North Sound Mental Health Administration Crisis System Review Final Report

March 30, 2010

MCPP Healthcare Consulting

Table of Contents

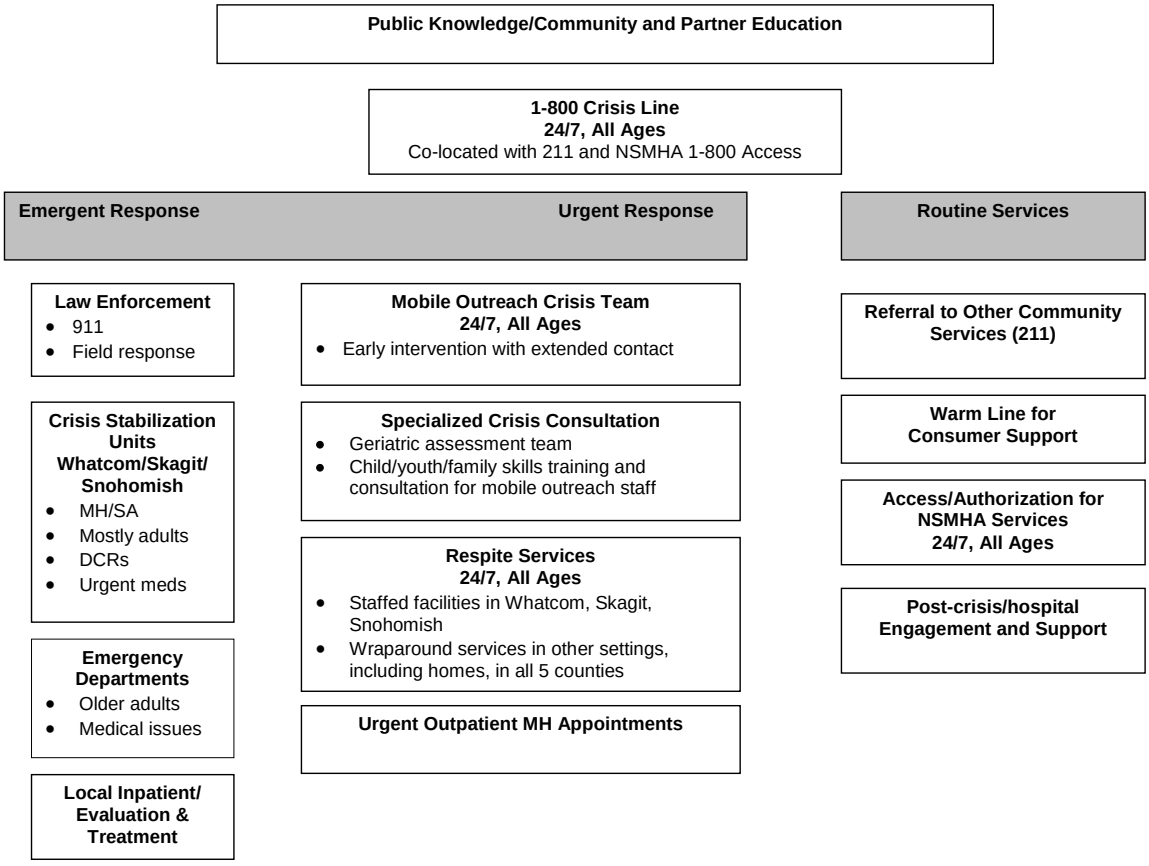
Background 1
Using This Report 1
Public Knowledge/Community and Partner Education 2
Crisis Telephone 3
Law Enforcement 4
Crisis Transportation 5
Mobile Outreach Crisis Team 5
Specialized Crisis Consultation 7
Designated Mental Health Professional/Crisis Responder 8
Crisis Stabilization Unit 8
Respite 9
Emergency Departments 11
Community Inpatient/Evaluation & Treatment 11
Connection to Ongoing Mental Health and Substance Abuse Services 12
Specific Recommendations for Ongoing Care for Children/Youth and Families 13
Specific Recommendations for Ongoing Care for Older Adults 14
Specific Recommendations for Ongoing Partnership with Criminal Justice 14
Workforce Development 14
Budget Analyses 15
Next Steps 16
Attachment A: Summary of What Works Well 18
Attachment B: Notes from Law Enforcement Forum 20
Attachment C: Acronyms 22
Attachment D: Federal IMD Exclusion 23
Attachment E: The Crisis Stabilization Unit Legislation and Regulations 25
Attachment F: King County Crisis Diversion Facility 28
Attachment G: Pierce County Then and Now 34
Attachment H: Multnohmah County Crisis Redesign and Inpatient Utilization 39
Attachment I: Involuntary Treatment Act Amendments in 2010 Session 42
Attachment J: Budget Summaries 43
Attachment K: Data Summary 45

Background

In late fall of 2009, the North Sound Mental Health Administration (NSMHA) convened a broad cross section of stakeholders from the network's five counties to collectively review the crisis system and recommend actions for the future. A series of six four-hour meetings was held, each attended by more than 50 participants, including representation from the counties, law enforcement, hospitals, provider agencies, consumers and advocates. A special forum for law enforcement agencies in the five counties was also well attended, with almost every agency represented.

The review process started by asking the participants to identify what has worked well about the key elements in the crisis/acute care system and what needs to be improved in both the mental health (MH) and substance abuse (SA) systems. The diagram below summarizes the components that are described for a future crisis/acute care system.

The NSMHA/Counties Regional Crisis System



Using This Report

This report is organized by the components of the crisis/acute system. Each component is briefly discussed (although some have more backup detail in the attachments) and recommended actions (73 in total) are listed.

- Public knowledge/community and partner education (four recommendations)
- Crisis telephone (four recommendations)
- Law enforcement (six recommendations)

- Crisis transportation (one recommendation)
- Mobile outreach crisis team (five recommendations)
- Specialized crisis consultation (five recommendations)
- Designated mental health responder/crisis responder (two recommendations)
- Crisis stabilization unit (six recommendations)
- Respite (seven recommendations)
- Emergency departments (four recommendations)
- Community inpatient/evaluation & treatment (six recommendations)
- Connection to ongoing mental health and substance abuse services (eight overall recommendations, with additional recommendations specific to child/youth and families (six), older adults (2), and partnership with criminal justice (3)

The discussion of each component is followed by discussions regarding workforce development (four recommendations) and budget analyses.

Throughout the review process, data was used to understand the current system and forecast a future system. The summary of what works well is in Attachment A, a summary of the Law Enforcement Forum is in Attachment B. Attachment C is a list of acronyms. Additional attachments provide an overview of relevant federal and state regulations, crisis initiatives in other counties, and a summary of budget analyses and data.

During the meetings, review of the data, and discussion of improvements, it was important to reflect on an adage from the Institute for Healthcare Improvement: *Every system is perfectly designed to achieve the results that it gets.* This is to say that individual employees, provider agencies and partner agencies are generally doing the best job they can within the system as it is designed and resourced. If improvements are to occur, “the system” needs to decide how it wants to provide services, how cases are handled, who has priority, what services will be available and then redesign policies and protocols to align with those priorities. Given the restricted resources within the Washington State MH/SA systems, difficult choices will need to be made, with changes to be implemented over time. The intent of the design process described here is to describe a blueprint for priorities and their implementation over the next several years, working within the projected available resources.

Throughout there are recommendations regarding *formal adoption of consistent protocols across the five-county region and with system partners*—many of these can be developed and implemented in the current environment, while others will not be necessary until new service capacities are developed. References to consistent *protocols* are always in *italics.*

Public Knowledge/Community and Partner Education

There is currently no formal public information activity regarding regional crisis services. Implementation of new types of crisis services will require that the public and partner agencies understand what is available and how to appropriately access crisis services.

Recommended actions include:

1. Implement an initial public education campaign regarding crisis telephone services, 211, and, for Medicaid enrollees, NSMHA access line and other aspects of NSMHA services. Once mobile outreach crisis teams and crisis stabilization units (CSUs) are in place, initiate a major public education/social marketing campaign.
2. For primary care practitioners (PCPs), seek informal inclusion of the NSMHA region in the Partnership Access Line and provide PCPs with information about how to obtain child psychiatry consultation through this system.
3. For Law Enforcement (LE), expand Crisis Intervention Training (CIT) to all first responders in the five counties (and investigate the possibility of a briefer, consolidated curriculum) and seek more training on MH/SA issues at the academy level.
4. Establish closer collaboration between the counties and NSMHA in system planning (e.g., for NSMHA funding and the counties' plans for 0.1% sales tax funding). The counties each have adopted plans for use of the 0.1% funds; where there are recommendations for use of these funds to expand or support certain components of the crisis system, the recommendations would have to be considered for the future, balanced against other priorities identified by stakeholders in each of the counties.

Crisis Telephone

There are multiple 911 dispatch units in the five county NSMHA region, each of which interacts with the crisis system and its telephone hub, operated by Volunteers of America (VOA). VOA operates the crisis telephone system within the policies and priorities that have been established by NSMHA.

Recommended actions include:

5. Develop *consistent protocols* between VOA and all 911 dispatch units (with training to accompany) that address these and other questions:
   - What is the role of 911 versus VOA?
   - How does 911 sort between criminal justice issues versus mental health issues?
   - Which calls could be transferred from 911 to VOA rather than to LE?
   - What information will VOA give 911 when requesting LE response?
6. Establish VOA *protocols and scripts* that assure consistent responses while balancing the need for responsiveness and flexibility, addressing:
   - Information on what to expect and how to talk to 911, if being directed to them; address the perception that callers must know the "magic words"
   - Criteria for a hand off to LE and the key information to gather and share with LE
   - About what services are available from which agencies
   - About direct access to designated crisis responders (DCRs) for first responders
   - Determine is there is different process for community callers vs. professional callers (LE, service provider, MDs)
   - Customize by county to reflect specific resources available (or not) in that county
7. Develop *new protocols* to support system as CSUs are developed
   - Direct community/families/callers to CSU rather than to emergency departments (EDs), including walk-ins
   - Direct to EDs if there is a significant medical issue

    - Process for dispatch of DCRs in addition to being accessed at CSUs—outreach to jails, EDs if patient already there
    - Collaborative relationship with mobile outreach crisis teams and CSUs
8. Provide more time on the phone for those needing support
    - Develop warm line in collaboration with peer drop in centers

Law Enforcement

There are 49 law enforcement agencies in the NSMHA region. In all five counties there are: Washington State Patrol, US Border Patrol, US Forest Service, and WA Fish & Game. There are eight in Skagit (includes three tribal police departments), twenty-four in Snohomish (includes two tribal departments & US Navy), one in San Juan, five in Island (includes US Navy), and seven in Whatcom. Recent data gathered from LE agencies gives us, for example, a snapshot of Whatcom County:

- About 90% of offenders in the Whatcom County Jail have SA issues, about 24% have MH conditions
- The Whatcom County Sheriff estimates that several calls a week relate to MH/SA conditions, requiring an average of an hour of intervention (not counting the extensive stand-by time at the ED or waiting for the DMHP), at an average cost of $50/hour for a single officer
- The Bellingham Police report that, from the beginning of 2010 through March 9, they responded to 204 calls that were MH related and 116 calls that were SA related, none of which were presented as a criminal or disturbance request. Most of these required a two-person response, at costs similar to those described above. Additionally, Bellingham has started tracking use of force involving individuals with MH issues. This year so far 7 of the 23 use of force incidents involved those with MH issues (4 related to criminal activity, 3 related to ITA custody)
- The Ferndale Police have about 3 MH/SA calls a month, the majority of which require a 2-person response, for an average time of 2 hours, at costs similar to those described above
- The Washington State Department of Corrections supervises parolees across the five-county region and reports that, almost every day, there is an interaction with an offender with a MH condition that is on the edge of needing hospitalization—when at this crisis stage, two officers are involved in the trip to the hospital and waiting for the evaluation (about 4 hours at a cost per hour of $75). If they are unable to arrange for hospitalization, the individual may instead be incarcerated at a cost of $75-100/day

The LE agencies attending the LE Forum indicated their willingness to collect data on the impact of MH/SA responses to their agencies; however, few have the current capacity to do so. In responding to the survey that generated the data above, many expressed willingness to do so in the future, which suggests the development of a standard data tracking approach to inform future policy decisions.

The overall challenge is to develop improved communication with dispatch systems supporting these agencies (see crisis telephone) and with front line officers, especially as the crisis system phases in new approaches. As noted in Community and Partner Education above, expansion of CIT training for all first responders is recommended.

Recommended actions include:

9. Develop standardized data tracking across LE agencies to quantify the volume of activity and track the impact of implementing new crisis system components
10. Work to bridge different cultures and languages
11. Establish *consistent protocols* for when first responders request assist and for when mobile crisis outreach teams (or DCR) needs assist (protocols should address children/youth, adults and older adults, as response approaches will vary)
12. Create more partnerships for joint outreach—DCRs with first responders
13. Develop *consistent protocols* with EDs regarding communication with LE regarding patients who eventually are not admitted (NSMHA might play a convening role with EDs and LE agencies)
14. When CSUs are in place, develop *new protocols* for when LE takes into custody and brings to CSU (per SSB 5533 and would need to coordinate with prosecuting attorneys to develop consistent approaches across the region) versus taking to jail or ED

Crisis Transportation

The issue to be addressed is mostly that of moving people to/from crisis locations to other services (for example, LE may bring a person to the ED, but then transport is needed to get to respite or some other community resource). The response should be to develop alternative mechanisms that work within the specifics of each county. Transportation issues are most pressing for San Juan and Island counties, followed by east of the I-5 corridor in Snohomish, Skagit, and Whatcom counties.

