Integrated Crisis System Policy

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Document Scope: (applies to Policy & Procedure only)

- – The requirements herein apply only to the GCBH BH-ASO Central Office and its functions.
- X The requirements herein apply, verbatim, to GCBH BH-ASO and its network providers[2].
- – The requirements herein apply to both GCBH BH-ASO and its network providers[2]. Additionally, network providers must have internal documents outlining their processes for implementing the requirements, insofar as they relate to actions for which network providers are responsible.

PURPOSE: To provide Greater Columbia Behavioral Health (GCBH BH-ASO BH-ASO) with clearly defined standards for the provision of crisis services; the oversight of crisis services; and the expected outcomes for provision of crisis care and to ensure compliance with RCW 71.24, 71.34, and 71.05; WAC 182-538D, WAC 182-100, HCA Contracts and Washington State Medicaid Waiver.

POLICY

I. Crisis System Values:

A. The GCBH BH-ASO Executive Committee is the single point of accountability for all GCBH BH-ASO funded services, including crisis services.

B. Crisis services are provided in a seamless manner throughout GCBH BH-ASO, guaranteeing timely access to crisis care.

C. Crisis Services and Information regarding all crisis line numbers is available 24 hours a day, 7 days a week, 365 days a year.

D. Crisis services are provided in a manner that is consistent with the concepts of recovery, choice, and individual needs.

E. Crisis services are culturally competent and responsive in the service recipient's language of choice. These services are provided in a manner that respects the service recipient's culture.

F. Crisis services are available to all persons needing mental health and substance use disorder crisis services regardless of their ability to pay, insurance, age, sex, minority status, status with the GCBH BH-ASO, allied system of care relationship, or place of residency. Insurance status, whether the person has insurance such as Medicaid, or has no coverage shall make no difference in a person receiving the full range of crisis services available to anyone covered by GCBH BH-ASO.

G. Individuals experiencing a psychiatric or substance use disorder crisis are stabilized in the most appropriate clinical setting, preferably in the community and in a voluntary manner.

[1]See definitions of document types in AD100, "Development, Approval & Review of Formal GCBH BH-ASO Documents"
[2]"Network Provider" – An organization with which GCBH BH-ASO is contracted for the provision of direct services.

H. Crisis services are responsive to and supportive of family members of persons experiencing a crisis. This includes obtaining collateral information from family members when available and appropriate.

I. Crisis services build upon existing systems of crisis provision, reflect innovation, and strive for best practices (quality of care). This includes applying aspects of the Practice Guidelines adopted by GCBH BH-ASO.

1. Staff shall have access to consultation with professionals such as psychiatrists, physicians, or ARNP who have at least one year's experience in the direct treatment of individuals who have a mental or emotional disorder:

J. Crisis services available throughout GCBH BH-ASO shall include, but are not limited to, the following:

1. Answering all calls with a live voice within 30 seconds.
2. Providing crisis counseling, support, and stabilization.
3. Scheduling next day appointments when appropriate.
4. Tracking the outcomes of face-to face services
5. Ensuring that age and culturally appropriate service/specialists are contacted at all critical junctures, having access to language bank interpreters and TDD equipment.

K. Crisis line access to emergent and non-emergent acute care:

1. Information regarding local crisis line numbers used to access acute care throughout GCBH BH-ASO is available through local law enforcement agencies, local hospitals, and in local telephone directories.
2. All local crisis line numbers are responded to by a person who is trained in the provision of crisis services, allowing for initial response via an answering service.
3. The individual requesting, or being referred for crisis services, shall receive a telephone call from a trained mental health crisis staff within 15 minutes.

L. Mobile Outreach Services. Crisis outreach shall be expected:

1. Mobile crisis outreach will respond within two (2) hours of the referral to an emergent crisis and within 24 hours for referral to an urgent crisis.
2. Face-to-face, and services are provided by crisis outreach unless telephone intervention can successfully stabilize the individual.
3. When clinically indicated or when the service recipient has no means to get to a clinic or emergency room, the crisis response staff will take services directly to the individual in crisis, stabilizing and supporting the person until the crisis is resolved or an appropriate referral is made.
4. Face to face evaluation and/or other interventions shall be required when requested by:
   a. GCBH BH-ASO Clinical staff

b. Law Enforcement

c. Designated Crisis Responder

d. Hospital Emergency Staff

e. Mental Health Outpatient Providers

f. Substance Use Disorder Treatment Services Providers

g. Detox Staff

h. Residential Providers

i. School Teachers/Counselors

j. Providers of Inpatient Psychiatric Services

k. Hospital Staff

l. Primary Care Physicians

M. Mobile Crisis Response (MCR) services:

1. Federal Block Grant (FBG) stimulus funds are to be used to enhance mobile crisis services by adding Certified Peer Counselors (CPCs)

   a. Existing MCR teams should have a minimum of one CPC

      i) CPCs are required to complete HCA's CPC continuing education curriculum for peer services in crisis environments

      ii) MCR team supervisors of CPCs must complete HCA's sponsored Operationalizing Peer Support training for supervisors

   b. GCBH must submit a quarterly Mobile Crisis Block Grant Stimulus report to HCA to include:

      i) A description of the aggregate number of individuals served by CPCs

      ii) A narrative describing success and challenges

N. Services are provided in the most natural, least restrictive, safest, and most appropriate environment possible. When feasible, voluntary services will be provided as the preferred approach to providing such Crisis services. Crisis services should reflect the following:

