North Sound Mental Health Administration

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

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

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NSMHA Contract Memorandum 2014-014

Date: September 30, 2014

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Cindy Paffumi, Interfaith
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Mitch Lykins, Pioneer Human Services
Dr. Jerry Jenkins, NWESD 189
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From: Joe Valentine, Executive Director

Subject: Revised Policies

Policy 1701.00 – Crisis Stabilization Standards for Adults
This policy has been through the complete review and approval process. The Executive Director signed and approved this policy September 30, 2014.

Policy 1719.00– Utilization of Crisis Stabilization for Hospital Discharge Planning
This policy has been through the complete review and approval process. The Executive Director signed and approved this policy September 30, 2014.

Policy 1724.00- ICRS-Law Enforcement Coordination
This policy has been through the complete review and approval process. The Executive Director signed and approved this policy September 30, 2014.

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

cc: Cindy Ferraro, Bridgeways
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Contract File

Effective Date: 5/29/2013; 5/29/2009; 5/30/2007; 12/21/2005
Revised Date: 8/28/2014
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North Sound Mental Health Administration

Section 1700: ICRS – Crisis Stabilization Standards for Adults

Authorizing Source: Per NSMHA and ICRS Management
Cancels: Policy 1512.00 –Stabilization Standards for Adults
See Also: Approved by: Executive Director Date: 9/30/2014
Providers must have a "policy consistent with" NSMHA policy
Responsible Staff: Deputy Director Signature:

POLICY #1701.00

SUBJECT: CRISIS STABILIZATION STANDARDS FOR ADULTS

PURPOSE

The purpose of this policy is to ensure consistent, safe, quality crisis stabilization services within treatment facilities across the North Sound region.

POLICY

Crisis stabilization facilities provide behavioral health stabilization to adult individuals in crisis and transitioning to and from inpatient facilities (refer to North Sound Mental Health Administration [NSMHA] Policy 1719.00). Crisis stabilization is a service that provides safety for the individual, includes short-term, face-to-face assistance with life skills training, offers medication education, and provides follow up services. Facilities providing these crisis stabilization services will use the following standards and procedures to assure access to quality services.

PROCEDURES AND STANDARDS

I. All facilities must have the capacity to admit individuals into crisis stabilization services on a 24-hour per day, 7-day per week basis. Length of stay is limited to 5 calendar days. Extensions may be granted when deemed clinically necessary.

II. Crisis stabilization facilities are available to all residents of the region. These facilities shall accept referrals from other counties within NSMHA's region when beds are available.

III. The intentions of these services are to:

   A. Evaluate and stabilize individuals in their community and prevent unnecessary hospitalization;
   B. Provide transition from state and community hospitals to reduce length of stay and assure stability prior to moving back into the community.
   C. Actively facilitate resource linkage so individuals can return to functionality; and
   D. Provide follow up contact to the individual to ensure stability after discharging from the facilities.

IV. **Screening and Admission**

Crisis stabilization staff shall use standardized admission and exclusion criteria in determining eligibility for crisis stabilization services. Exclusionary criteria assure that referrals to the crisis stabilization facilities are appropriate for the level of care available. Exceptions can be made on a case-by-case basis in consultation with the clinical supervisor. The rationale for all exceptions shall be noted in the record.

A. Inclusionary Criteria

1. Anyone in the region 18 years or older, experiencing an acute behavioral health crisis or in need of sub-acute detoxification services (Skagit County Crisis Center [SCCC] and Whatcom County Behavioral Triage Center [WCBTC]).
2. Individuals must be willing to admit to a voluntary facility.
3. Individuals, if a risk to self, must be willing to engage in safety planning.
4. Individuals must be willing and able to comply with house rules regarding violence, weapons, drug/alcohol use, medication compliance, and smoking.
5. Individuals must have the ability to maintain safe behavior towards staff and other residents of the facility.
6. Individuals must be able to self-administer prescribed medications and perform basic Activities of Daily Living (ADLs).
7. Individuals in crisis cannot be excluded from receiving crisis stabilization services solely due to intoxication or developmental disability.

B. Exclusionary Criteria

1. Individuals needing immediate medical intervention for an acute or chronic condition.
2. Individuals who present a high likelihood of violence or arson.

C. Direct referrals from NSMHA-contracted agency clinicians and community professionals shall be screened telephonically for admission by the crisis stabilization facilities. Examples of community professionals referral sources include, but are not limited to:

1. Department of Corrections;
2. Community housing case managers;
3. Community substance abuse treatment professionals;
4. Law Enforcement; and
5. Emergency Departments.

D. Individuals enrolled with a NSMHA-contracted provider agency can access stabilization services by contacting their Mental Health Care Provider (MHCP), calling the stabilization facility directly, or calling the Care Crisis Line at 1-800-584-3578.

E. Non-enrolled individuals, concerned family, friends, or natural supports in the community can access stabilization services by contacting the Care Crisis Line at 1-800-584-3578. Self-referrals and walk-ins are available to individuals at the Skagit and Whatcom facilities.