Currently, because most individuals are being transported pursuant to a 72 hour detention, these costs are covered, even when being transported to a hospital when a medical crisis might arise while detained, and then back to the E&T or back to a psychiatric unit. In changing the paradigm to provide early, voluntary interventions, transportation cost could be detrimental to consumers. As the revised crisis system is phased in, transportation issues should be carefully monitored and assessed, to assure that reasonable community solutions are developed.

Recommended actions include:

15. Budget flex funds for individual community solutions

Mobile Outreach Crisis Team

Currently, only Snohomish County has mobile outreach capacity that is focused on voluntary engagement rather than ITA assessment. In the future, with a new paradigm, most mobile outreach would be targeted to earlier intervention, not to ITA assessment, and DCRs would function principally at CSUs where their work would be expedited due to mobile teams' prior work with community and family.

Recommended actions include:

16. Create Mobile Outreach Crisis Teams that go to homes and other community settings

- Mobile outreach would be 24/7 and provide an early level of intervention (teams may vary to include peers) responding to both enrolled and unenrolled persons
- Mobile outreach teams would be co-located with the crisis stabilization units recommended for Whatcom, Skagit, and Snohomish counties
- Currently there is on-call mobile outreach/DCR capacity in both San Juan and Island counties—this coverage should be maintained, and these staff included in training to implement the new paradigm of early intervention rather than ITA focus
- Mobile outreach would activate short term crisis case management—partnering with other systems and supports—to facilitate voluntary admissions and/or provide extended intervention until the person is connected with ongoing resources
- Mobile outreach would have a longer time frame to connect with appropriate resources for individuals who are not enrolled in NSMHA services
- When the Geriatric Assessment team for older adults becomes available, it will serve as a consulting resource to mobile outreach; similarly, training and consultation will be established to develop skills for mobile services to children, youth and families
- There is currently a special contract with NSMHA to provide urgent assessment services for adults who are enrolled clients of the Division of Developmental Disabilities (DDD)—the crisis system also needs to develop competence in serving children and adults with developmental disabilities, who may or may not be enrolled in DDD services, and the current urgent assessment service could be used as a consulting resource in order to develop the skills needed to serve the population with developmental disabilities

17. Develop *consistent protocols* for:
    - Lower level of criteria for outreach with safety assessment
    - Addressing violence (e.g., PACT/intensive outpatient examples)
    - Timing in the reading of rights (use statewide protocols)
18. Develop mechanisms to bill insurance for mobile outreach services—as healthcare reform is implemented, there will be more coverage of the population and the costs of these services should not be borne solely by Medicaid and state funding
19. Develop mechanisms and *consistent protocols* for communication among providers based on HB2025, passed in the 2009 legislative session:

    Treatment records of a person may be released without informed written consent in the following circumstances [new language follows]: (i) Consistent with the requirements of the health information portability and accountability act, to a licensed mental health professional…or a health care professional…who is providing care to a person, or to whom a person has been referred for evaluation or treatment, to assure coordinated care and treatment of that person. Psychotherapy notes, as defined in 45 CFR Sec 164.501, may not be released without authorization of the person who is the subject of the request for release of information…(j) To administrative and office support staff designated to obtain medical records for those licensed professionals listed in (i) of this subsection.

20. Use peer/parent partners on teams and bring their strengths to the process, including making follow-up calls to individuals that have received crisis services—currently there are parent partners serving on child and family wraparound teams

Specialized Crisis Consultation

The demand forecasts and budget constraints suggest the need for specialized training and consultation as a regional resource—providing this support to the mobile outreach component of the system.

Recommended actions include:

21. Implement a regional Geriatric Assessment Team to provide non-24/7 outreach and assessment for older adults in the community, in private homes and in facilities. In addition to outreach and assessment, services would include targeted training and consultation for:
    - Hospitals/EDs
    - Dementia facilities
    - Skilled nursing facilities (SNFs)
    - Adult family homes (AFHs)
    - Mobile outreach staff

    The King County geriatric team includes a RN, geriatric MH specialist, social worker, occupational therapist, SA professional and a part-time consulting psychiatrist
22. For older adults living alone and isolated, not voluntarily seeking services, work to support their current living setting rather than removing them
23. Collaborate with Adult Protective Services (APS) to develop *consistent protocols* for shared clients (e.g., assessment, planning, ongoing communication)

The planning group discussed reviving a Family Assessment and Stabilization Team (FAST) or FAST-like program for children/youth and families that is 24/7, integrated with wraparound and other high intensity child services and implemented in partnership with Children's Administration (CA). FAST is a crisis stabilization service intended to provide rapid and intensive response to families and children/youth in crisis resulting in improved stability, prevention of hospitalization and/or out of home placement, access to ongoing community supports, and increased family connections. Services include: initial outreach followed by 90 days of intensive services; foster home beds available for up to 72 hour respite; and, transition into appropriate level of ongoing care.

In an extended discussion with NSMHA staff and county human services coordinators, it was recognized that the size and distance logistics in providing FAST-like capacity across the region made a single regional team not feasible. While economies of scale for service demand and budget constraints preclude multiple FAST-like teams, it would be unfair to focus such a resource on only one part of the region. It was determined that adding child/youth and family capacity into mobile outreach would result in more rapid response and ability to follow the child/youth/family for a period of time until they were integrated into local services and supports. To be successful, mobile outreach teams will need specialized training and consultation in the models for intervention with

children/youth and families and knowledge of the child/youth and family resources in the community.

Recommended actions include:

24. Ensure that mobile outreach capacity includes child specialists across the region
25. Establish formal training and consultation capacity to support mobile outreach in their services to children, youth and families

Designated Mental Health Professional/Crisis Responder

With a change in the paradigm of mobile outreach, the DCR function would be located within CSUs. Because the intent of the CSU is to change the public and LE pattern of going to Emergency Departments, most ITA assessments would take place at the CSU. DCRs would continue to respond to jails for ITA assessments, to EDs (with reduced frequency) and would go into the field, often partnered with LE, if requested by mobile outreach or based on other protocol criteria.

Recommended actions include:

26. Establish the DCR function within the staffed operations of the CSUs (e.g., as employees)
27. Develop *consistent protocols* for:
    - Reading of rights (use statewide protocols)
    - Interpretation of what meets ITA criteria
    - Dispatch criteria for DCR outreach (e.g., EDs, jails, DCR with LE)

Crisis Stabilization Unit

There is no current facility that meets state CSU certification requirements in the NSMHA region. (See Attachment E for an overview of the enabling CSU legislation and WACs, Attachment F for details about King County's planned implementation and Attachment G for a description of Pierce County's current operation as the first certified CSU in Washington.) Established pursuant to SSB 5533, a CSU:

- Operates 24/7
- Is essentially an E&T level of licensure (residential treatment)
- Can be a portion of a facility licensed as E&T or hospital, so it would be feasible to co-locate a CSU and E&T

According to the legislation, law enforcement can bring a person directly to the CSU when:

- The individual committed a non-felony crime that is not a serious offence [based on standards agreed upon with the prosecuting attorney] and is known to suffer from a mental disorder
- There is cause to believe that the person is suffering from mental disorder and presents imminent likelihood of serious harm or is in imminent danger because of being gravely disabled

The person must be seen by a mental health professional within 3 hours of arrival and, within 12 hours, a DMHP/DCR must determine if the individual meets detention criteria.

Recommended actions Include:

28. Establish CSUs in Whatcom, Skagit, and Snohomish counties (which if sited properly, might also serve Island and San Juan counties). Use the CSUs as regional resources, to maximize crisis supports within the five county NSMHA region.
29. Make the CSUs the new point of entry to the crisis system (rather than EDs) welcoming families and consumer walk-ins, voluntary and involuntary individuals.
    - Assure a wide open door (not triaged by age, voluntary/involuntary, payor source or MH/SA status)
    - Include a welcoming, peer component at the front door
    - Put best staff up front as triage
    - Take a wholistic approach, work to engage individuals
    - Don't confront with ITA and rights at beginning of the process
    - Include DCR function on staff at CSU
30. Develop the following capacities:
    - Centralized shared information (among CSUs/DCRs, VOA, mobile outreach crisis teams)
    - Admission criteria (no cherry picking)
    - Immediate access to medications
    - Substance abuse service capacity/detox, co-occurring disorders
    - Deal with violent individuals, safely able to use restraint and seclusion, security that doesn't count on calling LE
    - Properly staffed/trained with ability to manage in crisis mode, with force as the last option
    - Staff to initiate treatment and engage people with ongoing treatment, housing supports and other aftercare services (manage the revolving door)
    - Alerts to current providers to engage in follow up planning
    - Address medication seeking (see EDs)
31. Build *consistent protocols* regarding:
    - Referral from community agencies
    - Criteria and process for LE drop off and follow up communication
    - Dealing with prior criminal history
32. Co-locate the Snohomish, Skagit, and Whatcom mobile outreach teams with the CSUs, to build a consistent systemic approach to crisis services and community partnerships.
33. Develop mechanisms to bill insurance for CSU services—as healthcare reform is implemented, there will be more coverage of the population and the costs of these services should not be borne solely by Medicaid and state funding

Respite

In addition to the CSU capacity there is a continued need for respite capacity, both facility and non-facility-based services. Current respite capacity includes:

- Whatcom
    - 13 beds (5 MH crisis, 8 detox)
    - There are physical facility issues (bays rather than rooms) and concerns about mix and safety
- Skagit

    - 11 beds integrated w/ subacute detox
    - MH side has access criteria (perceptions of difficulty in getting people in), admission issues are related to having double rooms, not mixing MH and SA or M and F, which leaves second beds frequently blocked
    - Staffed with entry level staff
- Everett
    - 16 beds (doubles and some single)
    - Work with PACT, step-down from E&T, WSH, IP
    - Staffed with entry level staff

Recommended actions include:

34. Retain current facility capacity and develop additional non-facility-based and smaller or mobile respite resources. Use the facilities as regional resources, to maximize crisis supports within the five county NSMHA region
    - Facility-based model with 24/7 staff (with peers in the staff mix) is needed, but need certain volumes to sustain
    - Add expanded menu of respite: a mix of home-based services, “crisis homes” for 1-2 days, peer supported apartments
    - Formalize the non-facility respite model and expectations, and operationalize the relationship to outreach services and ongoing care providers.
35. For San Juan
    - SNF with crisis bed, motel room, “crisis homes,” supported by some additional staffing
    - Available on more than one island
36. For Island
    - SNF with crisis bed, motel room, “crisis homes,” supported by some additional staffing
    - Crisis apartment with peer support
37. For Skagit, Whatcom, Snohomish rural areas east of I-5
    - Need same as Island and San Juan
38. For Children/Youth and Families
    - Age range from 3-18
    - Need different environments, less facility-based, goal of keeping in child/youth in out-of-home care for no more than 72 hours
    - Need respite that is not accessed through Children’s Administration
39. For Older Adults
    - Need different environments, less facility based, goal of keeping person in out-of-home care for no more than 72 hours
40. Establish *consistent protocols*
    - Admission criteria and rule outs (no cherry picking, accept challenging behaviors)
    - Medical clearance rules and processes
    - For some populations to “step over” to respite (without going to ED or CSU) via mobile outreach or current service provider
    - Work with housing agencies to hold housing while person is stabilized so they have a place to come back to after discharge

Emergency Departments
The intent of the recommendations above is to open multiple doors into the system rather than using EDs as the gateway to the system for people in crisis.

The current practice of using the EDs places heavy demands on them, and creates large volumes of uncompensated care. There are nine hospital emergency departments in the NSMHA five-county region (1 in Whatcom, 3 in Skagit, 4 in Snohomish and 1 in Island). Two of the four hospitals serving Snohomish County (Providence and Cascade Valley) reported a total of 5,527 visits for MH/SA conditions during the period 7/1/08-6/30/09. Sixty-nine percent of these visits (3,787) were Medicaid (1,758), Medicare (1,006) and self-pay [e.g., uninsured] (1,023). Providence's overall uncompensated costs of care were more then $3 million. In Skagit, one of the three hospitals (Skagit Valley) reported 5,647 MH/SA visits in the same time period, of which 2,205 were Medicaid, 807 were Medicare, and 1,217 were self-pay. The uncompensated care for the self-pay population alone amounted to over $2.4 million.

If mobile outreach, CSUs and more respite existed, this would change the future role of the EDs, refocusing on medical needs, and truly triaging, not holding. Changing current practices will require consistent training, outreach and communications with EDs.

