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North Sound BHO Contract Memorandum 2018-010

Date: May 18, 2018

To: Tom Sebastian, Compass Health and Compass Whatcom
Donna Konicki, Bridgeways
Jenny Billings, Lake Whatcom RTC
Will Rice, Catholic Community Services Northwest
Claudia D'Allegri, Sea Mar
Cammy Hart-Anderson, Snohomish County MH/CD/Vets Division Manager
Phil Smith, Volunteers of America
Shanon Hardie, Unity Care NW
Sue Closser, Sunrise Services
Robert Sullivan, Pioneer Human Services
Beratta Gomillion, Center for Human Services
Corky Hundahl, Phoenix Recovery Services
Julie Lord, Pioneer Human Services
Linda Grant, Evergreen Recovery Services
Marli Bricker, Therapeutic Health Services

From: Joe Valentine

Subject: Fast-Tracked/Revised Policies

Greetings BHA Providers:

Attached are the **fast-tracked/revised** Policies 1557.00, 1702.00, 1704.00, 1706.00, 1707.00, 1717.00, 1720.00 and 1727.00 approved by the Executive Director for the National Committee for Quality Assurance (NCQA) review.

Attached is **revised** Policy 1728.00, which was not fast-tracked, but approved by the Executive Director.

Please be mindful some of the **fast-tracked** policies for NCQA review may come back through committees for review and approval later.

Policy 1557.00 – Safety Policy
This **fast-tracked/revised** policy has been approved by the Executive Director and signed May 18, 2018.

Policy 1702.00 – ICRS Outreach Safety Screening for Dispatching for Behavioral Health Crisis
This **fast-tracked/revised** policy has been approved by the Executive Director and signed May 18, 2018.

Policy 1704.00 – Crisis Services – General Policy
This **fast-tracked/revised** policy has been approved by the Executive Director and signed May 18, 2018.

Policy 1706.00 – Safeguarding of Property
This **fast-tracked/revised** policy has been approved by the Executive Director and signed May 18, 2018.

Policy 1707.00 – Crisis System Clinical Dispute Resolution
This **fast-tracked/revised** policy has been approved by the Executive Director and signed May 18, 2018.

Policy 1717.00 – ICRS – Urgent Contacts & Follow-Up Services
This **fast-tracked/revised** policy has been approved by the Executive Director and signed May 18, 2018.

Policy 1720.00 – Administration of the Involuntary Treatment Program
This **fast-tracked/revised** policy has been approved by the Executive Director and signed May 18, 2018.

Policy 1727.00 – Crisis Prevention and Intervention Teams (CPIT)
This **fast-tracked/revised** policy has been approved by the Executive Director and signed May 18, 2018.

Policy 1728.00 – Single Bed Certification (SBC)/Inpatient Resource Availability
This **revised** policy has been approved by the Executive Director and signed May 18, 2018.

Please ensure all appropriate staff receives this information.

The NM contains **fast-tracked/revised** policies for NCQA review and one **revised** policy below for your convenience.

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

A redlined copy of the policies will be included as separate attachments via the email.

cc: Cindy Ferraro, Bridgeways
Becky Olson-Hernandez, Compass Health
Kay Burbidge, Lake Whatcom RTC
Pat Morris, Volunteers of America
Katherine Scott, Sea Mar
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Contract File

Effective Date: Fast-tracked 5/18/2018; 3/3/2015; 6/17/2010; 5/21/2008; 6/25/2007
Revised Date: 5/16/2018
Review Date: 5/16/2018

North Sound Mental Health Administration

Section 1500 – CLINICAL: Safety Policy

Authorizing Source: RCWs 49.19.030, 49.19.020, 71.05.700, 71.05.705, 71.05.710, 71.05.715 and 71.05.720
WACs 388-877-0515 388-877 0810,0900, 0905,0910, 0915,0920
Cancels:
See Also:
Providers Must comply with this policy and may develop individualized implementation guidelines as needed
Approved by: Executive Director
Responsible Staff: Deputy Director
Signature:
Date: 5/18/2018

POLICY #1557.00

SUBJECT: SAFETY POLICY

PURPOSE

To ensure community mental health employees who work directly with individuals are adequately trained and safety measures are in place for safety and violence prevention.

POLICY

1. Behavioral Health Agency (BHAs) shall conduct a security and safety assessment to identify existing or potential hazards for violence and determine the appropriate preventive action to be taken. The assessment shall include, but is not limited to, a measure of the frequency of and an identification of the causes for and consequences of violent acts at the setting during the preceding five (5) years.
2. Based on the assessment, each BHA shall develop and implement a workplace violence plan to reasonably prevent and protect employees from violence at the setting. In developing the plan, the healthcare setting may consider any guideline on violence in the workplace or in the healthcare setting issued by the Department of Health (DOH), Department of Social and Health Services (DSHS), Department of Labor and Industries (DLI), Federal Occupational Safety and Health Administration (FOSHA), Medicare and healthcare setting accrediting organizations. The workplace violence plan shall address security considerations related to the areas below:

   a. The physical attributes of the healthcare setting;
   b. Staffing, including security staffing;
   c. Personnel policies;
   d. First aid and emergency procedures;
   e. The reporting of violent acts; and
   f. Employees' education and training.

3. BHAs shall provide violence prevention training to direct services staff and supervisors to ensure they are provided an individualized, annual training plan on safety and violence prevention topics (as directed by the workplace violence plan), appropriate to their job duties and maintain documentation of individualized violence prevention training.

4. BHAs will keep a record of any violent act against an employee, a patient, or a visitor occurring at the setting.
5. BHAs will maintain written policies and procedures for clinical staff who engage in visits to individuals at private homes and other private locations in accordance with current RCWs.

