CHIP

Be Healthy Jefferson

BH Summit Meeting

January 19, 1:30pm

The BHC is funded by HRSA's RCORP-Implementation Grant
through September 2023

SUMMIT AGENDA

1:30 – 1:45 **Welcome and Introductions**

– Dr. Carlbom and Participants

1:45 – 2:00 **Case Review**

– David Carlbom / Participants

- What went well?
- What were the challenges?

2:00 –2:20 **Agency Highlights**

- EJFR – Bret Black
- DBH – Jim Novelli

2:20 – 2:45 **EMS Behavioral Health Guideline Review**

– David Carlbom / Participants

2:45 – 2:55 **Review of QRT Possibility** (mentioned at 10/27 Summit)

– Facilitated by David Carlbom

2:55 – 3:00 **Summit Wrap-Up – What Comes Next**

– David Carlbom

Case Review

- What went well?
- What were the Challenges?

Our Community's Behavioral Health Center

Licensed, state monitored Behavioral Health Center offering integrated Medicare/Medicaid Services

- Mental Health and Psychiatric care services
- Substance Use Disorder (SUD)
- Medically Assisted Treatment (MAT)
- 24/7 Crisis Services
- Case Management

Contracted Programs

- Sheriff's Team Navigator
- REAL Team

  (Recovery, Empowerment, Advocacy, and Linkage)

Innovation Highlight

- Integrating DBH and Sheriff's Department's efforts to address calls involving mental health
- Quilcene and Brinnon's Fire Departments are receptive to more collaboration

Opportunity Highlight

- Develop relationship with PTPD and EJFR to integrate efforts to address calls involving mental health

Request of This Group

To develop relationships with PTPD and EJFR, and use those relationships to deliver behavioral health services with intention and effectiveness.


EAST JEFFERSON
FIRE-RESCUE
SINCE 1872


Serving the
Communities of:
Port Hadlock
Chimacum
Irondale
Kala Point
Marrowstone Island
Cape George
Port Townsend

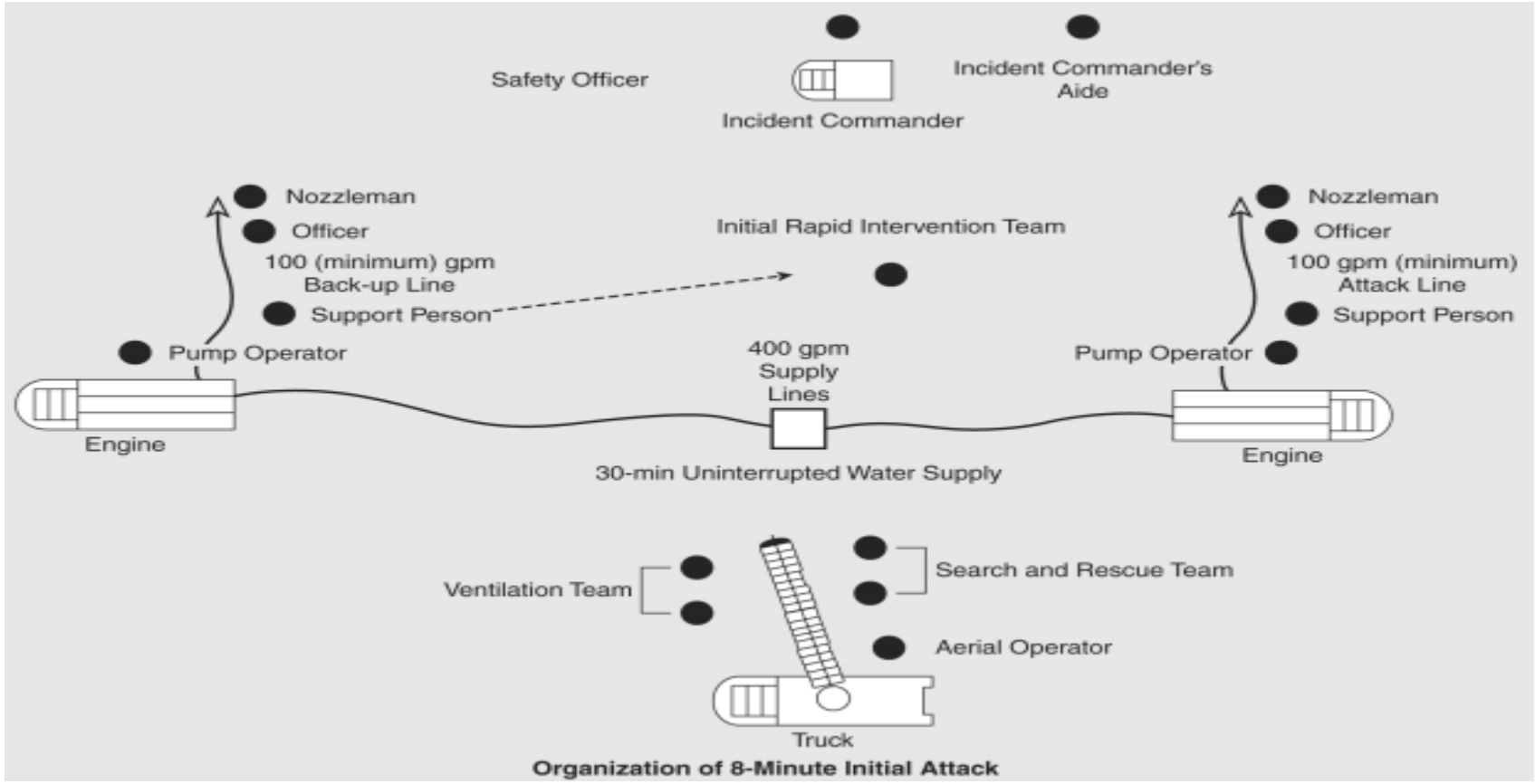
Service Area: 68 square miles
Population Served: 21,103