1. Services will include providing crisis telephone screening as defined WAC 246-341-0670.
2. Crisis outreach staff shall work collaboratively with mental health and substance use disorder treatment services/programs, serving adults and children in an age and culturally competent manner. All crisis services will be under the clinical supervision of a mental health professional and/or an independent practitioner licensed by department of health.
3. Services to approve and/or facilitate admission to a crisis bed.

4. Outreach services will be available face-to-face by a mental health professional, or a staff member under the supervision of a mental health professional with documented training in crisis response 24 hours a day, 7 days a week, 365 days a year.
5. Outreach workers will begin to formulate a crisis treatment plan based upon the array of options available at the time of crisis. When available, an existing Crisis Plan will be utilized.
6. When there is a question of safety, outreach services shall be provided in coordination with law enforcement or other mental health support.
7. A "no decline" policy will be enforced for both Designated Crisis Responder and Crisis Outreach Workers.

   Note: "No decline" means that when a Designated Crisis Responder or designated crisis outreach person is requested by persons identified in 3 b) above, they may not refuse to provide crisis services regardless of the person's age, culture, or ability to pay.

8. Safety of the Designated Crisis Responder (DCR)

   a. No DCR, or crisis intervention worker shall be required to respond to a private home or other private location to stabilize or treat a person in crisis, or to evaluate a person for potential detention under the state's involuntary treatment act unless a second trained individual accompanies them.

   b. The clinical team supervisor, on-call supervisor, or the individual professionally acting alone based on a risk assessment for potential violence shall determine the need for a second individual to accompany them.

   c. The second individual may be a law enforcement officer, a mental health professional, a DCR, a mental health paraprofessional who has received training that is compliant with HCA contracts, or other first responder, such as fire or ambulance personnel.

   d. No retaliation may be taken against individuals who, following consultation with the clinical team or supervisor refuse to go to a private home or other private location alone.

   e. All crisis providers must have a plan to provide training, mental health and SUD staff back-up, information sharing, and communication for crisis outreach staff who respond to private homes or other private locations. This will include annual violence prevention training on the safety and violence prevention topics described in RCW 49.19.030. The staff member's personnel record must document the training.

   f. Every mental health professional, or DCR who is dispatched on a crisis visit, as described in HCA contracts, has access to information about any history of dangerousness or potential dangerousness on the individual they are being sent to evaluate that is documented in crisis plans or commitment records and is

available without unduly delaying a crisis response. This would include access to an individual's crisis plan.

g. Every mental health professional, or DCR who is dispatched on a crisis visit is provided by their employer with a wireless telephone, or comparable device for the purpose of emergency communication as described in RCW 71.05.710

9. Communication Services (Crisis Telephonic Support Services)

   a. Any GCBH BH-ASO crisis provider delivering telephone support services must:

      I. Respond to crisis calls twenty-four-hours-a-day, seven-days-a week.

      II. Have a written protocol for the referral of an individual to a voluntary or involuntary treatment facility for admission on a seven-day-a-week, twenty-four-hour-a-day basis, including arrangements for contacting the designated mental health professional.

      III. Assure communication and coordination with the individual's mental health care provider, if indicated and appropriate.

      IV. Post a copy of the statement of individual rights in a location visible to staff and agency volunteers.

   b. Documentation of Crisis Services

      I. Communication service (Crisis Telephonic Support Services) documentation will include (at a minimum):

         a. The date, time, and duration of the telephone call;

         b. The relationship of the caller to the person in crisis, for example self, family member, or friend;

         c. Whether the individual in crisis has a crisis plan; and

         d. The outcome of the call, including:

            i. Any follow-up contacts made;

            ii. The name of the staff person who took the crisis call.

      II. Crisis Response Contacts documentation will include (at a minimum):

         a. The date, time, and location of the initial contact.

         b. The source of referral or identity of caller.

         c. The nature of the crisis (brief summary of circumstances).

         d. The name of the participants,

e. Whether the individual has a crisis plan and any attempts to obtain a copy.

f. The time elapsed from the initial contact to the face-to-face response.

g. The outcome, including:

i. The basis for a decision not to respond in person if applicable;

ii. Any follow-up contacts made; and

iii. Any referrals for services made, including referrals to emergency medical services

iv. The name of the staff person(s) who responded to the crisis.

10. Care Coordination Post Stabilization. Once the crisis is stabilized, GCBH BH-ASO and its providers will ensure a consistent and appropriate follow-up process for the individual.

11. Crisis Respite Services:

a. Crisis Respite Services will be available to avoid more restrictive levels of care.

b. Crisis respite beds will be accessible and available 24 hours a day, 7 days a week, as an alternate to more restrictive interventions (through the GCBH BH-ASO Level of Care Standard, access procedures will be uniform throughout the GCBH BH-ASO region).

c. Crisis Respite Services will include acute crisis respite (for children and adults) and planned respite.

