NORTH SOUND
MENTAL HEALTH ADMINISTRATION

QUALITY MANAGEMENT OVERSIGHT COMMITTEE

COMMITTEE MEETING PACKET

October 24, 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: October 24, 2007
Time: 12:30-2:30 PM
Location: NSMHA Conference Room
For Information Contact Meeting Facilitator Cindy Ainsley or Greg Long, 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: • Announcements	Inform/discuss	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	Inform	Approve	CINDY	1009 Critical Inc		**7**	5 min
ICRS Policies	Inform	Approve	Sandy	1717 1719		12	10 min
Medication Management P&Ps	Inform and discuss		GREG				5 min
Ombuds Report	Discuss	Inform	CHUCK DAVIS			**17**	20 min
ICRS Training Module	Discuss/Review/Approve		CHARISSA			**23**	15 min

Wraparound Policy	Inform	Must go back to PolicySub/QMC/QMOC	JULIE				10 min
Charter Review	Review charter revision (contingently approved last meeting for 6 mo)	Discuss and Approve	GARY/ALL	Charter & Roster		**38**	5 min
Open Forum for Discussion	discuss		ALL				20 min
Date and Agenda for Next Meeting	Ensure meeting date, time and agenda are planned.		All				5 min
***Review of Meeting**	Were objectives accomplished? How could this meeting be improved?		All				

Next meeting November 28, 2007, 12:30-2:30

Potential Future Agenda Items:

DRAFT – not yet approved

North Sound Mental Health Administration
Quality Management Oversight Committee
NSMHA Conference Room
October 4th, 2007
12:30 – 2:30
DRAFT MINUTES

Present:
Gary Williams, Whatcom County
Cindy Ainsley, NSMHA
Mary Good, NSMHA Advisory Board
Chuck Davis, North Sound Ombuds
Rochelle Clogston, Compass Health
Nathalie Gauteron, Bridgeways
Karen Kipling, VOA
Deborah Moskowitz, QRT
Susan Ramaglia, NAMI Skagit

Excused:
Janet Lutz-Smith, NSMHA Advisory Board
Anne Deacon, Snohomish County

Not Present:
Chuck Albertson, NSMHA Advisory Board
June LaMarr, the Tulalip Tribes
Rebecca Clark, Skagit County

Others Present:
Shannon Solar, NSMHA
Margaret Rojas, NSMHA
Tom Yost, NSMHA
Charissa Fuller, NSMHA
Kurt Aemmer, NSMHA
Sandy Whitcutt, NSMHA

1. Introductions, Review of Agenda, Previous Meeting Minutes
The meeting was convened at 12:35 p.m. and introductions were made. Chair Williams thanked the group for attending on a non-regular meeting day. The minutes from the previous meeting were reviewed, a motion was made to approve them as written, motion seconded, carried, all in favor.

2. Announcements - *None.*

3. Comments from the Chair - *None.*

4. Policy Subcommittee Report
Cindy noted policy 1519 (Provider Enrollee Communications) has been approved by the policy subcommittee. A motion was made to approve policy 1519 as written. Motion seconded, carried, all in favor.

Cindy noted that policy 1558 (Mental Health Specialist) was also approved by the subcommittee. A motion was made to approve the policy as written, motion seconded, carried, all in favor.

Chair Williams noted that he has to withdraw from the policy subcommittee despite his belief in its value due to time constraints.

5. Community Health Clinics Survey
Tom Yost presented his findings on the Community Health Clinics, which originated out of a request from this committee to determine the relationships providers have with community health clinics. Tom asked if there were questions and concerns, Chuck noted he has felt frustrations with health clinics when it is communicated to thim that doctors have to provide mental health medication that they should be getting from their mental health provider. Tom noted there are many problems that lead to this, it could be the person no longer qualifies for mental health services in our system and the referral to the doctor is not handled correctly. Chuck noted that there have been improvements in meds and requirements. Tom noted NSMHA hopes to develop a coordination plan and meeting with representatives from the medical community as it does quarterly with correctional representatives. Chair Williams noted this is a very important argument as critisizers of RSN's running the MH system is that access to medical treatment is not provided the way it could be if run by a Medical for-profit company such as Molina. We need have researched patient outcomes to show that our model coordinates with behavioral health needs of

consumers. Tom noted at some point we will need to consider how to get more medical care involved in mental health services. Chair Williams suggested getting primary care issues addressed as a PIP (performance improvement project). Rochelle noted QMOC originally wanted the report because it was unsure if any discussion at all was going on, and the report shows a variety of communication is occurring.

6. Secure Detox Pilot
Margaret Rojas joined the meeting to discuss policy 1718 (Integrated Crisis Secure Detox Pilot). A motion was made to approve policy 1718, motion seconded, carried, all in favor.

7. Charter Review/Clinical Redesign
Cindy distributed two suggested revisions of the QMOC charter. Cindy noted this is an important committee and we want correct representation. Revision 2 invites all providers to bring someone which might be more difficult to structure. Nathalie noted she feels providers will have more support with Revision 2, as all providers would be kept in the loop. Mary noted she does not want consumers to be pushed out; Cindy noted that this is not the case. Chair Williams noted that this committee has a different role than the Quality Management Committee; we want to have an increased number of consumers and advocates than providers. If we do choose to implement the Revision #2 wherein many more providers attend, then we will need to get more consumers and advocates at the meetings.
Cindy also suggested defining what a quorum is. Cindy noted that QMC has invited two representatives from every agency to attend. Rochelle noted that the discussion at QMOC is rich and valuable. Deborah voiced the need to get more consumers and advocates to the meeting. Chair Williams noted that transportation can be provided for consumers to facilitate their attendance. Karen agreed.
Deborah suggested we bring this issue back to an upcoming meeting when there is increased attendance. A recommendation was made for NSMHA staff to work on getting consumers and advocates present at the meetings.
A motion was made to follow Revision #2 charter, motion seconded, carried, all in favor.

8. Utilization Review
Sandy noted the Utilization Review is a six-month report of all UR's done from January-June 2007. Sandy noted the questions have been adjusted to focus more on the positive elements than the negative. Sandy walked through the report, noting improvement is being seen in documentation of UR's. Chuck commented that there are continual problems with scheduling. Nathalie noted there are barriers that create this that need to be worked on. Susan asked how the review knows when a consumers' needs have changed, Sandy noted the information comes from the 180-day review.

9. Regional Training Committee
Charissa noted that the new Regional Training Plan is being updated. The 2006-2007 plan was reviewed. The committee discussed that the 2006-2007 Training Plan was never actually approved as the reporting was so constrictive. Charissa noted that the next plan will be simplified. A motion was made to retroactively approve the 2006-2007 Training Plan. Motion seconded, carried, all in favor.

10. Critical Incident Report
Kurt Aemmer went through the Critical Incident Review Committee report from the first and second quarter of 2007. Kurt noted a 12% total decrease in critical incidents and a 44% reduction in deaths in Snohomish County. Chuck noted that there seems to be a general improvemet. Kurt agreed that he is pleased with the way providers are reporting this data. Cindy noted she is working with the new providers to make sure they know what we are looking for as far as elements to be reported.

11. Medication Management P&P's
Deferred.

12. Date and Agenda for Next Meeting/Review of Meeting
The meeting was adjourned at 2:18 p.m. Next meeting will be held on Wednesday October 24th.

