NORTH SOUND
MENTAL HEALTH ADMINISTRATION

QUALITY MANAGEMENT OVERSIGHT COMMITTEE

COMMITTEE MEETING PACKET

February 28, 2007

QMOC GUIDING PRINCIPLES

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

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

Adopted: 10-27-99
Revised: 01-17-01

NORTH SOUND MENTAL HEALTH ADMINISTRATION
QUALITY MANAGEMENT OVERSIGHT COMMITTEE AGENDA

Date: February 28, 2007
Time: 12:30-2:30 PM
Location: NSMHA Conference Room
For Information Contact Meeting Facilitator Greg Long/Debra Jaccard, NSMHA, 360-416-7013

Topic	Objective	ACTION NEEDED	Discussion Leader	Handout available pre-mtg	Handout available at mtg	Pg.	Time
Introductions	Welcome guests, presenters and new members		Chair				5 min
Review and Approval of Agenda	Ensure agenda is complete and accurate; determine if any adjustments to time estimates are needed. Meeting will start and end on time.	Approve agenda	Chair	Agenda		3	5 min
Review and Approval of Minutes of Previous Meeting	Ensure minutes are complete and accurate	Approve minutes	Chair	Minutes		5	5 min
Announcements	Inform QMOC of news, events: • PACT RFP • RFP • EQRO Check-In	Inform/discuss	DEBRA/ALL				10 min
Comments from the Chair	Update the committee on recent developments that impact QMOC- • Board actions	Inform	Chair				5 min
Policy Sub-Committee Report	Review and discuss policies reviewed by QMC	Review and approve	GARY WILLIAMS	1505.00 1717.00	Attach	9	15 min
Pre -PIP #3 Summary Mortality Review	Inform QMOC of Pre-PIP Summary, Review and Discuss	Discuss & Review, Make Recommendations	DEBRA/CHARISSA FULLER	Yes	Attach	20	15

Quality in Action: Trauma Based Training Opportunities	Inform QMOC of Trauma Focused Training Resources	Informational	DEBORAH M./MARTA PEARSON				20
Crisis Services Policies	QMOC to Review	Review and approve	SANDY WHITCUTT	1701 1703	Attach	26	10
Clinical Redesign Implications for Provider Training Needs	Inform QMOC of LOCUS Model and need for training	Inform and discuss	DEBRA		Available at Mtg.		10
Date and Agenda for Next Meeting	Ensure meeting date, time and agenda are planned.		All				5
*Review of Meeting	Were objectives accomplished? How could this meeting be improved?		All				5

Next meeting March 28, 2007, 12:30-2:00

Potential Agenda Items: **Policy Sub-Committee Update**
Integrated Report
CI Report
QM Plan

North Sound Mental Health Administration
Quality Management Oversight Committee
NSMHA Conference Room
January 24, 2007
12:30 – 2:30
DRAFT MINUTES

Present:
Gary Williams, QMOC Chair, Board of Directors, Human Services Supervisor, Whatcom County
Debra Jaccard, NSMHA Quality Manager
Mary Good, NSMHA Advisory Board
Nancy Jones, Snohomish County Human Services
Mike Manley, Snohomish County Human Services
Janet Lutz-Smith, Whatcom County Advisory Board
Dan Bilson, NSMHA Advisory Board
Russ Hardison, Sea Mar
Chuck Davis, Ombuds
Susan Ramaglia, NAMI Skagit
Rochelle Clogston, Compass Health

Excused:
Deborah Moskowitz, Ombuds

Not Present:
Maile Acoba, Skagit County Coordinator
Janelle Sgrignoli, Snohomish Co. Human Services
Terry Clark, Compass Health
Joan Lubbe, NSMHA Advisory Board
June LaMarr, the Tulalip Tribes
Donna Konicki, Compass Health

Others Present:
Shannon Solar, NSMHA
Charissa Fuller, NSMHA
Diana Striplin, NSMHA
Sandy Whitcutt, NSMHA
Angela Fraser-Holtz, NSMHA

1. Introductions

The meeting was convened at 12:32 p.m. and introductions were made.

2. Review and Approval of Agenda

The agenda was reviewed and Dan Bilson noted that we were going to discuss a residential council and requested this be added to the agenda. Chair Williams noted that Dan did research on this and found that there was no requirement for the state of Washington, federal law specifies the law for any residential council to form in any long-term facility. Chair Williams noted a residential council is resonant with our regions philosophy – client choice, hand in treatment, and suggested QMOC organize a workgroup to review, make recommendations. Dan noted that he has been told by a clinician in a nursing home that this is very beneficial. Rochelle noted a difference between Compass Housing and a nursing home – Compass has temporary housing, they do not want people staying long-term. Dan noted there are some housing facilities in the region that hold people up to 15 years. Dan referenced RCW 70.129 on this subject. He also noted he received a packet from Whatcom County Ombuds on how to set up a residential council. Chair Williams proposed setting up a group to report back at Feb QMOC meeting – review options. Motion seconded, passed, all in favor. Chair Williams requested members, Rochelle, Karen, and Dan will work together. Gary suggested that Chuck or Deborah join the residential council workgroup as well.

3. Review and Approval of November 2006 Minutes

The minutes from the previous meeting were reviewed. A motion was made to approve the November minutes. Motion seconded, passed, all in favor.