PROCEDURES

1. The violence prevention training shall occur within 90 days of the employee's initial hiring date, unless he or she is a temporary employee (for temporary employees, training would take into account unique circumstances) and then on an annual basis. The training may vary by the plan and may include, but is not limited to: classes, videotapes, brochures, verbal training, or other verbal or written training that is determined to be appropriate. The curriculum components, for the violence prevention training, developed collaboratively with DSHS, contracted mental health providers and employee organizations that represent community mental health workers will include:

    a. General safety procedures;
    b. Personal safety procedures;
    c. The violence escalation cycle;
    d. Violence-predicting factors;
    e. Obtaining patient history from a patient with violent behavior;
    f. Verbal and physical techniques to de-escalate and minimize violent behavior;
    g. Strategies to avoid physical harm;
    h. Restraining techniques (please see Policy 1541.00 – Rationale and Use of Seclusion and Restraint);
    i. Appropriate use of medications as chemical restraints (please see Policy 1541.00);
    j. Documenting and reporting incidents;
    k. The process whereby employees affected by a violent act may debrief;
    l. Any resources available to employees for coping with violence; and
    m. The healthcare setting's workplace violence prevention plan.

2. If there is a violent act against an employee, patient, or visitor at the BHA, the record of the violent act will include:

    a. BHA's name and address;
    b. Date, time and specific location at the healthcare setting where the act occurred;
    c. Name, job title, department and staff identification or social security number of the victim, if an employee; and
    d. Description of the person against whom the act was committed as:

        i. Patient;
        ii. Visitor;
        iii. Employee; or
        iv. Other.

e. Description of the person committing the act as:

   i. Patient;
   ii. Visitor;
   iii. Employee; or
   iv. Other.

f. Description of the type of violent act as a:

   i. Threat of assault with no physical contact;
   ii. Physical assault with contact but no physical injury;
   iii. Physical assault with mild soreness, surface abrasions, scratches, or small bruises;
   iv. Physical assault with major soreness, cuts, or large bruises;
   v. Physical assault with severe lacerations, a bone fracture, or head injury; or
   vi. Physical assault with loss of limb or death.

g. Identification of any body part injured;
h. Description of any weapon used;
i. Number of employees near the action when it occurred; and/or
j. Description of the actions taken by employees and the BHA in response to the act. (Each record shall be kept for at least five (5) years following the act reported, during which time it shall be available for inspection upon request).

3. For clinical staff who engage in visits to private homes or other private locations:

   a. When determined to be necessary for safety, clinical staff who provide outreach to individuals shall engage the use of a second person to accompany them. The second person can be a mental health professional or a mental health paraprofessional who has received training under RCW 71.05.715, a law enforcement officer, or other first responder, such as fire or ambulance personnel.
   b. If risk cannot be assessed, clinical staff shall consider other outreach options or arrange to see the individual at a staffed location (see Policy 1702.00 – Crisis Policy). No retaliation may be taken against clinical staff who following consultation with the clinical team, refuse to go to a private home, or other private location alone.
   c. BHAs will ensure individual's crisis plans are available to Designated Crisis Responders (DCRs), crisis teams, voluntary inpatient and involuntary inpatient Evaluation and Treatment facilities 24 hours a day/7 days a week. If commitment records or advanced directives exist, they should also be made available to DCRs. Additionally, this information must be available to North Sound BHO and state staff as required for management information, quality management and program review.
   d. BHAs will provide wireless telephone or comparable devices (for emergency communication purposes) to clinical staff who engage in home visits to individuals.

e. Crisis teams or DCR staff will have a plan for training, staff back-up, information sharing and communication for a staff member who responds to a crisis in a private home or a non-public setting.

4. North Sound BHO will provide an annual clinical audit/review to ensure adherence to sourced WAC and relevant RCW standards utilizing current related audit/review tools.

ATTACHMENTS

None

Effective Date: Fast-tracked 5/18/2018; 9/16/2016; 1/31/2014; 9/9/2011; 6/17/2008; 8/30/2007; 12/21/2005
Revised Date: 5/3/2018
Review Date: 5/3/2018

North Sound Behavioral Health Organization

Section 1700 – Integrated Crisis Response Services (ICRS):
ICRS Outreach Safety Screening for Dispatching for Behavioral Health Crisis

Authorizing Source: North Sound BHO and ICRS Management, RCW 71.05.700 and 71.05.715, WAC 388-877-0900, -905, -910, -0915, -0920 and -0810
Cancels:
Providers must comply with this policy and may develop individualized implementation guidelines as needed — Approved by: Executive Director
Responsible Staff: Deputy Director — Signature: — Date: 5/18/2018

POLICY #1702.00

SUBJECT: ICRS OUTREACH SAFETY SCREENING FOR DISPATCHING FOR BEHAVIORAL HEALTH CRISIS

PURPOSE

The purpose of this policy is to ensure a responsive and consistent safety screening process for crisis outreaches for individuals, family members, community members and ICRS staff. This policy addresses the roles of the Volunteers of America (VOA) Care Crisis Response Services (CCRS) Triage Clinician (referred to herein as "CCRS Triage Clinician"), Crisis Prevention and Intervention Team (CPIT) and Designated Crisis Responder (DCR).

POLICY

Outreach teams may be dispatched by VOA or self-dispatch from a direct call to the CPIT team by Law Enforcement.

If VOA dispatches, the CCRS Triage Clinician will have the responsibility of deciding when face-to-face evaluation and/or stabilization services is needed and dispatch CPIT and/or DCR staff to a community location. CPIT or DCR may not decline a referral for face-to-face services but decides if backup or other provisions are needed to mitigate risk.

If CPIT receives a direct call prior to self-dispatches from Law Enforcement, they should still assess for risk and contact VOA to check on any history VOA may have on the individual.

