpatient treatment it is at their discretion to file a petition for revocation. However, if a DMHP is notified by the treatment provider that an individual has violated the conditions and, as a result, poses an increased likelihood of serious harm, the DMHP is **required** to file a petition for revocation. The treatment provider is then **required** to submit an affidavit detailing the reason(s) for the "shall revoke" and be prepared to provide the main court testimony. Note: this does **not** guarantee a revocation hearing **and** the person could still be discharged by the treating psychiatrist/physician/psychiatric ARNP.

When serving a person on a LR/CR, it is required that the agency keep a copy of the court document listing the conditions in the clinical record. It is important to provide this document to the DMHP if requested. It is also necessary that the person communicating with the DMHP has specific knowledge about how the person on the LR/CR has violated the order (See Policy 1562.00), problems they have experienced that are causing the concerns, and what steps have been taken or considered to help support the person in a less restrictive way/setting. This information is crucial in determining whether the filing of a petition for revocation is appropriate and necessary. Family members/natural supports are often the first persons to identify the individual's non-adherence or deterioration and can share this information with the clinician without compromising confidentiality requirements. If the individual has not authorized the release of information, the clinician may simply listen to the family's concerns without revealing protected information. **Note:** A LR/CR is not intended to be used in a punitive manner, but to help the in individual maintain their health and safety in the community.

GLOSSARY OF TERMS

Crisis – A situation where an individual is acutely mentally ill or experiencing a serious disruption in cognitive, volitional, psychosocial, or neuro-physiological functioning.

Conditional Release (CR) is a court order that is filed by the treating physician during the involuntary inpatient commitment. This order specifies what the person needs to do to remain in the community. It differs from an LR in length and because there is no court hearing.

Designated Mental Health Professional (DMHP) is a mental health clinician appointed by the County to perform the duties specified in chapters RCW 71.05 and 71.34. This includes having the legal authority to detain a person against their will for up to 72 hours.

Evaluation and Treatment Center (**E&T) –** The North Sound Region operates one (1) facility via contract with Compass Health, in Mukilteo (Mukilteo E&T). This program provides involuntary evaluation and treatment to those detained by the DMHP staff. Other inpatient psychiatric facilities are licensed as Evaluation and Treatment Centers, but most often the term "E&T" refers to the regional facility.

Integrated Crisis Response System (ICRS) – This is the service system that provides crisis response interventions throughout Island, San Juan, Skagit, Snohomish and Whatcom Counties. Service providers include VOA, Compass Health, Snohomish County Human Services and Whatcom Counseling and Psychiatric Clinic and Pioneer Human Services.

Mental Illness Involuntary Treatment Act (ITA) – RCW 71.05 and Mental Health Services for Minors – RCW 71.34. These are the laws that allow persons who are a danger to themselves, others, property or who are gravely disabled as the result of a mental disorder to be detained against their will for inpatient psychiatric treatment.

Less Restrictive Order/Less Restrictive Alternative (LRO/LRA) – A court order that is put in place, by court hearing or stipulation, for some individuals after they have been involuntarily detained. This order specifies what the person needs to do to remain in the community after discharge from an inpatient unit.

CCRS Triage Clinician: The mental health professional at the Crisis Line, who coordinates services, dispatches the DMHP, Mobile Outreach Team (MOT), Emergency Mental Health Clinicians (EMHCs) and provides telephone-based support 24 hours a day.

Volunteers of America (VOA) Care Crisis Response Services (CCRS) – Provides telephone-based support and triage through the Crisis Line. The CCRS Triage Clinician can also schedule Urgent Appointments and dispatch local crisis response teams when face-to-face interventions are required.

Integrated Crisis Response NSMHA Training Module

Post-Test

Please circle the appropriate response to indicate whether the following statements are true or false:

1. T/F Individuals and the general public should be instructed to call the VOA CCRS Triage Clinician if they feel that they are in crisis.

2. T/F Crisis alerts expire after 10 days if they are not renewed.

3. T/F Crisis services appointments are only for individuals who are currently enrolled in services.

4. T/F When requesting admission for voluntary hospitalization, one should be prepared to discuss what less restrictive options have been considered.

5. T/F When DMHPs are doing an assessment for initial detention they are required to consider reasonably available history.

6. T/F When someone is on a LR or CR, it is not important to keep a copy of the order.

7. T/F Any person who is in crisis and who is physically located within the North Sound region is eligible for crisis response services

8. T/F Once a person is detained, a court hearing must be held within 48 hours to determine if he/she continues to meet commitment criteria.

Please fill in the appropriate response for each of the following statements:

1. Once dispatched, crisis response staff must make face-to-face contact within _____ hours.

2. What type of service should be considered when a individual is unwilling to accept voluntary services and presents a likelihood of serious harm to him/herself as the result of a mental disorder but is not in imminent danger? _____

3. When a person is discharged from an evaluation and treatment center on a LR, the requirements/constraints on their behavior are referred to as the _____ of their release.

4. When someone is returned to an inpatient unit for not complying with an LR, the process is called a _____.

Discussion questions *(will be reviewed by your supervisor, but not scored)***:**

1. How can crisis plans assist enrolled individuals who are in crisis?

2. Provide 3 situations in which using a crisis alert would be appropriate.

3. What is the clinician's role when voluntary hospitalization may be needed to support a person on his/her caseload?

WRITING AN AFFIDAVIT

See "How to Write an Affidavit" on the NSMHA website at:
http://nsmha.org/Committee/RTC/ICRS/Writing_an_Affidavit.pdf

North Sound Mental Health Administration
Regional Support Network for Island, San Juan, Skagit, Snohomish, and Whatcom Counties
117 North First Street, Suite 8 • Mount Vernon, WA 98273 • 360.416.7013
800.684.3555 • Fax 360.416.7017 • TTY 360.419.9008 • Email nsrsn@nsrsn.org • Web Site http://nsmha.org

NORTH SOUND MENTAL HEALTH ADMINISTRATION

INTEGRATED CRISIS RESPONSE SYSTEM TRAINING MODULE

TABLE OF CONTENTS

TRAINING OBJECTIVES:

1. Orient clinicians to the mental health crisis system's processes, resources and requirements.
2. Educate clinicians regarding voluntary and involuntary hospitalization.
3. Educate clinicians regarding involuntary treatment laws and processes.
4. Provide guidance regarding the completion of an affidavit for initial detention or petition to revoke.

INTRODUCTION

Crisis Services are one of the major components of public mental health services. Crisis services are available to all individuals and families physically located in the North Sound region's five counties, regardless of enrollment status with service providers, ability to pay, or funding source. Services are available on a 24 hour basis for those who are in a self-defined state of crisis (a turning point in the course of anything decisive or critical; a time, a stage or an event of great danger or trouble, whose outcome decides whether possible bad consequences will follow).

Crisis Services include a broad array of services: telephone-based crisis assessment and support, outreach, crisis triage centers and involuntary treatment assessments. Crisis services are intended to stabilize the individual in crisis in the least restrictive community setting possible. Services are matched to the individual's need and severity of the crisis. An individual in crisis is served from a non-stigmatizing, person-oriented approach, including responsive listening and respectful attention.[1] Crisis Services staff actively involve and collaborate with family members and other natural supports during a crisis as appropriate and within limits of confidentiality. **Note:** Triage Centers in the North Sound Region may have some restrictions to admission for Chemical Dependency services based upon county of residence of the referred individual.

Crisis Services are provided by the following agencies in the following counties:

County	Voluntary Crisis Services	Involuntary Investigations	Triage Centers	Mobile Outreach Team
Island	Compass Health	Compass Health	Island County residents may access triage if transportation can be arranged	Not available in Island County
San Juan	Compass Health	Compass Health	San Juan County residents may access triage if transportation can be arranged	Not available in San Juan County
Skagit	Compass Health	Compass Health	Pioneer Human Services	Pioneer Human Services
Snohomish	Compass Health	Snohomish County Human Services	Compass Health	Not available in Snohomish County
Whatcom	Whatcom Counseling and Psychiatric Clinic (WCPC)	WCPC	WCPC	WCPC

WHAT ARE THE PRINCIPLES OF THE ICRS?

1. Crisis services include voluntary and involuntary service options.
2. Crisis services are delivered across social service systems in a fully integrated, seamless and consistent manner.