F. For enrolled individuals to be admitted directly there must have been a face-to-face contact with a mental health clinician within 12 hours prior to admission. **Exceptions to this standard may be made on a case-by-case basis if both the referring clinician and program staff are in agreement.**

Enrolled individual's admission to a crisis stabilization facility will include a review of that individual's crisis plan (available through Volunteers of America Care Crisis Response Services (CCRS), 1-800-747-8654).

G. Individuals admitted for stabilization will be evaluated by a Mental Health Professional (MHP) within three (3) hours of the request.

Individuals screened by an MHP who are deemed inappropriate by the crisis stabilization facilities shall be referred by the MHP to the appropriate level of care and shall be transported off the premises.

H. Whenever possible, referrals to crisis stabilization facilities will include the following information:

1. Any known behaviors or symptoms that might cause concern or require special care or safety measures;
2. An evaluation of the individual's cognitive status and current level of functioning, including any disorientation, memory impairment, and impaired judgment;
3. History of mental health issues, including suicidality, depression, and anxiety;
4. Social, physical and emotional strengths and needs;
5. Current substance use;
6. Functional abilities in relationship to Activities of Daily Living (ADLs);and
7. Current medications and medical needs.
8. When information is not available at admission, program staff will strive to gather information as services are provided and use this information as clinically appropriate in the provision of services.

I. All appropriate documentation shall be completed at the time of admission. Admission documentation will include:

1. Initial assessment to include: demographics, reason for presentation, history, legal involvement, risk assessment, co-occurring screen and initial discharge plan;
2. A recovery care plan developed in collaboration with the individual and available natural and collateral supports;
3. Crisis stabilization Consent/Program Rules Form;
4. Copy of Client Rights;
5. Health and wellness screening;
6. Medication Sheet;
7. Inventory of personal effects/property;
8. Releases of Information for natural and collateral supports;
9. Global Appraisal of Individual Needs – Short Screener (GAIN-SS);
10. For individuals with a current service provider, crisis stabilization staff will attempt to obtain the current Recovery/Resiliency Plan to coordinate care with their primary clinician.

11. For direct calls or walk-ins, crisis stabilization staff should call CCRS for information on the individual, including a WATCH (Washington Access to Criminal History) report.
12. If the individual is unable to provide information at time of admission, this should be documented in the clinical record. The documentation should be completed as soon as clinically feasible or within 12 hours.

J. Medical screening is part of the admission screening and intake process. This will include taking basic vital health information (e.g.: blood pressure, heart rate, pulse, temperature, and blood alcohol level).

K. Being determined ineligible for crisis stabilization services does not impact the individual's eligibility for other clinically indicated services such as other crisis services, Involuntary Treatment Act (ITA) services, psychiatric hospitalization and/or cross-system referral, planning and coordination.

V. Ongoing Services Requirements

A. For enrolled individuals:

1. The Mental Health Care Provider (MHCP) shall consult with crisis stabilization staff on a daily basis to coordinate care and plan for discharge.
2. The MHCP shall contact the individual on a daily basis while the individual is in the crisis beds to coordinate care and plan for discharge.
3. Subsequent treatment/supports provided and progress toward achieving these will be documented at least daily during the crisis stabilization placement.

B. For un-enrolled individuals:

1. Crisis stabilization staff shall be responsible for coordinating treatment (including crisis case management services and referral to ongoing services, as necessary) and the discharge planning process.
2. Subsequent treatment/supports provided and progress toward achieving these will be documented at least daily during the crisis stabilization placement.

VI. Discharge

A. Planning for discharge is expected to begin at referral. Updates on the progress of the individual's recovery care plan and discharge plan shall be given at the change of shift to each incoming staff by the previous shift, and documented in the clinical chart.

B. Working in conjunction with the individual and whatever other systems/supports are appropriate, crisis stabilization staff will develop a written discharge plan prior to all scheduled discharges. The individual will receive a copy of this plan at the time of discharge. This plan will contain at a minimum:

1. A listing of all follow-up appointments (including time, place, telephone number, and name of the person with whom the appointment is scheduled);

2. The names and telephone numbers of any natural supports or other resources which have been identified as helpful during times of crisis;
3. A list of current medications;
4. The name and telephone number of the individual's case manager/primary clinician;
5. The name of the individual's prescriber; and
6. The telephone number to be used to get refills.

C. Prior to unplanned discharge, the on-duty crisis stabilization staff will contact the stabilization program coordinator for discharge approval, including review of current risk and necessary supports.

1. If there is a determination of risk, a consultation with and/or outreach request to an MHP or DMHP shall occur. Such a request shall be made through the Care Crisis Line. If necessary, arrangements will be made for the individual to be seen at an alternative location.
2. The Program will coordinate with whatever facility will be receiving the individual.
3. When clinically indicated, a Crisis Alert will also be filed when unplanned discharges take place.
4. For enrolled individuals, the MHCP, other professionals and/or natural supports and/or programs will be informed of all unplanned discharges.