Recommended actions include:
41. Change the culture of coming first to the ED for MH/SA conditions. Educate the community and key partner agencies. There are relationships that consumers have with EDs and ED staff, and this would need to be addressed
42. Establish a continued ED role to address medication seeking and provision of case management for medication seekers
43. Consider a focused crisis role for serving older adults, given the mix of medical, dementia, and MH/SA issues; detox is needed for elderly, medically involved people, but should be medically backed up
44. When CSUs are in place, develop *new protocols* for transfers from the ED to the CSU and communication between the CSUs and EDs.

Community Inpatient/Evaluation & Treatment
According to a 2008 Washington State Hospital Association Report, the state has insufficient psychiatric inpatient bed capacity.

> *In 2000, 28 community hospitals provided 799 community hospital inpatient mental health beds. Because of financial losses and other challenges between 2000 and 2006, Washington State experienced an 18 percent reduction in community inpatient hospital mental health bed capacity, dropping from 799 to 657 total psychiatric beds. As of today, 637 inpatient mental health beds are available in 23 community hospitals to serve our state's mental health population, slightly lower than in 2006, while the population and demand for services have continued to grow. Of these available beds, only 361 (57 percent) are in hospitals certified by the Washington State Division of Mental Health for involuntary treatment admissions.*

In the 2010 legislative session, SSHB3076 was passed to amend RCW 71.05, the Involuntary Treatment Act, broadening the criteria for detention (see Attachment I for a summary). Testimony regarding the bill pointed out that there are currently insufficient inpatient beds. The fiscal note observes that an accurate estimate of the increase resulting from the legislation is not possible and reported that RSNs estimated two to five percent increased detentions, which has been taken into account in the budget forecasts accompanying this report.

Individuals spend time "boarding" in EDs because there are not beds available anywhere in the state. There is a concern that people are diverted into the criminal justice system because of lack of access to acute care. What is not known is what the demand for IP service would be if there were other alternatives available in the crisis/acute care system. Financing of new crisis services could come from reductions in IP utilization (Attachment H summarizes Multnomah County's experience with such a paradigm shift). The goal should be to work with hospitals in the five-county region to address IP needs whenever possible within the region.

Recommended actions include:

45. Reduce transport to out-of-region beds through focused use of local capacity (currently all children/youth, and a portion of adults/older adults are hospitalized out of region)
46. Collaborate with existing inpatient units to develop appropriate inpatient care for persons with dementia (E&Ts are not designed for their care), and services for children and youth
47. Ensure bi-lingual and bi-cultural capacity
48. For San Juan's critical access hospital in 2011, design a safe, secure space for crisis hold and/or single bed certification and seek similar arrangement in Island county
49. Develop improvements in operations of IP/E&Ts including:
    - Peer staffing in E&Ts
    - Reductions in seclusion and restraint
    - Family involvement
50. Housing options need to be developed for post crisis/inpatient care (transitional and permanent)

Connection to Ongoing Mental Health and Substance Abuse Services

The data analyzed suggests that enrolled Medicaid consumers as well as unenrolled and non-Medicaid individuals have not been engaged in sufficiently intense services to avoid a crisis, or provided with timely follow up and engagement after an inpatient stay. A focus on those at risk of hospitalization or coming back from hospitalization is needed in the delivery of ongoing outpatient services. NSMHA has increased the capacity for intensive services in the outpatient system in recent years, but more focused care for those at-risk and not in intensive outpatient services is needed.

Recommended actions include:

51. Provide defined follow-up services post CSU, respite, and/or inpatient stay to assure that individuals become engaged or re-engaged in ongoing outpatient services
52. Develop *consistent protocols* for contacts between case managers/clinicians and CSU/E&T/IP and priority for follow up care
    - Proactive referrals from IP/E&T staff
    - In-hospital assessment and link to services; there was some discussion of a specialized follow-up capacity, especially for those not enrolled (for example, Skagit has funded an Extended Outreach Engagement Program)
    - Add certified peers to help engage people into services
    - Engage family members/supports
    - For those with multiple IP stays, add an additional component into the plan after each successive admission
    - Focus on transitions across systems
    - Keep VOA in the loop so they can track plans
53. For enrolled clients, PACT and intensive outpatient teams are accountable to manage crisis 24/7 and do outreach to current clients
    - Short-term intensive services to avert or resolve a crisis
    - Outreach to community, to IP, joint outreach with DCR
54. For other enrolled clients, provider must make contact within 3 business days of notification of IP admission
55. Use the rehabilitation case management code and federal block grant to fund work with new, unenrolled clients needing better links from IP to OP
    - Daily evaluation of status
    - Advance planning for discharge
    - Meet provider prior to discharge
56. Consider possible use of 0.1% sales tax funding for post crisis/IP follow-up MH case management for unenrollable clients
57. Weave SA into the crisis response system and create capacity for immediate SA follow up appointments—use 0.1% sales tax funding to expand SA access and case manager follow up after crisis as Skagit has done
58. Expand SA treatment options

In addition, there were a number of specific recommendations for improving the system of ongoing care that could reduce the necessity for a crisis/acute response.

Specific Recommendations for Ongoing Care for Children/Youth and Families

59. Coordinate care planning among all child-serving systems, including crisis planning, include family/adolescent so information is shared across systems with their consent
    - County-based Community Team model with joint funding from child-serving systems
60. Improve advance crisis planning and a single on-line source for all crisis plans
61. Develop *consistent protocols* across all child-serving systems regarding crisis response accountabilities
62. Use flex funds to support expansion of treatment aides, looking at how this might be combined with expanded staffing of mobile outreach, respite and CSUs
63. Develop school-based therapeutic day program with ESD as partner

64. Expand NAMI Basics program for families of children/youth into all five counties

Specific Recommendations for Ongoing Care for Older Adults

The loss of geropsych and exclusion of dementia from outpatient Access to Care standards, results in many older adults in EDs and E&Ts with few placement options.

65. In addition to dementia, there are depression, PTSD, and SA conditions to be addressed. Older adults are not currently accessing the MH system; developing primary care based MH/SA services could help address this need
66. Expand the ECS program (which can serve dementia patients) in all five counties, with hospital diversion and jails as referral sources, in partnership with ADSA and in coordination with older adult programs funded by Federal Block Grant in three counties

Specific Recommendations for Ongoing Partnership with Criminal Justice

67. Develop *consistent protocols* between jails, counties, NSMHA and providers:
- See protocols for dispatch of DCRs
- Jail health screening includes questions regarding current or past enrollment in MH/SA services
- Current MH/SA providers should be coordinating discharge planning with jail staff, proactive planning process
- Jails need to problem solve access for providers

68. Revisit *expedited procedures* to improve prioritization of lost Medicaid prior to jail discharge (CSOs have cut staffing and slowed the process down considerably)
69. Develop *consistent protocols* between juvenile detention, counties, NSMHA and providers per above

Workforce Development

One of the implications of expanding the acute/crisis system is identifying individuals with the required credentials to fill expanded positions (for example, there are crisis/DCR positions that have been posted, but vacant for as long as a year).

One of the strategies used by NSMHA providers is to create linkages with universities and community colleges with related training curricula, to encourage training placements and internships, creating a future pipeline for staff in the MH system. NSMHA might consider working with providers and educators throughout the five county NSMHA region in a formal workforce development alliance.

Recommended actions include:

70. Partner with providers and educators in the region to develop a more formal set of initiatives that will grow future staff capacity for the NSMHA system

Related to this potential initiative is the development of certified peer counselors to work in CSUs, mobile outreach, respite and in the delivery of ongoing outpatient services.

Certified Peer Counselors are people who have experienced mental illness themselves and are on their own recovery journey. Certified Peer Counselors are well grounded in

their own recovery and model competency in ongoing coping skills. They help people identify goals that promote recovery and resiliency and assist them in identifying services and activities to help them reach these goals. Medicaid has rules about the mental health services they will pay for—in order for a mental health agency to be reimbursed for "peer support services," the peer support person must be certified by the State of Washington as a Certified Peer Support Counselor. To be certified as a Peer Counselor a person must meet these criteria:

- Self-identify as a consumer who is receiving or has received mental health services. For a child under the age of thirteen, or for a child age thirteen or older whose parents or legal guardians are involved in the treatment plan, the definition of consumer includes parents or legal guardians. The mental health services they have received can be either privately funded (insurance) or publicly funded (Medicaid)
- Demonstrate that they have been well grounded in their own mental health recovery for at least one year at the time of application
- Receive specialized training approved by the state Mental Health Division—the training is free
- Pass a written and oral exam administered by the state Mental Health Division—the exam is free
- Register with the Washington State Department of Health as a Registered Counselor. To do this, one must also take a 3 or 4-hour class about Acquired Immune Deficiency Syndrome—there is a fee to register
- Pass a Washington State criminal background check—free.

The state Mental Health Division sponsors the Peer Counselor training state-wide. King County provides Peer Counselor training approved by the Washington State Mental Health Division. One of the local North Sound community colleges offers a curriculum to prepare consumers for the certified peer role.

Recommended actions include:

71. Develop additional capacity in local community colleges to provide certified peer counselor training that is also recognized by the state
72. Develop a module to train parents and caregivers as family partners prepared to serve families, children, and youth receiving MH services
73. Address other barriers related to increasing the number of certified peer counselors

One issue is the requirement that certified peer counselors must have an agency affiliation in order to receive the Registered Counselor designation by the State Department of Health. In past years, substantial criticism was directed at the Registered Counselor credential, and, as a result, requirements were strengthened. Consumers who have completed the peer counseling curriculum will need to identify an agency-affiliated position in order to fully function as a Certified Peer Counselor. This requirement may not be well understood in the consumer community and should be included in materials regarding Certified Peer Counselor opportunities.

Budget Analyses

Accompanying this report is a set of service forecasts and budget analyses that project the costs of implementing the proposed crisis/acute care system. The analyses include five separate documents.

Service forecasts for 2013, by county and for the NSMHA region, provide information on current and projected utilization of the major system components described in this report.

- Service forecasts related to youth aged 0 through 17
- Service forecasts related to adults aged 18 and older

Budget forecasts are included for each of the major system components, rolled up for the NSMHA region and compared to anticipated revenues. All dollars are 2010 values, to provide comparable information about spending patterns. (Budget summaries are in Attachment J.)

- Scenario A includes a forecast of Medicaid expansion revenue, funds the major system components and projects savings in the purchase of community inpatient beds to offset a portion of the expanded crisis system, leaving a shortfall of $7.8 million
- Scenario B uses Scenario A as a starting point, scales back the increases in mobile outreach capacity and evening DCR coverage, funds CSUs in Snohomish and Whatcom only, eliminates post crisis/hospital engagement services, and reduces funding for non-facility respite, resulting in a breakeven budget

Next Steps

The report and the budget analyses will be presented to the NSMHA Planning Committee and Board for review and action. Upon action by the Board, the following steps are recommended to create a phased implementation plan that will map out the transition to a new system over the next four years:

- Establish a small (10-12 people) implementation team that reports to the Planning Committee and includes NSMHA, county, provider, and consumer/advocate representation
- Review each of the recommendations and assign to one of four timeframes:
  - From April 2010 through June 2011
  - From July 2011 through June 2012
  - From July 2012 through June 2013
  - From July 2013 through June 2014
- Determine whether a recommendation in a future timeframe requires development of additional information and understanding as a context for proceeding on the plan (for example, making a field visit to the Pierce CSU) and add to the current (first) time frame
- Determine whether a recommendation can proceed on its own, or if it is tied to another recommendation having been completed first, and note the connection
- For each recommendation in the current timeframe, establish the key steps to implementation: What (is to be done), by Who, by When

- Review this analysis with the Planning Committee and Board and, upon adoption, proceed with implementation pursuant to Planning Committee and Board oversight

Attachment A: Summary of What Works Well

Public Knowledge/Community and Partner Education
- VOA does Crisis Intervention Training (CIT) in Skagit and Snohomish
- Very high level of Law Enforcement (LE) commitment; more involvement on agency boards than ever before (and big turnout to the LE Forum)

Crisis Telephone
- 911 dispatchers can and do make warm transfers
- 911 system is pretty consistent across the region
- Current regional system is best in the state, covers the small counties, is centralized and staffed with professionals
- Family member can call in and start a file on patients who are escalating—VOA can build a history of past contacts, even if the person isn't enrolled
- Provides immediate suicide intervention and assist people enrolled to alleviate emergent issues
- Great resource for other professionals in the community
- Refers families to NAMI (for family support and help)
- Connected to 211and Access lines so any call can be transferred to Crisis and vice-versa

Law Enforcement
- Strong working relationships to help ensure safety of crisis staff
- Law enforcement is responsive; when we call, they'll show up
- Willing and committed to establishing a better relationship
- Interdisciplinary team with a Community Service Officer in Mt. Vernon

Mobile Outreach, Specialized Teams
- PACT and intensive OP teams have 24/7 crisis responsibility
- For those not served by intensive teams, mobile outreach is available in Snohomish

Designated Mental Health Professionals/Crisis Responders
- DCRs are committed and compassionate, skilled as assessors and at working with people in crisis
- Increasing willingness to send DCRs to the crisis facilities, other sites in the community other than the EDs as a site to do outreach
- Appreciate the response times in light of the number of cases they are handling
- DCRs were trained to find the SA connection and have that skill set now

Crisis Stabilization Unit
- No current CSU in the NSMHA region

Respite (facility, non-facility)
- Fortunate to have a hospital diversion resource in Whatcom, Skagit and Snohomish
- In Skagit and Whatcom, crisis centers can respond to both MH/SU, having workers with skills in both is very useful

- Available as a step down for the hospitals including Western State

Emergency Departments
- They treat the families and the patients as human beings and listen
- Good partnerships are in place
- Appreciate the struggle with trying to meet the needs of those being boarded waiting for an IP bed and working to keep them safe.

