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
117 North First Street, Suite 8 • Mount Vernon, WA 98273
360.416.7013 • 800.684.3555 • Fax 360.416.7017 • Email nsmha@nsmha.org • Web Site http://nsmha.org

NSMHA Contract Memorandum 2015-006

Date: July 1, 2015

To: Tom Sebastian, Compass Health and Compass Whatcom
Donna Konicki, Bridgeways
Michael Watson, Lake Whatcom RTC
Will Rice, Catholic Community Services Northwest
Claudia D'Allegri, Sea Mar
Phil Smith, Volunteers of America
Cindy Paffumi, Interfaith
Sue Closser, Sunrise Services
Robert Sullivan, Pioneer Human Services
Dr. Jerry Jenkins, NWESD 189
Beratta Gomillion, Center for Human Services

From: Joe Valentine, Executive Director

Subject: New policies

Policy 1580.00 – Intensive Programs Crisis-Response
This policy has been through the complete review and approval process. The Executive Director signed and approved this policy June 29, 2015.

Policy 1581.00 – Roads to Community Living
This policy has been through the complete review and approval process. The Executive Director signed and approved this policy June 30, 2015.

Policy 1726.00 – Involuntary Treatment Program Court Liaison Role and Responsibilities
This policy has been through the complete review and approval process. The Executive Director signed and approved this policy June26, 2015.

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

cc: Cindy Ferraro, Bridgeways
Heather Fennell, Compass Health
Kay Burbidge, Lake Whatcom RTC
Pat Morris, Volunteers of America
Katherine Scott, Sea Mar
Richard Sprague, Interfaith
Danae Bergman, Center for Human Services
Barbara LaBrash, San Juan County Coordinator
Rebecca Clark, Mental Health Program Coordinator Skagit County
Anne Deacon, Whatcom County Coordinator
Jackie Henderson, Island County Coordinator
Cammy Hart-Anderson, Snohomish County
Eric Chambers, NWESD 189
Contract File

Effective Date: 6/29/2015
Revised Date: 6/24/2015
Review Date: 6/24/2015

North Sound Mental Health Administration

Section 1500: Intensive Programs Crisis Response

Authorizing Source: NSMHA
See Also: Contract
Providers must comply with this policy and may develop individualized implementation guidelines as needed.
Responsible Staff: Deputy Director

Approved by: Executive Director
Signature:

Date: 6/29/2015

POLICY #1580.00

SUBJECT: INTENSIVE PROGRAMS CRISIS RESPONSE

PURPOSE

This policy addresses roles and responsibilities of North Sound Mental Health Administration's Behavioral Health Agencies' adult intensive programs in responding to crises for individuals enrolled in those programs. It provides guidance for the collaboration of the adult intensive programs, Integrated Crisis Response Services (ICRS) and hospital emergency departments (EDs).

DEFINITIONS

Adult intensive program – a program that serves adults and has a contractual or policy based expectation of 24/7 service availability for outreach. This includes, but is not limited to, Programs for Assertive Community Treatment (PACT), Adult Intensive Outpatient and Geriatric Transitions Program.

POLICY

Intensive program clinicians know the individuals enrolled in these programs very well, including their baseline functioning and the individualized supports available to them. Program staff members are well-equipped and expected to assist these individuals in stabilizing during a crisis and to prevent hospitalization when possible. Voluntary ICRS should not be necessary in most crisis situations for individuals in an intensive program.

PROCEDURES

<u>General procedures</u>

I. Outreach should be performed when:

A. It is clinically indicated, for example, when:

1. The clinician determines that his or her presence will provide support to the individual, or
2. The clinician can assist in diverting a hospitalization, and
3. Presence of the clinician is not contra-indicated for the individual's treatment.

When community outreach is contra-indicated for a specific individual, this should be clearly indicated in their crisis plan. The crisis plan should also clearly outline alternative strategies for dealing with crisis.

B. It can be performed safely. If safety concerns cannot be effectively addressed, the team will work to coordinate an alternative plan to meet the individual's needs.

C. It is within the program's home county, or an adjacent county along the I-5 corridor, or within a 45 minute drive from the intensive program office to which the individual is assigned.