VII. OTHER PROGRAM PROCEDURES AND STANDARDS

A. Staffing

1. Crisis stabilization facilities must be staffed 24 hours per day;
2. Crisis stabilization programs shall have the ability to provide additional staff when this is necessary and sufficient to maintain a crisis stabilization placement;
3. Crisis stabilization facilities will be staffed by those trained in the treatment of individuals experiencing a behavioral health crisis;
4. Facility staff will receive training in admission and screening prior to providing single coverage;
5. DMHPs may provide clinical consultation to crisis stabilization staff and to provide face to face interventions to persons receiving crisis stabilization services when requested.
6. Staffing levels must meet all appropriate licensing requirements.

B. Medication Management
Medications will be reviewed and monitored in a manner that meets all applicable contractual, licensing and regulatory requirements.

ATTACHMENTS

None

Effective Date: 9/9/11; 11/8/2007
Revised Date: 8/28/2014
Reviewed Date: 8/28/2014

North Sound Mental Health Administration

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

Authorizing Source: Per NSMHA & ICRS
Cancels:
See Also:
Providers must have "policy that complies with NSMHA policies" | Approved by: Executive Director | Date: 9/30/2014
Responsible Staff: Deputy Director | Signature:

POLICY #1719.00

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

PURPOSE

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

POLICY

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

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

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

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

PROCEDURE

1. **Admission Criteria:**

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

1. The discharge plan will include a housing plan, which addresses proposed living arrangements and the funding arrangements for the proposed housing and ongoing living costs.
2. The discharge plan will address relapse prevention/intervention strategies including assessment of Less Restrictive/Conditional Release (LR/CR) needs and hospital readmission protocol for the individual.

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

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

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

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

2. Exclusionary Criteria:

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

3. Stabilization/Triage Services:

Individuals in this program shall receive all services defined in NSMHA Policy 1701.

ATTACHMENTS

None

Effective Date: 3/1/2012
Revised Date: 8/28/2014
Review Date: 8/28/2014

North Sound Mental Health Administration

Section1700 – Crisis Services – ICRS/Law Enforcement Coordination

Authorizing Source: NSMHA
Cancels:
See Also: Approved by: Executive Director Date: 9/30/2014
Providers must "comply with" this policy
Responsible Staff: Deputy Director Signature:

POLICY #1724.00

SUBJECT: ICRS/LAW ENFORCEMENT COORDINATION

PURPOSE

The purpose of this policy is to ensure that Volunteers of America Care Crisis Response Services (CCRS), Emergency Mental Health Clinicians (EMHCs). Designated Mental Health Professionals (DMHPs) and Stabilization/Triage facilities are working in a coordinated effort with law enforcement when there is a behavioral health crisis.

POLICY

North Sound Mental Health Administration (NSMHA) is committed to strengthening partnerships with law enforcement agencies in the Region to improve the coordination of services for individuals in behavioral health crisis. Law enforcement agencies are often the first responders on the scene when individuals and families are in crisis. To assist them when decisions are needed regarding crisis intervention, law enforcement officers may need to consult with the NSMHA Integrated Crisis Response System (ICRS) providers to determine the most appropriate course of action.

PROCEDURES

I. CCRS: Law enforcement officers, who request ICRS assistance, should contact CCRS at 800-584-3578, and alert them to the nature of the crisis. CCRS clinicians will triage the case with law enforcement officers to determine the next steps. This may include consultation with CCRS, consultation with the EMHC, DMHP, identifying linkage to appropriate and available resources or simply documenting information with CCRS.

II. Stabilization/Triage: Law enforcement officers intending to drop off individuals at a Stabilization/Triage facility should contact CCRS clinicians to work with the officer or they can directly contact the facility in their county. These facilities are located in Whatcom, Skagit and Snohomish counties.

   a. CCRS can initiate a three way call with the Stabilization/Triage Facility and law enforcement officer to facilitate coordination between the officer and the stabilization/triage facility.
   b. Officers must speak directly with stabilization/triage program staff before transporting the individual to the facility.
   c. Stabilization/Triage staff will get background information and a description of the current problems from the officer.

d. Stabilization/Triage center staff will obtain a copy of the mental health contact report from the law enforcement officer. The officer will be requested to remain at the facility until a brief screening has been completed and it has been determined that the individual meets criteria for admission. The officer may be requested to transport the individual to jail or a hospital when more appropriate.

e. In Skagit and Whatcom counties, Stabilization/Triage facilities are able to admit voluntary individuals only.

f. In Snohomish County, Stabilization/Triage facility is able to admit both voluntary individuals, as well as, individuals delivered by law enforcement on a 12-hour hold because it is a secured locked facility.

g. Stabilization/Triage facilities will coordinate with law enforcement to facilitate appropriate, safe outcomes for individuals and the community to assure the crisis is resolved. This may include, upon request, providing disposition information to the jurisdiction that delivered the individual to the facility as well as other exchanges of information with appropriate authorization.

III. After CCRS triages a case with law enforcement, outreach teams will respond with consultation or dispatch as directed by triage clinician. The outreach teams will prioritize community (non-hospital/jail) outreach responses. Law enforcement cases will be a top priority.

IV. The final disposition of the consult will be communicated back to CCRS and can be communicated back to law enforcement by the DMHP if requested as part of the crisis response to the ITA investigation per 71.05 390.

ATTACHMENTS

None