12. Para-professional Stabilization Services (such as Peer Counselors), when available, may be provided:

a. When the person in crisis (as assessed by a Designated Crisis Responder or qualified crisis outreach worker) requires ongoing supervision to maintain safety, basic medication compliance, or necessary activities of daily living necessary to avoid grave disability and/or further decompensation;

b. When there is a high risk that the person may lose their current residence or require a higher level of care without this service;

c. When recipient's symptoms would likely exacerbate if placed in a crisis respite bed; or

d. When the crisis episode can be expected to resolve or be transferred back to the primary agency within 24 hours.

13. Designated Crisis Responder (DCR) Services. As defined in RCWs 71.05 and 71.34, and WAC 246-341, Involuntary Treatment Act responsibilities are required.

O. Contractual Requirements:

1. All service providers contracting with GCBH BH-ASO to provide crisis services shall adhere to applicable WACs including WAC 246-341 and will be completed when clinically appropriate.

2. *GCBH BH-ASO will at a minimum annually assure compliance with these contractual requirements through on-site audits, desk audits, review etc.*

P. Ancillary Requirements of the GCBH BH-ASO Crisis System:

1. Staff are identified by name, title and organization name when initiating or returning calls regarding UM issues.

2. All GCBH BH-ASO providers of crisis services shall document at a minimum the following elements:

   a. A brief summary of each crisis service encounter, including the date, time, and duration of the encounter;

   b. The name of the participants,

   c. And a follow-up plan, including any referrals for services, as well as emergency medical services as indicated.

3. All GCBH BH-ASO providers of crisis services shall demonstrate concrete evidence of their efforts to maintain functional working relationships with: local law enforcement, local hospitals, allied systems of care (Developmental Disabilities Division, Division of Children and Family Services, etc.), homeless services, and correctional facilities.

4. Crisis services to the Yakama Nation will be provided on and off the Reservation.

5. All GCBH BH-ASO providers of crisis services shall use an appropriate method, such as their electronic health record, to record the fact of contact with each person, where, when and which crisis services they received, care coordination provided and their demographic and clinical information.

6. All GCBH BH-ASO providers of crisis services shall provide evidence of and demonstrate an ability to transmit that data to GCBH BH-ASO, per contract terms, to meet all data requirements of timely and complete reporting of such services and individual information.

II. Integration in/with GCBH BH-ASO Quality Assurance:

The following mechanisms and parameters shall be used to monitor crisis system efficiency, effectiveness, and satisfaction:

A. The GCBH BH-ASO will survey allied systems of care and family members who utilize crisis services. Surveys will determine the level of satisfaction. Resulting data will also go to the QMOC for analysis which will in turn make recommendations to the Executive Committee of GCBH BH-ASO.

B. Crisis response efficiency and effectiveness will also be monitored based on desired outcomes listed below in Section E.1. of this standard. GCBH BH-ASO will also monitor crisis services to assess effectiveness of hospital diversion,

ability to stabilize at the least restrictive level of care possible, ability to provide culturally relevant care (as evidenced by utilization of translator services and cultural specialists), and ability to maintain the individual in the community.

C. The GCBH BH-ASO Crisis Level of Care Criteria provides standardized clinical criteria to determine the most appropriate level of care needed for each individual in crisis.

D. The QMOC and GCBH BH-ASO Utilization Management Services (UMS) shall be responsible for ensuring that the appropriate clinical criteria are followed and the crisis interventions are evaluated by Utilization Management Services based on objective criteria as developed in a review protocol or instrument.

E. GCBH BH-ASO will ensure crisis providers are adherent to both contract and applicable policies by using a variety of methods:

1. Together, these monitoring activities will ensure:
    a. Provision of effective and appropriate types of outreach services;
    b. Compliance with clinical necessity guidelines and conformance to GCBH BH-ASO Level of Care Standards;
    c. Adherence to the "no decline" policy;
    d. Crisis Plans are complete and accessible throughout GCBH BH-ASO;
    e. Effective and efficient coordination with allied systems of care;
    f. Appropriate assessment, triage, and hospital referral processes are followed including the evaluation of information from collateral informants such as family members, guardians or other system participants (police, social services workers, medical providers, etc.);
    g. Services are age, culturally, and linguistically appropriate and that specialists and interpreters are used when indicated and required; and;
    h. Where appropriate, that the requests of persons in crisis are respected.

III. Integration of Crisis Care with Allied Systems of Care:

The GCBH BH-ASO crisis delivery system works with all allied systems of care, especially the Developmental Disabilities Division, to ensure the GCBH BH-ASO community and crisis recipient are kept safe and maintained in the least restrictive environment possible. Crisis services also work with local law enforcement, community mental health programs, SUD treatment providers, hospitals, shelters, and homeless services.

APPROVAL

Karen Richardson or Sindi Saunders, Co-Directors — Date 10/9/2024