4. Announcements

- Debra noted the process to choose who will receive the 100-slot PACT (program for assertive community treatment) program is complete, three agencies in Snohomish County, Compass Health, bridgeways, and Sunrise Services will be contracted with. Greg noted the program is open to anyone in the region, it is designed for high-need individuals. Rochelle clarified that services would be provided to individuals from anywhere in the region, but services would occur in Snohomish County. Debra noted training will begin Feb. 2nd, staff will be recruited and trained and the first clients will be served in June. Greg noted this program is required to have its own Advisory Board, to be comprised of 51% consumers. Compass Health will begin recruiting representatives soon. Debra noted RSN staff will carry out authorizations for the program. Nancy added that only 4-6 people (over age 18) will be admitted to the program per month. Gary noted the State has an expectation this will lead to less utilization of State hospital beds. Debra noted there will be updates as the program is developed and implemented.
- Debra noted the Board of Directors approved modified fee-for-service delivery model. NSMHA is putting together an RFP for providers across the region to go out Feb. 2nd. This will be posted on the NSMHA website, advertised in newspapers, and a mass mail out will occur. Submittals will be due about 6 weeks after it is sent. There will be 3 week review period and then contract negotiations will begin with implementation to begin July 1. Chair Williams noted if there are new providers, regional staff will need to maintain quality process and prevent any disconnect. Greg noted the only limitations to agencies who wish to apply is that they need to be a LMHA (licensed mental health agency) or be in the process to be licensed by July 1.
- Debra noted providers started using GAIN-SS screening tool beginning January 1 as per State requirements. The purpose of the tool is to assess co-occurring disorders/substance abuse and set up adequate referral and treatment. Debra noted this will be monitored, acknowledging this is another bit of paperwork required. It should be filled out wherever the consumer's first point of contact is. There have been some concerns using the tool in the crisis system. Nancy noted the validity of the tool is in question when someone is obviously intoxicated. Nancy clarified how long the assessment is valid, Sandy stated it is 6 months, she is trying to discover if it needs to be done every following 6 months. Sandy noted this form has been time-tested and is a valid tool.
- Debra noted NSMHA received EQRO questions and sent their responses. Compass and CCS as well as NSMHA had a site review. Debra described EQRO's site review/questioning at NSMHA, Diana added the focus of the questioning was on QA/QI. Greg noted EQRO was very impressed with the PIP on Seclusion and Restraint at E&T's, but the RSN will likely criticize use of interpretive services. There was also concern with how NSMHA trains providers to our P&P's and WAC's. Debra noted that results from EQRO's preliminary report will be shared when it is received. Rochelle noted she heard the EQRO visit of Compass Health went well.

5. Comments from the Chair

There are no comments from the Chair.

6. Policy Sub-committee Report

Chair Williams drew attention to the three policies that were brought forward from the Policy Subcommittee: 1006 (policy development and review), 1504 (assessments for ongoing services), and 1527 (high-intensity treatment).

Chair Williams entertained a motion to accept 1006. Motion seconded. Discussion: Nancy asked what is different about this policy, Debra noted the committee did not want to limit policies which only have a fiscal or clinical impact from review.
Motion to accept policy 1006 carried, all in favor.
Chair Williams entertained a motion to accept policy 1504. Motion seconded. Discussion: Debra noted the policy was condensed, and WAC citations were added. Janet asked if this policy is a contract item, Debra noted it will be included in a numbered memorandum, providers will have 60 days to implement the policy.
Motion to accept policy 1504 carried, all in favor.
Chair Williams entertained a motion to accept policy 1527. Motion seconded. Discussion: Debra noted this policy struggled with assigning a name to the high-intensity treatment program. The only change to the policy is that all previous acronyms have been removed.
Motion to accept policy 1527 carried, all in favor.

Chair Williams noted these three motions will be reported to the Board of Directors.
Chuck complimented this procedure of reviewing policies. Susan noted the policy subcommittee is making an effort to make the policies more consumer and family friendly. Chair Williams asked the committee to make sure to read the policies previous to the meeting.

7. Exhibit N

Debra noted review of the Exhibit N will be postponed as it needs to go through the Quality Management Committee first, which will be held tomorrow.

8. Quality in Action—EPSDT

Angela noted EPSDT (early and periodic screening, diagnosis, and treatment) are comprehensive checks/screening of medical and mental well-being of a child, done at the child's PCP. This is comprehensive care for children, a way for professionals in many different systems to make sure children are receiving the care they need mentally and physically. Chair Williams noted in Whatcom County they do the Teen Screen program and asked what the PCP's ability is to assess and care for client MH needs. He was dismayed to see some responses to referrals from this program. Angela noted she and Julie de Losada may do a training of physicians, Gary asked that it be tied to the Teen Screen program. Gary noted there has been criticism of this program. Mike noted at the last Association of County Human Services meeting this issue was discussed as being a transfer of responsibility from the med community to the MH community to monitor issues which should remain in the medical community. Greg noted this comes from federal law and has been part of Medicaid rules for over a decade. Janet noted we need to move toward holistic approaches in treating our children and commended Angela and Julie for their work. Chair Williams suggested having regional medical director Dr. Keith Brown involved in the training. Susan noted the state of Massachusetts was penalized for not having the EPSDT program in place

9. Crisis Service Policies

Sandy noted ICRS has developed their own policy review subcommittee and are working through a number of policies, one of which is 1704 (crisis services – general policy). Minor changes were made to 'ICRS Service Components'.
Mary entertained a motion to accept policy 1704. Motion seconded. Discussion: Chair Williams had a question as to 'emergency services during business hours' and why business hours were noted. Sandy noted this may have been clarified for the Crisis Team, but she will research what the original language was. Susan asked how they get 24/7 access to crisis plans, Greg noted the Crisis Plan is available through Raintree. Karen noted there is no mention of the Crisis Line throughout the policy, which seems like an

omission. Sandy agreed this should be added. Janet asked about contractors who would purchase crisis services, Sandy noted this applies to providers such as Sea Mar or CCS who apply for a Designated Crisis Responder who serve the region. Janet noted this is not written clearly. Nancy suggested that Interpreter Service be highlighted more in view of the fact EQRO may be scrutinizing this. Greg asked if NSMHA has a policy on interpretive services, if we do, it should be cross-referenced. Greg noted he found providers are not clear on their requirements around interpretive services.
Motion tabled until policy is reviewed further by ICRS.

10. PIPS
Charissa summarized PIP #4, Restraint and Seclusion at Freestanding E&T's. The goal was to eliminate death, injury, or illness of a consumer while in seclusion and restraint and to reduce use of seclusion and restraint by 10%. Both goals were met and surpassed. Chuck noted Ombuds have had no complaints related to use of seclusion and restraint. Charissa noted intervention of face-to-face monitoring was the primary element in reducing the instances of seclusion and restraint. Charissa noted Compass Health carried out quality improvement measures on their own which also improved outcomes. The PIP will be continued after discussion with E&T directors. Chair Williams asked if the ability for medical staff to be retained at the E&T's has improved. Rochelle noted Compass has reduced use of agency staff at the E&T. Janet noted this project has made a positive difference and asked how it will be maintained. Charissa noted it will be as the PIP is continued, training is a possibility. Rochelle acknowledged the extreme amount of work done by Carol Kerr-Ragan, director of the North Sound E&T. Chair Williams recommended that NSMHA staff pass on QMOC's appreciation and commendation of her work. The committee reached consensus to do so. Debra will draft a letter to send to Carol and Compass Health on behalf of QMOC regarding this issue. Greg noted that Debra Jaccard has also been key as she has a background in nursing and the committee commended her as well. Debra noted that currently there is more monitoring at the E&T's than the community hospitals.