[1] See Journal of Psychiatric Practice, Vol. 9, No. 1: *Individuals' Wants and Needs During a Psychiatric Emergency*

3. An individual in crisis is treated as a whole person, rather than focusing on categorical problems.
4. A crisis is self-defined, rather than needing to meet categorical criteria.
5. An individual in crisis will have easy and timely access to appropriate intervention and care.
6. Clinicians involved in crisis response intervention will be able to refer to a complete continuum of care in order to respond to a variety of needs.
7. Individuals experiencing a behavioral health crisis will be stabilized in the least restrictive setting, in the individual's home or in any in vivo setting, and will be referred to the least restrictive resource available to manage the crisis.
8. Crisis response services are community-based.
9. Crisis response services are available to both adults and children.
10. Crisis services and information will be available 24 hours a day, 365 days a year throughout the Region.
11. Crisis services will be fully integrated and coordinated at both the local and regional level.
12. All crisis services will be culturally competent and responsive.
13. Standards of care will be adhered to throughout the region.
14. Crisis services will be provided in a manner recognizing the uniqueness of each individual.
15. The integrated crisis system will utilize a flexible array of services and supports, formal and informal, which fit the needs of the individual.

WHAT TOOLS ARE AVAILABLE FOR MANAGING CRISES?

CRISIS PLANS

The crisis plan is a document that the outpatient clinician develops in collaboration with the North Sound Mental Health Administration (NSMHA) enrolled individual and his/her family and/or other natural supports. The plan is intended to help both the clinician and ~~the~~ individual in the event that ~~the individual~~he/she experiences a crisis during treatment. Working together, the outpatient clinician and the individual anticipate potential problems that might create a crisis ~~for the individual~~. The outpatient clinician helps the individual identify his/her specific triggers, ~~or~~ "red flags", or early warning signs, ~~that~~ and alert ~~the individual~~him/her that trouble may be developing. The outpatient clinician and the individual then make a plan for what ~~the individual will~~to do when the individual sees these early warning signs. The plan starts with low intensity interventions that the individual can probably accomplish on his/her own, then progresses to interventions of increasing intensity that include family, natural supports and possibly professional staff. A copy of the crisis plan is kept in the individual's chart, ~~a copy is~~ given to the individual, and ~~a copy is~~ given to the identified family or natural supports with the individual's approval.

CCRS receives and stores crisis plan information as well. If the individual or a family member/ natural support calls the Crisis Line during a crisis, the Crisis Line staff can provide assistance based on the information in the crisis plan. When responding to a crisis, clinicians, CCRS, and crisis services workers will continue to work with family members and other natural supports to best support the individual within limits of confidentiality. Crisis plans shall be reviewed at least every 180 days, updated to reflect any changes in the individual's needs, or as requested by the individual, their parent, or other legal representative. This shall include any known safety concerns. See NSMHA Policy 1551 for additional requirements related to crisis plans.

CRISIS ALERTS

Crisis alerts contain important up-to-date information about individuals who are likely to require crisis services within the next 10 days. Crisis alerts are created by clinicians and contain information pertinent to the current crisis situation, in contrast to crisis plans, which contain long-term strategies. CCRS receives, stores, and utilizes this time-sensitive information, and makes it available to Mobile Outreach Teams (MOT), Emergency Mental Health Clinicians (EMHC) and Designated Mental Health Professional (DMHP) staff to assess risk and effectively intervene in a crisis. Crisis alerts are kept on file for 10 days and can be renewed if clinically warranted.

MENTAL HEALTH ADVANCE DIRECTIVES

A Mental Health Advance Directive is a written document, consistent with the provisions of RCW (Revised Code of Washington) 71.32, in which a person makes a declaration of instructions or preferences and/or appoints an agent to make decisions on her/his behalf regarding that individual's mental health treatment during times when he/she is incapacitated by a mental disorder and cannot give informed consent. If the clinician has received an individual's advance directive, it will become part of the individual's medical record and the clinician will be considered to have actual knowledge of its contents. More information regarding compliance and conditions for noncompliance can be found in RCW 71.32.150, RCW 7.70.40 and in NSMHA Policy 1518.

WELLNESS RECOVERY ACTION PLAN (WRAP)

WRAP® is an Evidenced Based self-management and recovery system designed by Mary Ellen Copeland and developed by a group of people who had mental health difficulties and were struggling to incorporate wellness tools and strategies into their lives. WRAP is designed to:

1. Decrease and prevent intrusive or troubling feelings and behaviors;
2. Increase personal empowerment;
3. Improve quality of life; and
4. Assist people in achieving their own life goals and dreams.

WRAP is a structured system to monitor uncomfortable and distressing feelings and behaviors and, through planned responses, reduce, modify or eliminate them. It also includes plans for responses from others when individuals cannot make decisions, take care of themselves or keep safe.

**The clinician may ask if an individual has a crisis plan, mental health advance directive or WRAP, but he/she may have chosen not to create these plans. The mental health advance directive and WRAP are not available through VOA.*

WHAT IS THE ROLE OF VOA CARE CRISIS RESPONSE SERVICES (CCRS)?

CARE CRISIS LINE~~CRS~~

CCRS provides 24-hour a day, 7 day a week, professionally staffed crisis line system. When someone is in distress and is seeking assistance with a crisis situation, he/she should call the Crisis Line at 1-800-584-3578. They provide a range of support and referral services including:

A. Making requested mental health referrals to the community;
B. Having access to language bank interpreters and TDD equipment;
C. Assuring referral to age and culturally appropriate services and specialists;

D. Scheduling crisis appointments;
E. Providing telephone stabilization and intervention services for individuals with non-acute issues;
F. Assuring timely and consistent crisis response;
G. Providing telephone consultation, intervention and stabilization for individuals and/or family members/natural supports as appropriate and within limits of confidentiality;
H. Determining when face-to-face services are needed, both voluntary and involuntary, and dispatching a DMHP, MOT or EMHC;
I. Tracking the outcome of face-to-face services and seeing if further services are warranted;
J. Deciding when cross-system services are needed;
K. Working closely with law enforcement when appropriate;
L. Consulting with detoxification providers, licensed care facilities, hospitals and other community providers;
M. Troubleshooting cross-system referrals in which there is a difference of opinion of appropriate services or system response; and
N. Providing telephone follow-up with individuals after-hours as part of an individual crisis plan.

TRIAGE SERVICES

VOA CCRS Triage Clinicians are Masters-level mental health professionals. When a professional wishes to speak with someone at the Crisis Line, they can contact the CCRS Triage Clinician directly at 1-800-747-8654.

The CCRS Triage Clinician will have the responsibility of deciding when face-to-face evaluation and/or stabilization services are needed and dispatch the MOT, EMHC, and/or DMHP staff to a community location outside of the provider's office. The MOT, EMHC, or DMHP may not decline a referral for face-to-face services, but decides if backup or other provisions are needed to mitigate risk.

Outreach services shall be provided within two (2) hours of dispatch by the CCRS Triage Clinician.

MOT, EMHC, and DMHP will report the disposition of the case back to the CCRS Triage Clinician by phone or fax within one (1) hour of the completion of the case and to law enforcement when requested.

WHAT FACE-TO-FACE SERVICES ARE AVAILABLE?

CRISIS SERVICES APPOINTMENTS

Urgent and follow-up appointments are available for adults and children who are not currently enrolled in the public mental health system, are determined to be in need of face-to-face evaluation or intervention, and who meet certain criteria. Appointments are available at provider agencies in each county, and are scheduled by VOA CCRS staff. Crisis Services appointments provide brief treatment on a voluntary basis, generally for persons at risk of harm to self or others, at risk of hospitalization, and/or who may be in need of a referral for an emergency medication evaluation. Enrolled individuals' urgent needs will be addressed by their outpatient clinician, treatment team or backup as appropriate.

EMERGENCY PSYCHIATRIC SERVICES

Emergency psychiatric medication evaluations are available for those ~~that~~ individuals who have been assessed by an EMHC or DMHP and deemed at risk of ~~imminent~~ hospitalization. Access to these psychiatric appointments is through the EMHC or DMHP. This process varies from county to county. Follow up psychiatric consultations are available when clinically indicated by the prescriber. Generally this service is used for non-enrolled individuals.

OUTREACH

Outreach is the provision of face-to-face evaluation and/or intervention services (voluntary or involuntary) in community locations. The expectation is that emergency outreach clinicians providing crisis response services will provide services to the individual in the community. Outreach services are an important and available service, both when necessary to support the person in crisis and to provide services in the least restrictive, appropriate manner, with the use of family and natural supports within limits of confidentiality. The intent, however, is never to promote outreach at the expense of anyone's safety – including individual, staff, family/natural support, and the public.

EMHCs/DMHPs must respond to pages from the VOA within 10 minutes. Once dispatched, the EMHC and DMHP must be on-site with the person in crisis within 2 hours. Within 1 hour following the completion of any outreach, the EMHC and DMHP calls the CCRS Triage Clinician to relay the disposition of the case back to the CCRS Triage Clinician and, when appropriate, the referral source, to include the individual's clinician. If EMHC or DMHP is unable to arrive to the dispatch location within two hours due high volume, inclement weather, etc., they will document the reason for the delay.