Outreach services shall be provided within two (2) hours of dispatch for emergent cases by the CCRS Triage Clinician or after contacting the CCRS Triage Clinician. Any exceptions shall be clearly documented in the individual's record(s) and are subject to North Sound Behavioral Health Organization (North Sound BHO) review. The disposition of all cases referred to CPIT or DCR by a CCRS Triage Clinician will be reported to the CCRS Triage Clinician via phone by the end of their shift.

Once the safety screening has been completed by the CCRS Triage Clinician or CPIT and the decision is made to dispatch for an outreach, the dispatched CPIT or DCR assumes responsibility for further assessing the safety of the situation. CPIT or DCR must provide the most appropriate clinical intervention (via outreach) in the safest manner possible. There is an understanding that each situation is fluid and there is often missing information. The system allows for decisions to be re-evaluated in the face of new or different information.

PROCEDURES

I. Initial telephone safety screening for callers that do not seem to be under the influence of drugs or alcohol

a. If the caller is an immediate risk to self or others and unable to maintain safety for up to two (2) hours, 911 must be called to initiate law enforcement response.

b. If the risk is elevated, but not immediate, the CCRS Triage Clinician/CPIT/DCR must complete a more thorough risk assessment. Depending on the clinical assessment, degree of risk and the individual's needs, the individual will be referred to the appropriate services, which may include 911, hospital emergency department, Triage/Crisis Center, crisis appointment, or other community services. If the individual is able to maintain safety, per assessment of risk with the use of the safety screening assessment tool, a crisis outreach may be considered.

c. Ongoing safety screening by CPIT and DCR staff shall continue to occur during the crisis outreach.

  1) Upon outreach to an unstaffed location, CPIT or DCR will continue to perform an ongoing risk assessment.

    i) CPIT or DCR must assess risk factors, which can include:

      a) Location;
      b) Access to weapons;
      c) History (i.e., watch);
      d) Volitility;
      e) Consistency of known information;
      f) Ability to summon assistance if needed (i.e., cell phone coverage);
      g) Time of dispatch;
      h) Gender;
      i) Age;
      j) Presence of others at the location;
      k) History of ICRS contacts;
      l) Presence of animals; and/or
      m) Presence of drugs and/or alcohol.

    ii) CPIT or DCR must determine (based upon evaluated risk) how and where to see the individual.

  2) Options to consider to increase safety include:

    i) Arranging for family members or significant others to be present;
    ii) Moving the location of the outreach to a safer community setting;
    iii) Arranging for law enforcement to escort CPIT or DCR; and/or
    iv) Conducting the outreach with a second ICRS staff person for additional safety.

II. **Initial telephone safety screening for callers that seem to be under the influence of drugs or alcohol**

a. If the caller's judgment is significantly impaired and they are a risk to themselves or others and are unable to maintain safety, 911 must be called to initiate law enforcement response.
b. If the risk is elevated, but not immediate, the CCRS Triage Clinician/CPIT/DCR must complete a more thorough risk assessment. Depending on the clinical assessment, degree of risk and individual's needs, the individual will be referred to the appropriate services, which may include 911, hospital emergency department, Triage/Crisis Center, crisis appointment, or other community services. If the individual is able to maintain safety, per assessment of risk with the use of the safety screening assessment tool, a crisis outreach may be considered.
c. **When alcohol or drugs are present, CPIT/DCR may provide outreach services, after completing a safety screening assessment, but must consider the risk factors noted above**. The CCRS Triage Clinician/CPIT/DCR must agree an outreach is appropiate in the presence of alcohol or drugs.

If the outreach is not appropriate, arrangements can be made for the individual in crisis to go to a staffed location, the hospital emergency department, or Triage/Crisis Center.

III. No CPIT or DCR staff shall be required to respond alone to a private home or other private location to stabilize or treat an individual in crisis, or to evaluate an individual for potential detention under the state's involuntary treatment act. When determined to be necessary for safety, clinical staff who provide outreach to individuals shall engage the use of a second person to accompany them. The second person can be another agency clinical staff, law enforcement officer, or other first responder, such as fire or ambulance personnel. Additionally, CPIT or DCR, dispatched on a crisis visit, shall have prompt access to information about any history of dangerousness or potential dangerousness of the individual they are being sent to evaluate. At a minimum, information documented in crisis plans or commitment records shall be available without unduly delaying a crisis.

IV. If risk cannot be assessed, clinical staff shall consider other outreach options or arrange to see the individual at a staffed location.

V. CPIT or DCR staff will re-contact the CCRS Triage Clinician regarding changes in dispatch due to elevated risk concerns.

VI. CPIT or DCR staff will be provided with wireless phones and participate in annual safety training as addressed in North Sound BHO Policy #1557.00 – Safety Policy.

VII. CPIT or DCR staff will have a plan for training, staff back-up, information sharing and communication for a staff member who responds to a crisis in a private home or a non-public setting.

VIII. North Sound BHO will provide an annual clinical audit/review to ensure adherence to sourced WAC and relevant RCW standards utilizing current related audit/review tools.

ATTACHMENTS

None

Effective Date: Fast-tracked 5/18/2018; 3/31/2014; 8/28/2009; 5/30/2007; 11/29/2005
Revised Date: 5/3/2018
Review Date: 5/3/2018

North Sound Behavioral Health Organization

Section 1700 – Crisis Services – General Policy

Authorizing Source: WAC 388-877-0810, 0900, -0905, -0910, -0915 and -0920; North Sound BHO/ICRS Management agreement
Cancels:
See Also:
Providers must comply with this policy and may develop individualized implementation guidelines as needed
Approved by: Executive Director
Responsible Staff: Deputy Director
Signature:
Date: 5/18/2018

POLICY #1704.00

SUBJECT: CRISIS SERVICES – GENERAL POLICY

PURPOSE

To provide an integrated, coordinated and seamless crisis response system for the North Sound Behavioral Health Organization LLC (North Sound BHO) and its member counties: Island, San Juan, Skagit, Snohomish and Whatcom (North Sound BHO Service Area).