Community Inpatient/Evaluation & Treatment
- Appreciate that hospitals are keeping capacity, even in light of losing money
- Doing single bed certifications in some locations can help

Connection to Ongoing Mental Health and Substance Abuse Services
- Urgent MH appointments are available as follow up to crisis
- Skagit used 0.1% sales tax funding to expand SA treatment on demand beyond DASA system and to fund CM follow up after crisis center contact or ED contact
- Skagit has implemented High Intensity Outreach team to reach out to those who refuse services post ED or IP
- Whatcom has social detox and a mobile assist van

Ongoing Partnership with Criminal Justice
- NSMHA passes jail services funding through to the counties, counties staff jail assessments and link up to services, notify providers
- Skagit uses 0.1% sales tax funding for jail MH/SU services, crisis triage and counseling
- Whatcom has dually licensed MH/SU staff in jail transition and jail crisis staff

Attachment B: Notes from Law Enforcement Forum

On 1/8/2010, representatives of the 49 law enforcement agencies were invited to a special forum to discuss the crisis review process and the ideas that were being discussed. The following notes summarize the discussion.

Overarching Law Enforcement (LE) issues and concerns

- Need to address changes in RCWs (legislative issue)
- Access to IP services (a statewide issue)
- EDs get filled up, individuals may be detainable, but no E&T/IP bed capacity
- Tying up LE resources because MH resources aren't available (could improve this locally with CSU model)
- Practice of "no harm" contracts that results in releases to the street

The CSU sounds like a good idea, but to be effective it should:

- Not cherry pick who is admitted
- Not revolve the door
- Be prepared to deal with violent individuals
- Have protocols for dealing with prior criminal history
- Treat alcohol and drug issues (SA)
- Create centralized, shared information (there is no central repository for ITA history)
- If releasing, appraise LE
- Create consistent protocols for ITA
- Build credibility with LE on street—this comes from their experience of the system, not through training (e.g., Whatcom crisis center not seen as helpful)
- Similarly, crisis respite should:
  - Not cherry pick
  - Accept challenging behaviors
  - Establish clear protocols and rule outs

Improving the relationship between VOA, 911, LE, DCRs

- Network with LE, build trust
  - Build interactions between 911 dispatch and VOA
  - LE calls should not be screened
  - Need to improve communication
- Frustration with VOA and DCRs
  - VOA had pushed back on jail referrals
  - Call screening by VOA
  - DCRs not dispatched to field, LE told to take to ED (in Wenatchee, Yakima they go out, often with LE)
  - Not enough information to LE when asked to go out
  - VOA or ED determines whether to involve DCR—3rd party gatekeeper undermines trust
  - In old days DCR would go out to screen
- Dual crisis system in Snohomish Isn't effective, reduces credibility

- Decrease the complexity / Keep it simple

Support joint outreach of DCR and LE?
- Yes, consider doing joint outreach w/DCR and LE
- Would have to assure availability of DCRs in a timely manner, increase response times
- Downside of joint LE response, if there are warrants, need to act

Joint Session of LE Forum with Crisis Review Working Group
What are child/ youth issues?
- Need better dialogue with judicial system
- Lack of bed space
- Need specialized outreach team for kids (had one in Snohomish in the past)

What level of care do we need at CSU?
- Restrain and seclude safely
  - EDs don't have the right facilities
- Training and ability to manage in a crisis mode (force should be the last option)
- Proper staffing
- Don't call LE as security at triage or E&T
- Need protocol to rapidly medicate
- Setting and presence makes a difference
  - LE uniform can help or hurt

LE and MH/SA speak different languages and have different cultures
- Provide LE with information on the support that is needed
- Regarding ITA detainability—the requirement of imminence (not congruent with LE requirements of probable cause)
- Need to meet and talk more often

Notification from EDs to LE if individual is being released
- Interpretation is, if officer stays, still in custody and will release back
- If officer leaves, the ED has custody and works within HIPAA requirements
- There is specific RCW language regarding callback to LE, but hospital attorneys say that HIPAA overrides
- Need to create an agreed upon communication protocol
- Build a better, more streamlined partnership between LE and VOA

Attachment C: Acronyms

AFH	Adult Family Home
APS	Adult Protective Services
ARNP	Advanced Registered Nurse Practitioner
BH	Behavioral Health
CIT	Crisis Intervention Training
CSO	Community Services Office
CSU	Crisis Stabilization Unit
DBHR	Division of Behavioral Health and Recovery
DCR	Designated Crisis Responder
DMHP	Designated Mental Health Professional
E&T	Evaluation and Treatment
ECS	Extended Care Services
ED/ER	Emergency Department/Room
EMS	Emergency Medical Services
ESD	Educational Services District
FAST	Family Assessment and Stabilization Team
IMD	Institutions for Mental Disease
IP	Inpatient
ITA	Involuntary Treatment Act
LE	Law Enforcement
MD/ED	Medical Doctor/Emergency Department
MH	Mental Health
MH/SA	Mental Health and Substance Abuse
NAMI	National Alliance on Mental Illness
NSMHA	North Sound Mental Health Administration
OP	Outpatient
PACT	Program for Assertive Community Treatment
PCP	Primary Care Practitioner
PTSD	Post-Traumatic Stress Disorder
RCW	Revised Code of Washington
RSN	Regional Support Network
SA	Substance Abuse
SNF	Skilled Nursing Facilities
VOA	Volunteers of America
WSH	Western State Hospital

Attachment D: Federal IMD Exclusion

In planning for the co-location of CSUs, E&Ts and respite facilities, care must be taken to avoid activating the federal IMD exclusion, which would result in not being able to use Medicaid funding for the facilities—an important issue, given the lack of state-only funds for mental health services.

The following information is excerpted from *An Analysis of the Medicaid IMD Exclusion,* by Sara Rosenbaum, JD, Joel Teitelbaum, JD, LLM, D. Richard Mauery, MPH, DrPH (Cand.) for the Center for Health Services Research and Policy. Department of Health Policy, George Washington University School of Public Health and Health Services. December 19, 2002.

> *The departure from the normal federal/state payment allocation ratios in the case of treatment for conditions classified as mental diseases is in part the result of a special payment exclusion under Medicaid, the nation's largest public insurance program. This exclusion, known as the "Medicaid IMD exclusion" and part of the program since its 1965 enactment, bars federal contributions to the cost of medically necessary inpatient care incurred in treating Medicaid beneficiaries ages 21-64 who receive care in certain institutions that fall within the definition of an "institution for mental disease." An "institution for mental diseases" is defined as "a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care and related services."*
>
> *Beyond the population exemptions to the IMD exclusion, there are two other notable limits on the exclusion. The first is an exemption under 1988 amendments in the case of institutions with fewer than 17 beds. The history of this exemption indicates that Congress was particularly concerned that Medicaid be used to promote small, community based group living arrangements as an alternative to large institutions. The second limitation focuses on the inpatient status of the patients; that is, the exclusion applies only in the case of health providers that are institutions for mental diseases with 17 beds or more. Services furnished by partial hospitalization and day treatment programs that do not institutionalize their patients are not excluded.*
>
> *As a practical matter therefore, the IMD exclusion only affects federal Medicaid payments to certain types of institutions, and then only in the case of certain beneficiaries (i.e., eligible adults ages 21-64). To the extent that a state furnishes treatment in outpatient or small facility settings, the IMD exclusion has no impact. At the same time however, the IMD exclusion is significant because of its scope and application well beyond the range of large state mental hospitals to virtually any form of long-term institutional placement in a facility with more than 16 beds that is skilled in the acute or long-term management of mental diseases and to which patients with mental diseases therefore would be admitted.*

Federal guidelines specify the attributes of an entity that is considered an IMD and also provide guidance regarding how to recognize which entity is to be assessed as an IMD. In determining whether an entity is appropriate for consideration as an IMD (as opposed to simply a portion of a larger entity to which the exclusion would not apply), HHS will examine the following matters:

- *governance (e.g., all components controlled by one owner or governing body);*
- *medical direction (one chief medical officer in control of medical staff in all components of the entity)*
- *administrative control (one CEO in control of all administrative activities in all components of the entity);*
- *licensure (is there a separate entity license)*
- *organizational operation as a single entity*
- *an ability of several operating components within a larger unit to independently meet the conditions of participation under the applicable*

Thus, while there are economies of scale that might be accomplished by co-location of facilities, these need to be balanced with the possible loss of Medicaid funding.

Attachment E: The Crisis Stabilization Unit Legislation and Regulations

SSB 5533

Effective on 7/22/2007, the legislative intent section of this bill states that the needs of individuals with mental illness and the public safety needs of society are better served when individuals with mental illness are provided with an opportunity to obtain treatment and support.

The legislation includes general statutory provisions regarding competency evaluation and restoration of individuals with mental disorders are consolidated into one new section. New sections are created to address specific procedures in misdemeanor and felony restoration cases. The procedure for non-emergent detentions is modified and a definition of imminent is added. The summons process and 24-hour reporting period in non-emergent Involuntary Treatment Act cases is eliminated and replaced with an "order to detain" process.

The language regarding Crisis Stabilization Units includes:

- "Crisis stabilization unit" means a short-term facility or a portion of a facility licensed by the Department of Health and certified by the Department of Social and Health Services under RCW 71.24.035, such as an evaluation and treatment facility or a hospital, which has been designed to assess, diagnose, and treat individuals experiencing an acute crisis without the use of long-term hospitalization.
- The Department of Social and Health Services is required to certify and to establish minimum standards for crisis stabilization units, such as:

  1) physical separation from the general offender population if in a jail;

  2) administering treatment by mental health professionals; and

  3) securing appropriately, given the nature of the crime involved.
- Emergent Detention: (1) When a designated mental health professional receives information alleging that a person, as the result of a mental disorder, presents an imminent likelihood of serious harm, or is in imminent danger because of being gravely disabled, after investigation and evaluation of the specific facts alleged and of the reliability and credibility of the person or persons providing the information if any, the designated mental health professional may take such person, or cause by oral or written order such person to be taken into emergency custody in an evaluation and treatment facility for not more than seventy-two hours as described in RCW 71.05.180.

  (2) A peace officer may take or cause such person to be taken into custody and immediately delivered to a crisis stabilization unit, an evaluation and treatment facility, or the emergency department of a local hospital under the following circumstances:

  (a) Pursuant to subsection (1) of this section; or

(b) When he or she has reasonable cause to believe that such person is suffering from a mental disorder and presents an imminent likelihood of serious harm or is in imminent danger because of being gravely disabled.

(3) Persons delivered to a crisis stabilization unit, evaluation and treatment facility, or the emergency department of a local hospital by peace officers pursuant to subsection (2) of this section may be held by the facility for a period of up to twelve hours: PROVIDED, That they are examined by a mental health professional within three hours of their arrival. Within twelve hours of their arrival, the designated mental health professional must determine whether the individual meets detention criteria. If the individual is detained, the designated mental health professional shall file a petition for detention or a supplemental petition as appropriate and commence service on the designated attorney for the detained person.

WAC 388-865-0750

The regulations regarding crisis stabilization unit certification include:

- Procedures for ensuring a secure environment appropriate to the legal status of the person, and necessary to protect the public safety. “Secure” means having:

  (i) All doors and windows leading to the outside locked at all times;
  (ii) Visual monitoring, either by line-of-sight or camera as appropriate to the individual;
  (iii) Adequate space to segregate violent or potentially violent persons from others;
  (iv) The means to contact law enforcement immediately in the event of an elopement from the facility; and
  (v) Adequate numbers of staff present at all times that are trained in facility security measures.
- Procedures for admitting persons needing crisis stabilization services seven days a week, twenty-four hours a day
- Procedures to ensure that for persons who have been brought to the unit involuntarily by police, the stay is limited to twelve hours unless the individual has signed voluntarily into treatment
- Procedures to ensure that within twelve hours of the time of arrival to the crisis stabilization unit, individuals who have been detained by a designated mental health professional or designated crisis responder under chapter 71.05 or 70.96B RCW are transferred to a certified evaluation and treatment facility
- Procedures to assure appropriate and safe transportation of persons who are not approved for admission or detained for transfer to an evaluation and treatment facility, and if not in police custody, to their respective residence or other appropriate place
- Procedures to detain arrested persons who are not otherwise detained and transferred to an evaluation and treatment facility for a period of up to eight hours in order to enable law enforcement to return to the facility and take the person back into custody

- Procedures to ensure access to emergency life-sustaining treatment, necessary medical treatment, and medication
- Procedures to ensure the protection of personal and familial rights as described in WAC 388-865-0561 and chapter 71.05 RCW
- Procedures to inventory and safeguard the personal property of the persons being detained
- Procedures to ensure that a mental health professional (as defined in chapter 388-865 WAC) is on-site twenty-four hours a day, seven days a week
- Procedures to ensure that a licensed physician is available for consultation to direct care staff and patients twenty-four hours a day, seven days a week

Concern has been expressed that the requirement that police officers can only bring a non-felony situation to the CSU may be overly narrow, since property damage can frequently exceed misdemeanor limits. This may be a matter for legislative action in a future session.