MOBILE OUTREACH TEAM (MOT)

Mobile Outreach is a community service available in Skagit and Whatcom counties for individuals and families not currently enrolled in Medicaid outpatient services. These teams are intended to respond to non-emergent mental health situations, defined as situations where the level of stress has overwhelmed the individual's ability to cope. The teams are available to provide early intervention to assess, engage, and provide temporary support and make referrals to community resources. These teams can be accessed by calling the VOA Care Crisis Line or directly contacting the provider. The teams are designed to integrate with the existing Emergency Services and Involuntary Treatment Investigation Services.

INVOLUNTARY INVESTIGATION SERVICES

Involuntary investigations are another crisis service available in all five counties and performed by the DMHPs. These individuals have specialized training in performing mental health investigations, and are designated by their counties. Their role is to assess for danger to self, others, property and/or grave disability as a result of an acute mental disorder. They work closely with the voluntary teams, hospitals, triage facilities, and other allied systems. Their specific role and investigation procedures are further detailed later in this module.

WHAT SERVICES ARE AVAILABLE FOR ADULTS ENROLLED WITH THE DIVISION OF DEVELOPMENTAL DISABILITIES (DDD)?

For adults (18 or older) who are enrolled with the DDD, there are additional services that are available during times of crisis. These services are based on an urgent, not emergent, model and rely upon referral from the DDD Case Manager during business hours.

The EMHC/DMHP can check on an individual's enrollment status by calling the Care Crisis Line. An assessment for stabilization services can be arranged through the DDD Mental Health/ Developmental Disability Resource Manager, if criteria are met (enrolled with DDD, not currently enrolled with the RSN, and at risk of hospitalization or loss of placement).

Region 2-North DDD also has access to one Hospital Diversion bed located in North Seattle. Referrals for hospital diversion bed services should be made to the DDD Mental Health/ Developmental Disability Resource Manager.

WHAT RESIDENTIALLY BASED CRISIS SERVICES EXIST IN THE REGION?

Crisis stabilization/triage facilities for adults are located in Whatcom, Skagit, and Snohomish counties. These programs typically provide short-term support (up to 5 days) in a staffed facility for adults who are in or at high risk of experiencing a mental health crisis. The programs in Skagit and Whatcom Counties provide sub-acute detoxification and the program in Snohomish ~~Counties~~ County ~~are able to provide limited~~ provides (non-medical) sobering services for chemically abusing or dependent individuals. ~~The program in Skagit County is able to provide sub-acute detoxification services for chemically abusing or dependent individuals.~~ When an outpatient clinician believes that an individual would benefit from crisis stabilization/triage, they may call the facility directly to make the referral or call the Care Crisis Line and speak to a CCRS Triage Clinician to make the referral. Staff at each facility is trained to review the presenting information and establish whether placement is appropriate.

WHATCOM COUNTY BEHAVIORAL HEALTH TRIAGE CENTER (WCBHTC)

Pioneer Human Services and Whatcom Counseling and Psychiatric Clinic have a cooperative agreement to provide crisis services and sub acute detoxification services at the WCBHTC. Pioneer Human Services has started a suboxone program on site and has a physician who runs a suboxone clinic several times a week.

WCBHTC is licensed for 13 beds, 8 beds are designated for detoxification and 5 beds are designated for crisis stabilization. The residential services are 24/7 and the usual length of stay in both programs is between 3 to 5 days. This is a less restrictive option to hospitalization. The services offered at WCBHTC are voluntary. Referral sources include, but are not limited to, hospital staff and social workers, case managers, law enforcement, correctional officers and jail staff.

There are DMHPs housed at the site who can assist with crises that may need their expertise. ~~These DMHPs also work with individuals who are in the adjoining jail and are in need of mental health assessments.~~ A Physician~~'s~~ Assistant is available to assist residents in stabilization beds with their

basic medical needs, as well as, being available to staff for medical consultations. A strong and developing part of WCBHTC is the utilization of Certified Peer Counselors who provide supportive services to those in residence. WCBHTC also provides access to the Behavioral Health Access Program (BHAP) that provides mental health and chemical dependency treatment for residents who have no source of funding. BHAP workers regularly interview their individuals on site.

~~The Mobile Outreach Team (MOT), housed at WCBHTC, provides voluntary outreach and consultation to the community for individuals who are in "pre-crisis" and who can be stabilized without more intensive interventions.~~

SKAGIT COUNTY CRISIS CENTER (SCCC)

Pioneer Human Services operates the Skagit County Crisis Center (SCCC) in Burlington, WA. The SCCC provides short-term stabilization services for individuals who are experiencing a mental health crisis or are experiencing the effects of intoxicants and require sub-acute detoxification services. SCCC will provide supportive care 24 hours a day, 7 days a week, for individuals while they stabilize from a mental health crisis or withdraw from the transitory effects of intoxication. SCCC is a non-medical, community based program that offers a less-restrictive placement option to inpatient hospitalization, or acute detoxification. This facility is a voluntary unit and does not use restraints or seclusion.

~~The Mobile Outreach Team (MOT), housed at SCCC, provides voluntary outreach and consultation to the community for individuals who are in "pre-crisis" and who can be stabilized without more intensive interventions.~~

SCCC services are based on a Strength-based Recovery model and utilize SAMHSA Principles of Recovery. Staffing includes Chemical Dependency Professionals, Mental Health Professionals (MHPs), Certified Peer Counselors, as well as, other professional staff. Referrals can be made by community professional staff, to include case managers, chemical dependency providers, mental health clinicians, hospital social workers and discharge planning staff, and law enforcement.

SCCC is a combined facility providing integrated care for individuals who are experiencing mental health and/or chemical dependency issues. It is unable to accept individuals who are leveled sex offenders, violent, assaultive or have a history of fire setting.

1. Sub-acute detoxification referrals:
    a. Sub Acute Detoxification placement is offered at ~~Skagit County Crisis Center~~SCCC. As with other non-medical, detoxification service facilities, ~~Skagit County Crisis Center~~SCCC is unable to accept individuals who are detoxing from benzodiazepines or barbiturates.
    b. Face-to-face assessment may be necessary and completed by medical personnel to determine the appropriateness of placement in a non-medical setting for unknown persons or those with known history of severe withdrawal symptoms. Referrals will also be accepted from community providers using the Community Professional/Case Manager Screening Form.
    c. The referral source will contact the SCCC regarding the availability and the appropriateness (review inclusion/exclusion criteria) of the placement.

If the placement is appropriate and the SCCC agrees to accept the individual, the referral source or SCCC staff will arrange for appropriate transportation.

SNOHOMISH COUNTY TRIAGE CENTER (SCTC)

Compass Health operates the ~~Snohomish County Triage Center (~~SCTC~~)~~ in Everett. This facility provides short-term stabilization services for individuals experiencing a behavioral health crisis, which might include mental health or chemical abuse/dependency symptoms. The program does not provide detoxification services, but does provide support to those who are sobering.

SCTC services are based on a Recovery Model, and staffing includes Certified Peer Counselors, as well as, other professional staff. Referrals can be made by a wide range of professional staff to include case managers, chemical dependency providers, mental health clinicians, hospital social work and discharge planning staff, and others. Additionally, this facility is "locked", and accepts direct referrals from any Snohomish County Law Enforcement officer as a diversion from jail or hospital emergency departments.

Duration of stay averages three to four days, but may be as short as one day or as long as five with the need for continued stay based on clinical criteria to include presentation and strength of discharge planning.

1. Referral Process:

    a. For Mental Health Clinicians or Case Managers, referral to any of this program can be accomplished by calling the program directly. Program staff will complete a screening questionnaire during the call, and will evaluate the referral to determine whether any exclusionary criteria are present. Generally an answer to the referral can be made during this initial call but sometimes some internal consultation is necessary. Program staff is committed to providing an answer to the referral as quickly as possible.
    b. For Mental Health Clinicians or Case Managers, it is generally expected that the individual being referred has been seen recently and evaluated as being in need of this level of care.
    c. Once accepted, it is the responsibility of the referring Mental Health Clinician or Case Manager to ensure safe transportation to the facility and to assist with all details related to admission. These details may include obtaining medications, communicating with other supports/systems, assisting with obtaining releases to facilitate discharge planning, etc.

2. Length of Stay/Discharge Planning:

    a. The length of stay is limited; up to 5 days but extensions are available if clinically warranted.
    b. The discharge planning will begin at the time of initial placement at the facility.

WHAT IS THE PROCESS FOR PSYCHIATRIC HOSPITALIZATION?