Six Fire Stations – 3 Staffed, 3 Volunteer
9 Firefighters Per day

Fire Definitions

Task Analysis

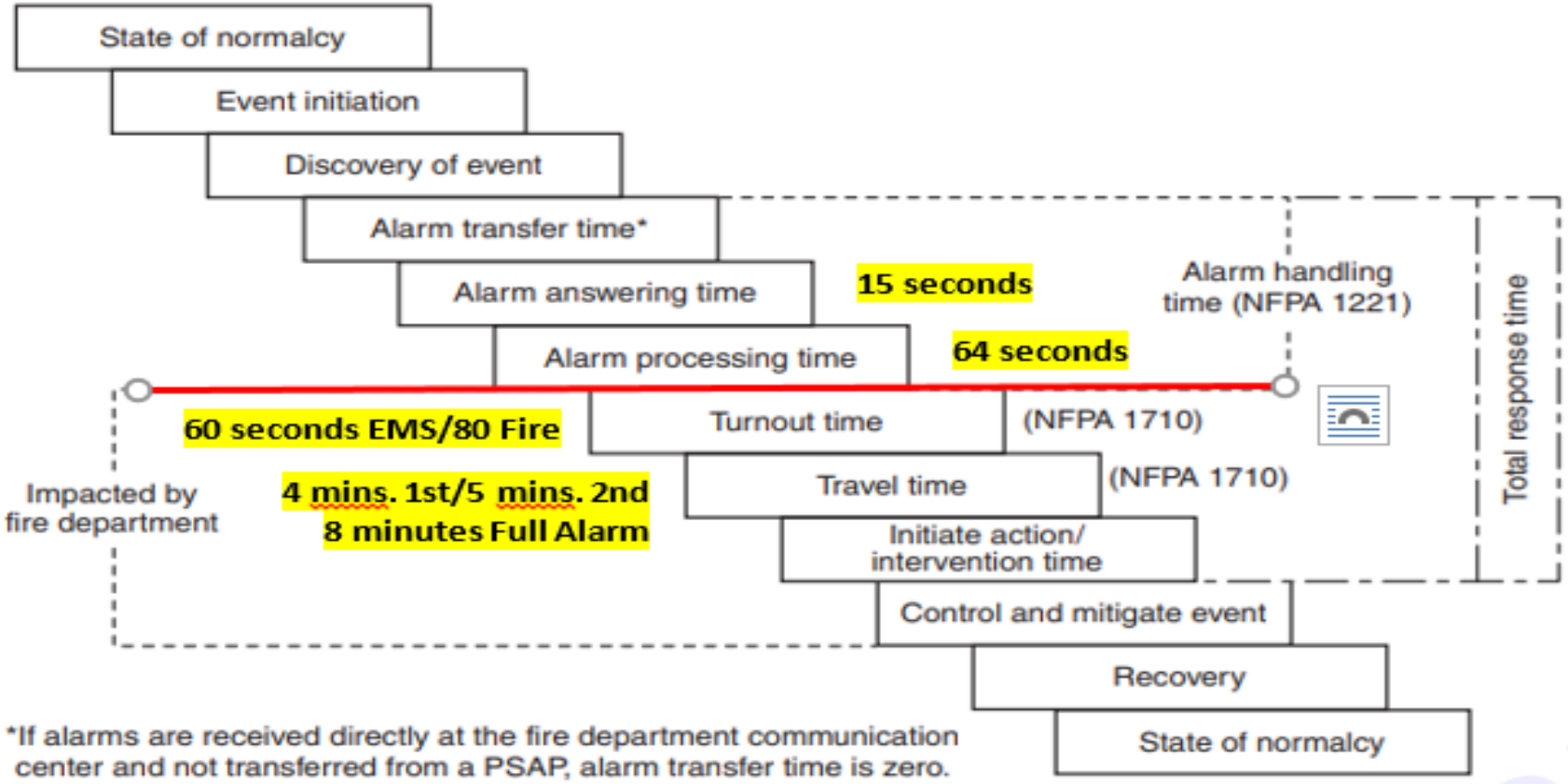
NFPA 1710 defines an Initial Full Alarm Assignment comprised of 16 members