Attachment F: King County Crisis Diversion Facility

On 3/11/10, King County released an RFP for Crisis Diversion Services, which includes a Crisis Diversion Facility. The following is an excerpt from the RFP, describing the services envisioned in the Crisis Diversion Facility. Following the service description is an excerpt from the memorandum by the King County Prosecuting Attorney which outlines the criteria for use of the facility.

Crisis Diversion Facility (CDF)

The CDF will be a 16 bed facility to accept people age 18 and over in mental health and substance abuse crisis to divert them from jails and hospitals. Individuals arriving at the facility will be evaluated within three hours with some being linked directly to services and released while others are admitted to the CDF. In this way, the capacity to assist people may be more than 16 as not everyone will need to be admitted to a bed.

Individuals found by police and suspected of a crime may be brought to the CDF. Any person in mental health or substance abuse crisis and suspected of a minor non-violent crime and a limited and non-violent criminal history may be considered for diversion from jail to the CDF. Police officers may suspend the arrest of a consumer favoring diversion to the CDF. A report and other proper paperwork will accompany consumers sent to the CDF by police. CDF staff will follow up appropriately with police on the status of consumers sent to the CDF. If a consumer admitted to the CDF in lieu of arrest demands to leave before their crisis is stabilized or resolved, staff may contact police for disposition.

Individuals experiencing crisis in the community who are in good behavioral control and willing to cooperate with CDF services may be diverted from hospital emergency departments to the CDF. A telephone screening call with the facility from a professional in the community or concerned other will precede a consumer coming to the CDF. Individuals may be diverted from hospital admission out of the emergency department to the CDF. The CDF also needs the capacity to address the needs of walk-ins, although the facility will not be advertised as having that capacity.

The CDF is not intended to be a substitute for detoxification or sobering services provided by other facilities and consumers will be pre-screened to determine which facility is most appropriate. If a consumer in crisis is admitted to the CDF and begins to shows signs of withdrawal, the consumer will be referred to other resources as appropriate.

Submitted proposals for this RFP must address criminal justice and medical exclusionary criteria for admission to the CDF as well as a plan to achieve restraint-free operation.

Restraint free facility: The County will give preference to proposals that use a recovery oriented model of care system that is consistent with the principles of trauma-informed care, with policies and procedures that maintain the safety of service recipients an staff as well as the dignity and self-determination of

individuals who are in crisis. The following publication is provided as a reference: Roadmap to Seclusion and Restraint Free Mental Health Services. DHHS Pub. No. (SMA) 05-4055. Rockville, MD, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2005.

Medical exclusionary (Hospital Diversion) criteria: The medical exclusionary criteria was developed in partnership with local hospitals and mental health care providers and are designed to provide a broad overview of conditions /illnesses that would exclude an individual from receiving services through the CDF. Specific medical exclusionary criteria may need to change once the CDF has been in operation for enough time to evaluate how they are working. The county, in partnership with the MIDD 10b subcommittee are willing to entertain suggestions for small modifications to the exclusion criteria as long as the change would not result in a reduction in the effectiveness of the CDF as a hospital or jail diversion resource.

The physical plant of the CDF must include:

- *At least 7,200 square feet.*
- *Locking doors and security measures to assure that consumers do not leave the facility without the awareness of staff members.*
- *Interview rooms of which at least two (2) have security features that would allow for containment of consumers who become behaviorally out of control.*
- *Beds arranged in single cubicles allowing for some privacy but allowing for line of sight monitoring by staff members.*
- *Common areas that include a locking medical supply closet, a secure records room, medical exam room, medication dispensary, intake/interview area, food storage and preparation areas, an eating area, offices for police, DMHPs and other professionals.*
- *Showers, some secure storage, laundry and a stocked clothes closet should also be incorporated.*

The services offered at the CDF must include:

- *24 hour per day, 7 day per week operation.*
- *Psychiatric evaluation, medication management, and stabilization services.*
- *Peer support and other mental health counseling.*
- *Chemical dependency evaluation.*
- *Case management that focuses on specific linkage with needed services such as benefits, housing, medical care, mental health and chemical dependency treatment.*
- *Transportation arrangements for consumers leaving the CDF (vehicle costs are available as part of start-up and within the annual budget).*
- *Nursing services.*
- *Three meals per day (arrangements may be made to have meals pre-prepared and delivered or prepared on-site) with snacks and produce available on-site.*
- *Shower and laundry facilities*.

- *Capacity for a maximum length of stay of 72 hours with an average length of stay less than 24 hours.*

Submitted proposals must include a staffing model for the CDF that contains a 4:1 consumer to staff ratio, peer support staff, and access to medical and psychiatric staff.

The preferred staffing model includes:
- *1 CDF director (assigned full time to the CDF)*
- *1 office support person*
- *3 supervisors (1 per shift)*
- *9 Mental Health Professionals (2 per shift)*
- *4.5 Chemical Dependency Counselor (1 per shift)*
- *4.5 Behavioral Health Specialists (1 per shift)*
- *4.5 Registered Nurses/psychiatric ARNPs preferred (1 per shift)*
- *4.5 Peer support specialists (1 per shift)*
- *1 Psychiatric ARNP or Psychiatrist on-call after hours*
- *Medical staff needed on-call 24/7*

Eligibility Criteria for the MIDD Crisis Diversion Facility Based Upon Criminal Acts

Before proceeding, it is important to understand what the term "diversion" means in the criminal justice system context. In the context of KCMHC and the CDF, a diversion means that a person will be asked to fulfill a contract with certain conditions in the contract, including things like attending treatment or counseling sessions, possibly taking medications, or signing up for job training or educational opportunities. In exchange for the person fulfilling these terms, the State (in this case the King County Prosecutor's office) will agree not to file a criminal charge of theft or property damage or whatever the charge may be. If the person follows through on the conditions for a certain period of time, the criminal charge will never be filed, and the person will avoid the stigma and consequences of a criminal conviction. If the person fails to carry out the conditions agreed upon, then the State can file the criminal charge and pursue punishment upon conviction for that particular criminal act.

A. King County District Mental Health Court

The PAO currently allows dispositional continuances, in other words a diversion, of certain criminal charges in King County Mental Health Court. (KCMHC) To qualify for a diversion in KCMHC persons must also have limited to moderate criminal histories and no history of violent criminal convictions on their record in order to be eligible. Convictions for assault would automatically disqualify a person from eligibility for diversion to a CDF. Some other felony crimes like Robbery 2 would also disqualify an offender from diversion unless a sufficient period of time has passed since the commission of that crime so as to allow it to "wash out" for purposes of entry into KCMHC. The following is a list of current offenses that are allowed into KCMHC:

Criminal trespass II

Theft 3 < $50
Malicious mischief < $50
Unlawful bus conduct
Failure to appear/respond (court summons)
Disorderly conduct
Obstructing
Resisting arrest
Use of drug paraphernalia
Possession of marijuana
Alcohol in a park
NVOL (No Valid Operator's License)
DWLS (Driving with License Suspended) 3
Furnishing liquor to minor
Minor in possession of alcohol
Minor frequenting tavern or lounge
Unlawful issuance of bank checks
Prostitution
Patronizing a prostitute
Loitering for purposes of prostitution
Possess fraudulent driver's license
Failure to obey
Theft of rental property.

In addition to the listed misdemeanor crimes the King County Prosecuting Attorney's Office (KCPAO) may be willing to take felony level simple drug possession cases that are currently being sent to District Court and filed as "expedited misdemeanors" and allow police officers to divert those expedited cases to the CDF as well. Those charges would primarily consist of the following:

Violation of the Uniform Controlled Substance Act (VUCSA): simple possession of cocaine
VUCSA: simple possession of heroin < 3 grams
VUCSA: simple possession of methamphetamine <3 grams
VUCSA: possession of legend drugs (prescription drugs without proper prescription).

B. Seattle Municipal Mental Health Court
Seattle Municipal Mental Health Court offers dispositional continuances, or diversion. In determining which cases are eligible for a dispositional continuance, the SCA considers the facts of the crime charged, the defendant's criminal history, the impact of a conviction on the defendant's housing, and any other factors that may impact public safety. There is no specific list of charges that are eligible, but in practice most dispositional continuances in Seattle Municipal Mental Health Court occur in cases where the offense charged are of the type listed in subsection A above.

C. Eligibility Criteria for the Crisis Diversion Facility
In order to have a CDF that serves the mentally ill the, National GAINS center eligibility criteria appears to be well targeted and should be followed. The person should have a likely mental illness and/or substance abuse affecting behavior and committed or is about to commit a criminal offense that has been deemed divertible under the above criteria. The person then must be screened for disqualifying violence criminal history and or a history of civil commitment proceedings. The officer can check the criminal history in the field and the mental heath professional can access The Extended Client Lookup System (ECLS) to determine history and past diagnoses once the person is diverted to the CDF for follow up care.

Assuming hospital emergency rooms are allowed to refer patients into this facility, there will need to be some assurance that police referrals receive first priority when there are capacity issues at the CDF.

The PAO does currently prohibit individuals in MHC from seeking a diversion if they have an arrest for a violent incident in the last seven years. The reasoning is that we do not want actively psychotic individuals with a history of violence to be placed in a non-secure group setting.

Mentally ill individuals who do not qualify for MHC due to the current charge or due to a history of violence will still have the opportunity to connect with mental health treatment with the hope of reducing recidivism. The jail liaisons refer in-custody defendants to the 12 month co-occurring treatment program, Project IMPACT and Project START, which comes with housing, case management services, mental health and chemical dependency treatment including medication. They also have access to the housing voucher program. If the same parameters were established for eligibility in the CDF, persons who were excluded from the facility could still access services through MHC which takes referrals for misdemeanor and felony cases and comes with its own resources.

What Offenses are not allowed to be diverted to the Crisis Diversion Facility?
- violent current offense
- violent criminal history
- domestic violence offense (current state statute requires mandatory arrest and booking into jail)

Again, the most important factor that will determine who receives the resources that the CDF provides will be the discretion of the police officer. We will need to rely on the officer's judgment and experience when it comes to recognizing signs of mental illness and chemical dependency. The officer will also need to recognize who may be ready to receive some help in dealing with the challenges that mental illness and chemical dependency present.

Conclusion

Police officers who arrest offenders for minor criminal acts have limited choices when the offender may suffer from a mental illness and/or chemical dependency. This lack of choice can create a revolving door of low level offenders who simply sit in jail and possibly deteriorate. The CDF is designed to give police officers in the field who recognize mental illness and recurring chemical dependency a choice that can help break the cycle of going in and out of jail. Each and every case will not fit the model described above. However, if the population of low level offenders who have mental health and chemical dependency issues in the jail can be lowered with the option of a CDF, then the entire community benefits from having more productive community members and saves money by avoiding the repetitive cost of housing certain individuals in jail because there is nowhere else for them to go

Attachment G: Pierce County Then and Now

In *Planning for Mental Health Inpatient Alternatives* [Mauer, 2002], new approaches to acute/crisis care were summarized along with a review of key system components that served as alternatives to a psychiatric inpatient stay:

- Triage/23-hour observation beds
- Crisis stabilization/sub-acute beds
- Crisis respite/residential beds

Definitions and examples were from site visits, public documents and regulations in Arizona, California, Oregon and Washington. The descriptions were grouped by "like focus" rather than what they were locally named (for example, "stabilization" was used somewhere to describe each of these components of an acute care system). An example was the Triage Center operated in Pierce County, one of the first in Washington. Originally in a free standing setting, it was subsequently incorporated into the county-operated inpatient facility and modified in the process. In many ways, it provided the type of services now required of a Crisis Stabilization Unit (CSU) in Washington State.

This historical description from the 2002 report is followed by a brief summary of the newly certified and opened CSU in Pierce County, which adds a significant peer component to its services.

> ***Crisis Triage Center (CTC)***
> *This CTC serves a county with a population of about 687,000 who live in urban, suburban and rural settings. The CTC evaluates and treats individuals experiencing mental health, chemical dependency or developmental disabilities crises. It is a short-term psychiatric observation and treatment unit for individuals experiencing crisis, combining the mental health and chemical dependency expertise of a community mental health center and a chemical dependency provider to offer an effective clinical alternative to jails or more expensive medical services. The Center offers: a quiet and safe environment to stabilize individuals experiencing episodes of crisis; medical supervision at all times; observation areas for older adults and youth; accommodations for individuals with physical disabilities, and discharge planning for community transition. For some individuals who are engaged in ongoing services, use of the Center may be a part of a personal crisis plan. The CTC is located in a free standing facility that also houses the countywide crisis telephone service, the mental health center's mobile crisis team, the county mental health professionals (who initiate civil commitment procedures), and the detoxification unit operated by the chemical dependency provider. The facility is licensed as an outpatient evaluation and treatment facility under the emergency services component of state licensure for community mental health centers.*
>
> *The system design is to have emergency inpatient admissions for the public mental health system come to the CTC prior to admission. The CTC also serves the criminal justice system by making it easy for police to bring individuals for*

observation rather than placing them in jail. In addition to providing direct stabilization services, this role allows the public mental health system to diagnose system problems, as the gaps in the system tend to result in admissions to the CTC. There is a cross-system advisory committee that meets regularly, looks at data from the CTC and recommends system improvements.