Effective Date: 9/17/2007, Executive Director; 6/25/2007, Executive Director; 11/10/2005; 10/9/2003, Motion #03-054
Revised Date: 9/24/2007
Review Date:

North Sound Mental Health Administration

Section 1000 – Administrative: Critical Incident Reporting and Review Requirements
CIRC Quality Assurance and Improvement Process

Authorizing Source: 2007 Draft Amendment to the PIHP Agreements – Section 7.11.5
Cancels:
See Also:
Approved by: Executive Director
Date:
Responsible Staff: Quality Manager
Signature:

POLICY #1009.00

SUBJECT: CRITICAL INCIDENT REPORTING AND REVIEW REQUIREMENTS CIRC QUALITY ASSURANCE AND IMPROVEMENT PROCESS

PURPOSE

The purpose of the Critical Incident Reporting and Review Requirements and the Critical Incident Review Committee (CIRC) Quality Improvement and Assurance Process is to:

Ensure its ongoing commitment to quality assurance and improvement initiatives, that the North Sound Mental Health Administration (NSMHA) promotes consumer/patient safety and risk reduction by requiring the recognition and reporting of extraordinary occurrences. Specifically the purpose of this policy is to ensure that:

1. Care and services delivered meet the requirements of both the NSMHA/MHD, and provider contracts, including NSMHA Standards of Care, relevant Washington Administrative Codes, Revised Code of Washington, and the Federal Waiver
2. There is a timely and systematic reporting mechanism that promotes appropriate responses to critical incidents/extraordinary occurrences
3. Findings from investigation of critical incidents are reported to NSMHA stakeholders, and acted upon to minimize risk to consumers and contracted providers

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And to:

1. Provide a framework, structure and set of guidelines for the timely reporting of critical incidents, as defined by the Washington State Mental Health Division (MHD)
2. Support and protect the reporting and documentation of critical incidents under NSMHA's Coordinated Quality Improvement Program (CQIP)

NSMHA maintains CQIP status through the Washington State Department of Health for the purpose of improvement of the quality of health care services rendered to clients/consumers/patients and the identification and prevention of medical malpractice as set forth in RCW 43.70.510. NSMHA encourages the development of a system-wide culture that minimizes individual blame or retribution for involvement in critical incidents and emphasizes accountability, trust, system improvement and continuous learning. All documents related to critical incident reporting shall contain the following language:

COORDINATED QUALITY IMPROVEMENT DOCUMENT

This is a protected Coordinated Quality Improvement document solely for the purpose of assuring Continuous Quality Improvement, and Quality Assurance by the North Sound Mental Health Administration, its providers and component counties. This document is strictly confidential to the fullest extent allowed by RCW 43.70.10 and is not subject to disclosure pursuant to Chapter 43.17 RCW.

POLICY
This policy describes the processes, circumstances, methods and timelines by which the contracted provider shall provide information to NSMHA and the quality assurance and improvement activities involved regarding reporting and responding to critical incidents affecting mental health consumers of NSMHA services and NSMHA providers and networks.

Definition of Critical Incidents
Critical incidents are extraordinary and adverse occurrences that take place in the lives of mental health clients/consumers/patients. All occurrences listed in the definitions of critical incidents that occurred while the NSMHA consumer was enrolled in outpatient services, all patients detained at a NSMHA Evaluation and Treatment Facility, consumers seen by NSMHA Integrated Crisis Response Services/Crisis/Crisis Respite Episode, and consumers receiving Snohomish County Jail Mental Health Services shall be reported.

The following are critical incidents and require reporting to NSMHA

1. Completed suicide, or death under unusual circumstances
2. Homicide (perpetrator) resulting in arrest
3. Homicide (victim) resulting in arrest
4. Attempted homicide (perpetrator) resulting in arrest
5. Attempted homicide (victim) resulting in arrest
6. Incident referred to Medicaid Fraud Control Unit
7. Allegation of financial exploitation involving consumer
8. Allegation of financial exploitation involving provider
9. Assault of consumer by staff
10. Allegation of rape (perpetrator)
11. Allegation of rape (victim)
12. Allegation of sexual assault (perpetrator)
13. Allegation of sexual assault (victim)
14. Nonfatal injury resulting in arrest (perpetrator)
15. Nonfatal injury resulting in arrest (victim) – Includes suicide attempts resulting in arrest
16. Arson resulting in arrest
17. Substantial property damage resulting in arrest
18. Assault of NSMHA or NSMHA contracted provider staff by consumer resulting in hospitalization (not just ER visit)
19. Attempted Suicide (not resulting in arrest)
20. Elopement from a provider involuntary treatment program

Definition of client/consumer/patient
1. Mental Health Services – Consumer has been determined eligible following the intake assessment, and prior to the completion of a transition (discharge) summary
2. Integrated Crisis Response Services/Crisis Respite – Shall report Critical Incidents on individuals who have an open crisis/crisis respite episode. The event precipitating the evaluation is not considered a critical incident
3. Jail Services – Incidents that occur subsequent to the consumer being determined eligible for jail mental health services, and for 90 days post-release. The event for which the consumer was jailed

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is not considered a critical incident unless the individual was a current consumer of NSMHA mental health services or Crisis Services as defined above.

Delineation of non-MHD Reportable Critical Incidents

1. Attempted Suicide (not resulting in arrest)
2. Elopement from a provider involuntary treatment program

Note: The reporting of non-MHD reportable critical incidents is not required in the contract language set forth by MHD. These categories of critical incidents have been identified in past NSMHA Critical Incident Review Committee quality improvement activities as valuable outcome indicators from which the effectiveness of those quality improvement efforts can be measured.

Delineation of MHD Reportable Critical Incidents

1. Completed suicide, or death under unusual circumstances
2. Homicide (perpetrator) resulting in arrest
3. Homicide (victim) resulting in arrest
4. Attempted homicide (perpetrator) resulting in arrest
5. Attempted homicide (victim) resulting in arrest
6. Incident referred to Medicaid Fraud Control Unit
7. Allegation of financial exploitation involving consumer
8. Allegation of financial exploitation involving provider
9. Assault of consumer by staff
10. Allegation of rape (perpetrator)
11. Allegation of rape (victim)
12. Allegation of sexual assault (perpetrator)
13. Allegation of sexual assault (victim)
14. Nonfatal injury resulting in arrest (perpetrator)
15. Nonfatal injury resulting in arrest (victim) – Includes suicide attempts resulting in arrest
16. Arson resulting in arrest
17. Substantial property damage resulting in arrest
18. Assault of staff by consumer resulting in hospitalization (not just ER visit)

PROCEDURE

When a Critical Incident occurs it is the responsibility of the contracted service provider to notify NSMHA.

1. Contracted providers shall use the NSMHA Critical Incident form available online at www.nsmha.org to fax critical incident reports to NSMHA.
2. The report form shall be sent to the NSMHA within 24 hours of the event being known to the provider. When faxed, the form must include a cover sheet with a confidentiality disclaimer.
3. In cases where essential additional information that is necessary to understanding the incident is obtained, it will be submitted to NSMHA within 4 business days. The initial incident report in combination with this addendum information provides a comprehensive picture of the incident.
4. The contracted provider shall initiate and conduct a formal incident review as necessary for quality improvement or as requested by the CIRC or NSMHA. If requested, the provider shall submit the written report to NSMHA dated within 21 business days of the CIRC or NSMHA request.

Actions taken as a result of the occurrence, results of said actions, additional actions that are planned in the future, and efforts that have been undertaken designed to lessen the potential for recurrence. A copy of the written report shall be sent to the provider Quality Manager.