11. Clinical Redesign Implications for Provider Training Needs
Debra noted NSMHA is looking into resources on training provider staff on the LOCUS model, and passed out a informative sheet on this. Janet requested an overview of the LOCUS tool, Debra will bring this to the next meeting.

12. Date and Agenda for Next Meeting
The next meeting will be held on Wednesday, February 28th, 2007. Gary noted he is trying to keep the agenda streamlined in order to end the meeting with less than a two-hour meeting time. The meeting was adjourned at 2:25 p.m.

Respectfully submitted,

Shannon Solar

Please Note:
The attachments referenced herein are part of the official record and attached to the file copy. Please contact the NSMHA at 1-800-684-3555 if you have any questions, comments, or concerns.

Effective Date:
Revised Date: DRAFT - Rev G 2/12/07
Review Date:

North Sound Mental Health Administration

Section 1500 – Clinical: Authorization for Ongoing Outpatient Services

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

Approved by: Executive Director Date:
Signature:

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POLICY #1505.00

SUBJECT: AUTHORIZATION FOR ONGOING OUTPATIENT SERVICES

PURPOSE

To ensure consistent application of the NSMHA Clinical Eligibility and Care Standards (CECS).

POLICY

NSMHA will authorize an assessment for all persons calling the Access Line ~~Center~~ who are financially eligible as defined in the CECS. The consumer will be referred to a NSMHA provider agency for a face-to-face clinical assessment by a mental health professional (MHP). Individuals who are in crisis are referred to the Integrated Crisis Response System (ICRS) as appropriate to the situation. Expedited assessments and authorizations will be available when it is medically necessary. Once the assessment is completed, authorization or denial for ongoing outpatient services will be determined by NSMHA.

~~Callers who are not financially eligible are referred to other agency programs that do not require Medicaid or State Mental Health funding and/or other community providers as appropriate.~~

~~General Procedures~~

1) ~~Following completion of the assessment, providers will determine if the individual meets medical necessity as defined by the NSMHA Clinical Eligibility and Care Standards (CECS). The provider will send a completed electronic request for authorization to NSMHA.~~

2) ~~If the provider believes that CECS criteria are not met, the provider will send the assessment, Access call sheet and any other appropriate documentation or medical records to the NSMHA Utilization Review department, as a denial review request. The decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested will be made by a NSMHA staff. This NSMHA staff will be a mental health professional (MHP) who has appropriate clinical expertise in treating the enrollee's condition or disease.~~

3) ~~NSMHA will notify the consumer and provider of all authorizations and their benefits for medically necessary services. It will also notify the provider of all authorizations.~~

4) ~~NSMHA will notify the requesting provider, and give the enrollee written notice of any NSMHA action to deny the service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The NSMHA will give notice to the provider, which may, but need not be in writing.~~

Role of Provider:

Each NSMHA contracted provider will:

1) Identify, define, and specify the amount, duration, and scope of each service the consumer will receive.

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2) Ensure that all services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished.
3) Follow NSMHA specific processes for initial and continuing authorization for services.
4) Have in place and follow written policies and procedures consistent with NSMHA policies and procedures.
5) Comply with NMSHA mechanisms to ensure consistent application of review criteria for authorization decisions, including consultation with NSMHA when appropriate.
6) Ensure benefits are provided in accordance with the Contractor's level of care guidelines and are not arbitrarily denied or reduced, (for example, the amount, duration, or scope of a required service) based solely upon diagnosis, type of mental illness, or the enrollee's mental health condition.

Role of NSMHA:

1) Not abitrarily deny a service authorization request.

2) Not deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the beneficiary.

3) Ensure that authorization of a service in an amount, duration, or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease

4) NSMHA will comply with specified timeframes for decisions as required by federal and state standards.

5) NSMHA will provide for the following decisions and notices:
   a. **<u>Standard authorization decisions</u>**. For standard authorization decisions, provide notice as expeditiously as the enrollee's health condition requires and within State-established timeframes that may not exceed fourteen (14) calendar days following receipt of the request for service, with a possible extension of up to fourteen (14) additional calendar days, if the enrollee, or the provider, requests extension. An extension may also be obtained if NSMHA justifies (to the Washington State Mental Health Division upon request) a need for additional information and how the extension is in the enrollee's interest.
   b.**<u>Expedited authorization decisions</u>**. For cases in which a provider indicates, or NSMHA or its designee determines, that following the standard timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, NSMHA must make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than three (3) working days after receipt of the request for service. NSMHA may extend the three (3) working days time period by up to 14 calendar days if the enrollee requests an extension. An extension may also be obtained if NSMHA justifies (to the Washington State Mental Health Division upon request) a need for additional information and how the extension is in the enrollee's interest.

6) NSMHA may place appropriate limits on a service on the basis of criteria applied under the State plan, such as medical necessity; or for the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose, as required by federal and state standards. NSMHA and its contractors will consider what constitutes "medically necessary services" in a manner that is no more restrictive than that used in the Washington State Medicaid program as indicated in State statutes and regulations, the State Plan, and other State policy and procedures. NSMHA , in accordance with these regulations, is responsible for covering services related to the following:

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a. The prevention, diagnosis, and treatment of health impairments.
b. The ability to achieve age-appropriate growth and development.
c. The ability to attain, maintain, or regain functional capacity.

7) NSMHA will ensure that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee.

PROCEDURE

1. Access clinicians will screen callers requesting service to determine the caller's mental health requests and financial status. Access clinicians will determine whether following the standard timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function so that an expedited assessment can be authorized and scheduled.

2. Through Access, all callers who meet financial eligibility as defined in the CECS are assisted to make an assessment appointment at the appropriate provider. This appointment will be offered to occur within fourteen (14) calendar days of their request for services or for expedited assessment to occur as soon as is medically necessary and within three (3) calendar days to determine clinical eligibility and the appropriate level of care.

3. Assessment documents are completed within thirteen (13) calendar days of the initial request for service or within three (3) days for expedited authorizations.
   a. If seeking information presents a barrier to service ~~or if it is an expedited assessment~~ the item is left blank and the reason documented in the clinical chart.
   b. If the assessing clinician cannot complete the initial assessment, the consumer or the assessor may request an extension of up to 14 days. The extension request must be documented in the electronic record to NSMHA, who will track the number and reason for extensions. NSMHA will take appropriate action if the number of extensions is excessive or unwarranted.

4. The agency clinician conducting the face-to-face assessment will make an initial recommendation as to whether the person being assessed meets CECS.