The following describes the CTC component operated by the mental health center. It does not include detoxification statistics or staffing. The CTC started four years ago with seven to eight admissions a day; it now sees ten to twelve admissions a day. Patients are brought in by the police (21%), mental health center staff and/or mobile crisis staff (27%); transferred from an emergency room (ER) (25%); or referred by other community resources. Transfer to an ER for medical clearance occurs about once a week; medical backup is within blocks. The CTC is written into the protocols of the emergency medical system (EMS). If the EMS field staff declare a patient medically stable in the field and obtain approval from their base, they can bring a person directly to the CTC rather than going to an ER.

Children under 18 represent slightly over ten percent of the population served by the CTC. The youngest child seen to date was four. It is the police who bring in these youngsters in crisis. The "swing" rooms are used for children, who are often coming from chaotic situations. If they are already being served by the system and have case aides, the aides are asked to accompany them; if they are under the age of 12, parents are asked to accompany them.

Individuals who are intoxicated are brought to the CTC because they also appear to have a mental health issue, usually related to suicidality. Sobering beds are not available in the community, so by default this occurs in the CTC unit; patients requiring detoxification (medical or social) are transferred across the hall to the co-located detoxification program. The two programs provide constant informal consultation to one another regarding patient status and discharge planning. Restraints are used infrequently (for about one percent of admissions, usually methamphetamine-related). There are ten resting rooms with beds, and two observation rooms in the mental health component of the CTC.

The average length of stay is just under 20 hours, but some patients stay up to 72 hours. Ten percent of admissions to the center result in a subsequent voluntary inpatient admission, three percent in an involuntary inpatient admission. The remaining admissions are referred to follow-up services through the mental health system or a variety of community resources.

Nurse practitioners are on call twenty-four hours a day, seven days a week; a consulting psychiatrist rounds three hours a week and consults with staff; each shift is staffed with an RN with two years of psychiatric experience; and five psychiatric technicians. The operating budget is $1.5 million.

The physical design of the CTC creates a calming milieu; although not licensed as an inpatient or residential facility, it was built to residential treatment facility standards, with a large day room directly observed by staff, and rooms with permanently installed beds on the other side of the staff station. By design, there is no television, radio, or reading material; it is a low stimulus environment. The staff has created a team environment with a shared philosophy regarding this low stimulus approach.

There is a close working relationship with the community providers of public mental health services: the expectation is that if the CTC calls regarding a client active in services, there will be a response from either the case manager or supervisor. Discharge summaries are faxed to providers when the consumer leaves. A more complete discharge summary is prepared for transfer to inpatient units.

Crisis Stabilization Unit (CSU)

The new (in 2010) Recovery Response Center (e.g., CSU) in Pierce County shares a building with the new E&T. The facilities are operated by two separate organizations (Recovery Innovations and Telecare). Each facility operates 16 beds (because they are separately managed although within the same building, they are not subject to the IMD exclusion). The Recovery Response Center served 193 guests during its first month of operation.

The Recovery Response Center has a triage section which consists of four rooms with recliners: two rooms have a single recliner, another one has three recliners, and another two, for seven total. One room is usually reserved for guests who need some time out.

The stabilization section has beds: four rooms with two beds, and two rooms with one. All guests intermingle; although the recliners are on one end of the hall and the beds on the other, all guests have access to the same common areas—regardless of their status. The unit is locked even though most of the guests are on a voluntary basis.

Instead of staffing with psychiatric technicians, there are two peer specialists and an MHP on each shift, as well as a recovery educator from 10 AM to 5 PM. A full time prescriber (ARNP) is on site from Monday morning 8 AM until Friday 5 PM and is also on-call after hours during the week; two part time prescribers alternate covering week-ends. The week-end prescriber is on call as of Friday 5 PM until Monday 8 AM, and comes in on Saturday and Sunday to make rounds. The goal is to have four part time prescribers to ensure coverage at all times.

There is an RN on each shift so most referrals get screened by a nurse first to make sure that the referral is medically appropriate. The admission criteria are summarized below.

Although nurses can draw blood, lab testing is limited. The facility relies on breathalyzers, on urine screens, and on frequent vitals to determine the best course of action. Since the stay is short term—75% of the guests in the first month of operations

stayed at the center for less than 24 hours, 25% stayed for one or two extra days—in many cases the lab results wouldn't get back before the person left.

The CSU carries a small stock of drugs that are part of a standard/common formulary. The prescriber addresses the medication issues on a case-by-case basis.

Some patients bring their own medications in and are capable of administering them themselves: this is allowed.

The CSU often can access the crisis plans of patients who are enrolled in mental health agencies, which lists their meds; if the CSU carries the same medications they will offer them throughout the stay; if not, they will work out a plan with the agency's liaison staff to bring those medications into the facility.

Patients who are not on any medications can be started on a psychiatric medication regimen during their stay at the CSU (basic meds, such as Risperdal or Zyprexa) but the prescribers, understandably, want to make sure that there is a follow-up plan; this is not always easy to do.

Prescribers do write scripts—for about 7-days worth of meds after discharge. Still, the person has to have the funding to fill them.

Criteria to be Welcomed into the Recovery Response Center

A. 18 and over
B. Conditions that may not be appropriate for entry into the Recovery Response Center.
    1. Temperature above 101 degrees F; Pulse outside of 50 – 120; Blood pressure below 90 systolic; or above 200 systolic; Respiratory rate below 24. Any combination of these conditions that would present a medical concern.
    2. Red blood count – Hct below 30R%, Hb below 10 grams;
    3. Mental status which is stuporous, comatose or spontaneously fluctuating;
    4. Toxic or rising levels of medications or other substances (some substances may require serial levels to determine potential toxicity);
    5. Deterioration of vital signs prior to transfer (vital signs must be taken within two hours of transfer) or:
    6. Conditions requiring medical services not available at the Recovery Response Center.
    7. Individuals under the age of eighteen (18).
    8. Individuals that have already been deemed as needing involuntary commitment.
    9. Target population is not an individual with developmental disabilities.
    10. Individuals with a moderate to high CIWA score.
C. Medical Services that can be provided at the Recovery Response Center.
    1. Vital sign monitoring as frequent as every hour;

2. Routine neurological monitoring after minor head trauma or uncomplicated seizures;
3. Blood sugar monitoring;
4. Glucose below 60 or above 300;
5. CPR;
6. Monitoring for the risk of managing withdrawal symptoms with a low CIWA score.
7. Intramuscular and subcutaneous interventions;
8. Continuation of methadone treatment as provided by the participant's own outpatient clinic (i.e. outpatient clinic comes to the Recovery Response Center to provide continuation of treatment).
9. Routine prostheses care as needed;
10. Routine oxygen, when the participant can monitor.
11. Routine ostomy care, when the participant can change their own bag.
12. Additional medical procedures as deemed appropriate by the Recovery Response Center, after considering the participant's needs and available resources.

D. Conditions not appropriate for entry into the Recovery Response Center.

1. Eligibility requirements are not met as described in sections A and C of 20-103.
2. Unstable medical illness or condition which requires immediate medical treatment and management. Recovery Innovations is not equipped to address medical emergencies or conditions that require skilled nursing. These conditions generally include:

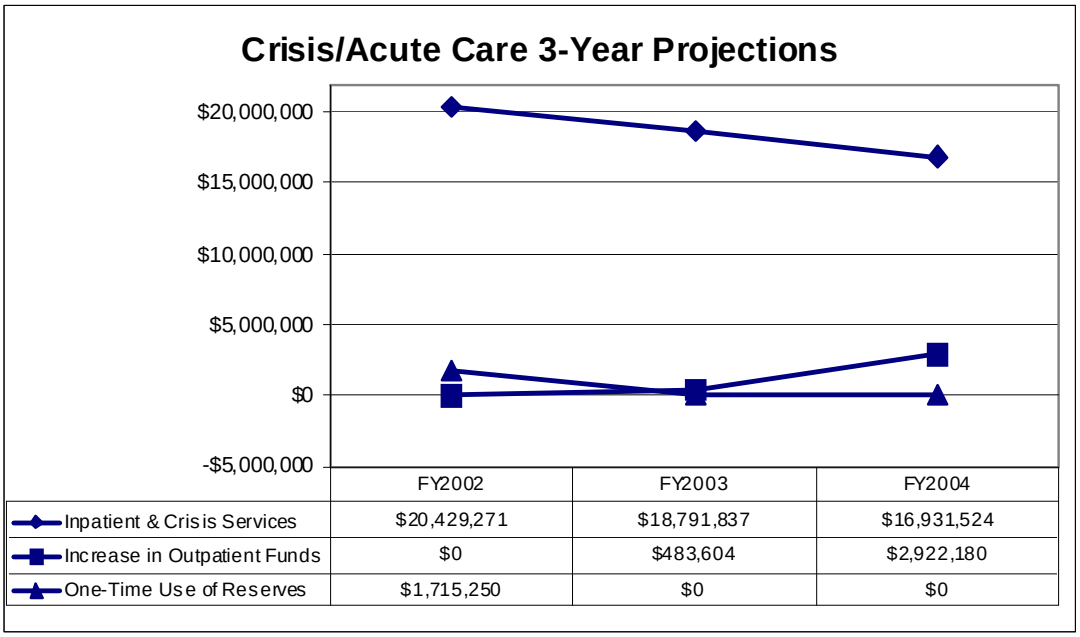
    - Vital sign monitoring more frequent than every hour;
    - Stat (within four hour) x-rays and blood work;
    - Nebulizers and respiratory therapy: arrangements could be made to have a nebulizer delivered;
    - IV therapies;
    - NG tubes;
    - Tracheotomy care (routine or otherwise);
    - Central catheter insertion and maintenance;
    - Medical isolation

Attachment H: Multnohmah County Crisis Redesign and Inpatient Utilization

Overview

In 2001, Multnomah County, Oregon completed a redesign of their crisis and acute care system in order to address the problem of high inpatient rates that were threatening the viability of the entire system.

The redesign plan called for significant expansion of the crisis system, including new services, which would be funded with $1.7 million from reserves in Year 1. The redesign plan projected that inpatient costs could be reduced in Year 2 to the extent that no reserve funding would be needed and the system could increase outpatient service funding from inpatient savings. The plan further projected that in year 3, an additional $2.5 million could be shifted from inpatient to outpatient services. This represented a $3 million reduction in inpatient services over a three year period. The following table illustrates the 3-year projections.[1]



	FY2002	FY2003	FY2004
Inpatient & Crisis Services	$20,429,271	$18,791,837	$16,931,524
Increase in Outpatient Funds	$0	$483,604	$2,922,180
One-Time Use of Reserves	$1,715,250	$0	$0

Crisis System Redesign

The redesign included development or expansion of the following crisis services.

- Access/Crisis Phone System: expansion of existing services
- Urgent Walk-In Clinics: creation of evening and weekend hours
- Mobile Crisis Teams: reinstatement of a 24/7 crisis service
- Secure Evaluation Facility: development of a facility to provide 23-hour observation and assessment services

[1] Resolving the Multnomah County Acute Care Crisis Action Plan - Phase I, August 8, 2001, Jim Gaynor, Director of Mental Health Redesign, Verity; Peter Davidson, MD, Chief Clinical Officer/Medical Director, Verity; Dale Jarvis, CPA, MCPP Healthcare Consulting, Inc.

- Acute Hospital Alternatives: expansion of intensive home-based stabilization services, respite beds, and flex funds
- Acute Care Coordination**:** implementation of an acute care coordination team

Outpatient Redesign

The second major change involved re-engineering the outpatient system in order to better address the needs of consumers, prevent crises and engage outpatient clinicians in the crisis resolution process. This included the implementation of three strategies.

- **Single Point of Accountability Structure**: Prior to and during the acute care crisis, if an individual who was enrolled with a mental health provider organization had a mental health-related crisis, there was no practical way to identify and contact the clinician who has the best clinical knowledge of that individual. In addition, there wasn't a standardized process for identifying individuals who were not currently enrolled and in need of mental health service, and connecting them to a "primary clinician." The redesign plan called for changes in philosophy and structure whereby each consumer of mental health services would have a primary clinician to assist them in meeting their service needs and aiding in their rehabilitation and recovery.
- **Accountability/Incentive Pool:** The single point of accountability structure was accompanied by a the development of an Accountability/Incentive Pool that was designed to provides financial incentives for proper management of the crisis and acute care system and hold providers accountable for poor outcomes. If inpatient costs were reduced for consumers of a given organization, that organization would receive a share of the savings. If inpatient costs increased, the agencies would hold partial risk for additional costs.
- **Caseload Reduction Strategy:** The redesign also changed the financing structure to incentivize the creation of a "back door" for clients so that caseload sizes could be brought under control and clinicians could focus on high-risk, high-need clients.