Required action when NSMHA receives an MHD-reportable

1. Initial notification and any follow up shall be provided to MHD by NSMHA using the MHD electronic incident reporting system. If the electronic reporting system is unavailable, MHD will provide a standardized form with instructions on how to submit
2. NSMHA shall notify the MHD Incident Manager within one working day of becoming aware of events involving a person who has an open case and is the alleged victim or perpetrator of any of the aforementioned MHD reportable incident types
3. In addition to all incidents described above, NSMHA shall utilize professional judgment and report incidents that fall outside the scope of this section

Provider

1. Responds within the requested timeframes and cooperates in other requests for documentation as requested by NSMHA
2. Submits formal CI review for the MHD reportable incidents, identified as requiring review on the provider reporting form, following prescribed NSHMA format review template
3. Ensures that all plans for corrective action following a review or investigation are implemented for quality assurance and improvement
4. Submits a report on statistics related to its critical incidents and quality improvements generated as a result of CI outcomes, as outlined and under the conditions of the contracted provider QM plan

NSMHA Staff Designee

1. Notifies County Coordinators and NSMHA Board Chair
2. Notifies MHD via the electronic incident reporting system or the standardized form if indicated
3. Tracks critical incidents reported to MHD, maintain log, database and timeline and writes any follow-up reports required. In some instances the designee initiates region-wide quality improvement activities related to an incident or group of incidents

CIRC QUALITY IMPROVEMENT PROCESS

NSMHA shall maintain CIRC whose purpose is to review all critical incidents submitted. The NSMHA CIRC membership will include Executive Director/staff designee, Quality Manager, Risk Management Quality Specialist, the Child and Adult Advocate Quality Specialists, and administrative support staff. The CIRC shall meet regularly to review all critical incident reports, request written follow-up reports from providers, investigate critical incidents utilizing internal selective reviews, and make quality improvement recommendations related to critical incidents to the Quality Manager and department for further appropriate action.

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During the regularly scheduled CIRC meeting, the Risk Management Quality Specialist will facilitate review and discussion of each new critical incident and critical incidents from previous months on which the committee determined further review was required before proper disposition of the case could be determined.

During a CIRC review, the following questions shall be answered by the committee:

1. Does the description of the critical incident and/or subsequent, supplemental information warrant concern about quality or appropriateness of care delivered by the provider?
2. Does the incident report indicate that appropriate action was taken immediately after the incident to lessen or prevent consumer loss or harm?
3. Does the incident report indicate that an appropriate plan for future action has been made to decrease the likelihood of this type of incident occurring in the future?
4. Can/should any further action be pursued by NSMHA or the provider?

When the CIRC members reach a consensus that the critical incident report and any follow up documentation/information answers the above questions 1 and 4 negatively, and questions 2 and 3 positively, the incident is considered "closed".

When NSMHA deems further action is warranted in the case of a particular critical incident or group of incidents, action may include a NSMHA Selective Review (See Procedure 1009B). Examples of other actions may include, but are not limited to:

1. Request for parts of or complete medical records
2. Requests for special meetings or quality initiatives (e.g., Root Cause Analysis), regarding quality concerns involved
3. Requests for the provider to initiated quality assurance and improvement activities based on incidents or groups or types of incidents
4. Other requests as deemed necessary

CIRC will develop a summary report and trend analysis each biennial quarter. Report of these quality improvement activities will be distributed to NSMHA Board of Directors, NSMHA Advisory Board, NSMHA Quality Management Oversight Committee (QMOC) and County Coordinators.

ATTACHMENTS

1009.07 – PRO-1009B: Conducting Selective Reviews
1009.16 – NSMHA Critical Incident Reporting Form

Effective Date: 6/25/2004
Revised Date: 9/27/2007
Review Date:

North Sound Mental Health Administration

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

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

POLICY #1717.00

SUBJECT: ICRS: URGENT CONTACTS & FOLLOW-UP SERVICES

PURPOSE
To define Emergent, Urgent, and Follow up consumer contacts and services within the Integrated Crisis Response Services (ICRS) system; to clarify the process for triaging and providing consumers with Urgent contacts and Follow-up services when indicated.

POLICY
ICRS Urgent contacts will occur in order to provide consumers in crisis with timely access to face-to-face mental health evaluation/intervention services when needed, to prevent the consumer's situation from deteriorating to the point that Emergent care is necessary (per State Mental Health Contract, item 1.35). ICRS Follow-up appointments and services will occur when needed to further support consumers in crisis needing follow-up face-to-face intervention.

PROCEDURES
Volunteers of America (VOA) Care Crisis Response Services Triage Clinicians determine the urgency of the caller's crisis and initiate the crisis services contact with NSMHA providers. There are three levels of face-to-face responses available in the ICRS system:

A. Emergent Contact: Calls in this category require a response within 2 hours of the dispatch of outreach staff by the VOA Triage Clinician (see Policy 1702, "ICRS Outreach Screening, Crisis Line Pre- and Post-Dispatch").

B. Urgent Contact: Calls in this category require a response by the NSMHA provider within 24 hours of the VOA 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 Triage Clinician, or by any other Clinician within the ICRS system. Follow-up services may also be offered to non-enrolled consumers needing Follow-up contact while awaiting transition into ongoing care.

1. **Urgent Contact**

   a) Urgent Contacts are available for consumers in crisis who are not in Emergent need, but who are so decompensated that they are at risk of harm to self or others and/ 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).

b) Callers with an open outpatient episode:

i) During typical business hours, callers who are currently enrolled with a NSMHA 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, ICRS staff may serve as a back up.
ii) When the primary clinician will be unavailable to the VOA Triage Clinician within 24 hours of the identified need for contact (e.g. the need is identified on a Friday evening), the ICRS staff will be contacted and briefed and requested to respond via face-to-face intervention within 24 hours.
iii) ICRS staff will contact the VOA Triage Clinician and provide disposition upon completion of the Urgent contact (should complications arise, these will be communicated to the VOA Triage Clinician as well, and the plan may be modified according to current consumer need).

c) Callers without an open outpatient episode:

i) NSMHA provider agencies will maintain a Monday through Friday schedule of available appointment times and will make this schedule available to VOA Triage Clinicians.
ii) VOA Triage Clinicians will schedule Urgent Appointments for callers when an appointment is available within 24 hours.
iii) VOA Triage Clinicians will notify the NSMHA Provider agency as soon as possible regarding the scheduled contact and will provide summarized clinical information in a standard format.
iv) When an appointment is not available within 24 hours (e.g. the need is identified on a Friday evening), the ICRS staff will be contacted and briefed and requested to respond via face-to-face intervention within 24 hours.
v) ICRS staff will contact the VOA Triage Clinician and provide disposition upon completion of the Urgent contact (should complications arise, these will be communicated to the VOA Triage Clinician as well, and the plan may be modified according to current consumer need).

2. Follow-Up Services

a) Follow-up appointments are available for 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. Follow-up appointments may be scheduled by the VOA Triage Clinician as an outcome to a phone intervention, or they may be scheduled by an Emergency Services clinician who believes that a consumer would benefit from further intervention.

b) Callers/consumers with an open outpatient episode

i) Follow-up services for these consumers will be provided by the primary clinician or another member of the clinical team. Emergency Services is not responsible for providing Follow-up services to enrolled consumers.

ii) The Triage Clinician or Emergency Services staff referring an enrolled consumer for Follow-up services will notify the NSMHA Provider agency as soon as possible, and will provide summarized information in a standard format.

c) Callers/consumers without an open outpatient episode

i) VOA Triage Clinicians will notify the NSMHA Provider agency regarding the referral and will provide summarized clinical information in a standard format.
ii) Emergency Services staff is responsible for providing clinically necessary Follow-up services to non-enrolled consumers in crisis when needed, until the crisis is resolved, or until the referral to ongoing services is complete.
iii) During this period of ICRS Emergency Follow-up services, Emergency Services staff will communicate directly with the consumer regarding scheduling appointments, etc., as needed.
iv) It is understood that follow up through Emergency Services is not a substitute for ongoing services and that consumers will be moved as quickly as possible into ongoing care.

ATTACHMENTS

None

Effective Date:
Revised Date: 8/9/2007
Reviewed Date:

North Sound Mental Health Administration

Section 1700 – ICRS: Utilization of Crisis Respite for Hospital Discharge Planning

Authorizing Source: Per NSMHA & ICRS
Cancels:
See Also: Approved by: Executive Director Date:
Responsible Staff: Sandy Whitcutt, Quality Specialist Signature:

POLICY #1719.00

SUBJECT: UTILIZATION OF CRISIS RESPITE FOR HOSPITAL DISCHARGE PLANNING

PURPOSE: The purpose of this policy is to identify a coordinated discharge procedure between hospitals and contracted community crisis respite programs in the NSMHA region to assure rapid and safe discharges from hospitals to less restrictive options.