POLICY

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

PROCEDURE

I. North Sound BHO intends Integrated Crisis Response Services (ICRS) will be delivered in accordance with WAC 388-8770900 through 0920, North Sound BHO contract, and the following Substance Abuse and Mental Health Administration (SAMHSA) principles:

   a. ICRS will deliver timely access to supports and services throughout North Sound BHO/PHP for children and adults;
   b. ICRS will have the capacity to provide outreach when an individual cannot come to a traditional service site;
   c. A behavioral health crisis is defined as a turning point in the course of anything decisive or critical, a time, a stage, or an event or a time of great danger or trouble, whose outcome decides whether bad consequences will follow;
   d. Individuals experiencing a psychiatric crisis will be stabilized in the least restrictive manner and setting, preserving the individual's connectedness to his or her world;
   e. Adequate time will be spent with the individual and families to assist in resolution of the crisis;
   f. ICRS will develop strength-based plans with the individual and natural supports in resolution of the crisis;

g. Interventions will consider the whole context of the individual's plan of services;
h. ICRS services will be performed in a culturally competent manner;
i. Rights are respected;
j. ICRS services are trauma-informed;
k. Helping the individual regain a sense of control is a priority;
l. When peer support is available (directly or via referral), offering opportunity for contact with others whose personal experiences with mental health crisis allow an ability to convey a sense of hopefulness;
m. ICRS will be prepared to refer to a variety of services and supports;
n. Delivery of services will be seamless and consistent throughout the region;
o. Recognition that recurring crises are signaling problems in assessment, engagement, or care; and
p. Meaningful measures will be taken to reduce the likelihood of future crises.

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

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

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

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

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

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

VII. North Sound BHO will provide an annual clinical audit/ review to ensure adherence to sourced WAC and relevant RCW standards utilizing current related audit/review tools.

ATTACHMENTS

None

Effective Date: Fast-tracked 5/18/2018: 2/1/2016; 10/3/2013; 3/3/2008; 8/30/2007
Revised Date: 1/10/2018
Review Date: 5/3/2018

North Sound Behavioral Health Organization

Section1700 – Crisis Services: Safeguarding of Property

Authorizing Source: WAC 388-877-1126 & RCW 71.05.220, 71.05.700-71.05.715
Cancels:
See Also:
Providers must comply with this policy and may develop individualized implementation guidelines as needed
Approved by: Executive Director
Responsible Staff: Deputy Director
Signature:
Date: 5/18/2018

POLICY #1706.00

SUBJECT: SAFEGUARDING OF PROPERTY

PURPOSE

North Sound Behavioral Health Organization (North Sound BHO) providers of crisis services and providers who operate psychiatric inpatient Evaluation and Treatment (E&T) facilities shall have appropriate policies and processes to ensure reasonable precautions are taken to safeguard an individual's property.

POLICY

When a Peace Officer or Designated Crisis Responder (DCR) escorts an individual to a facility to be evaluated, the DCR must take reasonable precautions to safeguard the individual's property.

Providers who operate E&T facilities shall take reasonable precautions to inventory and safeguard the property of the individual detained to that facility.

PROCEDURE

1. Agencies employing DCRs shall provide adequate training and have protocols regarding:

    a. Safeguarding the individual's property in the immediate vicinity, if involved, at the point of apprehension;
    b. DCRs will make every reasonable effort to ensure individuals and service animals (per Americans with Disabilities Act (ADA) definition) will be kept together.
    c. Safeguarding belongings not in the immediate vicinity, if made aware that there may be possible danger to those belongings; the DCR may coordinate with law enforcement and/or other available collateral supports to address these needs;
    d. Taking reasonable precautions, if made aware, to lock and otherwise secure the individual's home or other property as soon as possible after the individual's initial detention; the DCR may coordinate with law enforcement and/or other available collateral supports to address these needs;
    e. Ensuring requirements for crisis outreaches to home visits (RCW.71.05.700 through 71.05.715) are met; and
    f. Documenting, if made aware, the actions taken to safeguard the individual's property.

2. At the time an individual is involuntarily admitted to an E&T facility, a copy of the inventory, signed by the E&T facilities' staff member completing it, shall be given to the individual detained. In addition, the inventory contents shall be open to inspection to any responsible relative, subject to limitations, if any, specifically imposed by the detained individual. For purposes of this section, "responsible relative" includes the guardian, conservator, attorney, spouse, parent, adult child, or adult brother or sister of the individual. The facility shall not disclose the contents of the inventory to any other person without the consent of the individual or order of the court.
3. North Sound BHO will provide an annual clinical audit/review to ensure adherence to sourced WAC and relevant RCW standards utilizing current related audit/review tools.

ATTACHMENTS

None

Effective Date: Fast-tracked 5/18/2018; 3/7/2016; 8/27/2012; 1/28/2008; 11/29/2005
Revised Date: 1/10/2018
Review Date: 1/10/2018

North Sound Behavioral Health Organization

Section 1700 – Crisis Services: Crisis System Clinical Dispute Resolution

Authorizing Source: North Sound Behavioral Health Organization and ICRS Management
Cancels: Policy 1507.00
See Also:

Providers must comply with this policy and may develop individualized implementation guidelines as needed	Approved by: Executive Director	
Responsible Staff: Deputy Director	Signature:	Date: 5/18/2018

POLICY #1707.00

SUBJECT: CRISIS SYSTEM CLINICAL DISPUTE RESOLUTION

PURPOSE

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

DEFINITIONS

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

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

*****ICRS providers include Designated Crisis Responders (DCRs), Crisis Prevention and Intervention Team (CPIT), Triage Facility staff, Substance Use Disorder (SUD) Professionals, Certified Peer Counselors (CPCs) and Evaluation and Treatment (E&T) Staff (not all agencies identified have all types of ICRS providers).