5. If the provider believes CECS are met, they will transmit a completed electronic request for authorization including a full five-axial classification, eligibility criteria, and requested Level of Care to NSMHA for authorization. If necessary, NSMHA Utilization Review staff will request additional clinical information to justify the authorization. Each contracted provider will identify a contact person to whom requests for additional information can be made.

6. For expedited authorizations, phone notification will be made to NSMHA (360-416-7013) to alert them to the need for immediate authorization. Phone notification should be followed by faxing the authorization request and assessment to NSMHA (360-416-7017) for review. An electronic record of the expedited authorization request will also be sent to NSMHA.

7. All persons who meet the financial and CECS are authorized by NSMHA within 24 hours. NSMHA will notify the consumer and provider of all authorizations and their benefits. If authorized, the person is accepted into services and appropriate appointments are made.

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Provider Requested Denial Reviews

1. If the provider believes CECS are not met, they will send the intake assessment form, Access call sheet and any other available documentation or medical records reviewed in the assessment process to NSMHA Utilization Review staff with the completed NSMHA Denial Determination form within fourteen (14) calendar days from the initial request for service or immediately following completion by the end of that day for an expedited assessment.
2. NSMHA Utilization Review staff will make the final determination of whether the person being assessed meets CECS.
   a. If the NSMHA staff, upon review, determine the person to meet the criteria they will notify the consumer and provider that the individual is authorized for services. The consumer will be notified of their benefit package.
   b. If the decision is to deny the authorization request or to authorize a service in an amount, duration, or scope that is less than requested the NSMHA will notify the requesting provider, and give the enrollee written notice in sufficient time to ensure that State-established timeframes are met for standard or expedited authorization.
   c. NSMHA staff will maintain written records of all denied requests for service.

Residential Facility Authorizations:

Western State Hospital Discharges and Community Hospital Discharges: Residential service providers will notify VOA Access when they schedule an assessment appointment for a consumer to be admitted to their facilities from hospitals. If this is more than 14 days ahead of when the person is ready for discharge, VOA will retain the information in a pending file. This application will be considered incomplete until the consumer is fully ready to be discharged from hospitals at which time the provider will notify Access and the time requirements will begin. The standard access procedures and timelines will be followed from the date of assessment.

Authorization Process for individuals in service with a provider and shifting mental health coverage: For individuals already in treatment with an agency who gain Medicaid eligibility, a current diagnostic justification must be present in the clinical record. The current assessment and treatment plan must meet or be enhanced to meet NSMHA/WAC/CMHS standards. Authorization for services will be submitted to NSMHA within fourteen (14) days of the time the provider becomes aware of the change in payer. Because authorization periods are for one year, only one annual request for authorization is required to be submitted, regardless if the consumer gains or loses financial eligibility. Providers are responsible for assuring that the appropriate funding source is charged for services depending upon the individual's financial eligibility.

NSMHA Quality Specialist requested Focused Reviews

NSMHA Quality Specialist staff will work with providers to identify any areas for potential Utilization Reviews based upon information received/reviewed during the Authorization process.

Consumer Withdrawal of Request for Service

If a consumer requests an assessment for services and during or at the completion of the assessment the consumer indicates they no longer wish to receive services, the consumer will be asked to sign a document to that effect, and documentation of their withdrawal of request will be kept in their record. All other completed assessments will go through the standard authorization process.

ATTACHMENTS: None

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Policy status – to be removed once policy in ready for final approval.

Policy subcommittee made some changes.
Debra and Diana conducting research on #3 under "Role of Provider".
Committee will re-review at the next meeting 2/5/07.

The subcommittee added "be" in front of "asked" in section "Consumer Withdrawal of Request for Service". They also requested that resources be added and Debra will confirm the status on #3 under "Role of Provider". This will be sent out via email by Debra Jaccard for one final review by the subcommittee and consensus on the changes. It will then be forwarded to QMC/QMOC.

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The shaded areas in yellow are the latest changes, as of 2/12/07, via all email correspondence. Please respond with comments ASAP to Debra.

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NSMHA may place appropriate limits on a service on the basis of criteria applied under the State plan, such as medical necessity; or for the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose, as required by federal and state standards. NSMHA and its contractors will consider what constitutes "medically necessary services" in a manner that is no more restrictive than that used in the Washington State Medicaid program as indicated in State statutes and regulations, the State Plan, and other State policy and procedures. NSMHA , in accordance with these regulations, is responsible for covering services related to the following:

The prevention, diagnosis, and treatment of health impairments.
The ability to achieve age-appropriate growth and development.
The ability to attain, maintain, or regain functional capacity.

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that the provider is required to offer.

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NSMHA will ensure that:

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Clinical Eligibility and Care Standards

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that do not require immediate referral to the Integrated Crisis Response System

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Clinical Eligibility and Care Standards

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Effective Date: 6/25/2004
Revised Date: Rev A – 2/5/2007
Review Date:

North Sound Mental Health Administration

Section 1700 – ICRS: Crisis Services Appointments

Authorizing Source:
Cancels: Renumbering Clinical Policy 1514.00 – no language change
See Also: Approved by: Executive Director Date:
Responsible Staff: Sandy Whitcutt Motion #:

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POLICY #1717.00

SUBJECT: CRISIS SERVICES APPOINTMENTS

PURPOSE
To clarify the process for scheduling crisis services appointments.

POLICY
Crisis services appointments will be made available in order to provide timely access to face-to-face mental health evaluation/intervention services for persons in crisis who do not require emergent care.

PROCEDURES
VOA determines the urgency of the caller's crisis and schedules crisis services appointments with NSMHA providers.

1. Calls determined to be "**Emergent**" require a response within 2 hours of the dispatch of crisis outreach staff. [See "Dispatch of Outreach Services" protocol].
2. Calls determined to be "Urgent" require a response within 24 hours of the request for services.
3. Callers that do not require either "emergent" or "urgent" care, but for whom a delay in evaluation or intervention may lead to further decompensation, will be given a Next Business Day (NBD) appointment.

<u>Urgent Appointments</u>
Urgent Appointments are available to see consumers in crisis who are not emergent, but who are so decompensated that they are at risk of self-harm or hospitalization if not seen within the next 24 hours. Urgent appointments must be available within 24 hours of the consumer's initial contact with the Integrated Crisis Response System (ICRS).

Crisis response and outpatient providers recognize that, whenever possible, consumers with active outpatient authorizations should receive voluntary crisis services through their primary clinicians. To this end, consumers who are currently enrolled with an NSRSN provider agency will be seen whenever possible by their primary clinician/team. If the primary clinician is unavailable, the program supervisor will be contacted to determine if another member of the treatment team can see the consumer. In those rare circumstances where support through the treatment team is also unavailable, Crisis Response staff may serve as a back up in scheduling the consumer to be seen.