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

PROCEDURE

Admission Criteria

A. Hospital personnel will complete comprehensive discharge planning prior to contacting the Crisis Respite program in the consumer's county.

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

B. The consumer must have a source of funding that addresses basic needs including the ability to obtain any prescribed medications and other medical equipment.
C. The consumer must have an open outpatient episode or a scheduled assessment for admission to outpatient service prior to their admission to crisis respite beds for step-down from a hospital.
D. Western State Hospital Liaisons and hospital personnel will coordinate with the Crisis Respite contact (program manager and/or designee) to address the needs of the client and the rationale for the use of the crisis respite bed.
E. Crisis Respite admissions to this service will meet the inclusionary criteria defined in Policy #1701.
F. Crisis bed placements after discharge from an inpatient setting are a transitional placement. The bed use days should not exceed 30 days. Exceptions will be considered on a case-by-case basis.
G. There will be availability of two (2) beds for this program in Snohomish County, one (1) bed in Whatcom County, and one (1) in Skagit County.

1. The preference is to provide crisis bed placement for consumers living in their identified county, but consideration will be given to consumers from the NSMHA region requiring this crisis bed placement, who meets the other conditions outlined in this policy. Exceptions to the use of the beds will be considered on a case-by-case basis, after review by the program manager.
2. Priority would be given to those individuals who are ready for discharge from Western State Hospital. The use of the respite program would also be available to the Evaluation and Treatment Centers (E&Ts) and Community hospitals on a case-by-case basis.

H. **Exclusionary Criteria:**

1. Individuals who appear to have housing needs that are expected to exceed 30 days to resolve would not be considered for this program.
2. Exclusionary criteria, as defined in policy # 1701, apply in this policy.

I. **Respite Services:**

Consumers in this program would have a case manager assigned to assist with the coordination and transition needs of the consumer. Examples of this coordination would include:

1. Facilitating transition into the community.
2. Assistance with enrollment into outpatient treatment programs that may include Mental Health or Chemical Dependency programs as appropriate.
3. Facilitation of connection to community supports and resources that address basic needs (e.g. food, housing) and other needs (e.g. socialization, medical care).

AGENCY COMPLAINTS, Fall, 2007

Compass Health, Snohomish: 5 Occurrences (6 last period)
Consumer Rights: 1
Dignity & Respect: 1
Physicians & Meds: 1
Quality Appropriateness: 2

Compass Health, Marysville: 2 Occurrences (2 last period)
Housing: 1 (Child)
Access: 1 (Child)

Compass Health, Whidbey: 6 Occurrences (8 last period)
Consumer Rights: 1
Access: 2
Emergency Services: 2
Physicians & Meds: 1

Compass Health, Smokey Point: 1 Occurrence (none last period)
Quality Appropriateness: 1 (Child)

Compass Health, Lynnwood: 8 Occurrences (4 last period)
Access: 1
Consumer Rights: 2
Other: 2
Physicians & Meds: 2
Phone Calls not returned: 1

Compass Health, Skagit: 20 Occurrences (15 last period)
Access: 2 (1 Child)
Consumer Rights: 2
Dignity & Respect: 3
Financial: 4
Housing: 1
Physicians & Meds: 2
Quality Appropriateness: 3 (1 Child)
Phone Calls Not Returned: 1
Emergency Services: 1 (Child)
Service Intensity: 1 (Child)

Compass Health, Skagit Crisis Beds: 4 Occurrences (none last period)
Dignity & Respect: 4 (2 provider grievances)

Compass Health, San Juan: 1 Occurrence (none last period)
Housing: 1

Haven House: 4 Occurrence (1 last period)
Residential: 1 (Child)
Dignity & Respect: 1 (Child)
Housing: 1 (Child)
Other: 1 (Child)

Compass Health, Everett: Occurrences 96 (69 last period)

Access: 4 (1 Child)
Quality Appropriateness: 11 (2 Children) (1 provider grievance) (1 RSN grievance)
Physicians & Meds: 5 (1 provider grievance) (1 RSN grievance)
Consumer Rights: 18 (1 Child) (3 provider grievances)
Financial Services: 15 (4 provider grievances)
Housing: 10 (2 provider grievances)
Emergency Services: 5 (2 provider grievances)
Dignity & Respect: 14 (5 provider grievances) (1 RSN grievance)
Services Intensity: 5 (1 Child) (1 provider grievance)
Other: 2 (1 provider grievance)
Phone Calls not returned: 6 (1 provider grievance)
Residential: 1 (Child)

Evaluation & Treatment Center: 20 Occurrences (19 are North Sound E&T) (21 last period)
Emergency Services: 5 (1 provider grievance) (Mukilteo had 1)
Financial: 3 (1 provider grievance)
Physicians & Meds: 5 (1 provider grievance)
Dignity & Respect: 3 (1 provider grievance)
Consumer Rights: 1
Quality Appropriateness: 3

Sea Mar, Everett: 11 Occurrences (8 last period)
Access: 4 (2 RSN grievances)
Consumer Rights: 1 (1 RSN grievance)
Dignity & Respect: 5 (2 RSN grievances)
Physicians & Meds: 1 (1 RSN grievance)

Sea Mar, Bellingham: 9 Occurrences (5 last period)
Consumer Rights: 3
Dignity & Respect: 3
Physicians & Meds: 3

Lake Whatcom Center: 19 Occurrences (9 last period)
Consumer Rights: 1
Dignity & Respect: 1
Emergency Services: 2
Financial Services: 3
Physicians & Meds: 3
Housing: 3
Quality Appropriateness: 1
Residential: 3
Services Intensity: 2

Whatcom Counseling & Psychiatric Clinic: 27 Occurrences (23 last period)
Financial: 4
Consumer Rights: 4
Physicians & Meds: 7
Housing: 4
Dignity & Respect: 3
Quality Appropriateness: 1
Access: 1
Emergency Services: 1

Phone Calls not returned: 1
Other: 1

Medicaid Transportation: 1 Occurrence (4 last period)
Access: 1

Stevens Hospital: 7 Occurrences (4 last period)
Dignity & Respect: 2
Emergency Services: 2
Access: 1
Physicians & Meds: 1
Quality Appropriateness: 1

St. Joseph Hospital: 14 Occurrences (9 last period)
Quality Appropriateness: 1
Dignity & Respect: 5
Access: 2
Emergency Services: 2
Physicians & Meds: 1
Consumer Rights: 3

Western State Hospital: 10 Occurrences (8 last period)
Consumer Rights: 3
Emergency Services: 3
Physicians & Meds: 2
Quality Appropriateness: 2

Skagit Valley Hospital: 3 Occurrences (1 last period)
Access: 1 (Child)
Consumer Rights: 1
Emergency Services: 1

Providence Hospital: 1 Occurrence (5 last period)
Access: 1

VoA: 3 Occurrences (none last period)
Access: 1
Dignity & Respect: 1
Physicians & Meds: 1

Non-Community Mental Health Program Agencies): 27 Occurrences (14 last period)
Consumer Rights: 5
Dignity & Respect: 1
Emergency Services: 2
Financial: 2
Housing: 7 (1 Child)
Other: 2 (1 Child)
Physicians & Meds: 4
Transportation: 1
Services Intensity: 1 (Child)
Unreturned Phone Calls: 1
Quality Appropriateness: 1

COMPLAINT & RESOLUTION DEFINITIONS

COMPLAINTS:

Access: Concerns (1) access to initial inpatient or outpatient services and (2) terminations from services primarily. Deals with having trouble getting into services or having on-going services cut back or terminated. May deal with eligibility for services or taking too long to receive services. A complaint about access is not only about access into services, but perhaps how long it took, or sometimes about a type of service not available to the consumer.

Dignity & Respect: Actual or perceived such treatment. How the consumer felt treated by the staff.