Redesign Implementation and Results

Work began on the new services and structures in August 2001. In May 2002, a Nine Month Evaluation Report was completed that demonstrated a successful ramp-up of new services. The following excerpt from the report illustrates the progress that was made.

> *A decentralized urgent access system improves linkage with the array of community based mental health services and alternatives to hospitalization. The following is a summary of Cascadia walk-in clinic's case dispositions:* [2]

	Projected	*Actual*
% triaged to Sub-Acute Beds	*2%*	*.1%*
% triaged to Respite Beds	*2%*	*.4%*
% triaged to Inpatient	*9%*	*.8%*
% triaged to Home-based Stabilization	*5%*	*0*
% triaged to OP Svcs/Community	*82%*	*95.6%*
% triaged to ER	*Not Projected*	*1.2%*

[2] 9 Month Evaluation of Walk-in and Mobile Outreach Acute Care Services, May, 2002, Primary Author: Kim Burgess, LCSW, Executive Vice President Clinical Services, Cascadia Behavioral Healthcare

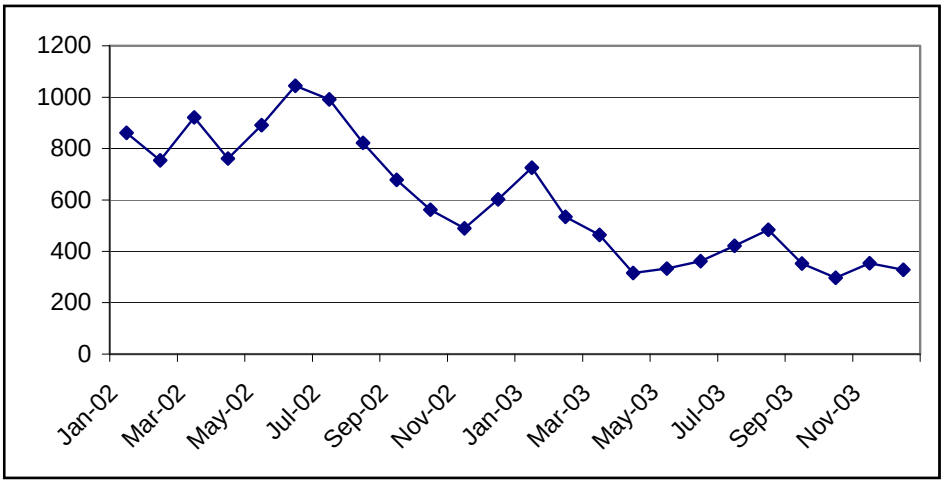
Note the very high problem resolution rates and the very low referrals to inpatient and emergency rooms. The following table from the report provides similar information for the mobile crisis services.

	Projected	*Actual*
% triaged to Sub-Acute Beds	*4%*	*0*
% triaged to Respite Beds	*4%*	*.3%*
% triaged to Voluntary Inpatient	*5%*	*1%*
% triaged to Involuntary Inpatient	*8%*	*8%*
% triaged to Home Based Stab.	*5%*	*Note*
% triaged to OP Svcs/Community	*74%*	*85%*
% triaged to ER	*Not projected*	*5%*

Note: Not collected

A follow-up assessment of the redesign was completed in early 2004. The assessment confirmed that inpatient utilization had decreased to levels that enabled the County to regain its financial footing, including the programming of freed up inpatient dollars into outpatient services. The following graph, taken from the assessment, illustrates the extent of the reduction in inpatient days.[3]

Multnomah County Oregon Health Plan Verity Acute Inpatient Days



The assessment went on to recommend that Multnomah County was in a position to proceed with two forward thinking initiatives – a System of Care for Child and Families and a System of Care for Adults with Serious Mental Illness. These initiatives helped strengthen the system and today inpatient rates continue to be at reasonable and affordable levels.

[3] Verity Observations and Recommendations, February 25, 2004, Dale Jarvis, CPA, MCPP Healthcare Consulting, Inc.

Attachment I: Involuntary Treatment Act Amendments in 2010 Session

In the 2010 legislative session, SSHB3076 was passed, amending RCW 71.05, the Involuntary Treatment Act. The bill:

- Modifies the definition of "likelihood of serious harm" in the Involuntary Treatment Act to include an additional basis for commitment.
- Requires the Washington State Institute for Public Policy, in collaboration with the Department of Social and Health Services and others, to search for a validated mental health assessment tool or combination of tools for the assessment of persons for detention, commitment, or revocation under the Involuntary Treatment Act.
- Allows designated mental health professionals, when making a determination for initial detainment, to consider historical information and information provided by family members or others who have had significant contact with the individual or who are familiar with the individual's history.
- Adds the following language:

  Symptoms and behavior of the respondent which standing alone would not justify civil commitment may support a finding of grave disability or likelihood of serious harm when:
  (a) Such symptoms or behavior are closely associated with symptoms or behavior which preceded and led to a past incident of involuntary hospitalization, severe deterioration, or one or more violent acts;
  (b) These symptoms or behavior represent a marked and concerning change in the baseline behavior of the respondent; and
  (c) Without treatment, the continued deterioration of the respondent is probable.
- Requires the E&T or state hospital to provide notice of a person's discharge to the DMHP responsible for the initial commitment and the DMHP where the person is expected to reside.
- Contains a provision that declares specific sections (1, 2, and 3) null and void if there is no specific funding in the omnibus appropriations act.

Attachment J: Budget Summaries

North Sound MHA Acute Care/Crisis CY2013 Budget

Scenario A

1 Summary	Current	2013	$ Change	Change %	Other Rev %	Less Other Revenue	Subtotal RSN Net
RSN Revenue	$23,615,194	$26,401,709	$2,786,515	12%	0%	$0	$26,401,709
Call Center							
Baseline VOA Budget	$1,064,878	$1,139,308	$74,430	7%	0%	$0	$1,139,308
Add-On for CSU Staffing	$0	$0	$0	N/A	0%	$0	$0
Total Call Center	$1,064,878	$1,139,308	$74,430	7%		$0	$1,139,308
Mobile Crisis & DCRs							
Mobile Team	$5,708,100	$6,876,974	$1,168,874	20%		-$207,209	$6,669,764
DCR Costs (current in Mobile Team)	$0	$2,968,000	$2,968,000	N/A	0%	$0	$2,968,000
Subtotal	$5,708,100	$9,844,974	$4,136,874	72%		-$207,209	$9,637,764
Specialized Child & Family Consult	$0	$160,000	$160,000	N/A	0%	$0	$160,000
Geriatric Specialized Team	$0	$355,500	$355,500	N/A	0%	$0	$355,500
Total Mobile Crisis & DCRs	$5,708,100	$10,360,474	$4,652,374	82%		-$207,209	$10,153,264
Post Crisis/Hospital Engagement	$0	$3,376,799	$3,376,799	N/A	0%	$0	$3,376,799
Crisis Stabilization Units	$0	$5,805,000	$5,805,000	N/A		-$1,773,600	$4,031,400
Crisis Respite							
Facility-Based	$2,482,932	$2,482,932	$0	0%		-$438,987	$2,043,945
Non-Facility-Based	$0	$1,506,803	$1,506,803	N/A	0%	$0	$1,506,803
Crisis Transportation	$0	$50,000	$50,000	N/A	0%	$0	$50,000
Total Crisis Respite	$2,482,932	$4,039,735	$1,556,803	63%		-$438,987	$3,600,748
Community Hospital Involuntary	$5,470,919	$3,635,887	-$1,835,032	-34%	0%	$0	$3,635,887
Community Hospital Voluntary	$3,415,673	$2,822,639	-$593,034	-17%	0%	$0	$2,822,639
Evaluation & Treatment	$5,472,692	$5,472,692	$0	0%	0%	$0	$5,472,692
Total Inpatient	$14,359,284	$11,931,218	-$2,428,066	-17%		$0	$11,931,218
Total Expenditures	$23,615,194	$36,652,533	$13,037,339	55%		-$2,419,796	$34,232,737
Excess (Deficit)							-$7,831,027

Scenario A Assumptions:

- Assume Medicaid Expansion results in 16% additional capitation revenue for NSMHA
- All system changes implemented: CSUs, Mobile Crisis/DCR changes, added Respite, E&Ts brought up to 90% occupancy
- Assume 20% inpatient drop from efforts, but 2% increase due to new ITA law for a net 18% decrease
- CSU Cost per Slot adjusted up; cannot assume economies of scale from co-locating with E&T
- Assumes CSU partially funded by other payors plus a portion of County 0.1% sales tax funding
- Crisis Respite-Facility-Based includes entire Skagit facility (including Detox);Other Revenue offset for Crisis Respite only
- Expanded CIT training is assumed to be funded through existing County efforts

North Sound MHA Acute Care/Crisis CY2013 Budget

Scenario B

1 Summary	Current	2013	$ Change	Change %	Other Rev %	Less Other Revenue	Subtotal RSN Net
RSN Revenue	$23,615,194	$26,401,709	$2,786,515	12%	0%	$0	$26,401,709
Call Center							
Baseline VOA Budget	$1,064,878	$1,139,308	$74,430	7%	0%	$0	$1,139,308
Add-On for CSU Staffing	$0	$0	$0	N/A	0%	$0	$0
Total Call Center	$1,064,878	$1,139,308	$74,430	7%		$0	$1,139,308
Mobile Crisis & DCRs							
Mobile Team	$5,708,100	$4,414,849	-$1,293,251	-23%		-$151,607	$4,263,242
DCR Costs (current in Mobile Team)	$0	$2,650,000	$2,650,000	N/A	0%	$0	$2,650,000
Subtotal	$5,708,100	$7,064,849	$1,356,749	24%		-$151,607	$6,913,242
Specialized Child & Family Consult	$0	$160,000	$160,000	N/A	0%	$0	$160,000
Geriatric Specialized Team	$0	$355,500	$355,500	N/A	0%	$0	$355,500
Total Mobile Crisis & DCRs	$5,708,100	$7,580,349	$1,872,249	33%		-$151,607	$7,428,742
Post Crisis/Hospital Engagement	$0	$0	$0	N/A	0%	$0	$0
Crisis Stabilization Units	$0	$4,730,000	$4,730,000	N/A		-$1,214,600	$3,515,400
Crisis Respite							
Facility-Based	$2,482,932	$2,234,639	-$248,293	-10%		-$438,987	$1,795,652
Non-Facility-Based	$0	$301,361	$301,361	N/A	0%	$0	$301,361
Crisis Transportation	$0	$50,000	$50,000	N/A	0%	$0	$50,000
Total Crisis Respite	$2,482,932	$2,585,999	$103,067	4%		-$438,987	$2,147,012
Community Hospital Involuntary	$5,470,919	$3,871,546	-$1,599,373	-29%	0%	$0	$3,871,546
Community Hospital Voluntary	$3,415,673	$2,822,639	-$593,034	-17%	0%	$0	$2,822,639
Evaluation & Treatment	$5,472,692	$5,472,692	$0	0%	0%	$0	$5,472,692
Total Inpatient	$14,359,284	$12,166,878	-$2,192,406	-15%		$0	$12,166,878
Total Expenditures	$23,615,194	$28,202,533	$4,587,339	19%		-$1,805,194	$26,397,339
Excess (Deficit)							$4,370

Scenario B Assumptions:

- Scenario B uses Scenario A as a starting point
- Assume more modest growth in Mobile Crisis Team FTEs; 30% increase instead of the 83% increase in Scenario A
- This Scenario scales back Whatcom & Skagit evening DCRs from 2 per shift to 1 per shift
- This Scenario eliminates additional funding for Post Crisis/Hospital Engagement services
- This Scenario funds CSU in Snohomish and Whatcom; not Skagit
- Non-Facility-Based Crisis Respite funded at 20% of Scenario A level
- Assume 16% net inpatient drop from efforts, down from 18% decrease in Scenario A, based on reduction of service expansion

Attachment K: Data Summary

North Sound MHA Acute Care/Crisis Planning Data Book

Youth, Ages 0-17, FY2009 (July 2008 - June 2009)