1. Outreach to more distant locations is not expected, but can be provided at the program's discretion.
2. When outreach cannot be performed due to distance, geographical limitations (such as ferry schedules), or other factors, the clinician should provide as much assistance as possible via phone and/or other available means.

II. The following timelines are expected for phone and in-person responses:

A. Telephone response should be within 10 minutes of the initial page or contact.
B. In-person outreach should occur within two hours of the initial page or contact.
C. Whenever VOA contacts an intensive services clinician, the intensive services program should call in a disposition to VOA within 1 hour of completion of their response to the crisis situation.

III. Crisis situations in the community (other than hospital emergency departments)

A. If an individual in intensive services experiences a crisis and contacts VOA Care Crisis, VOA Care Crisis will contact a clinician from the intensive program and the clinician will determine what follow-up is needed. The clinician will call in the disposition to VOA Care Crisis after response to the crisis situation.

1. VOA Care Crisis may choose not to contact an intensive program clinician when:

    a. They are able to successfully help the individual through the crisis and no additional follow up is needed; and
    b. The client is not requesting to speak to a clinician from their intensive program.

2. If VOA is able to resolve the crisis and chooses not to contact the intensive program, the primary clinician will be notified of the call the following business day.

B. The intensive program should coordinate any voluntary crisis response, including community outreach, referral to crisis stabilization, voluntary hospitalization, and any other options less restrictive than evaluation by a Designated Mental Health Professional (DMHP). When voluntary hospitalization is deemed appropriate, the clinician should facilitate the hospitalization, including locating the bed, contacting VOA for certification/authorization, and communicating with the admitting hospital.
C. If the intensive services clinician believes an involuntary evaluation is needed, the clinician will contact VOA Care Crisis to request dispatch of a DMHP, and will indicate to VOA that this is the disposition of their involvement in the crisis situation. The clinician should provide any necessary information to the DMHP and VOA. The DMHP will call in their disposition to VOA Care Crisis after completion of their response to the crisis situation.

1. Prior to requesting a DMHP evaluation, the expectation is that a program clinician will have had face-to-face contact with the individual within the 12 hours prior to the request for an ITA evaluation. Face-to-face contact does not have to be conducted by the same

individual requesting evaluation, but the requester should be able to discuss relevant clinical details.

Exceptions to this standard are made on a case-by-case basis if both the referring clinician and the VOA staff are in agreement. For example, if the individual is unwilling to see the intensive program or participate in less restrictive options, the intensive program may request DMHP dispatch without having recently evaluated the individual.

2. Only DMHPs are able to write custody authorizations (pick-up orders) allowing law enforcement to involuntarily transport individuals. Therefore, in cases where evaluation for involuntary detention is warranted, but DMHP dispatch is deemed unsafe, DMHPs should consult with intensive program staff to determine a course of action, which if appropriate may include a pick-up order.

IV. Responding to crisis situations at hospital emergency departments (EDs)

A. If an individual enrolled with an intensive program arrives at an ED, hospital ED staff are requested to contact VOA at 1-800-747-8654 after they have evaluated the individual. VOA will contact the intensive program and communicate the hospital's information to the clinician. Follow up will be coordinated between the intensive program clinician and the hospital ED staff. The intensive program clinician will call in the disposition to VOA Care Crisis after responding to the crisis situation.

1. Intensive programs clinical staff responding to crisis situations are considered to have sufficient educational and professional experience to respond to crisis situations by providing community support services.
2. Intensive program staff involvement is not intended to supplant ED staff duties, although there may be some overlap in the rare circumstances noted below.
3. After phone consultation with the hospital ED staff, the clinician will perform an outreach to the hospital if it is determined by the clinician to be clinically warranted.
4. The clinician will clearly indicate to the ED staff whether they intend to perform an outreach, and if so, the approximate time they will arrive at the ED.
5. If all less restrictive options have been attempted, and the individual is determined to need voluntary hospitalization, the hospital staff should facilitate the hospitalization, including locating the bed, contacting VOA for certification/authorization, and communicating with the admitting hospital.

B. In some circumstances, the hospital emergency department may not have an on-duty social worker or other appropriate staff to facilitate voluntary hospitalization. If this is the case, the intensive program clinician should facilitate the hospitalization. This can be expected to occur at some of the region's smaller hospitals.