POLICY

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

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

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

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

PROCEDURE

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

1. When involved, the CCRS Triage Clinician mediates conflicts between other service or system providers and ICRS providers. Resolution of the dispute will be attempted at the time of the call with the appropriate managers involved. In the event there is no resolution, the CCRS Triage Clinician will inform those parties of the next day follow up procedure. The following shall occur:
   The CCRS Program Manager will inform the appropriate Crisis Services Manager or their designee of the situation.
2. When an issue comes to the attention of Crisis Services Managers, they will contact the other service or system provider by the next working day. If notification of the issue did not come from VOA CCRS, the Crisis Services Manager may inform the CCRS Program Manager of the issue.
3. If the dispute cannot be resolved, information may be brought to a case review. Venues for this case review can include staff meetings, local oversight committees and the Regional ICRS Committee. All relevant information will be gathered and reviewed to determine if the dispute arose from a systems issue, problem with customer service, extraordinary occurrence, training issue, or other reason. When the reason for the dispute is ascertained, appropriate measures will be taken to address the cause.
4. Disputes will be reported to the Regional ICRS Committee for monitoring and quality improvement purposes.

B. INTRA-SYSTEM DISPUTES (between ICRS providers)

1. When clinical disputes arise between ICRS providers, the CCRS Triage Clinician will have the final determination as to what service will be provided at that time.
2. Information on the incident will be brought to the appropriate ICRS Program Managers.
3. Resolution of the dispute will be attempted at the time of the call with the appropriate Program managers. In the event there is no resolution, the ICRS managers involved will inform other parties of the next day follow up procedure.
4. During the next business day, managers will connect and come to a resolution informally whenever possible.

5. 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(4).

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

ATTACHMENTS

None

Effective Date: Fast-tracked 5/18/2018; 3/7/2016; 1/25/2013; 11/8/2007; 6/25/2004
Revised Date: 5/16/2018
Review Date: 5/16/2018

North Sound Behavioral Health Organization

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

Authorizing Source: WACs 388-877-0810, -0910, -0915, and -0920 and Contract
Cancels: Policy 1514.00
See Also:
Providers must comply with this policy and may develop individualized implementation guidelines as needed
Approved by: Executive Director
Responsible Staff: Deputy Director
Signature:
Date: 5/18/2018

POLICY #1717.00

SUBJECT: ICRS – URGENT CONTACTS & FOLLOW-UP SERVICES

PURPOSE

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

POLICY

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

A. Emergent Contact: Calls in this category require a response within two (2) hours of the dispatch of outreach staff by the VOA CCRS Triage Clinician (see North Sound BHO Policy 1702, ICRS Outreach Screening, Crisis Line Pre- and Post-Dispatch, for additional policy and procedures related to Emergent contacts).

B. Urgent Contact: Calls in this category shall provide individuals in crisis with timely access to face-to-face mental health evaluation/intervention services when needed, to prevent the individual's situation from deteriorating to the point that Emergent care is necessary. These calls require a response by the North Sound BHO provider within 24 hours of the VOA CCRS Triage Clinician's notification.

C. Follow-up Services: Follow-up appointments are offered when the caller does not require "Emergent" or "Urgent" intervention but there is an indication that without prompt assessment/intervention further decompensation is likely. This appointment may be initiated at the request of the VOA CCRS Triage Clinician or by any other Clinician within the ICRS system. Follow-up services may also be offered to non-enrolled individuals needing follow-up contact while awaiting transition into ongoing care.

PROCEDURES

A. Urgent Contacts

1. Individuals with an open outpatient episode:

a) During typical business hours, individuals who are currently enrolled with a North Sound Behavioral Health Agency (BHA) shall be seen, whenever possible, by their Behavioral Health Care Provider (BHCP)/team. If the BHCP is unavailable, the program supervisor will be contacted to determine if another member of the treatment team can see the individual. In those rare circumstances where support through the treatment team is unavailable, ICRS staff may be dispatched by VOA CCRS Triage Clinician.

b) When the BHCP will be unavailable to the VOA CCRS Triage Clinician within 24 hours of the identified need for contact (e.g., the need is identified on a Friday evening), the ICRS staff shall be contacted, briefed and requested to respond via face-to-face intervention within 24 hours.

2. Individuals without an open outpatient episode:

a) Designated ICRS providers shall maintain a Monday through Friday schedule of available appointment times and shall make this schedule available to VOA CCRS Triage Clinicians.

b) VOA CCRS Triage Clinicians shall schedule an available Urgent Appointment for callers, within 24 hours of the call to VOA.

c) VOA CCRS Triage Clinicians shall notify the BHA as soon as possible regarding the scheduled contact and shall provide summarized clinical information in a standard format.

d) When an appointment is not available within 24 hours (e.g., the need is identified on a Friday evening), the ICRS staff shall be contacted, briefed and requested to respond via face-to-face intervention within 24 hours. Disposition will follow the ICRS process.

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

1. Individuals with an open outpatient episode:

a) Follow-up services for these individuals shall be provided by the BHCP or another member of the clinical team. ICRS is not responsible for providing follow-up services to enrolled individuals.

b) The VOA CCRS Triage Clinician or Emergency Services (ES) staff referring an enrolled individual for follow-up services shall notify the BHA as soon as possible and shall provide summarized information in a standard format.

2. Individuals without an open outpatient episode:

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

Disposition will follow the ICRS process.

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

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

C. North Sound BHO will provide an annual clinical audit/review to ensure adherence to sourced WAC and relevant RCW standards utilizing current related audit/review tools.