VOLUNTARY HOSPITALIZATION

The clinician evaluates whether a less restrictive option such as increased outpatient services, staying with family or natural supports, a crisis triage center stay, might be sufficient to stabilize the individual. If all less restrictive options are ruled out (i.e., have been tried unsuccessfully, are inappropriate for some clear and documentable reason), the clinician may proceed with the voluntary hospitalization process.

The VOA Inpatient Utilization Management Team conducts the authorization process for voluntary psychiatric hospitalization for all Medicaid and Medicaid-eligible residents of the North Sound region. The program is available 24 hours per day, 7 days per week. When a clinician feels that the individual they have assessed requires psychiatric hospitalization they must do the following:

1. Contact a psychiatric hospital and secure a bed.
2. After a bed has been identified, but before admission, the clinician must call VOA at 1-800-707-4656 and request the authorization.

    a. The clinician will have to provide clinical and demographic information;
    b. Discuss and justify the reasons, including specific symptoms and behaviors, requiring inpatient hospital care;
    c. Describe what less restrictive options have been attempted.

3. VOA consults with a psychiatrist on all requests for hospitalization of children/youth and on any requests for which medical necessity is in question.
4. If the individual meets medical necessity criteria the hospitalization episode will be authorized. For those requests that are denied, the consumer has the right to appeal or grieve and the admitting psychiatric facility has the right to appeal (see NSMHA policies 1001-1004 and 1020).
5. The outpatient clinician may then make the final arrangements for admission (e.g., contacting the hospital to notify of authorization or denial, transportation, etc). In those instances where a denial has been issued and an admission will not occur, the outpatient clinician is responsible for developing an alternative plan with the individual to address the individual's needs.

ASSESSMENTS FOR INVOLUNTARY TREATMENT

Persons who are alleged to be a danger to themselves, others or property or are gravely disabled (unable to meet their basic needs of health and safety) as the result of an acute mental disorder may be assessed for involuntary treatment.

Note: ~~Persons~~ Individuals, who are developmentally disabled, impaired by chronic alcoholism or drug abuse, or suffering from dementia shall not be detained ~~for evaluation and treatment or judicially committed~~ solely by reason of that condition ~~unless such condition causes a person to be gravely disabled or, as a result of a mental disorder such condition~~ there exists that ~~constitutes a likelihood of serious harm. Straight out of 71.05 – we left out part 2 – might want to add. 71.05.040~~. The detention may be appropriate if said condition meets the definition of acute mental disorder as defined in RCW 71.05 and detention grounds are met.

In Washington State, DMHPs conduct all assessments for involuntary treatment. In assessing whether or not a person should be detained against their will to an inpatient psychiatric unit DMHPs focus their evaluations on the following questions:

1. Is the person suffering from an acute mental disorder? RCW 71.05 defines mental disorder as "any organic, mental or emotional disorder which has substantial adverse effects on an individual's cognitive and volitional functions."
2. Is there evidence that the person, as the result of mental disorder:

    a. Presents a likelihood of serious harm to him or herself, other persons, or the property of others; or
    b. May be gravely disabled?

3. Does imminent danger exist?

    a. A DMHP should take a person into emergency custody only when the person presents an **imminent** likelihood of serious harm or is in imminent danger because they are gravely disabled.
    b. Before filing the petition, the DMHP must personally interview the person, unless the person refuses an interview, and determine whether the person will voluntarily receive appropriate evaluation and treatment at an evaluation and treatment facility.

4. Does the person present, as a result of a mental disorder, likelihood of serious harm, or grave disability, but without imminent danger?

    a. If the person does meet criteria for detention, but no imminent danger exists, then the DMHP may initiate a non-emergent detention by petitioning the superior court for an order to detain. There are variances between counties on this. **Note:** Imminent danger is not required for the emergency detention of minors.

5. What appropriate alternatives to involuntary hospitalization exist? Will the person voluntarily accept appropriate, available, less restrictive treatment options?

In evaluating a person for involuntary treatment, DMHPs investigate not only the immediate circumstances around the request for the evaluation, but also must consider reasonably available history. This includes reviewing reasonably available records and/or databases in order to obtain the person's background and history prior to interviewing the person to be investigated. If family members are available and deemed credible, the DMHP will interview them to obtain further information and may request a written statement. The DMHP reviews, if available, at a minimum, a person's history of violent acts, suicide attempts and prior detentions/commitments.

This information should always be considered in light of the intent to provide prompt evaluation, as well as, timely and appropriate treatment.

WHAT HAPPENS AFTER AN INVOLUNTARY ADMISSION TAKES PLACE?

When a person is detained, he or she is entitled to a court hearing within 72 hours of the initial detention. This is called a probable cause hearing. Weekends and holidays are excluded in the calculation of the initial 72 hours. The treating psychiatrist/physician or psychiatric Advanced Registered Nurse Practitioner (ARNP) may discharge any patient at any time during a commitment if, in their opinion, the criteria for involuntary treatment are no longer being met. The focus of the probable cause hearing is to determine if the person continues to require involuntary treatment. In the hearing, it will be determined whether the initial commitment was appropriate and, if so, does the person still present a danger to themselves, others or property or is gravely disabled as the result of an acute mental disorder. Family member/natural support input is generally encouraged in preparation for these hearings. The judge has the option of continuing the detention, discharging the individual back home on a voluntary basis (dismissal of petition), or releasing the person on a Less Restrictive Order (LRO or LR). An LR contains a number of requirements. These are called the "conditions" of the LR. Examples include taking medications as prescribed, attending scheduled appointments, not using non-prescribed drugs or alcohol, refraining from threats or acts of harm toward themselves or others, and not having access to weapons.

COURT ORDERS (LESS RESTRICTIVE ORDER AND CONDITIONAL RELEASE)

When a person is released on an LR, they receive a written notice containing the conditions of their release. Caregivers, including those providing residential supports and the mental health system, are expected to support the individual in meeting these conditions. This includes getting the person to appointments, and working closely together as service providers to address problems in a proactive manner. Family members/natural supports can also help the individual adhere to the conditions especially if the individual resides with them.

There is another type of court order called a Conditional Release (CR). When an individual is committed to the hospital for 14 days or 90 days (this is called the More Restrictive Order (MRO)) the treating physician can decide to discharge the person on a CR. He/she must have an accepting outpatient provider to follow up on the CR. The physician writes a document outlining the conditions the person agrees to follow. This document is given to the receiving outpatient provider, the individual on the CR and is filed with the court without a hearing taking place.

Sometimes, however, people either do not follow through on the conditions of their LR/CR or experience substantial deterioration in their functioning even when following the conditions. Under these circumstances, a DMHP may file a petition for revocation which places the individual back in the hospital for up to five days (including holidays & weekends) pending a revocation hearing. This hearing is held in order to determine whether the individual needs to be returned to inpatient status ("revoked") for up to however many days are left on the order. Whenever possible, the person will be stabilized and released back to where they were living, often on the same LR/CR. The facility may choose to release the person on the existing LR/CR without requesting a court hearing.

When a DMHP receives notice that an individual has violated the conditions of their LR/CR and/or is experiencing substantial deterioration that requires inpatient treatment it is at their discretion to file a petition for revocation. However, if a DMHP is notified by the treatment provider that an individual has violated the conditions and, as a result, poses an increased likelihood of serious

harm, the DMHP is **required** to file a petition for revocation. The treatment provider is then **required** to submit an affidavit detailing the reason(s) for the "shall revoke" and be prepared to provide the main court testimony. Note: this does **not** guarantee a revocation hearing **and** the person could still be discharged by the treating psychiatrist/physician/psychiatric ARNP.

When serving a person on a LR/CR, it is required that the agency keep a copy of the court document listing the conditions in the clinical record. It is important to provide this document to the DMHP if requested. It is also necessary that the person communicating with the DMHP has specific knowledge about how the person on the LR/CR has violated the order (See Policy 1562.00), problems they have experienced that are causing the concerns, and what steps have been taken, or considered to help support the person in a less restrictive way/setting. This information is crucial in determining whether the filing of a petition for revocation is appropriate and necessary. Family members/natural supports are often the first persons to identify the individual's non-adherence or deterioration and can share this information with the clinician without compromising confidentiality requirements. If the individual has not authorized the release of information, the clinician may simply listen to the family's concerns without revealing protected information. **Note:** A LR/CR is not intended to be used in a punitive manner, but to help the in individual maintain their health and safety in the community.

GLOSSARY OF TERMS

Crisis – A situation where an individual is acutely mentally ill or experiencing a serious disruption in cognitive, volitional, psychosocial, or neuro-physiological functioning.

Conditional Release (CR) is a court order that is filed by the treating physician during the involuntary inpatient commitment. This order specifies what the person needs to do to remain in the community. It differs from an LR in length and because there is no court hearing.