C. If there is disagreement between the hospital and the intensive program about who should facilitate the hospitalization, the intensive program clinician should perform these duties. The intensive program can contact NSMHA after the crisis situation is resolved with any concerns about this process.
If all voluntary options have been deemed inappropriate, and an involuntary evaluation is needed following a hospital emergency department intervention, the hospital staff should contact VOA Care Crisis to request dispatch of a DMHP.

D. The intensive program clinician should provide any necessary information to the DMHP and VOA.
E. In circumstances where the hospital has no social worker on duty, the clinician will contact VOA Care Crisis to request dispatch of a DMHP.
F. As above, if there is disagreement about who should perform these duties, the intensive program clinician should do so.

V. Disputes

A. In the case of dispute, please reference policy #1707, Crisis System Clinical Dispute Resolution.
B. The emphasis should always be on providing the best service possible to the individual.

ATTACHMENTS

None

Effective Date: 6/30/2015
Revised Date: 5/27/2015
Review Date: 5/27/2015

North Sound Mental Health Administration

Section 1500 – Clinical: Roads to Community Living (RCL)

Authorizing Source: WAC 388-106, DSHS/NSMHA RCL Contract
Cancels:
See Also: Approved by: Executive Director Date:
Responsible Staff: Signature:

POLICY #1581.00

SUBJECT: ROADS TO COMMUNITY LIVING (RCL)

PURPOSE

To provide guidance on accessing RCL funds for community-based services/supports which help individuals meet their treatment goals when discharging from qualified institutional settings back into the community.

DEFINITIONS

RCL – is a mix of federal and state funds provided to Medicaid eligible individuals discharging from qualified institutional settings. These funds are designed to fund services/supports to ameliorate symptoms, prevent the need for future hospitalizations and/or residential treatment and are not funded by any other system or resource.

Qualified Institutional Setting – Children's Long-Term Inpatient Program (CLIP – youth under age 18), state psychiatric hospital, nursing home, or residential habilitation center.

Qualified Community Setting – home, apartment, licensed residential setting with four (4) or less unrelated individuals.

POLICY

The North Sound Mental Health Administration (NSMHA) will authorize RCL for individuals who meet the eligibility criteria and have identified, qualifying unmet needs stated in the transition care plan, not otherwise provided by Medicaid or a more appropriate system/provider.

PROCEDURE

Eligibility Criteria

RCL funding **may** be accessed while the individual is in a qualified institutional setting provided the eligibility criteria are met. From the date of discharge, the benefit period for each individual is a maximum of 365 days beginning the date of discharge into a qualified community setting. No extensions shall be granted for RCL funding.

In order to be eligible to access RCL funding, individuals:

I. Must be under age 21 or over age 65.
II. Must be residing in a qualified institutional setting, receiving services for more than 90 consecutive days and are not admitted for the sole purpose of short-term rehabilitative services.

III. Must be receiving Medicaid benefits for services in a qualified institutional setting for at least one (1) day prior to transitioning into the community.
IV. Must sign the Participation Form (available at http://nsmha.org/Forms/index.asp) prior to the date of discharge from a qualified institutional setting and be preauthorized to participate in the program by the Department of Behavioral Health and Recovery (DBHR) RCL Administrator.

Process

I. Qualified institution will fill out the provided NSMHA request for RCL funding form, outlining the needs to be supported by RCL. NSMHA care coordinator and outpatient providers will work with facilities and families to help identify the appropriate resources in the family's local community.
II. Individual, and where appropriate the legal guardian, shall consent to participate in the RCL program by signing the Participation Form prior to the date of discharge from a qualified institutional setting. The signed Participation Form must be sent to NSMHA care coordinator prior to the discharge date.
III. NSMHA care coordinator will send the signed participation form to the appropriate DBHR RCL Administrator for pre-authorization.
IV. NSMHA care coordinator will work with NSMHA contracts, NSMHA providers and the identified RCL community provider to develop a contract for the requested services. A copy will be sent to the fiscal department in order to facilitate payment.
V. NSMHA care coordinator will review deliverables from the contracted RCL providers.