ATTACHMENTS

None

Effective Date: Fast-tracked 5/18/2018; 12/23/2016; 3/28/2014; 7/14/2010; 8/30/2007
Revised Date: 5/16/2018
Reviewed Date: 5/16/2018

North Sound Behavioral Health Organization

Section 1700 – ICRS: Administration of the Involuntary Treatment Program

Authorizing Source: North Sound BHO contract, DCR protocols, WAC 388-877-0810 and -0900 through -0915, (except -0905); RCW 71.05, 71.34, & 10.77
Cancels:
See Also:
Provider must comply with this policy and may develop individualized implementation guidelines as needed
Approved by: Executive Director
Responsible Staff: Deputy Director
Signature:
Date: 5/18/2018

POLICY #1720.00

SUBJECT: ADMINISTRATION OF THE INVOLUNTARY TREATMENT PROGRAM

PURPOSE

The purpose of this policy is to ensure Involuntary Treatment Services are provided by Designated Crisis Responders (DCRs) to evaluate an individual in crisis and determine if involuntary services are required.

POLICY

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

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

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

PROCEDURE
Definitions

DCR means a Mental Health Professional (MHP) designated by the county or other authority authorized in rule to perform the duties specified in these chapters.

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

1. North Sound BHO will have agreements in place with ICRS Service Providers, Snohomish, Skagit, Island Whatcom and San Juan Counties to provide services in accordance with the designation noted above.
2. MHPs designated to perform these duties will have the necessary training required to perform these duties.
3. North Sound BHO will provide an annual clinical audit/review to ensure adherence to sourced WAC and relevant RCW standards utilizing current related audit/review tools.

ATTACHMENTS

None

Effective Date: Fast-tracked 5/18/2018; 8/28/2015
Revised Date: 4/30/2018
Review Date: 4/30/2018

North Sound Behavioral Health Organization

Section 1700 – Crisis Services – Crisis Prevention and Intervention Teams (CPIT)

Authorizing Source: North Sound BHO contract, WACs 388-877-0910, -0915 and -0920
Cancels:
See Also:
Providers must comply with this policy and may develop individualized implementation guidelines as needed
Approved by: Executive Director
Responsible Staff: Deputy Director
Signature:
Date: 5/18/2018

POLICY #1727.00

SUBJECT: CRISIS PREVENTION AND INTERVENTION TEAMS (CPIT)

PURPOSE

The purpose of CPIT is to provide community outreach and engagement to individuals who are experiencing a behavioral health crisis or who are believed to be suffering from significant behavioral health symptoms which are interfering with activities of daily living. These individuals may be referred to CPIT via themselves, family, friends, law enforcement, emergency medical services, or others and prompt attempts will be made to engage them in order to reduce the likelihood of the need for more intense interventions.

POLICY

CPIT is designed to provide proactive and/or early intervention to those experiencing a behavioral health crisis or who are believed to be suffering from significant behavioral health symptoms. This program is intended to provide early intervention and to assess, engage, stabilize and make appropriate linkage to community treatment and support resources.

Program outcomes should include diversion from jail, emergency departments and inpatient psychiatric facilities and active engagement with available community resources. Additionally, CPIT will address community concerns about those who have apparent unmet needs and actively partner with community members (e.g., law enforcement, emergency departments, homeless outreach programs, shelters and general community members) to address potentially problematic situations and facilitate continuity of care.

CPIT will respond to emergent needs within 2 hours of request and to urgent requests within 24 hours. Requests for intervention may come from the Crisis Line or via direct referral to the team. Any concerned person may request CPIT response, to include the individual themselves, family, friends, or other concerned community members. The individual does not have to be well known, can be in crisis, or just of significant concern, but must be identifiable. Every effort will be made to coordinate with collateral formal and informal supports, to include current treatment providers and other supports.

When CPIT responds to a crisis situation, the team is expected to stay involved until the situation is stabilized or resolved. Episodes of care are expected to be no more than 14 days, although in rare circumstances an extension to this time period may be requested.

Program staffing must include professionals who are able to rapidly respond and address a broad range of behavioral health concerns in a varied population. To this end, Certified Peer Counselors, Mental Health Professionals (MHP) and Chemical Dependency Professionals (CDP) will be critical members of the CPIT and management staff will be available for consultation at all times.

PROCEDURES

I. CPIT Composition and Coverage

A. Snohomish County CPIT will be staffed 24/7/365. Core staffing will include an MHP, CDP, and Certified Peer Counselor available at all times to provide paired outreach. Management will be available for consultation at all times.
B. Skagit County CPIT will be staffed 7 days per week at peak day and evening hours (e.g., 0900 through 2400 hours). Core staffing will include an MHP, CDP and Certified Peer Counselor available at all times to provide (at least) paired outreach. Management will be available for consultation at all times. During "uncovered hours", the DCR staff may be dispatched by the Crisis Line to respond to Emergent (2-hour response) outreach needs.
C. In Whatcom County, CPIT will be staffed 7 days per week at peak day and evening hours (e.g., 0900 through 2400 hours). Core staffing will include an MHP, CDP and Certified Peer Counselor available at all times to provide paired outreach. Management will be available for consultation at all times. During "uncovered hours", the Designated Crisis Responder (DCR) staff may be dispatched by the Crisis Line to respond to Emergent (2-hour response) outreach needs.

II. CPIT Workflow and Response Expectations

A. CPIT must follow all applicable WACs.
B. Referrals come from the Crisis Line. Crisis Line pages require a response within 10 minutes.
C. Initial screening will result in a determination of whether an Emergent (2 hours or less) or Urgent (within 24 hours) response is warranted.
D. If the individual is enrolled with a Community Mental Health provider, that provider is responsible for crisis response that may be needed during typical business hours. If the individual is in an "intensive program" (to include Program for Assertive Community Treatment [PACT], Wraparound with Intensive Services [WISe], etc.) there is an expectation the intensive program will provide 24/7/365 response.
E. Prior to any community-based (unstaffed) location a safety screening must be completed and documented using standard criteria. CPIT and the Crisis Line will check on any available information, to include history of contacts with the community mental health system and performance of a WATCH screening. CPIT will dispatch to locations per Policy 1702.00 – Outreach Safety Screening.