<u>Next Business Day (NBD) Appointments</u>
NBD appointments are available to see consumers in crisis who do not require urgent care, but for whom a delay in evaluation and/or intervention would likely lead to further decompensation.
Emergency Services staffs are responsible for providing medically necessary follow-up services to consumers in crisis until the crisis is resolved or the referral to ongoing services is complete. This includes

getting mental health specialist consultation when appropriate. Emergency Services staff will communicate **directly** with the consumer during this follow-up period, scheduling follow-up appointments, etc., as needed. The consumer should **not** be instructed to call VOA to schedule their follow-up appointment or to make arrangements for other follow-up care. The Emergency Services "action plan" for these consumers will be communicated back to VOA to keep them apprised of the status of the consumer during the current crisis episode. It is understood that Emergency Services is not a substitute for ongoing services and that consumers will be moved as quickly as possible into needed services.

Scheduling of Appointments

Normal Business Hours *(Note: For the purposes of this protocol, Normal Business Hours are defined as 3:00 pm or later when the next day is a business day. For example, when there are no holidays in a given week, Normal Business Hours would extend from 3:00 pm on Sunday to 3:00 pm on Thursday. If Monday is a holiday, Normal Business Hours would extend from 3:00 pm on Monday to 3:00 pm Thursday)*

Urgent and Next Business Day Appointments for consumers **with an active outpatient authorizations.**

1. The Volunteers of America (VOA) determines that the client has an active outpatient authorization and is in need of either an urgent or NBDA appointment.
2. VOA enters DISP code "Agency to Sch NBD Appt with Prim Clin" into the Call Record.
3. Automated e-mail with enough data to schedule appointment is sent to the agency site where primary clinician is located (and to primary clinician if e-mail is available).
4. If the request is made before 12:00 on a business day, the caller with be told that his/her primary clinician will be contacting him/her before the end of the business day to schedule the appointment.
5. If the request is made after 12:00 on a business day, the caller will be told that his/her primary clinician will be contacting him/her by noon the following day.
6. If the request is made after 12:00 and the next day is not a business day, the request will be referred to ICRS staff for follow up.
7. Once the follow up appointment has been scheduled, agency staff will enter the appointment into the agency scheduler using an Urgent or NBD appointment type code.
8. Upon the scheduling of the appointment, agency staff will print an event ticket (optional).
9. If the client attends the appointment, the clinician will document the provision of services using either an event ticket or an ICRS contact sheet.
10. If the client does not attend the appointment, the clinician will document the no-show using either an event ticket or an ICRS contact sheet.
11. Event slip or contact sheet data is entered into the MIS system.
12. All data will be entered into the MIS system within 3 working days of the completion of service.

Urgent and Next Business Day Appointments for consumers **without an active outpatient authorization**

1. VOA searches the database for an urgent or Next Business Day Appointment at the nearest ICRS office to the client.
2. If there is an appointment slots available within applicable timelines, VOA schedules the Urgent or NBD appointment at the nearest ICRS office and confirms the time and place with the client.

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3. If there is no slot available, VOA staff will schedule a placeholder appointment and tell the client the location of the appointment and will let him/her know that he/she will receive a call from ICRS staff by noon the following day informing him/her of the appointment time.
4. ICRS staff will contact the client by noon the following day and let him/her know of the appointment time and the staff person he/she will be seeing.

Non-business hours *(after 3:00 pm when the next day is not a business day)***:**

Urgent Appointments for consumers **with or without an active outpatient authorization**

7:00 am to 9:00 pm

1. VOA staff page the ICRS clinician.
2. ICRS clinician returns the page. VOA tell him/her of the presenting problem, the need for an urgent appointment and providing sufficient information for the ICRS clinician to contact the client.
3. The ICRS clinician will contact the client and set up a face-to-face contact within 24 hours of receiving the call. The ICRS clinician will then call back VOA to confirm the appointment time. VOA staff updates the call log record and enters the DISP.
4. If the ICRS clinician is not able to contact the client, he/she will call VOA to advise them that contact has not been made and to determine whether additional follow up is needed.

9:00 pm to 7:00 am

1. VOA staff will inform the client that he/she will be receiving a call by noon the following day from the ICRS clinician letting him/her know of the time and location of the appointment.
2. VOA will page the ICRS clinician at 7:00 am the following day telling him/her of the client's presenting problem, the need for an urgent appointment and providing sufficient information for the ICRS clinician to contact the client.
3. ICRS clinician will call the client by noon the following day and establish the time and location of the appointment. The ICRS clinician will then call VOA back to confirm the appointment time. VOA staff updates the call log record and enters the DISP.
4. If the ICRS clinician is not able to contact the client, he/she will call the VOA to advise them that contact has not been made and to determine whether additional follow up is needed.

Next Business Day Appointments for consumers **with or without an active outpatient authorization**

Use the same process described above for scheduling appointment during business hours.

ATTACHMENTS

None

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NSMHA Performance Improvement Project #3
PRE-INVESTIGATION MORTALITY REVIEW
12/20/2006

The Background of the Selected Study Topic

How was the study topic selected?

- Description of the identified problem – which should include some key dimension(s) of quality care, such as appropriateness, competency, continuity, effectiveness, efficacy, efficiency, respect and caring, safety, and/or timeliness.

There is growing evidence that people with serious mental illness (SMI) are dying prematurely, as much as 25 years before the general population (National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council, 2006). While a portion of deaths in this population can be attributed to suicide and injury, approximately 30-40%, the rest of premature death may be of natural causes due to medical conditions. In fact, Dickey et al. (2002) found that individuals with serious mental illness were at higher risk of having one or more medical conditions than those without a mental illness. The most typical medical conditions for this population include obesity, diabetes, heart disease, hyperlipidemia, hypertension, and pulmonary diseases (Marder et al., 2004).

In their 2004 grant program, *Health Behavior Change in People with Mental Disorders*, National Institute of Health (NIH) states:

> **Like many Americans, people with mental disorders may engage in health behaviors that increase their risk for disability, morbidity, and mortality. These behaviors include a lack of regular physical exercise, poor nutrition and excess caloric intake, smoking and other drug abuse, infrequent visits to health care professionals, and inadequate sleep habits. Such behaviors can increase risk for leading causes of disability and mortality such as obesity, heart disease, cancer, diabetes, asthma, and strokes.**

While mental health symptoms may impair an individual's ability to access medical care or follow through on recommendations, it may also be that this population lacks access to medical care and continuity of care between medical and mental health care providers may not be adequately integrated (Miller et al., 2003). It should also be considered that mental health symptoms and/or psychiatric medications can mask or contribute to medical conditions (NASMHPD Medical Directors Council, 2006).