Quality Appropriateness: Appropriate type of service needed either isn't available or isn't being provided. Example: Client has PSTD and is put in an anxiety group. Client questions quality of the therapist, isn't satisfied with anxiety group counseling, and wants individual therapy for PTSD.

Phone Calls Not Returned: Just what it says--usually client to case manager/therapist. This would normally be when the consumer is already in services.

Service Intensity or Coordination of Services: Has to do with insufficient amount of services being provided. It may involve level of care or a type of therapy not available in that agency (for instance, treatment for eating disorders). Also deals with coordination between provider and another agency or possibly between service providers in the same agency. Example is an alcoholic client where there must be coordination between the person's medical doctor, substance abuse treatment provider and mental health clinician. This could have to do with something like personal care in the home while also in therapy. Could have to do with case manager not coordinating appointments with the right providers.

Consumer Rights: These are listed in the WAC and in our NSMHA brochure. It has a number of sub-categories. Mental health consumers have specific rights as listed in the WACs; this would involve a complaint that one or more had been violated. (Remember that "dignity and respect" is its own category).

Physicians and Medications: When someone wants another type of medication or different dosage. Perhaps they think their psychiatrist isn't listening to what they say about their medications. It may involve interaction with the PCP. Usually it involves medication and refers to psychiatrists and psychiatric meds. Complaints in this area might be around side effects and the doctor not paying attention to the consumer's concerns about them.

Financial and Administrative Services: Having to do with client funds. Generally deals with payees and pay problems. We would generally seek assistance from the case manager and payee. These complaints might be about SSI eligibility, or the consumer having a payee that controls his or her benefits.

Residential: This deals with any agency-provided housing. It may be an issue concerning supported living, boarding alone, agency-owned housing. Aurora House is an example of agency-owned housing. These complaints would involve supported living situations managed by the agency.

Housing: This deals with regular, independent housing out in the community, or perhaps integrating mental health clients back into the community. It also involves Section 8 applications or Shelter Plus Care. A complaint here might be that the agency hasn't done enough to find a consumer independent living.

Transportation: May deal with transportation coupons, bus passes, taxis, obtaining an access bus, or possibly transportation to and from services or places they need to go for normal living. May deal with clients who have agoraphobia and have trouble with public transportation. A complaint here would involve transportation to and from mental health services.

Emergency Services: Has to do with crisis services such as Crisis Clinics, or may involve E & T centers. May involve interaction with CDMHP. This complaint would involve crisis services, either the crisis line, or a CDMHP evaluation, or difficulty in the hospital emergency room during a mental health crisis.

Participation in Treatment: Client's voice and viewpoint aren't being heard by the treatment provider or reflected in their treatment.

Violation of Confidentiality: An aspect of a client's diagnosis, treatment history, or current treatment has been inappropriately revealed.

Access to Inpatient Treatment: A client is denied access to needed hospitalization.

Other: Any other type of complaint.

RESOLUTIONS:

Information or Referral: Giving information/names/numbers, or referring to another source. May involve significant follow up by Ombuds.

Referral to QRT: This is done when we see a trend.

Conciliation/Mediation: Working out the issue between Ombuds, the provider and the client. Usually involves meetings, letters, phone calls, etc.

Arbitration: Grievance or Fair Hearing ruling by a higher authority.

Fair Hearing: Normally filed with an administrative law judge when an RSN's grievance ruling is unsatisfactory to a client.

Other: Another type of resolution. Perhaps the client moved away or died, is hospitalized, etc.

Not pursued: Client dropped the complaint. Perhaps the client didn't understand the system and were satisfied once they understood the whole situation, or they became satisfied during the working of the complaint or grievance.

GRIEVANCES REPORT (Fall 2007)

PROVIDER LEVEL GRIEVANCES: (Heard by provider agency)

COUNTY:	AGENCY:	GRIEVANCE SUBJECT:	RESOLUTION:
Whatcom	NS E&T Center	Financial; Dignity/respect Emergency Services Physicians & meds	Open
Skagit	Crisis Beds	Dignity/respect (2)	Conciliation
Snohomish	Compass-Everett	Quality appropriateness Unreturned phone calls Financial (2)	Open
Snohomish	Compass-Everett	Dignity/respect Consumer rights (2)	Other type
Snohomish	Compass-Everett	Dignity/respect; Housing Service intensity; Other	Open
Snohomish	Compass-Everett	Dignity/respect; Housing Emergency Services	Conciliation
Snohomish	Compass-Everett	Dignity/respect; Financial Consumer rights Physicians & meds	Conciliation
Snohomish	Compass-Everett	Financial	Conciliation
Snohomish	Compass-Everett	Dignity/respect; Emergency Services	Conciliation

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NSMHA LEVEL GRIEVANCES: (Heard by NSMHA)

Snohomish	Compass-Everett	Dignity/respect; Quality Appropriateness; Physicians/meds	Conciliation
	Sea Mar-Everett	Dignity/respect (2); Access Physicians/meds	Open
	Sea Mar-Everett	Access; Consumer rights;	Conciliation

North Sound Mental Health Administration
Regional Support Network for Island, San Juan, Skagit, Snohomish, and Whatcom Counties
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INTEGRATED CRISIS RESPONSE SYSTEM NSMHA TRAINING MODULE

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    E. What face-to-face services are available?
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    H. What is the process for psychiatric hospitalization?
    I. What happens when an involuntary admission takes place?
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5. Attachment: Writing an affidavit for commitment or revocation.

TRAINING OBJECTIVES:

1. Familiarize clinicians with tools and resources in the crisis system.
2. Facilitate clinician understanding of the voluntary hospitalization and involuntary treatment processes.
3. Provide guidance regarding the completion of an affidavit for initial detention or subsequent revocation.

GLOSSARY OF TERMS:

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

DCR: Designated Crisis Responder. A mental health clinician appointed by the County to perform the duties specified in RCW 70.96B also referred to as the Pilot Project. The DCR may detain under this law, those who display imminence of harm or grave disability as a result of their chemical dependency and those who may have co-occurring mental health and chemical dependency disorders.

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

E & T: Evaluation and Treatment Center. The North Sound Region operates 2 facilities via contract with Compass Health, one in Sedro Woolley (North Sound E&T) and one in Mukilteo (Mukilteo E&T). These programs provide involuntary evaluation and treatment to those detained by the DMHP/DCR staff. Other inpatient psychiatric facilities are licensed as Evaluation and Treatment Centers, but most often the term "E&T" refers to one of the 2 regional facilities.

ICRS: Integrated Crisis Response System. This is the service system that provides crisis response interventions throughout Island, San Juan, Skagit, Snohomish and Whatcom Counties. Service providers include the Volunteers of America, Compass Health, Snohomish County Human Services and Whatcom Counseling and Psychiatric Center.

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

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

Pilot Project: The North Sound Region is one of two sites in the state implementing RCW 70.96B as a pilot to address the need for detention of those individuals who are a danger to self, danger to others, or gravely disabled as a result of their chemical dependency. The Project is scheduled to run through June 2008 at which time a decision will be made about efficacy and statewide implementation.

Secure Detox: As part of the Pilot Project, a secure facility was developed to provide initial detox and evaluation services to those detained under RCW 70.96B. The facility in our region is known as North Cascades Secure Detox and is located in Sedro Woolley.

Triage Clinician: The mental health professional at the Crisis Line, who coordinates services, dispatches DMHP/DCRs and emergency mental health clinicians and provides telephone-based support 24 hours/day.