	Snoh	Skagit	San Juan	Island	Whatcom	Other/ Unknown	Total
Summary Data							
0 Residents	171,939	27,621	2,742	18,322	42,234	N/A	262,858
1 Crisis Calls	896	196	14	82	214	74	1,476
1 Crisis Calls per 100,000 Residents	521	710	511	448	507	N/A	533
1 Crisis Call Rate % of Average	98%	133%	96%	84%	95%	N/A	100%
2 Mobile Crisis Service Cases	502	83	10	44	95	51	785
2 Mobile Crisis Services per 100k Residents	292	300	365	240	225	N/A	279
2 Mobile Crisis Rate % of Average	105%	108%	131%	86%	81%	N/A	100%
3 Community Inpatient Involuntary Admits	55	18	3	6	36	4	122
3 Admissions per 100,000 Residents	32.0	65.2	109.4	32.7	85.2	N/A	46.4
3 Admit Rate % of Average	69%	140%	236%	71%	184%	N/A	100%
3 Average Length of Stay	13.96	9.72	9.33	22.33	11.75	13.75	13.48
4 Community Inpatient Voluntary Admits	70	16	3	11	28	12	140
4 Admissions per 100,000 Residents	40.7	57.9	109.4	60.0	66.3	N/A	53.3
4 Admit Rate % of Average	76%	109%	205%	113%	124%	N/A	100%
4 Average Length of Stay	10.44	4.44	15.33	11.27	11.07	9.92	10.41
5 Total Community IP Admissions	125	34	6	17	64	16	262
5 Admissions per 100,000 Residents	72.70	123.09	218.82	92.78	151.54	N/A	99.67
5 Admit Rate % of Average	73%	123%	220%	93%	152%	N/A	100%
5 Total Community IP Days	1,499	246	74	258	733	174	2,984
5 Total Community IP Days per 100k	872	891	2,699	1,408	1,736	N/A	1,135
5 Total Comm IP Days Rate % Avg	77%	78%	238%	124%	153%	N/A	100%
5 Total Comm IP Avg Daily Census	4.1	0.7	0.2	0.7	2.0	0.5	8.2
6 Comm-Based Svc 30 Days < Admit							
No Prior Service	47%	35%	33%	35%	52%	81%	48%
3 hrs or less	26%	38%	17%	53%	28%	19%	29%
4 - 10 hrs	18%	9%	50%	12%	17%	0%	16%
11 - 30 hrs	7%	12%	0%	0%	2%	0%	5%
31+ hrs	2%	6%	0%	0%	2%	0%	2%
Total	100%	100%	100%	100%	100%	100%	100%
7 Comm-Based Svc 30 Days > Discharge							
No Further Service	45%	38%	33%	59%	45%	75%	47%
3 hrs or less	25%	18%	33%	24%	19%	19%	22%
4 - 10 hrs	22%	29%	33%	18%	28%	6%	24%
11 - 30 hrs	7%	3%	0%	0%	8%	0%	6%
31+ hrs	1%	12%	0%	0%	0%	0%	2%
Total	100%	100%	100%	100%	100%	100%	100%

North Sound MHA Acute Care/Crisis Planning Data Book
Adults, Ages 18+, FY2009 (July 2008 - June 2009)

	Snoh	Skagit	San Juan	Island	Whatcom	Other/ Unknown	Total
Summary Data							
0 Residents	483,862	83,279	12,757	57,678	139,566	N/A	777,142
1 Crisis Calls	10,289	3,748	149	1,284	5,134	17,083	37,687
1 Crisis Calls per 100,000 Residents	2,126	4,501	1,168	2,226	3,679	N/A	2,651
1 Crisis Call Rate % of Average	80%	170%	44%	84%	139%	N/A	100%
2 Mobile Crisis Service Cases	3,064	1,055	76	371	1,321	502	6,389
2 Mobile Crisis Services per 100k Residents	633	1,267	596	643	947	N/A	758
2 Mobile Crisis Rate % of Average	84%	167%	79%	85%	125%	N/A	100%
3 Crisis Stabilization/Respite Admissions	407	128	1	10	162	46	754
3 Admissions per 100,000 Residents	84.1	153.7	7.8	17.3	116.1	N/A	97.0
3 Admit Rate % of Average	87%	158%	8%	18%	120%	N/A	100%
3 Average Length of Stay	9.09	5.63	13.00	4.20	4.92	5.83	7.35
4 Community Inpatient Involuntary Admits	477	172	12	55	420	93	1,229
4 Admissions per 100,000 Residents	98.6	206.5	94.1	95.4	300.9	N/A	158.1
4 Admit Rate % of Average	62%	131%	59%	60%	190%	N/A	100%
4 Average Length of Stay	12.03	9.67	5.50	9.45	9.01	18.87	11.01
5 Community Inpatient Voluntary Admits	320	69	-	27	73	98	587
5 Admissions per 100,000 Residents	66.1	82.9	-	46.8	52.3	N/A	75.5
5 Admit Rate % of Average	88%	110%	0%	62%	69%	N/A	100%
5 Average Length of Stay	7.01	4.19	-	5.04	7.19	6.70	6.56
6 Evaluation & Treatment Involuntary Admits	349	135	3	36	177	38	738
6 Admissions per 100,000 Residents	72.1	162.1	23.5	62.4	126.8	N/A	95.0
6 Admit Rate % of Average	76%	171%	25%	66%	134%	N/A	100%
6 Average Length of Stay	14.50	11.92	26.33	12.14	12.26	11.55	13.27
7 Total Community IP/E&T Admissions	1,146	376	15	118	670	229	2,554
7 Admissions per 100,000 Residents	236.84	451.49	117.58	204.58	480.06	N/A	328.64
7 Admit Rate % of Average	72%	137%	36%	62%	146%	N/A	100%
7 Total Community IP/E&T Days	13,045	3,562	145	1,093	6,479	2,851	27,175
7 Total Community IP/E&T Days per 100k	2,696	4,277	1,137	1,895	4,642	N/A	3,497
7 Total Comm IP/E&T Days Rate % Average	77%	122%	33%	54%	133%	N/A	100%
7 Total Community IP/E&T Avg Daily Census	35.7	9.8	0.4	3.0	17.8	7.8	74.5
8 Comm-Based Svc 30 Days < Admit							
No Prior Service	49%	35%	60%	30%	41%	72%	46%
3 hrs or less	35%	45%	40%	53%	42%	24%	38%
4 - 10 hrs	11%	14%	0%	15%	11%	2%	11%
11 - 30 hrs	4%	6%	0%	3%	5%	0%	4%
31+ hrs	1%	0%	0%	0%	0%	1%	1%
Total	100%	100%	100%	100%	100%	100%	100%
9 Comm-Based Svc 30 Days > Discharge							
No Further Service	48%	35%	67%	38%	34%	74%	44%
3 hrs or less	31%	35%	27%	33%	35%	19%	31%

North Sound MHA Acute Care/Crisis Planning Data Book
Youth, Ages 0-17, FY2009 (July 2008 - June 2009)

	Medicaid Consumers					Ratio of Medicaid Consumers				
	Persons in Hi Intensity Prgms	LOCUS Level 0-3	LOCUS Level 4-6	Unknown LOCUS Level	Not Served in Outpatient	Persons in Hi Intensity Prgms	LOCUS Level 0-3	LOCUS Level 4-6	Unknown LOCUS Level	Not Served in Outpatient
How Much Community-Based Service Was Provided in the 30 Days before Admission?										
No Prior Service	3	11	11	5	42	6%	26%	29%	83%	93%
3 hrs or less	18	13	18	1	3	38%	31%	47%	17%	7%
4 - 10 hrs	9	17	9	-	-	19%	40%	24%	0%	0%
11 - 30 hrs	13	1	-	-	-	27%	2%	0%	0%	0%
31+ hrs	5	-	-	-	-	10%	0%	0%	0%	0%
Total Admissions	48	42	38	6	45	100%	100%	100%	100%	100%
How Much Community-Based Service Was Provided in the 30 Days after Discharge?										
No Further Service	4	7	2	3	41	8%	17%	5%	50%	91%
3 hrs or less	12	13	18	2	4	25%	31%	47%	33%	9%
4 - 10 hrs	15	21	18	1	-	31%	50%	47%	17%	0%
11 - 30 hrs	12	1	-	-	-	25%	2%	0%	0%	0%
31+ hrs	5	-	-	-	-	10%	0%	0%	0%	0%
Total Discharges	48	42	38	6	45	100%	100%	100%	100%	100%

	Non-Medicaid Consumers					Ratio of Non-Medicaid Consumers				
	Persons in Hi Intensity Prgms	LOCUS Level 0-3	LOCUS Level 4-6	Unknown LOCUS Level	Not Served in Outpatient	Persons in Hi Intensity Prgms	LOCUS Level 0-3	LOCUS Level 4-6	Unknown LOCUS Level	Not Served in Outpatient
How Much Community-Based Service Was Provided in the 30 Days before Admission?										
No Prior Service	-	6	1	1	44	0%	60%	13%	20%	83%
3 hrs or less	2	4	4	4	9	33%	40%	50%	80%	17%
4 - 10 hrs	4	-	3	-	-	67%	0%	38%	0%	0%
11 - 30 hrs	-	-	-	-	-	0%	0%	0%	0%	0%
31+ hrs	-	-	-	-	-	0%	0%	0%	0%	0%
Total Admissions	6	10	8	5	53	100%	100%	100%	100%	100%
How Much Community-Based Service Was Provided in the 30 Days after Discharge?										
No Further Service	1	7	1	4	51	17%	70%	13%	80%	96%
3 hrs or less	2	2	2	1	2	33%	20%	25%	20%	4%
4 - 10 hrs	2	1	4	-	-	33%	10%	50%	0%	0%
11 - 30 hrs	1	-	1	-	-	17%	0%	13%	0%	0%
31+ hrs	-	-	-	-	-	0%	0%	0%	0%	0%
Total Discharges	6	10	8	5	53	100%	100%	100%	100%	100%

North Sound MHA Acute Care/Crisis Planning Data Book
Adults, Ages 18+, FY2009 (July 2008 - June 2009)

Medicaid Consumers

	Persons in Hi Intensity Prgms	LOCUS Level 0-3	LOCUS Level 4-6	Unknown LOCUS Level	Not Served in Outpatient
How Much Community-Based Service Was Provided in the 30 Days before Admission?					
No Prior Service	13	121	35	78	122
3 hrs or less	108	243	83	52	36
4 - 10 hrs	101	72	35	3	-
11 - 30 hrs	60	15	5	-	1
31+ hrs	15	-	-	-	-
Total Admissions	297	451	158	133	159
How Much Community-Based Service Was Provided in the 30 Days after Discharge?					
No Further Service	12	51	19	68	132
3 hrs or less	102	234	77	55	26
4 - 10 hrs	92	148	54	9	1
11 - 30 hrs	76	18	8	1	-
31+ hrs	15	-	-	-	-
Total Discharges	297	451	158	133	159

Ratio of Medicaid Consumers

	Persons in Hi Intensity Prgms	LOCUS Level 0-3	LOCUS Level 4-6	Unknown LOCUS Level	Not Served in Outpatient
How Much Community-Based Service Was Provided in the 30 Days before Admission?					
No Prior Service	4%	27%	22%	59%	77%
3 hrs or less	36%	54%	53%	39%	23%
4 - 10 hrs	34%	16%	22%	2%	0%
11 - 30 hrs	20%	3%	3%	0%	1%
31+ hrs	5%	0%	0%	0%	0%
Total Admissions	100%	100%	100%	100%	100%
How Much Community-Based Service Was Provided in the 30 Days after Discharge?					
No Further Service	4%	11%	12%	51%	83%
3 hrs or less	34%	52%	49%	41%	16%
4 - 10 hrs	31%	33%	34%	7%	1%
11 - 30 hrs	26%	4%	5%	1%	0%
31+ hrs	5%	0%	0%	0%	0%
Total Discharges	100%	100%	100%	100%	100%

Non-Medicaid Consumers

	Persons in Hi Intensity Prgms	LOCUS Level 0-3	LOCUS Level 4-6	Unknown LOCUS Level	Not Served in Outpatient
How Much Community-Based Service Was Provided in the 30 Days before Admission?					
No Prior Service	19	101	42	182	465
3 hrs or less	34	100	58	128	138
4 - 10 hrs	22	28	13	2	1
11 - 30 hrs	15	5	3	-	1
31+ hrs	1	-	-	-	-
Total Admissions	91	234	116	312	605
How Much Community-Based Service Was Provided in the 30 Days after Discharge?					
No Further Service	14	48	21	228	540
3 hrs or less	32	91	54	72	59
4 - 10 hrs	28	87	36	11	4
11 - 30 hrs	15	8	5	1	2
31+ hrs	2	-	-	-	-
Total Discharges	91	234	116	312	605

Ratio of Non-Medicaid Consumers

	Persons in Hi Intensity Prgms	LOCUS Level 0-3	LOCUS Level 4-6	Unknown LOCUS Level	Not Served in Outpatient
How Much Community-Based Service Was Provided in the 30 Days before Admission?					
No Prior Service	21%	43%	36%	58%	77%
3 hrs or less	37%	43%	50%	41%	23%
4 - 10 hrs	24%	12%	11%	1%	0%
11 - 30 hrs	16%	2%	3%	0%	0%
31+ hrs	1%	0%	0%	0%	0%
Total Admissions	100%	100%	100%	100%	100%
How Much Community-Based Service Was Provided in the 30 Days after Discharge?					
No Further Service	15%	21%	18%	73%	89%
3 hrs or less	35%	39%	47%	23%	10%
4 - 10 hrs	31%	37%	31%	4%	1%
11 - 30 hrs	16%	3%	4%	0%	0%
31+ hrs	2%	0%	0%	0%	0%
Total Discharges	100%	100%	100%	100%	100%