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The NSMHA's awareness of morbidity and mortality of our own consumers was heightened through the Critical Incident reporting process. By means of collecting Critical Incident reports and compiling them into a database, a subset of consumer deaths were identified that were not overt suicides or homicides, but included deaths due to natural causes, accident, or unexpected deaths. Of particular note, was that there seemed to be fair percentage of these deaths occurring in consumers under the age of 50 who did not have a known serious medical condition. As a result of these events and the noted research, the NSMHA decided to conduct case reviews to determine if common factors could be targeted for quality improvement to decrease the incidence of death from natural causes in adult consumers.

- Description of the collected and analyzed data used to understand the problem that impacts the Medicaid enrollees' or consumers' care, needs, and/or services. How did you use the data to understand the problem? Use charts, graphs, or tables to display the data.

NSMHA began by reviewing the data from our Critical Incident Database. In some cases the Critical Incident Review Committee (CIRC) was able to ascertain causality through the Critical Incident Report, for example, individuals with known severe medical conditions such as cancer, COPD or severe heart conditions. In some cases, the death certificate was obtained to gain clarification of the cause of death as relating to a medical condition. However, a number of deaths remained that lacked overt causality. As a result, a clinical chart review was conducted in an attempt to determine if medical conditions existed that may have contributed to death and also to explore access to primary care and coordination between medical and mental health care.

This review process was initially designated as the Performance Improvement Project (PIP). However, given what the NSMHA has since found out about conducting a PIP, it was felt that the PIP needed redesign and that the review data would serve a pre-investigative role to aid in the development of a project.

The 27 charts to be reviewed were identified through the critical incident reporting process as those of consumers, under the age of 50, who had passed away in 2004. The reviewer deselected charts where the cause of the consumer's death was determined to be homicide or suicide. The following data is based on 22 charts of consumers, under age 50, who died from natural causes, accident and/or unexpectedly, as defined in the Critical Incident Reporting Policy, between January 1, 2004 and December 31, 2004. It should also be noted that the reviews were conducted by a NSMHA Quality Specialist who is a mental health professional, but not a medical professional. Following are the results of the chart reviews.

- ***Possible cause of death***
  The data for this category was gathered from a medical examiner's report, a death certificate and/or the provider's critical incident report. From these

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sources, it was suggested that the possible cause of the 22 deaths were as follows: 13 by natural causes and six by accident. The cause of three of the deaths could not be determined by the reviewer from the records. Of those 13 deaths that were possibly the result of natural causes, the provider identified that 11 of them were not expected.

- ***Medical History***
  The reviewer looked at the intake assessments to determine whether medical history was discussed at that time. Thirteen of the 22 charts showed that medical history was discussed at intake. In seven of the charts it appeared that medical history was not discussed at initial intake, while it was unclear in two of the charts whether medical history was discussed.

- ***Substance Use***
  The reviewer indicated that half of the charts (11) contained information that identified the consumer as having a substance abuse issue and that ten of those cases had also been identified by the provider. However, in six of those 11 cases, the consumer's treatment plan did not reflect a plan to address substance abuse (e.g. referral to substance abuse treatment). In these cases it was undocumented or unclear why the consumer's treatment plan did not include substance abuse treatment.

- ***Access to Primary Care Provider***
  In 15 of the 22 charts reviewed, it was determined that the consumer had a primary healthcare provider (PCP) at the time of death. Four of the consumers did not appear to have a PCP at the time of their death and for the remaining three consumers it could not be determined whether they had a PCP.

- ***Medical Conditions***
  Nineteen of the 22 charts contained documentation to indicate that the consumer had at least one medical condition that was identified prior to his/her death. Only one consumer had a medical condition that was identified at the time of death that had been previously unidentified. Of the 19 consumers who had an identified medical condition prior to their deaths, 11 of them were identified as having multiple medical conditions.

- ***Psychiatric Medications***
  Twenty-one of the total 22 consumers were taking at least one psychiatric medication as identified in the chart. Fifteen of these consumers received their psychiatric medications from their mental health provider, two saw their PCPs, three were prescribed for by multiple sources and one was indeterminable.

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- ***Coordination of Care***
  It was difficult to determine in the chart review if consultation occurred between the mental health care provider and the PCP, but the reviewer also examined whether an exchange of records occurred. In ten of the 22 charts reviewed, records were not exchanged. Six charts revealed an exchange of records, two were classified as 'cannot determine', one did not appear to need consultation, and three of the consumers did not have medical services.

- ***Pain Issues***
  The reviewer determined that 12 of the 22 consumers had chronic pain issues. Of those 12, nine were receiving pain medications and two were receiving some other type of treatment.

- How is this topic important to the PIHP? Did the identified problem fall under one of the key dimensions of quality care? If not, explain why this problem continues to be an improvement effort priority.

This topic is extremely important to NSMHA. We want to understand what contributes to the premature death of mental health consumers and what we can change in our delivery of service and or coordination of care within health systems to decrease the incidence of premature death in our consumers. We believe that this issue is primary and falls under the dimensions and definitions of quality care.

Study Question

We are in the process of reviewing this data with our Medical Director and stakeholders in order to identify an intervention and further development of this Performance Improvement Project. Should consensus be gained on this topic, we will proceed in 2007 to develop the study question and research methodology, if applicable.

Potential recommended study areas include measuring coordination of care between PCP and outpatient mental health providers with current consumers or ensuring increased communication and coordination of care regarding medical issues.

Should we choose to pursue this topic, research based recommendations will be considered such as Dickey et al. (2002) who recommends there needs to be some way to "bridge the gap between medicine and mental health services" (p. 866). While some of these interventions would need to occur at the federal and state level, the NASMHPD Medical Directors Council (2006) suggests some possible solutions for the provider agency/clinician level including:

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- ***Coordinated Care***
  Implement models and policies that promote coordination between medical and mental health care. For example, having integrated records, a system of communication between providers, and/or having a medical practitioner at the mental health clinic who is responsible for monitoring and coordinating medical care.

- ***Recovery and Wellness***
  Promote the message of recovery and wellness for medical and mental health with consumers by educating them, collaborating with them regarding healthy choices and lifestyle changes, and developing natural supports.