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

INTRODUCTION

Crisis services are available to all persons physically located in the NSMHA service area that are in a self-defined state of crisis and/or who meet the WAC definition of crisis (a situation where a person is acutely mentally ill or experiencing a serious disruption in cognitive, volitional, psychosocial, or neurophysiological functioning). A person in crisis is served from a respected person orientation, which is a non-stigmatizing, person-oriented approach including responsive listening and respectful attention.[1]

Crisis services include a broad array of services, from telephone-based support via the VOA through assessments for involuntary treatment done by Designated Mental Health Professionals/Designated Crisis Responders (DMHP/DCRs). Services are available regardless of enrollment status with NSMHA funded service providers, age, ability to pay, or funding source. Crisis services are offered in the least restrictive community setting possible to effectively and safely resolve the crisis, and such services are matched to the individual need and severity of the crisis. Crisis services actively involve and collaborate with family members and other natural supports during a crisis as appropriate and within limits of confidentiality.

WHAT ARE THE PRINCIPLES OF THE INTEGRATED CRISIS RESPONSE SYSTEM?

1. Crisis services include voluntary and involuntary service options.
2. Crisis services are delivered across social service systems in a fully integrated, seamless and consistent manner.
3. A person in crisis is treated as a whole person, rather than focusing on categorical problems.
4. A crisis is self-defined, rather than needing to meet categorical criteria.
5. A person in crisis will have easy and timely access to appropriate attention and care.
6. Clinicians involved in crisis response intervention will be able to refer to a complete continuum of care in order to respond to a variety of needs.
7. A person in crisis will be referred to the least restrictive resource available to effectively manage the crisis.
8. Crisis response services are community-based.
9. Crisis response services are available to both adults and children.
10. Crisis services and information will be available 24 hours a day, 365 days a year through the region.
11. Crisis services will be fully integrated and coordinated at both the local and regional level.
12. All crisis services will be culturally competent and responsive.
13. Standards of care will be adhered to throughout the region.

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

14. Individuals experiencing a psychiatric crisis will be stabilized in the least restrictive setting, in the person's home or in any in vivo setting.
15. Crisis services will be provided in a seamless manner recognizing the uniqueness of each individual case.
16. The integrated crisis system will utilize a flexible array of services and supports, formal and informal, which fit the needs of the individual.
17. The integrated crisis system will be responsive and supportive of family members and persons experiencing a crisis.

WHAT TOOLS ARE AVAILABLE FOR MANAGING CRISES?

Crisis Plans:

The crisis plan is a document that the consumer's outpatient clinician develops in collaboration with the consumer and his/her family and/or other natural supports. The plan is intended to help both the consumer and the clinician in the event that the consumer experiences a crisis during treatment. Working together, the outpatient clinician and the consumer "anticipate" potential problems that might create a crisis for the consumer. The outpatient clinician helps the consumer identify his/her specific triggers or "red flags", early warning signs that alert the consumer that trouble may be developing. The outpatient clinician and the consumer then make a plan for what the consumer will do when he/she sees these early warning signs. The plan starts with low intensity interventions that the consumer can probably accomplish on their own, then progresses to interventions of increasing intensity that include family, natural supports, and possibly professional staff. A copy of the crisis plan is kept in the consumer's chart, a copy is given to the consumer, a copy is given to identified family or natural supports with the consumer's approval, and an electronic copy is available to the VOA Care Crisis Response Services. If the consumer or a family member/natural support calls the Crisis Line during a crisis, the staff can access the crisis plan and provide assistance based on the information in the crisis plan. When responding to a crisis, clinicians, Volunteers of America Care Crisis, and crisis services workers will continue to work with family members and other natural supports to best support the consumer within limits of confidentiality.

Crisis Alerts:

Crisis alerts contain important information about individuals already receiving services who are in a current crisis state and who have been identified as likely to require crisis services within the next 10 days. Crisis alerts are created by a clinician and contain information pertinent to the current crisis situation, in contrast to crisis plans, which contain long term strategies. VOA Care Crisis Response Services receives, stores, and utilizes this time-sensitive information, and makes it available to emergency mental health clinicians and DMHP/DCR staff when necessary. Crisis alerts should contain up-to-date information that helps emergency mental health clinicians assess risk and conduct intervention strategies based on the most current and accurate information available. Crisis alerts are kept on file for 10 days.

Mental Health Advance Directives:

A written document, consistent with the provisions of RCW 71.32, in which a person makes a declaration of instructions or preferences and/or appoints an agent to make decisions on her or his

behalf regarding that person's mental health treatment during times when he or she is incapacitated by a mental disorder and cannot give informed consent.

If the outpatient clinician has received a consumer's advance directive, it will become part of the consumer's medical record and the outpatient clinician will be considered to have actual knowledge of its contents. The outpatient and emergency mental health clinician must act in accordance with the directive to the fullest extent possible, unless compliance would violate the accepted standard of care established in RCW 7.70.40, the requested treatment is not available, compliance would violate applicable law, or it is an emergency situation and compliance would endanger any person's life or health. More information regarding compliance and conditions for noncompliance can be found in RCW 71.32.150.

Wellness Recovery Action Plan (WRAP):

This is a program designed by Mary Ellen Copeland in the 1990s after she interviewed hundreds of people with mental illness. They described their strategies for getting by on a daily basis, while experiencing psychiatric symptoms.

A written document created by the consumer, which provides structure that helps the person monitor uncomfortable and distressing symptoms and plan responses to those situations. It also includes plans for responses from others who serve as supports, when the symptoms make it impossible for the person to continue to make decisions, take care of themselves and keep themselves safe.

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

WHAT IS THE ROLE OF THE VOA CARE CRISIS RESPONSE SERVICES?

VOA Crisis Line Services:

VOA Care Crisis Response Services provides the 24-hour a day, 7 day a week, professionally staffed crisis line system. When someone calls the crisis line in distress and is seeking assistance with a crisis situation, he/she should call the Crisis Line at 1-800-584-3578. Crisis line staff are mental health clinicians who accept calls from the general public and other professionals. They provide a range of support and referral services including,

A. Screening calls and passing acute situations to the Triage Clinician
B. Making requested mental health referrals to the community
C. Having access to language bank interpreters and TDD equipment
D. Assuring referral to age and culturally appropriate services and specialists
E. Scheduling crisis appointments
F. Providing telephone stabilization and intervention services for non-acute consumers

VOA Triage Services:

VOA Care Crisis Response Services Triage Clinicians are Masters-level mental health professionals. When a professional wishes to speak with someone at the crisis line, they can

contact the Triage Clinician directly at 1-800-747-8654. Triage Clinicians perform all of the following functions:

A. Assure timely and consistent crisis response.
B. Provide telephone consultation, intervention and stabilization for consumers and/or family members/natural supports as appropriate and within limits of confidentiality.
C. Determine when face-to-face services are needed, both voluntary and involuntary, and dispatch a DMHP/DCR or emergency mental health clinician.
D. Track the outcome of face-to-face services and see if further services are warranted.
E. Decide when cross-system services are needed.
F. Decide when joint outreach between voluntary and involuntary services is indicated.
G. Work closely with law enforcement when appropriate.
H. Consult with detox providers, nursing homes, hospitals and other community providers.
I. Troubleshoot cross-system referrals in which there is a difference of opinion of appropriate services or system response.
J. Provide telephone follow-up with consumers after-hours as part of an individual crisis plan

Emergency mental health clinicians and DMHP/DCRs may not decline a referral for services from the Triage Clinician.

WHAT FACE-TO-FACE SERVICES ARE AVAILABLE?

Crisis Services Appointments:

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

Emergency Psychiatric Services:

Emergency psychiatric medication evaluations are available on a one-time basis for those that have been assessed by an emergency mental health clinician or DMHP/DCR and deemed at risk of imminent hospitalization.

Voluntary Outreach:

Outreach is the provision of face-to-face evaluation and/or intervention services (voluntary or involuntary) in community locations. The expectation is that all clinicians providing crisis response services will give first consideration to taking services to the person in crisis before requesting that the person present themselves at a facility to receive services. Outreach services are an important and available service, both when necessary to support the person in crisis and to provide services in the least restrictive, appropriate manner, with the use of family and natural

supports within limits of confidentiality. The intent, however, is never to promote outreach at the expense of anyone's safety – including consumer, staff, family/natural support, and the public.