Designated Mental Health Professional (DMHP) is a mental health clinician appointed by the County to perform the duties specified in chapters RCW 71.05 and 71.34. This includes having the legal authority to detain a person against their will for up to 72 hours.

Evaluation and Treatment Center (**E&T) –** The North Sound Region operates one (1) facility via contract with Compass Health, in Mukilteo (Mukilteo E&T). This program provides involuntary evaluation and treatment to those detained by the DMHP staff. Other inpatient psychiatric facilities are licensed as Evaluation and Treatment Centers, but most often the term "E&T" refers to the regional facility.

Integrated Crisis Response System (ICRS) – This is the service system that provides crisis response interventions throughout Island, San Juan, Skagit, Snohomish and Whatcom Counties. Service providers include VOA, Compass Health, Snohomish County Human Services and Whatcom Counseling and Psychiatric Clinic and Pioneer Human Services.

Mental Illness Involuntary Treatment Act (ITA) – RCW 71.05 and Mental Health Services for Minors – RCW 71.34. These are the laws that allow persons who are a danger to themselves, others, property or who are gravely disabled as the result of a mental disorder to be detained against their will for inpatient psychiatric treatment.

Less Restrictive Order/Less Restrictive Alternative (LRO/LRA) – A court order that is put in place, by court hearing or stipulation, for some individuals after they have been involuntarily detained. This order specifies what the person needs to do to remain in the community after discharge from an inpatient unit.

CCRS Triage Clinician: The mental health professional at the Crisis Line, who coordinates services, dispatches the DMHP, Mobile Outreach Team (MOT), Emergency Mental Health Clinicians (EMHCs) and provides telephone-based support 24 hours a day.

Volunteers of America (VOA) Care Crisis Response Services (CCRS) – Provides telephone-based support and triage through the Crisis Line. The CCRS Triage Clinician can also schedule Urgent Appointments and dispatch local crisis response teams when face-to-face interventions are required.

Integrated Crisis Response NSMHA Training Module

Post-Test

Please circle the appropriate response to indicate whether the following statements are true or false:

1. T/F Individuals and the general public should be instructed to call the VOA CCRS Triage Clinician if they feel that they are in crisis.

2. T/F Crisis alerts expire after 10 days if they are not renewed.

3. T/F Crisis services appointments are only for individuals who are currently enrolled in services.

4. T/F When requesting admission for voluntary hospitalization, one should be prepared to discuss what less restrictive options have been considered.

5. T/F When DMHPs are doing an assessment for initial detention they are required to consider reasonably available history.

6. T/F When someone is on a LR or CR, it is not important to keep a copy of the order.

7. T/F Any person who is in crisis and who is physically located within the North Sound region is eligible for crisis response services

8. T/F Once a person is detained, a court hearing must be held within 48 hours to determine if he/she continues to meet commitment criteria.

Please fill in the appropriate response for each of the following statements:

1. Once dispatched, crisis response staff must make face-to-face contact within _____ hours.

2. What type of service should be considered when a individual is unwilling to accept voluntary services and presents a likelihood of serious harm to him/herself as the result of a mental disorder but is not in imminent danger? _____

3. When a person is discharged from an evaluation and treatment center on a LR, the requirements/constraints on their behavior are referred to as the _____ of their release.

4. When someone is returned to an inpatient unit for not complying with an LR, the process is called a _____.

Discussion questions *(will be reviewed by your supervisor, but not scored)***:**

1. How can crisis plans assist enrolled individuals who are in crisis?

2. Provide 3 situations in which using a crisis alert would be appropriate.

3. What is the clinician's role when voluntary hospitalization may be needed to support a person on his/her caseload?

WRITING AN AFFIDAVIT

See "How to Write an Affidavit" on the NSMHA website at:
http://nsmha.org/Committee/RTC/ICRS/Writing_an_Affidavit.pdf

NSRSN COMMITTEE DISCUSSION FORM

AGENDA ITEM: Contract Deliverable Grievance report to DBHR

PRESENTER: Diana Striplin/Greg Long

COMMITTEE ACTION: Action Item ( ) FYI & Discussion (x) FYI only ( )

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:

This is the May 15th 2012 Grievance System report sent to DBHR. It covers the period of October 2011 through March 2012.

Processes

1. NSMHA no longer collects and unduplicates overall complaint and grievance data.

2. We do continue to collect Grievance data, enrollee appeal data, fair hearing data and notice of action and notice of adverse determination data.

3. Ombuds and providers continue to collect complaint data and provide semiannual reports.

    - Providers continue to report complaint and grievance data for continuous quality improvement and report these efforts to NSMHA every 6 months.
    - Providers have incorporated complaint and grievance information into their quality management processes
    - Ombuds continue to provide reports and make recommendations every 6 months.

4. NSMHA also continues to monitor providers on a yearly basis.

5. NSMHA realigned its internal structure. The internal flow and structure for quality improvement and recommendations related to the Grievance System has been discussed by Leadership Team.

    - Recommendations go through NSMHA Internal Grievance Committee to Leadership Team and then QMOC. There has also been discussion about

coordinating Ombuds recommendations with this process.

Data from latest report--For this latest report there was a decrease in grievances, notices of action, and notices of adverse determination reported.

CONCLUSIONS/RECOMMENDATIONS:

1. **New Recommendation:** There is one new recommendation that has been reviewed by the NSMHA Internal Grievance Committee and Leadership Committee. This recommendation is to contract for assessments and/or second opinions in specialty areas (DID, possibly complex PTSD, Eating Disorders). The recommendation is to look for expertise in these areas within the network but not restrict ourselves to the network.

   NSMHA has also had broader discussions about trauma informed care.

2. **Review Status of Previous ongoing Recommendations**

TIMELINES: May 15th 2012 Report (October 2011 through March 2012)

ATTACHMENTS: 1. May 15 2012 Grievance System Report (NORTH SOUND MENTAL HEALTH ADMINISTRATION GRIEVANCE, FAIR HEARING, ACTION, and APPEAL SUMMARY October 2011 through March, 2012 2. Attachment A1, 3. Attachment A2, and 4 Attachment B.

NORTH SOUND MENTAL HEALTH ADMINISTRATION
GRIEVANCE, FAIR HEARING, ACTION, and APPEAL SUMMARY
October, 2011 through March, 2012

INTRODUCTION

NSMHA has continued to report grievances, fair hearings, appeals, and actions in accordance with DBHR reporting templates and requirements. NSMHA has transitioned back to reporting this data on a semiannual basis in accordance with the 2009-2011 contract requirements.

GRIEVANCE, ACTION, APPEAL, and FAIR HEARING DATA

There were eleven (11) grievance or fair hearing cases and thirty five (35) occurrences reported for October through March 2012. This is a decrease from the last period.

There were thirty four (34) actions reported. This is also a decrease from the last period. Thirty (30) were for inpatient services and four (4) were for outpatient services. Twenty one (21) were for adults and thirteen (13) were for children. There were also fourteen (14) notices of adverse determination for inpatient services to state funded consumers. All fourteen (14) were for adults.

There were one hundred and eleven (111) notices of adverse determination for outpatient services and this was also a decrease from the last period. As outlined before, NSMHA restructured the Notice Process for outpatient services to be consistent with our understanding of the DBHR change in the definition of denial as outlined in the Washington Public Mental Health Benefits Booklet. This accounts for the continued decrease in outpatient actions.

There was one (1) appeal by an enrollee reported. *(See Attachments A (1) PIHP Medicaid Grievances, Fair Hearings, and Actions, and (2) RSN State Funded Grievances and Fair Hearings, and Attachment B Notice of Action Appeals Report).*

QUALITY MANAGEMENT PROCESSES and RECOMMENDATIONS

NSMHA continues to restructure its quality management processes and has developed a NSMHA Internal Grievance Review Committee and a Leadership Team. System recommendations related to the grievance system are reviewed by NSMHA Leadership Team and then taken to NSMHA Quality Management Committee.

NSMHA providers and designees continue to use complaint and grievance information in their internal quality management processes and provide a semiannual summary of this information to the NSMHA. NSMHA providers and designees also continue to provide a summary about how complaint and grievance information is integrated into provider/designee Quality Management Plans.

The North Sound Regional Ombuds services also provide a semiannual summary of their recommendations for quality improvement or further study and review to Leadership Team.

NSMHA Leadership Team will review this report, identify any new recommendations, and review status of previous system recommendations identified below. The report will then be taken to NSMHA Quality Management Committee.