- ***Evidenced-based Care***
  Adopt "standards of care for prevention, screening and treatment" (p. 46) such as mental health care providers screening and monitoring for medical conditions, providing illness self-management support, and/or reducing polypharmacy.

In conclusion and consistent with recent literature, this preliminary study has found that consumer morbidity and mortality may be premature and preventable. The NSMHA's commitment to addressing consumer health and safety as it relates to this topic remains primary as we proceed in developing new performance improvement projects.

The remainder of the study and data components were not completed as the study is in its preliminary development.

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POLICY #1701.00

SUBJECT: CRISIS RESPITE STANDARDS FOR ADULTS

PURPOSE
The purpose of this policy is to assure consistent, safe, quality crisis respite services across the North Sound Region.

POLICY
Crisis Respite Programs are voluntary programs serving adults having crises. These programs will use the following standards and procedures in providing services to assure access to and quality of crisis respite services.

PROCEDURES AND STANDARDS

I. Crisis Respite facilities must be staffed 24 hours per day.
II. All programs must have the capacity to admit clients into Crisis Respite services on a 24-hour per day, 7-day per week basis.
III. Crisis Respite staff shall use standardized admission and exclusion criteria in determining eligibility for Crisis Respite Services.

   A. At minimum, referral information must contain an assessment of the consumer's potential risk to themselves and others. The risk assessment should include details about any patterns of dangerous behavior.
   B. Inclusionary Admission Criteria

      1. Must be 18 years of age or older.
      2. Must meet criteria of acutely mentally ill, chronically mentally ill, or seriously disturbed as defined by RCW 71.24.025 as the primary presenting problem.
      3. Must be determined to be in a state of decompensation or at risk of decompensation due to a situational crisis.
      4. Must be manageable in an unlocked, neighborhood-based program without restraints or seclusion.
      5. Must be free of significant medical problems for which medical or hospital treatment is indicated for this non-medical facility. They must be able to take care of their basic medical needs, such as wound care or insulin injections.
      6. If under the influence of alcohol or drugs, admission will be negotiated taking into consideration the level of impairment of mental/behavioral functioning.
      7. Must be able to take oral medications, if prescribed, with minimal supervision.
      8. Must be willing and able to comply with house rules regarding violence, weapons, drug/alcohol use, medication compliance, and smoking.
      9. If suicidal, must comply with a no-harm contract.

10. Persons in crisis cannot be excluded from receiving Crisis Response services solely due to intoxication or developmental disability.

C. Exclusionary Admission Criteria

1. The consumer is an imminent danger to others.
2. The consumer is unmanageable in any setting less restrictive than a locked in-patient facility.
3. The consumer refuses to agree to a plan involving crisis respite services.
4. Has a recent history of:

   a) Committing a serious assault that resulted in the provision of medical treatment to either the victim or the perpetrator and/or arrest (within the past 6 months); or
   b) Arson (within the past 3 years) and has been determined by an MHP to currently pose a risk for this behavior.

5. The consumer has a recent history (within 6 months) of committing physical or sexual violence/abuse and/or currently poses a risk for this behavior.
6. The consumer has been assessed to be a Level 1, 2, or 3 sexual offender.
7. The consumer has physical/medical concerns causing inappropriateness for a non-medical setting.

Note: Exceptions to these exclusionary criteria may be granted on a case-by-case basis when both the referring MHP and program staff are in agreement regarding the appropriateness and safety of the placement. All exceptions/rationale will be noted in the record.

IV. For current service recipient's admission to crisis respite will include a review of that client's crisis plan (available through the VOA Triage supervisor, 1-800-747-8654.

V. There must be a face-to-face assessment by an MHP at the time of referral for all unknown clients. For active APN clients to be admitted directly, there must have been face-to-face contact with a clinician within 4 hours prior to the admission. Exceptions to this standard may be made on a case-by-case basis if both the referring MHP and program staff are in agreement regarding the appropriateness of the placement.

VI. Whenever possible, referrals to Crisis Respite will include the following information:

A. Any known behaviors or symptoms that might cause concern or require special care.
B. An evaluation of the person's cognitive status and current level of functioning, including any disorientation, memory impairment, and impaired judgment.
C. History of mental health issues, including suicidality, depression, and anxiety;
D. Social, physical, and emotional strengths and needs;
E. Functional abilities in relationship to activities of daily living.
F. Preferences and choices regarding daily life that are important to the person.
G. Preferences for activities.
H. When such information is not available at admission, program staff will strive to gather such information as services are provided and use this information as clinically appropriate in the provision of services.

VII. Medical Screening

A. The APN Health and Medical Questionnaire will be completed for all persons admitted into Crisis Respite Services. If the necessary information to complete the form is not available at admission it will be completed as soon as possible thereafter.
B. Based on this screening, appropriate referrals and/or assistance in securing medical services will be provided and documented in the Crisis Respite record.

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

A. Treatment plan will be developed by the case manager in conjunction with crisis respite staff detailing the goals that are hoped to be achieved as a result of the Crisis Respite Placement. If there is no case manager, the crisis respite staff will develop this treatment plan.
B. Crisis Respite Consent/Program Rules Form
C. Copy of Client Rights (New clients only. One copy given to the client.)
D. APN Health and Medical Information Form
E. Medication Sheet
F. Inventory of personal effects.
G. Subsequent treatment/supports provided and progress toward achieving these will be documented at least daily during the Crisis Respite placement.

IX. When intoxicated individuals are referred to crisis Respite programs, behavioral indicators and the mix of clients already admitted into services will be considered in determining whether the individual is appropriate for admission.

Deleted: Crisis Respite services to intoxicated individuals (those with a BAL at or above .08) will generally be provided through outreach to the client by Crisis Outreach staff and/or Crisis Stabilization Aides. Such services will be provided only at a staffed location (Detox, Emergency Rooms, Jails, etc.).

X. Crisis Respite programs shall accept out-of-County referrals when space is available. Reference: Cross-Agency Placements.

XI. Discharge Criteria/Procedures

A. Planning for discharge is expected to begin at referral. Updates on the progress of the discharge plan shall be given at the change of shift to each incoming staff by the previous shift. Prior to actual discharge, the on-duty staff will contact the respite program coordinator for discharge approval, including review of current risk and necessary supports.
B. Working in conjunction with the client and whatever other systems/supports are appropriate, staff will develop a written discharge plan to all scheduled discharges. The client 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 listing of current medications;
4. The name and telephone number of the client's case manager/primary clinician;
5. The name of the client's prescriber;
6. The telephone number to be used to get refills;

7. The telephone number for the VOA Care Crisis Line;
8. Any additional pertinent information at the time of discharge; and
9. All personal effects and medications will be returned to the client at the time of discharge and the client will sign for their return.