Emergency mental health clinicians must respond to pages from the VOA within 10 minutes. Once dispatched, the emergency mental health clinician must be on-site with the person in crisis within 2 hours. Within 1 hour following the completion of any outreach, the emergency mental health clinician calls the Triage Clinician to relay the disposition of the case back to the Triage Clinician and, when appropriate, the referral source.

Specialized Services for Children and Families:

A. Skagit County:

Skagit County manages children's crisis primarily through the position of Children's Crisis Response Specialist. The Children's Crisis Response Specialist currently works from 9:30 a.m.-6:00 p.m. Monday through Friday. The Children's Crisis Response Specialist is the first response to children/adolescent crisis calls coming in through Care Crisis Response Services. This clinician, trained in child crisis intervention and stabilization, travels to multiple settings, performs an assessment of risk, consults with appropriate others and provides alternatives to hospitalization whenever possible using behavioral aides, urgent follow up, natural supports, and remediation of the causes leading to crisis. During off-hours, DMHP/DCR or emergency mental health clinicians handle children's crises.

B. Snohomish County:

The Compass Health Children's Crisis Team (CCT) provides crisis services to Snohomish County consumers ages 0-17. The CCT provides a full range of voluntary services to children and their families, including phone intervention, outreach, and in-office appointments. When a child is a consumer of Compass Health, the CCT is the primary responder to crisis events after-hours and provides back up for the child's treatment team when crisis events occur during business hours. Cases are rarely held by clinicians of the CCT, but are quickly referred to ongoing services and supports.

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

For adults who are enrolled with the DDD, there are additional services that are available during times of crisis. This includes the availability of crisis stabilization aides to provide additional support and safety in the person's home (including residential programs). Crisis stabilization aides can also be accessed to provide additional staff support during an inpatient stay when necessary to facilitate admission to a local inpatient facility. Crisis stabilization aides can be accessed during the business day through the DD Crisis Stabilization staff at Compass Health or by calling the VOA Triage Clinician. Region 3 DDD also has access to a Hospital Diversion bed located in North Seattle. Referrals for hospital diversion bed services should be made to the DDD Mental Health/Developmental Disability Resource Manager.

During evenings, weekends and holidays, services through this program are accessed through DMHP/DCRs and emergency mental health clinicians. All of these programs can be accessed through the VOA Triage Clinician.

Note: These services are only available to adults (18 years of age or older) who are currently enrolled with the Division of Developmental Disabilities. Information about enrollment status is available through the VOA Triage Supervisor.

WHAT RESIDENTIALLY BASED CRISIS SERVICES EXIST IN THE REGION?

Crisis respite facilities for adults are located in Whatcom, Skagit, and Snohomish counties. These programs typically provide short-term support (up to 5 days) in a staffed facility for adults who are in or at high risk of experiencing a mental health crisis. The programs in Whatcom and Skagit Counties are also able to provide limited (non-medical) detoxification services for chemically abusing or dependent individuals. When an outpatient clinician believes that their consumer would benefit from crisis respite, they may call the facility directly to make the referral. After hours, the emergency mental health clinician will facilitate the referral. Staff at each facility are trained to review the presenting information and establish whether placement is appropriate.

A. Whatcom County Behavioral Health Triage Center (WCBHTC)

Pioneer Human Services and Whatcom Counseling and Psychiatric Clinic operate the Triage Center. It is located in Bellingham in the same building as the minimum-security jail. It provides 24-hour emergency outpatient response services to all Whatcom County residents experiencing a mental health or substance abuse crisis. The facility provides a single point of access to mental health crisis assessment and stabilization and chemical dependency crisis assessment and treatment referral services including: crisis intervention counseling, mental health and substance abuse crisis screening and assessment, crisis stabilization, referral to services such as psychiatric hospitalization and ITA evaluation, admission to Substance Abuse Protective Custody (SAPC; up to an eight-hour hold), admission to Social Detox Unit (up to five days), admission to crisis respite (up to five days). To use the services an individual must be 18 years of age, voluntary, in crisis and/or intoxicated or in withdrawal from alcohol or other substances, noncombative, capable of being calmed by others, and not requiring medical care.

B. Compass Health Crisis Respite Facilities

The Skagit County Behavioral Health Crisis Center and Compass Health Crisis Beds provide short-term stabilization services for individuals who are experiencing an acute mental health crisis or are intoxicated and require detoxification services. A Mental Health Professional or medical professional will evaluate and refer these consumers for admission. Both facilities are non-medical, community-based programs that offer a less restrictive placement option than inpatient hospitalization. The duration of stay can range from one to five days; the need for continued services will be evaluated on a daily basis.

Referral Process for Mental Health Placement:

- A Mental Health Professional or a clinician completes a face-to-face assessment. If crisis respite is deemed to be the best option, the referral source will assess whether the

consumer meets the inclusion/exclusion criteria.

- The referral source will contact either facility regarding the availability and the appropriateness of the placement.
- If the placement is appropriate and the facility agrees to accept the consumer, the referral source would then complete the necessary documentation.

Referral Process for Sub Acute Detoxification Placement (Skagit County Crisis Center only):

- Sub Acute Detoxification placement is only offered at our Skagit County Behavioral Crisis Center. As with other non-medical, detoxification service facilities, Skagit County Behavioral Health Crisis Center is unable to accept consumers that are detoxing from benzodiazepines or barbiturates.
- A face-to-face assessment is necessary and completed by medical personnel to determine the appropriateness of placement in a non-medical setting.
- The referral source will then contact the Skagit County Behavioral Health Crisis Center regarding the availability and the appropriateness (review inclusion/exclusion criteria) of the placement.
- If the placement is appropriate and the Skagit County Behavioral Health Crisis Center agrees to accept the consumer, the referral source or Skagit County Behavioral Health Crisis Center staff will arrange for appropriate transportation.
- Skagit County Behavioral Health Crisis Center is a combined facility for both mental health and chemical dependency consumers. We are unable to accept consumers that are sexual offenders, violent, assaultive or have a history of fire setting.

Length of Stay/Discharge Planning:

- The length of stay is limited; up to 5 days
- The discharge planning will be completed at the time of initial placement

WHAT IS THE PROCESS FOR PSYCHIATRIC HOSPITALIZATION?

Voluntary Hospitalization:

The VOA Hospital Certification Team provides pre-certification for voluntary psychiatric hospitalization for all Medicaid and Medicaid-eligible residents of the North Sound region. The program is available 24 hours per day, 7 days per week. When a clinician feels that the consumer they have assessed requires psychiatric hospitalization they must first contact a psychiatric hospital and secure a bed. Once a bed has been identified, but before admission, the assessing clinician must call 1-800-707-4656 and request the certification. The assessing clinician will have to provide clinical and demographic information and be prepared to discuss whether less restrictive options might meet the client's needs. If the consumer meets medical necessity criteria the hospitalization episode will be certified and arrangements for admission can be made.

Assessments for Involuntary Treatment:

Persons who are alleged to be a danger to themselves or others or are gravely disabled (unable to take care of their basic needs) as the result of a mental disorder or chemical dependency may be assessed for involuntary treatment. DMHP/DCRs do all assessments for involuntary treatment. In assessing whether or not a person should be detained against their will to an inpatient psychiatric

unit or secure detoxification facility, DMHP/DCRs focus their evaluations on the following questions:

A. Is the person suffering from a mental disorder or chemical dependency? RCW 71.05.020(22) defines mental disorder as "any organic, mental or emotional disorder which has substantial adverse effects on an individual's cognitive and volitional functions." RCW 70.96b.010(5) defines chemical dependency as "alcoholism, drug addiction or dependence on alcohol and one or more psychoactive chemicals, as the context requires."

B. Is there evidence that the person, as the result of mental disorder or chemical dependency:

   (1) Presents a likelihood of serious harm to him or herself, other persons, or the property of others; or
   (2) May be gravely disabled?