Previous System Recommendations through the Quality Management Committee Process that are related to grievance system include:

1. **Consultation during Assessment Process:** (Recommendation for was made for providers to consult with prescribers of psychiatric medication during the assessment process prior to recommending to NSMHA that individual's do not meet access to care standards. Recommendation was also made for providers to send information about medications to NSMHA when recommending that individual's don't meet access to care standards if they are currently being prescribed psychiatric medications which might be reducing symptoms)

This item was reviewed in QMOC. It was decided that providers would do the following:
1. Seek information from prescribers if they plan to recommend that individuals do not meet access to care standards, 2. Ask for an extension if needed, and 3. Clearly document the reason if the information was unable to be obtained. It was also decided that 4. Providers would send in information about psychiatric medications to NSMHA when recommending that individuals do not meet access to care standards.

Update: *There have not been recent grievances to NSMHA regarding consultation with outside prescribers. We will review implementation in QMOC.*

2. **Dignity and Respect** (Recommendation for further study and review of dignity and respect in the region).

As outlined in previous reports, the NSMHA plan was to develop a system-wide partnership with consumers, advocates, providers and other stakeholders to explore how dignity and respect is experienced and perceived within our system of care. This plan was reviewed and approved by RQMC and QMOC.

In part due to concerns raised by consumers, Dignity and Respect was also a topic of required training on the NSMHA Regional Training Plan.

NSMHA had initiated the dignity and partnership as outlined above and developed the charter**.** The following recommendations have been made to the NSMHA Planning Committee.
1. Develop a Dignity and Respect Campaign
2. Develop a Dignity and Respect Toolkit. The toolkit will include training resources, organizational self assessments, etc.

EQRO highlighted dignity and respect workgroup as NSMHA strength in 2010 EQRO Annual Report.

The Dignity and Respect site has been added to the NSMHA website and the dignity and respect pledge, part of the dignity and respect campaign, was initiated. NSMHA and providers continue to work to revise the organizational self assessment tool.

Update: *NSMHA will be contracting with the University of Pittsburgh Medical Center (UPMC) to assist us with developing and maintaining our dignity and respect campaign. The UPMC Campaign includes 3 toolkits to be implemented over a 3 year period. UPMC launched a national dignity and respect campaign in 2010. We will also continue work on the Dignity and Respect Organizational Self Assessment.*

3. **Letters of Closure for Episode of Care** (Recommendation was to review process by providers to provide written letters of closure for episodes of care)

The Discharge from Treatment Policy 1540 had been updated to include the requirement for providers to send a 30 day advanced letter that they plan to close the episode of care. The 30 day letter was required unless the consumer/enrollee agreed in writing to end services. NSMHA had also identified that further work was indicated to standardize the core elements in the content of these letters from providers.

NSMHA Clinical Operations Team had been reviewing this area to consider whether to recommend continuation or modification of this requirement.

Update: *NSMHA has revised the Discharge from Treatment Policy. This includes this process improvement effort. A 30 day letter of closure will be provided to individuals with high needs. This concludes this process improvement effort at this time.*

4. **Medication Management Services** (Recommendation for further study and review of access to medication management services.) As outlined in the previous reports, medication management services, including access and triage to medication management services, medication management capacity, and discharge from medication management services has been identified as an area for further study and review. (Ombuds services concerns and complaint data were one factor leading to further study and review of access to medication management services.)

   NSMHA completed a plan to study medication management services and the NSMHA and providers adopted a modified fee for service model that purchases an increase in medication management services. NSMHA also began the process to study medication management services by requesting copies of provider medication management triage policies and procedures for review.

   NSMHA has developed a Performance Improvement Project (PIP) to decrease the days to medication evaluation appointment after request for service.

   Update: *NSMHA continues to implement the Performance Improvement Project, regarding the days to medication evaluation appointment after request for services.*

5. **Database for Complaints, Grievances, and Fair Hearings** (Recommendation to develop a regional database for complaints, grievances and fair hearings to track, monitor and analyze data related to complaints, grievances and fair hearings and unduplicate cases.)

   The NSMHA has discontinued collecting and unduplicating overall complaint and grievance data. Ombuds continue to collect complaint data. NSMHA continues to report grievance and fair hearing data. NSMHA will begin by developing a centralized method to collect notices of action and notices of adverse determination.

   Update: *NSMHA has been meeting to develop a centralized method to collect notices of action and notices of adverse determination.*

6. **Risk Assessment** (Recommendation was to review process for risk assessment and management)

   Individual grievances had shown the need for additional risk assessment and management. NSMHA reviewed risk assessment and management through utilization review and added additional question in this area. Utilization review did not show systemic issues with risk assessment and management based on the questions that were added. NSMHA clinical oversight team has reviewed their utilization tool and may recommend revision or additional standards in this area**.** NSMHA asked provider Quality Managers to review their process of risk assessment and management and provide a report to QMOC. Reports were provided to QMOC in March of 2011.

   Some providers were in the process of revising their information regarding risk assessment. NSMHA will ask that providers submit their policies/paperwork regarding risk assessment in the future to be compiled and distributed.

   Update: *NSMHA compiled and distributed provider risk assessments in QMOC. This item is completed at this time.*

COMPLETED or INACTIVE QUALITY IMPROVEMENT INITIATIVES

The NSMHA continues to track areas for further study and review or quality improvement related to complaint, grievance, fair hearing, denial, and appeal data. Information about complaints, grievances, fair hearings, or denials has been one factor in quality improvement efforts over time towards:

- ✓ Providing a series of region-wide trainings about **eating disorders** and adopting APA Guidelines that outline a continuum of care for eating disorders.
- ✓ Developing a clinical practice guideline for **Adult Attention Deficit Hyperactivity Disorder (ADHD)**
- ✓ Increasing **Flex Funds**
- ✓ Reviewing the **region wide access processes** used to gather information and records when consumers are entering services
- ✓ Efforts to provide **trauma informed services** including the development of trauma pilot projects in 3 counties, the development of a PTSD training module and review of trauma screening tools
- ✓ Assuring staff is trained on **Dignity and Respect** and **Consumer Rights**
- ✓ Clarifying policies and procedures regarding the **outpatient discharge process**
- ✓ The development of a **medication management transfer policy** to ensure seamless transition to primary care physicians
- ✓ The development of region wide **diagnostic practice standards** utilized in determining eligibility for services
- ✓ Identifying the need to address a shortage **of case management services** at a provider during the transition to modified fee for service contracts.
- ✓ Recommending to **statewide peer support trainers** that they consider adding training about employee issues

07-09 Report - PIHP - Medicaid Services Only

PIHP Name NSMHA

Contact Name: Diana Striplin

Contact Phone No. (360) 416-7013

Reporting Period: October 2011 through March 2012 *(Month and Year)*

Total Unduplicated Number of Adult Cases 9

Total Unduplicated Children Cases 0

Occurrence — Adult (21 Yrs. and over)	CMHA Grievances	PIHP Grievances	Fair Hearings	Outstanding	Denials
Access to Outpatient	4	2	0	1	4
Dignity and Respect	2	3	0	0	
Quality/ Appropriateness	1	1	0	1	
Phone calls not returned	0	2	0	0	
Service -- Intensity, Not Available, Coordination	1	1	0	0	
Consumer Rights	2	2	0	0	
Physicians & Medications	2	2	0	0	
Financial & Admin Svs	1	0	0	0	
Transportation	0	0	0	0	0
Emergency Services	1	0	0	0	0
Access to Inpatient	0	0	0	0	17
Violation of Confidentiality	1	0	0	0	
Participation in Treatment	0	0	0	0	
Other	1	2	0	0	0
Total	**16**	**15**	**0**	**2**	**21**

Occurrence — Children (0-20 Yrs.)	CMHA Grievances	PIHP Grievances	Fair Hearing	Outstanding	Denials
Access to Outpatient	0	0	0	0	0
Dignity and Respect	0	0	0	0	
Quality/ Appropriateness	0	0	0	0	
Phone calls not returned	0	0	0	0	
Service -- Intensity, Not Available, Coordination	0	0	0	0	
Consumer Rights	0	0	0	0	
Physicians & Medications	0	0	0	0	
Financial & Admin Svs	0	0	0	0	
Transportation	0	0	0	0	0
Emergency Services	0	0	0	0	0
Access to Inpatient	0	0	0	0	13
Violation of Confidentiality	0	0	0	0	
Participation in Treatment	0	0	0	0	
Other	0	0	0	0	0
Total	**0**	**0**	**0**	**0**	**13**

Resolutions — Adult (21 Yrs. and over)	CMHA Grievances	PIHP Grievances	Fair Hearings	Outstanding from Last Period	
Info/Referral	6	0	0	0	
Referral to QRT	0	0	0	0	
Conciliation/Mediation	10	5	0	2	
Arbitration	0	8	0	11	
Fair Hearing	0	0	0	0	
Other	0	0	0	0	
Not Pursued		0	0	0	
Total	**16**	**13**	**0**	**13**	**0**