C. Program staff will consult with a mental health professional whenever unplanned discharges are being considered. This consultation will take place whether it is program staff or the client who is initiating this discharge.

XII. When there is a staff-initiated, unplanned discharge from crisis respite services, a face-to-face crisis service evaluation or face-to-face evaluation by an MHP or Crisis Services MHP shall be arranged by the crisis respite staff.

A. This assessment may need to be conducted at a neutral site away from the crisis respite facility.
B. This assessment can be arranged by contacting the crisis line and requesting a crisis outreach assessment.
C. This evaluation shall assess the risk and assure there are adequate supports and treatment plans for this discharged individual.
D. If the consumer refuses this assessment, the need for an involuntary assessment should be discussed with an MHP or the Crisis Line Triage MHP.

XIII. If it is a consumer-initiated, unplanned discharge, consultation with an MHP shall occur as to whether a face-to-face assessment by a crisis services MHP or other MHP should occur.

XIV. When clinically indicated, a Crisis Alert will also be filed when unplanned discharges take place.

A. Being determined to be ineligible for Crisis Respite services does not impact the client's eligibility for other clinically indicated services, such as other crisis/ITA services, psychiatric hospitalization, cross-system referral, planning, and coordination.
B. For active clients, Primary Clinicians and/or programs will be informed of all unplanned discharges.

OTHER PROGRAM PROCEDURES AND STANDARDS

I. **Staffing**

A. Crisis Respite programs shall have the ability to provide additional staff within 2 hours when this is necessary and sufficient to maintain a Crisis Respite placement.
B. Crisis Respite programs will be staffed by those trained in the treatment of individuals experiencing a mental health crisis.
C. Program staff will receive training in admission and screening prior to providing single coverage.
D. Emergency Services/DMHP staff shall be responsible for providing clinical consultation to Crisis Respite staff and for providing face-to-face interventions//support/evaluations to persons receiving Crisis Respite services as needed. Emergency Service/DMHP staff will provide immediate case management services when an issue is outside the scope of practice

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of crisis residential staff and when a case manager is not available, not assigned, or on weekends and evenings.

E. Staffing levels must meet all appropriate licensing requirements.

II. **Length of Stay**

Initial admissions to Crisis Respite shall be limited to a maximum of five (5) business days. An extension of up to five (5) business days may be authorized by the Program Director or designee

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III. **Interactions/Support from Primary Clinicians for Enrolled Clients**

A. When enrolled clients are receiving Crisis Respite services, the primary clinician shall be responsible for coordinating their treatment, medications, and the discharge planning process. Primary clinicians shall contact the client on a daily basis while the client is receiving Crisis Respite services and are responsible for coordinating services/discharges with Crisis Respite staff.

B. Primary clinicians and program staff shall coordinate reasonable efforts to engage and involve significant others (family members, spouses, friends) during the provision of crisis respite services.

C. When primary clinicians are not available, their supervisor and/or members of their primary program/clinical team shall assume responsibility for the activity described above.

IV. **Clinical Responsibility/Support for Unenrolled Clients**

A. When unenrolled clients are receiving Crisis Respite services, the program staff shall be responsible for coordinating treatment (including crisis case management services) and the discharge planning process. Emergency services staff will serve as backup and support for program staff during such placements.

B. Program staff shall coordinate reasonable efforts to engage and involve significant others (family members, spouses, friends) during the provision of crisis respite services.

C. Staff will assist clients in doing an inventory of their personal effects at the time of admission. Any high-value items (i.e., jewelry, money, etc.) or item that might be used as a weapon will be placed in a locked cabinet until the client is discharged from the program.

V. **Treatment Planning/Documentation**

A. Treatment Plan will be developed detailing the goals that are hoped to be achieved as a result of the Crisis Respite Placement.

B. Subsequent treatment/supports provided and progress toward achieving these will be documented at least daily during the Crisis Respite placement.

VI. **Cross-Agency Placements**

A. Consumers receiving ongoing services through one agency, but placed in another agency's crisis bed, shall continue to receive those services from the original agency, as appropriate during the crisis bed stay. The agency admitting the consumer to its crisis bed shall notify the ongoing service provider of that admission on the next working day to coordinate continuity of care.

B. Once the ongoing service provider has received notification of the crisis bed admission, the consumer's case manager or another agency representative will be responsible for the consumer's ongoing care. Staff will contact the crisis bed house staff within one working day to assist in the development of the crisis care plan and arrange contact with the consumer. At a minimum, this collaborative crisis care plan will detail the roles and responsibilities of staff from the two agencies, frequency of contact for the ongoing care provider (with a minimum of one contact per day), and whether such contact will be face to face or by telephone.

VII. **Medication Management**

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

ATTACHMENTS

None

North Sound Mental Health Administration

Section 1700 – Integrated Crisis Response Services: Duration of Crisis Services

POLICY #1703.00

SUBJECT: DURATION OF CRISIS SERVICES

POLICY

Crisis Outreach and Crisis Stabilization Services are provided until the individual is stabilized to that individual's normal, pre-crisis, functioning or no longer presents an immediate, acute, or heightened risk of harm to self, others or gravely disabled. Crisis Outreach and Crisis Stabilization Services will end when it seems reasonably likely the individual will not need to be re-admitted for further crisis services or more restrictive services to remain stable for at least the next 48 hours. Crisis Services also will end when the individual is referred to other services.

Crisis Service and Stabilization Services are short-term in nature and are intended to last for a few hours or days and in unusual cases a few weeks. Individuals may re-enter crisis services if a new crisis arises or a person's functioning deteoriates.

PROCEDURES

I. Appropriate and timely discharge from crisis services is a consideration from the beginning of each crisis intervention.

II. When discharge from crisis services is being planned, the following shall occur:

A The risk of harm to self, others or physical harm shall be re-assessed and documented in the clinical record and these risks are of an acceptable level so the consumer will be safe and not need services again for at least 48 hours.

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B A plan(The Action Plan) for the continued resolution of the crisis and stability has been developed. This means the following:

1. The action plan has been agreed to by the consumer who was in crisis;
2. The action plan has been coordinated with significant others and other professionals; as appropriate.
3. If the consumer is being referred to another service, the consumer has the referral contact information and alternative plans, if this referral does not work out;
4. The consumer and significant others have a plan to respond if the issues of concern become more acute again and
5. The action plan has been documented in the clinical record.

ATTACHMENTS

None