Transition Planning

From the date of discharge, the benefit period for each individual is a maximum of 365 days beginning the date of discharge into a qualified community setting. No extensions shall be granted for RCL funding.

I. The benefit period will end for the follow reasons:

   A. 365 days have been completed;
   B. Individual returns to an institutional setting for longer than 30 days. In this case, an individual may reapply when discharging from the qualified institutional setting after the 90 consecutive day mark has been satisfied;
   C. Individual moves out of state;
   D. Individual no longer wants the service; or
   E. Individual passes away.

   If the individual is dis-enrolled from RCL for any reason during the contract period, the Disenrollment Form shall be completed and turned into the DBHR RCL Administrator.

   Prior to the end of the benefit period, RCL contracted provider shall collaborate with other community providers (e.g. NSMHA providers) to develop and implement a sustainable discharge plan that continues to address the identified needs.

II. The Transition Plan shall include at least:

A. The services/supports provided by RCL funding are stable and sustainable after the end of the benefit period.
B. RCL service provider, in conjunction with other community providers, will ensure the individual is residing in stable sustainable housing and have the necessary supports in place to continue placement in the community.
C. If an individual is enrolled with NSMHA provider, NSMHA provider will coordinate with RCL contracted provider to ensure the individual has all the necessary supports in place to continue placement in the community

ATTACHMENTS

None

Effective Date: 6/29/2015
Revised Date: 5/28/2015
Reviewed Date: 6/24/2015

North Sound Mental Health Administration

Section 1700 – ICRS: Involuntary Treatment Program Court Liaison Role and Responsibilities

Authorizing Source: WAC 388-865-0245(1); RCW 71.05, 71.34, and 70.96 B
Cancels:
See Also:
Provider must "comply with this policy and may develop individualized implementation guidelines as needed"
Approved by: Executive Director Date: 6/29/2015
Responsible Staff: Deputy Director Signature:

POLICY #1726.00

SUBJECT: INVOLUNTARY TREATMENT PROGRAM COURT LIAISON ROLE AND RESPONSIBILITIES

PURPOSE

To ensure the duties of court liaisons provided under Involuntary Treatment Services are administered by professionals knowledgeable in the Involuntary Treatment Act (ITA) court process in accordance with RCWs 71.05, 71.34 and 70.96B (refer to Policy 1720.00 – Administration on Involuntary Treatment for definitions).

POLICY

The North Sound Mental Health Administration (NSMHA) has developed a region-wide process that facilitates the interaction between the Designated Mental Health Professional (DMHP) teams, the inpatient facilities and court systems when an individual (respondent) is detained, identified as the role of court liaison. This role supports the legal processes of the courts during the inpatient stay.

This role has generally been an adjunct to the DMHP teams. However, it can also be a function of hospital professionals assigned the court work who is knowledgeable with the ITA court process.

There are variations in the duties based on workload and the size of the counties but there are core elements specific to the functions of this role.

This policy provides elements and expectations for NSMHA provider agencies contracted to provide court liaison function.

PROCEDURE

A. Individuals performing this function will:

1. Have a thorough understanding of all applicable laws and procedures;
2. Have excellent clinical assessment skills and a solid understanding of the court process;
3. Act as an expert contact regarding the process and workflows.

B. Upon direction of the attending physician/psychiatric ARNP/designee, the court liaison will initiate the process of pursuing further involuntary treatment and if applicable, file the appropriate petition.

C. The court liaison will prepare, file and make all court documents available to public defense, prosecution, the inpatient unit and respondent within expected timeframes.

D. The court liaison is prepared to testify at the discretion of the court.

E. They will document their activities with and on behalf of respondents; these activities will be retained in the clinical record.
F. The court liaison will provide coordination, communication and collaboration between the court system and clinical system throughout the involuntary inpatient stay.
G. NSMHA provider agencies contracted to perform the court liaison role will have the ability to provide liaison support throughout their contracted county(ies).
H. NSMHA provider agencies contracted to perform the court liaison role will provide training and administrative oversight to this position, including any changes in policies relevant to this position.
I. NSMHA will monitor this function through the typical auditing and oversight process.

ATTACHMENTS

None