F. Each situation will be assessed in the context of the role of CPIT and a response plan developed between the members of the team. Management should be consulted when appropriate and all service requests, services and service attempts thoroughly documented and transmitted to North Sound BHO, per established protocol.
G. Initial contacts by CPIT should focus on engagement and stabilization of the presenting concern(s). CPIT should build a short-term focused Care Plan grounded in Recovery and evidence-based clinical models (e.g., Trauma-Informed Care, Motivational Interviewing, Cognitive Behavioral Therapy [CBT], etc.).
H. Initial outreach contacts should be coordinated with other involved parties (e.g., law enforcement, homeless outreach team, outpatient provider, etc.) and done with these entities when that might facilitate engagement.
I. The need for ongoing contact by CPIT, to include coordination with formal and informal supports, should be evaluated and included in the Care Plan. The over-arching goal should be engagement with ongoing supports within the span of CPIT episode (within two [2] weeks). Appropriate Releases of Information (ROI) should be obtained to facilitate communication.
J. CPIT should call in a disposition on all cases referred to them upon completion of first contact with the individual of concern. If the individual is unable to be located, the disposition should be called in within two (2) days of the referral.
K. CPIT should coordinate as needed with all parts of the regional crisis system, to include Triage/Crisis Stabilization Facilities, DCR teams, Crisis Line, etc.
L. Services after the initial contact and stabilization should be consistent with the established Care Plan and may include phone contacts, outreach, or facility-based appointments. Further, services may be provided to the individual directly or in support of their family, friends, or other service providers. These services may last for up to 14 days. If appropriate, CPIT should assist the individual in applying for Medicaid and/or other state and local programs.
M. CPIT is expected to actively work to divert individuals from costly and restrictive interventions, to include jail, emergency departments and inpatient psychiatric care. Triage and Crisis Stabilization Facilities and other community-based interventions must be thoroughly explored before referral to more acute or restrictive resources, including voluntary hospitalization and referring the individual to the DCR for evaluation.
N. There are individuals who are frequent utilizers of the crisis system for various reasons. CPIT will work actively with North Sound BHO Care Managers to address the needs of these individuals when either party is made aware of a particularly troublesome situation.
O. Psychiatric medication evaluation is available on a limited basis for individuals who have needs that can be addressed in this short-term program.
P. Flex Funds are also available and typically can be used to address targeted transportation needs, assist with medication purchase, or address other basic need issues for which there are no other community or personal resources available.

III. Program Leadership Expectations

A. Leadership should be available for consultation during all covered hours of CPIT operation.
B. Leadership should actively market the program to the communities within which the team(s) will be active, to include local Emergency Departments and Emergency Medical Services (EMS).
C. Leadership should make particular efforts to engage law enforcement regarding CPIT and the interface between CPIT and the law enforcement.
D. Leadership should attend local community meetings as appropriate (e.g., local Crisis Oversight meetings).
E. Leadership should actively engage in a process of continuous quality improvement with CPIT and should promote a program culture that can adapt to changing needs within the local communities.

IV. North Sound BHO Oversight

North Sound BHO will provide an annual clinical audit/review to ensure adherence to sourced WAC and relevant RCW standards utilizing current related audit/review tools.

ATTACHMENTS

None

Effective Date: 8/28/2015; 7/31/2008; 7/13/2005
Revised Date: 4/30/2018
Review Date: 4/30/2018

North Sound Behavioral Health Organization

Section 1700 – Clinical: Single Bed Certification (SBC)/Inpatient Resource Availability

Authorizing Source: WAC 388-877-0810, RCW 71.05, 71.34, DCR protocols

See Also:
Providers must comply with this policy and may develop individualized implementation guidelines as needed
Approved by: Executive Director
Responsible Staff: Deputy Director
Signature:
Date: 5/18/2018

POLICY #1728.00

SUBJECT: SINGLE BED CERTIFICATION (SBC)/INPATIENT RESOURCE AVAILABILITY

PURPOSE

The availability of a certified Evaluation and Treatment (E&T) bed or secure detox facility (April 1, 2018) bed will not be a factor in determining whether or not to conduct an involuntary investigation for mental health or substance use disorders (SUD). Nor shall it influence the determination if an individual meets detention criterion.

The purpose of this policy is to outline the process for requesting an SBC from Western State Hospital (WSH) delegate for the Division of Behavioral Health and Recovery (DBHR) when there is a need for an individual to be detained to a facility not certified under WAC 388-865-0500 to provide **involuntary** mental health treatment to an adult.

The SBC request is also used when there is a need for a community facility to provide treatment to an adult on a 90- or 180-day inpatient involuntary commitment order for a maximum of 30 days; or to a facility not certified under WAC 388-865-0500 to treat an involuntarily detained or committed child until the child's discharge from that setting to the community or until he or she transfers to a Children's Long-term Inpatient Program (CLIP).

An SBC will not be available for individuals detained due to substance use disorder until July 1, 2026.

The purpose is also to define and provide direction to Designated Crisis Responder (DCR) staff in our region when they are unable to find an appropriate placement in a certified E&T facility.

DEFINITIONS

Single bed certification (SBC) refers to the process for requesting an exception to be granted to allow a facility that is willing and able, but is not certified, under WAC 388-865-0500 to provide timely and appropriate, involuntary inpatient mental health treatment to an adult on a 72-hour detention or 14-day commitment or for a maximum of 30 days to allow a community facility to provide treatment to an adult on a 90- or 180-day inpatient involuntary commitment order [RCW 71.05.745, WAC 388-865-0526].