Resolutions — Children (0-20 Yrs.)	CMHA Grievances	PIHP Grievances	Fair Hearing	Outstanding from Last Period	
Info/Referral	0	0	0	0	
Referral to QRT	0	0	0	0	
Conciliation/Mediation	0	0	0	0	
Arbitration	0	0	0	0	
Fair Hearing	0	0	0	0	
Other	0	0	0	0	
Not Pursued	0	0	0	0	
Total	**0**	**0**	**0**	**0**	**0**

Revised 10/2001 By: MIS (rgs)
File: Att A (1) PIHP Griev FH and Actions Final
Part 3 of 3

State of Washington DSHS/Mental Health Division
PO Box 45320, Olympia, WA 98504-5320

07-09 Report -- RSN -- State Funded Services Only

RSN Name NSMHA

Contact Name: Diana Striplin

Contact Phone #: 360 416-7013

Reporting Period: Oct 2011 through March 2012 *(Month and Year)*

Total Unduplicated Number of Adult Cases 2

Total Unduplicated Number of Children Cases 0

Occurrence — Adult (21 Yrs. and over)	CMHA Grievances	RSN Grievances	Fair Hearings	Outstanding
Access	0	0	0	0
Dignity and Respect	1	0	0	0
Quality/ Appropriateness	0	0	0	0
Phone calls not returned	0	0	0	0
Service -- Intensity, Not Available, Coordination	0	0	0	0
Consumer Rights	1	0	0	0
Physicians & Medications	0	0	0	0
Financial & Admin Svs	0	0	0	0
Residential	0	0	0	0
Housing	0	0	0	0
Transportation	0	0	0	0
Emergency Services	1	0	0	0
Violation of Confidentiality	0	0	0	0
Participation in Treatment	0	0	0	0
Other	1	0	0	0
Total	**4**	**0**	**0**	**0**

Occurrence — Children (0-20 Yrs.)	CMHA Grievances	RSN Grievances	Fair Hearings	Outstanding
Access	0	0	0	0
Dignity and Respect	0	0	0	0
Quality/ Appropriateness	0	0	0	0
Phone calls not returned	0	0	0	0
Service -- Intensity, Not Available, Coordination	0	0	0	0
Consumer Rights	0	0	0	0
Physicians & Medications	0	0	0	0
Financial & Admin Svs	0	0	0	0
Residential	0	0	0	0
Housing	0	0	0	0
Transportation	0	0	0	0
Emergency Services	0	0	0	0
Violation of Confidentiality	0	0	0	0
Participation in Treatment	0	0	0	0
Other	0	0	0	0
Total	**0**	**0**	**0**	**0**

Resolutions — Adult (21 Yrs. and over)	CMHA Grievances	RSN Grievances	Fair Hearings	Outstanding from Last Period
Info/Referral	0	0	0	0
Referral to QRT	0	0	0	0
Conciliation/Mediation	2	0	0	0
Arbitration	0	0	0	0
Fair Hearing	0	0	0	0
Other	2	0	0	0
Not Pursued	0	0	0	0
Total	**4**	**0**	**0**	**0**

Resolutions — Children (0-20 Yrs.)	CMHA Grievances	RSN Grievances	Fair Hearing	Outstanding from Last Period
Info/Referral	0	0	0	0
Referral to QRT	0	0	0	0
Conciliation/Mediation	0	0	0	0
Arbitration	0	0	0	0
Fair Hearing	0	0	0	0
Other	0	0	0	0
Not Pursued	0	0	0	0
Total	**0**	**0**	**0**	**0**

PIHP Notice of Action Appeals Report 07-09

PIHP NSMHA

Report Period October 2011 through March 2012

ADULTS

Expedited Appeals

	Resolution within **3** working days	Resolutions: Wholly in favor of Enrollee	Resolutions: Partially in favor of Enrollee	Resolutions: Appeal Denied
Referred to Standard Appeals				
Denials				
Reduction				
Suspensions				
Terminations				
Total				

Standard Appeals

	Resolution within **45** days	Resolutions: Wholly in favor of Enrollee	Resolutions: Partially in favor of Enrollee	Resolutions: Appeal Denied
Denials	1	1		
Reduction				
Suspensions				
Terminations				
Total	1	1		

	Resolution within **59** days	Resolutions: Wholly in favor of Enrollee	Resolutions: Partially in favor of Enrollee	Resolutions: Appeal Denied
Denials				
Reduction				
Suspensions				
Terminations				
Total				

CHILDREN

Expedited Appeals

	Resolution within **3** working days	Resolutions: Wholly in favor of Enrollee	Resolutions: Partially in favor of Enrollee	Resolutions: Appeal Denied
Referred to Standard Appeals				
Denials				
Reduction				
Suspensions				
Terminations				
Total				

Standard Appeals

	Resolution within **45** days	Resolutions: Wholly in favor of Enrollee	Resolutions: Partially in favor of Enrollee	Resolutions: Appeal Denied
Denials				
Reduction				
Suspensions				
Terminations				
Total				

	Resolution within **59** days	Resolutions: Wholly in favor of Enrollee	Resolutions: Partially in favor of Enrollee	Resolutions: Appeal Denied
Denials				
Reduction				
Suspensions				
Terminations				
Total				

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: Individuals Transferring between NSMHA Agencies

PRESENTER: Charissa Westergard

COMMITTEE ACTION: Action Item () FYI & Discussion (X) FYI only ()

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:
NSMHA Policy 1510 Intra-Network Consumer Transfers and Coordination of Care, addresses the procedure for assisting individuals transferring from one NSMHA agency to another. Periodically, it comes to NSMHA's attention that a particular transfer did not go according to policy. Recently, however, there seems to have been an increase in notifications to NSMHA of transfers that did not adhere to the identified procedure. Specifically, consumers are being told that their chart must be closed at their current agency and then they must call VOA Access to initiate services at the other agency they want to receive services from.

Per NSMHA policy, the current agency is supposed to assist the individual/family, with consent from the individual/family, by:

- Assisting the individual in calling VOA Access
- With an ROI, sending records to the second agency prior to the intake appointment
- Leaving the treatment episode open until the second agency accepts the individual for services

CONCLUSIONS/RECOMMENDATIONS:
What factors are contributing to the lack of adherence to this policy/procedure?

TIMELINES:
N/A

ATTACHMENTS:
NSMHA Policy 1510

Effective Date: 6/25/2004
Revised Date: 2/4/2008
Review Date:

North Sound Mental Health Administration

Section 1500 – Clinical: Intra-network Consumer Transfers and Coordination of Care

Authorizing Source: Per NSMHA
Cancels:
See Also:
Responsible Staff: Quality Manager

Approved by: Executive Director Date: 3/3/2008
Signature:

POLICY #1510.00

SUBJECT: INTRA-NETWORK CONSUMER TRANSFERS AND COORDINATION OF CARE

PURPOSE

To assure continuity and coordination of care for Medicaid and other North Sound Mental Health Administration (NSMHA)-eligible consumers between provider agencies.

POLICY

There are certain services within the NSMHA region that are offered by some providers, but not others. It is the policy of NSMHA to ensure that consumers, upon their request, are transferred to the provider(s) who has/have the capacity to meet their service needs. In some cases, it is appropriate for consumers to remain enrolled with a given provider for some of their services, augmented by specific services from another provider(s). The following procedure differentiates and describes the transfer and coordination processes.

Generally, consumers will transfer to another agency when the services requested are duplicative of the services they are currently receiving. If the services requested augment the current services, then coordination of care between agencies shall be considered unless the consumer requests transfer of all care.

Each agency in the North Sound Mental Health Administration region shall have a process in place for providing services as a secondary agency including: designating a contact person, setting assessment appointments, clinical management of care and data management.

PROCEDURE

Transfers

Prior to initiating a consumer transfer from one agency to another, the consumer or legal guardian shall be requested to sign a release of information allowing clinical documentation to be shared between the agencies involved. The transfer process cannot be fully facilitated by the clinician without a release of information. During the transfer process the consumer will have charts open in both agencies. The transferring agency retains overall responsibility for consumer care until completion of the transfer process. Completion occurs when the receiving agency indicates to the initial agency (1) that it accepts responsibility for overall consumer care (including medication management, if applicable) and (2) that the initial agency can close its consumer chart. When a consumer transfers from one NSMHA agency to another, the start and end dates of the outpatient authorization and residential approval, if applicable, remain the same.

If the plan is to transfer the client to a specific program that has limited capacity, such as Wraparound or Intensive Outpatient for Adults/Older Adults, then the transferring clinician must first contact the other agency to determine if space is available. If space is not available, the agency shall not transfer the

consumer unless he/she still requests the transfer for regular outpatient services at the other agency. If space is available, the transferring agency clinician shall complete the appropriate referral form to NSMHA for approval. If NSMHA approves the service, the transferring clinician shall follow the transfer process as described below.