C. Does an imminent danger exist?

   (1) According to 71.05.150(2), a DMHP/DCR should take a person into emergency custody only when the person presents an imminent likelihood of serious harm or is in imminent danger because they are gravely disabled.
   (2) Before filing the petition, the DMHP/DCR must personally interview the person, unless the person refuses an interview, and determine whether the person will voluntarily receive appropriate evaluation and treatment at an evaluation and treatment facility, a detoxification facility or other certified chemical dependency provider.

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

   (1) If the person does meet criteria for detention, but no imminent danger exists, then the DMHP/DCR may initiate a non-emergent detention by petitioning the superior court for an order directing the referred person to appear at an inpatient evaluation and treatment facility, certified detoxification facility, or outpatient treatment provider within 24 hours after the order is served. RCW 71.05.150(1). Note: Imminent danger is not required for the emergency detention of minors.

E. What appropriate alternatives to involuntary hospitalization exist? Will the person voluntarily accept appropriate, available, less-restrictive treatment options? RCW 71.05.150 (1)(a), RCW 71.34.050, and RCW 70.96b.050(b)(i)(A).

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

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

When a person is detained, he or she is entitled to a court hearing within 72 hours of the initial detention. This is called a probable cause hearing. Weekends and holidays are excluded in the calculation of the initial 72 hours. The focus of the probable cause hearing is to determine if the person continues to require involuntary treatment by meeting detention criteria. Based on testimony and other available information, the court will determine one of the following outcomes of the hearing:

A. Order the detention on an inpatient basis for an additional period of up to 14 days;

B. Order the person to a 90-day Less Restrictive Order ("LRO"); or

C. Dismiss the petition.

WHAT HAPPENS AFTER AN INVOLUNTARY ADMISSION TAKES PLACE?

Court Orders (Less Restrictive Order and Conditional Release):

Once an involuntary admission takes place, the person being detained is entitled to a judicial hearing within 72 hours (*note: usually this excludes weekends and holidays).* This hearing is used to determine whether the initial commitment was appropriate and, if so, does the person still present a danger to themselves or others as the result of a mental disorder. Family member/natural support input is generally encouraged in preparation for these hearings. The judge has the option of continuing the detention, discharging the individual back home on a voluntary basis, or releasing the person on a Less Restrictive Order (LRO), also known as a Less Restrictive Alternative (LRA). An LRO is a court order telling the patient and mental health professionals what things need to occur or not occur for the person to remain in the community. These are called the "conditions" of the Less Restrictive Order. Examples include not using non-prescribed drugs, not using alcohol, refraining from threats or acts of harm toward themselves or others, attending mental health appointments and not having access to weapons.

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

There is another type of court order called a Conditional Release (CR). When an individual is committed to the hospital for 14 days or 90 days (this is called the MRO, More Restrictive Order) the treating physician can decide to discharge the person on a CR. He/she must have an accepting outpatient provider to follow up on the CR. The physician writes a document outlining the conditions the person agrees to follow. This document is given to the receiving outpatient provider, the individual on the CR and is filed with the court. There is not a court hearing with a CR as there is with an LRO.

Sometimes, however, people either do not follow through on the conditions of their LRO/CR or experience substantial deterioration in their functioning even when following the conditions. Under these circumstances, a DMHP/DCR can return the person to the inpatient unit. This is called a "revocation" of a Less Restrictive Order or Conditional Release. If such an assessment is needed, DMHP/DCRs are accessed by calling the Volunteers of America Crisis Triage Supervisor.

When serving a person on a LRO/CR, it is required to keep a copy of the court document listing the conditions in the clinical record. It is important to provide this document to the DMHP/DCR if requested. It is also necessary that the person communicating with the DMHP/DCR has specific knowledge about how the person on the LRO/CR has violated the order, problems they have experienced that are causing the concerns, and what steps have been taken or considered to help support the person in a less restrictive way. This information is crucial in determining whether a revocation is appropriate and necessary. Family members/natural supports are often the first persons to identify the consumer's non-adherence or deterioration and can share this information with the clinician without compromising confidentiality requirements. If the consumer has not authorized the release of information, the clinician may simply listen to the family's concerns without revealing protected information.

A revocation occurs when someone on an LRO/CR is returned to an inpatient unit. They are entitled to a court hearing within 5 days and, in many ways, this hearing is similar to the one leading to the initial release. Whenever possible, the person will be stabilized and released back to where they were living, often on another LRO.

Integrated Crisis Response NSMHA Training Module

Post-Test

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

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

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

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

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

5. T / F When Designated Mental Health Professionals/Designated Crisis Responders are doing an assessment for initial detention they are required to consider reasonably available history.

6. T / F When someone is on a Less Restrictive Order or Conditional Release, it is not important to keep a copy of the order.

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

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

For enrolled consumers needing voluntary crisis response services, please list the following parties in order of their responsibility for serving the consumer. 1 (first option), 2 (second option) or 3 (back-up):

_____ The treatment team
_____ The outpatient clinician
_____ Crisis Response staff

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

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

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

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

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

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

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

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

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

Key for Integrated Crisis Response Services NSMHA Training Module

True/False Questions

1. F Consumers should be instructed to call the Crisis Line, not the Triage Clinician
2. T
3. F Persons who are not enrolled in services are also eligible for crisis services appointments
4. T
5. T
6. F Clinicians should retain access to a copy of the Less Restrictive Order/Conditional Release
7. T
8. F Hearings must be held within 72 hours (excluding weekends and holidays)

Rank Order Question

1 = Outpatient clinician, 2 = Treatment team, 3 = Crisis Response staff

Fill-in Questions

1. 2

2. A non-emergent detention

3. Conditions

4. Revocation

Quality Management Oversight Committee Charter
Revision proposed 10/4/07, contingently accepted for 6 months

The Quality Management Oversight Committee (QMOC) is a standing committee of the NSMHA Board of Directors. It is responsible for the oversight of quality management systems of the entire NSMHA, and for reviewing all quality management activities and making recommendations for quality improvement to the Board. QMOC ensures the gathering and analysis of data and reports to recognize the need for improvement or change (as outlined in the Quality Management Work Plan).

The Quality Management Oversight Committee (QMOC) is chaired by a Member of the Board of Directors (or designated alternate). Two Members of the Board of Directors (or designated alternates) are voting members of QMOC.
Other voting members are:

- Six members nominated by the NSMHA Advisory Board, at least two of whom shall be current Advisory Board members, and of the six, membership must include a minimum of two current consumers. Facilitation and support will be provided to assist consumers to participate if needed.
- One Quality Review Team (QRT) member
- One Ombuds representative
- Three County Coordinators who report QMOC activities to colleague county coordinators who then report to their Advisory Boards
- NSMHA's Quality Manager (staff to the committee)
- Representatives of contracted providers from diverse geographic and service populations who deliver services in each of the five counties.
- In addition, NSMHA would ask our Tribal Committee to appoint a representative to QMOC

Because of the important role of this Board committee in the oversight of NSMHA's Quality Management program, members of the committee are expected to participate in an orientation session upon joining the committee, attend a majority of meetings unless excused by the Chair, and review all meeting materials.

Members of the Quality Management Oversight Committee are approved annually by the Board of Directors. The Committee meets at least quarterly. Subcommittees of QMOC will meet as often as needed to accomplish their tasks in a timely manner.

The Quality Management Oversight Committee is accountable for:

- Overseeing the development, approval, and evaluation of the biennial NSRSN Quality Management Plan, including its submission to the Board of Directors for adoption, as well as any needed revisions
- Reviewing and recommending action on reports from contracted service providers or the NSMHA Quality Management Committee
- Reviewing the data from providers' measurement tools
- Making recommendations to all providers on actions to be taken
- Reviewing the NSMHA quarterly and biennial quarter reports related to concurrent/retrospective reviews, consumer and advocate reports and reports on performance indicators; makes recommendations
- Keeping attendance and minutes of all QMOC and subcommittee meetings