For involuntarily detained or committed children, this exception may be granted to allow timely and appropriate treatment in a facility not certified, until the child's discharge from that setting to the community, or until they transfer to a bed in a Children's Long-term Inpatient Program (CLIP) [WAC 388-865-0526].

Attestation means the facility confirmed it is willing and able to provide adequate treatment services and will provisionally accept placement upon receipt of the approved SBC.

No-Bed Report (also Unavailable Detention Facilities Report) refers to when a DCR determines a person meets criteria for involuntary inpatient treatment but is unable to detain the person at risk due to the lack of an available bed at an Evaluation and Treatment facility or the person cannot be served by using an SBC. The DCR is required to make a report to the Department within 24 hours.

Substance use disorder (SUD): a cluster of cognitive, behavioral and physiological symptoms indicating an individual continues using the substance despite significant substance-related problems; the diagnosis of SUD is based on a pathological pattern of behaviors related to the use of the substances [71.05.020(52)] (effective April 1, 2018).

Mental disorder: any organic, mental, or emotional impairment, which has substantial adverse effects on an individual's cognitive or volitional functions [RCW 71.05.020(29)].

POLICY

SBCs must meet all requirements as outlined in this policy. The facility that is the site of the proposed SBC confirms it is willing and able to provide directly or by direct arrangement with other public or private agencies, timely and appropriate mental health treatment and the request describes why the individual meets at least one (1) of the following criteria:

1. The individual is expected to be ready for discharge from inpatient services within the next 30 days and being at a community facility would facilitate continuity of care, consistent with the individual's treatment needs.
2. The individual can receive appropriate mental health treatment in a residential treatment facility, as defined in WAC 246-337-005.
3. The RTF is a certified E&T (If RTF is not a certified E&T the SBC will need an attachment documenting how the RTF will meet the person's E&T needs per WAC & RCW.)
4. The individual can receive appropriate mental health treatment at a:

    a. Hospital with a psychiatric unit;
    b. Hospital that can provide timely and appropriate mental health treatment; or
    c. Psychiatric hospital.

5. The individual requires medical services that are not generally available at a facility certified under WAC 388-865-0526.

6. The individual is awaiting transportation to an identified bed at a certified E&T and the Emergency Room is willing and able to provide mental health treatment in the interim.

PROCEDURE

1. When conducting an Involuntary Treatment Act (ITA) investigation in circumstances which suggest an E&T bed may not be readily available to meet the treatment needs of an individual, the DCR will proceed as follows:

    a. DCR determines whether or not the person meets detention criteria following all applicable Washington State laws for the ITA or Less Restrictive Alternative (LRA) process.
    b. When the DCR determines the individual meets emergent detention criteria, the DCR shall contact Volunteers or America (VOA) Placement Coordinator through the bed census phone number at 844-282-8666 [option #1 – the greeting will be "For Bed Census Information, press 1] to check on these resources. VOA has the responsibility for updating bed availability throughout the state.
    c. The Placement Coordinator will advise the DCR to any psychiatric potential inpatient availability in the region/state.
    d. Based on (c), the DCR will then attempt to locate an E&T bed, secure provisional acceptance from that facility, and complete the detention.

2. If there is no E&T bed located and the DCR makes a determination the individual's treatment needs can be met via attestation with an SBC (defined above), the DCR will complete the detention.

    a. The DCR will complete and fax the SBC form to WSH.
    b. The DCR/DCR offices will ensure the attesting facility has a copy of the approved SBC.
    c. The DCR will call in the disposition in to the VOA Triage line, voicemail is acceptable.
    d. The DCR/DCR office shall send a copy of the SBC to North Sound BHO by the next business day (encrypted email or fax to 360-416-7017).

3. If an E&T bed has not been located and the hospital cannot attest to being able to meet the individual's treatment needs, the DCR will notify the hospital of the inability to detain. The patient is now referred back to the hospital's care. The DCR is expected to do the following:

    a. Document the individual has met detention criteria (RCW 71.05.150, 71.05.153, 71.34.700, or 71.34.710), but there are not any appropriate beds available and will leave documentation to that effect. The DCR will also leave "the hospital call list" which includes the number for the VOA Placement Coordinator for further follow up and possible placement.

b. Fax the “DCR report of a Person Meeting Detention Criteria and no available E&T beds or LRAs” (DCR no bed report) to DBHR, at # 253-756-2873 with the fields completed within 24 hours of the determination the individual has met detention criteria.
c. Shall then re-contact the VOA Placement Coordinator (or triage clinician), in person, with the disposition. VOA will need name, location, date and time the investigation was completed, what facilities were contacted, what the hospital has advised they are going to do with the patient.
d. The DCR/DCR offices shall also send copy of the DCR report to North Sound BHO, via fax by the next business day.

4. VOA will, the next business day, re-contact the Emergency Department (ED)/hospital, through the Placement Coordinator, to check on the individual’s status.

    a. VOA will continue to coordinate daily with the ED/hospitals and DCR office on re-evaluation if the individual continues to meet criteria for detention.
    b. The DCR office will attempt, regardless of location, to re-evaluate the individual on a daily basis to determine if the individual continues to meet criteria for detention.
    c. When LRAs to detention are viable, the DCR will ensure the appropriate less restrictive occurs.

5. DBHR will be sharing the (DCR no bed) report with North Sound BHO to monitor those cases closely.
6. North Sound BHO will continue to attempt to engage the individual for appropriate services for which the person is eligible and report back those attempts to DBHR within seven (7) days.
7. North Sound BHO will provide an annual clinical audit/review to ensure adherence to sourced WAC and relevant RCW standards utilizing current related audit/review tools.

ATTACHMENTS

None