The transferring agency primary clinician coordinates transfer of the consumer to the receiving agency by (a) assisting the consumer through coordination with Volunteers of America-Western Washington (VOA) ACCESS and the receiving agency's scheduler to transfer all applicable Management Information System (MIS) data and to schedule the initial assessment appointment at the new agency; (b) sending completed authorization for release of information; and (c) providing the following items to the receiving agency prior to the consumer's initial assessment appointment at the receiving agency:

1. Most recent assessment
2. Most recent Child and Adolescent/Level of Care Utilization System (CA/LOCUS) form
3. Global Appraisal of Individual Needs – Short Screener (GAIN-SS) form
4. Current treatment plan
5. Health and Medical Information form
6. Behavioral and Development form, if applicable
7. Progress notes covering the last 30 days of treatment with additional progress notes when clinically indicated
8. The last three prescriber notes, if applicable
9. Last psychiatric evaluation, if applicable
10. Last Treatment Plan (180-Day) Review, if applicable
11. Medication list (current and historical), if applicable

The ACCESS Clinician completes the ACCESS Call Record. The ACCESS Clinician contacts the scheduler at the receiving agency and follows standard procedures for obtaining an appointment and transferring the MIS information to the new agency. At this point the consumer will be open at both the transferring and receiving agencies.

The receiving agency must offer the consumer an initial assessment appointment within the standard ten business days (not to exceed 14 calendar days) from the date the referral is made and must follow all other procedures and requirements for new consumers except where otherwise noted. Since the consumer is in an open authorization period, the assessment does not need to establish eligibility per the state's Access to Care Standards.

If the consumer does not attend their assessment appointment at the receiving agency, the receiving clinician contacts the transferring clinician notifying them that the consumer did not show. Receiving clinician follows assessment "no show" protocol and closes the case if indicated. The transferring clinician attempts to follow up with the consumer and closes the case if indicated.

If the receiving clinician accepts the consumer into services, the receiving clinician contacts the transferring clinician noting that the receiving agency (a) has accepted responsibility for treatment, including medication management, if applicable, and (b) that the transferring agency may close its record. The primary clinician at the transferring agency sends closing documents to MIS for entry.

When prescriptive services are being transferred, the transferring agency will provide the consumer with a prescription for medications for up to 60 days unless this is not clinically indicated and the two agencies

have agreed to an alternative plan. The receiving agency will schedule a medication evaluation within 30 days unless otherwise indicated by the mutually agreed upon plan.

If the receiving clinician believes the transfer warrants further discussion, the receiving clinician first discusses the issues with the consumer and then contacts the receiving agency's clinical director. The receiving agency's clinical director contacts the transferring agency's clinical director. Agency clinical directors discuss and develop a plan for the best way to meet the consumer's need. A plan is developed within 30 days of consumer's assessment date at the receiving agency. The transferring agency retains responsibility for the consumer's care during this period of time. An agency's decision not to serve a consumer should occur only in rare instances.

Receiving and transferring clinicians follow through with agreed upon plan. If agreed upon plan for referral is community resources, one agency will be identified to case manage the referral. The case will not be closed until appropriate resources are in place, provided the consumer is willing to follow through with referrals.

Coordination between agencies:

Prior to initiating additional services at another agency, the consumer or legal guardian shall be requested to sign a release of information allowing clinical information to be shared between the agencies involved. Coordination of care between agencies cannot be facilitated by the clinician without a release of information. The primary agency clinician shall then contact the agency where the desired service is located (secondary agency).

If the secondary agency is unable to accommodate the request because the service is at capacity, the primary agency shall be directed to check back at a later date. Waiting lists shall not be utilized. If the secondary agency agrees to provide the requested service to the consumer, all agencies involved in providing services for a single consumer shall ensure there is a clear understanding of which agency is primary and what services each agency is providing. The primary agency maintains responsibility for the consumer's care including crisis management.

The primary agency clinician coordinates services by (a) calling the designated contact at the secondary agency to arrange an initial appointment for assessment and assuring all applicable MIS data is available, (b) sending completed authorization for release of information, and (c) providing the following items to the receiving agency prior to the consumer's assessment appointment at the other agency:

1. Most recent assessment
2. Most recent CA/LOCUS
3. GAIN-SS
4. Current treatment plan
5. Current consumer and clinician crisis plans
6. Health and Medical Information form
7. Behavioral and Development form, if applicable
8. Progress notes covering the last 30 days of treatment with additional progress notes when clinically indicated
9. The last three prescriber notes, if applicable
10. Last psychiatric evaluation, if applicable
11. Last Treatment Plan (180-Day) Review, if applicable
12. Medication list (current and historical), if applicable

If the secondary agency, upon completion of the assessment, confirms that they will provide the requested service(s), the secondary agency's clinician shall contact the primary agency to 1) notify the primary agency of the provision of the requested service and 2) identify who will be responsible for the consumer's care and be the ongoing point of contact at the secondary agency. The secondary agency will also need to set up an outpatient episode or special episode, but shall not set up the episode as the primary outpatient episode.

If the secondary agency, upon completion of the assessment, determines that they will not provide the requested service(s), the secondary agency's clinician discusses the issues with the consumer and contacts the secondary agency's clinical director. The secondary agency's clinical director contacts the primary agency's clinical director. Agency clinical directors discuss and develop a plan for the best way to meet the consumer's need. A plan is developed within 30 days of consumer's assessment date at the receiving agency. An agency's decision not to serve a consumer should occur only in rare instances.

All agencies involved in a consumer's care must maintain a complete clinical chart. The secondary agency may obtain copies of certain documents from the primary agency with a release of information, but shall complete their own versions of the following documentation:

1. Release of information between the primary agency and the secondary agency providing service
2. Initial assessment
3. Current treatment plan – the plan should be complete and identify any needs being addressed by other agencies in addition to those being addressed by clinician's own agency
4. Progress notes
5. Documentation of coordination of care such as phone calls, exchange of relevant clinical information, etc.
6. Treatment Plan (180-Day) Reviews

The secondary agency does not complete a new crisis plan, CA/LOCUS form, GAIN-SS form or Telesage. This information, along with other documents provided prior to assessment, shall be provided to the secondary agency by the primary agency.

The primary agency is also responsible for maintaining a current authorization as medically necessary. However, the secondary agency shall also be aware of the authorization end date and communicate with the primary agency regarding the necessity of continued services. If the primary agency ends an episode of care or does not request reauthorization of services, this information shall be communicated to the secondary agency prior to disposition. The consumer may request a transfer to the secondary agency or another agency.

In cases where transfer to the secondary agency is requested, the primary agency clinician shall contact the secondary agency clinician to arrange transfer of care. This transfer process shall not go through ACCESS as an intake assessment has already been completed. The secondary agency becomes the primary agency and shall close the current outpatient episode and open a new one as the primary agency. The transferring agency shall ensure that the receiving agency has all required documentation as indicated previously and the receiving agency shall complete (e.g. crisis plan, CA/LOCUS form, GAIN-SS form, Telesage) and update (e.g. treatment plan) forms as needed to maintain a complete clinical record. The primary clinician at the transferring agency sends closing documents to MIS for entry.

For those consumers for whom prescriptive services are being transferred or the two agencies do not agree on the necessity of transfer, follow the regular transfer procedure for these situations. Also, if the consumer wants to transfer to an agency other than the secondary agency, follow the regular transfer process.

If the consumer will no longer be receiving services from the secondary agency, the secondary agency shall notify the primary agency and use the appropriate disposition code. The disposition code used shall be one that will not be transmitted to NSMHA indicating the end of an episode of care.

ATTACHMENTS

1510.01 – Guidelines for Transfer or Coordination of Care by Service

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: Requests for Re-admission of Individuals Recently Closed

PRESENTER: Charissa Westergard

COMMITTEE ACTION: Action Item () FYI & Discussion (X) FYI only ()

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:
Individuals with a Medicaid mental health benefit or who meet state-funding priorities are eligible for an intake (i.e., there is no assessment at Access regarding the clinical eligibility/medical necessity for services. This occurs at intake). This includes individuals who may have recently received services or recently been denied services. It was recently brought to NSMHA's attention that occasionally those individuals whose treatment episode has been closed or who have recently been denied services are requesting re-admission/another intake within a short period of time after closing. While we have all worked/continue to work to reduce the barriers to accessing services, the process that is followed currently may result in some use of intake resources.

CONCLUSIONS/RECOMMENDATIONS:
Are there alternatives to the existing process that would promote a more efficient use of resources while continuing to minimize barriers to accessing services?

TIMELINES:
N/A

ATTACHMENTS:
None