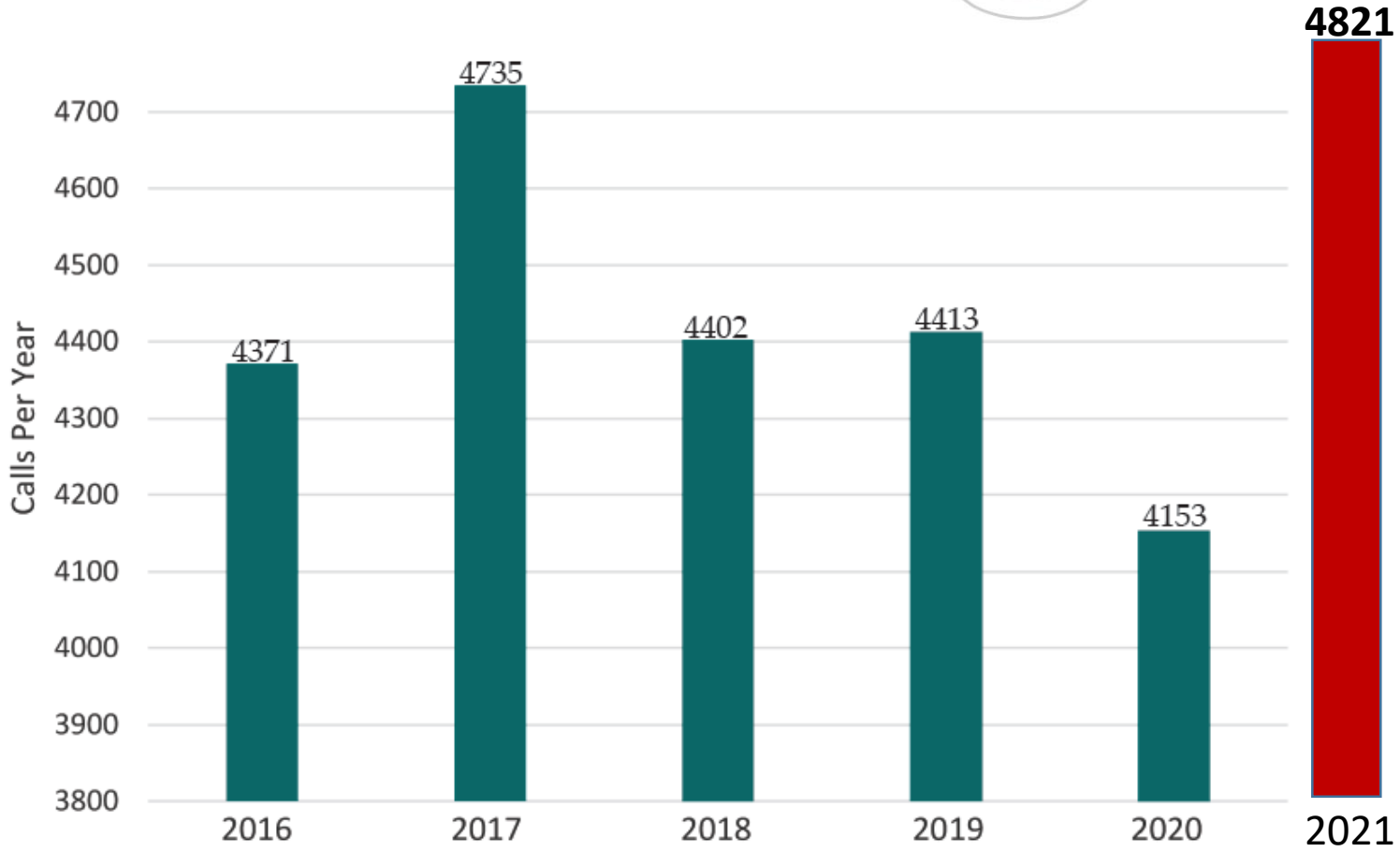


Organization of 8-Minute Initial Attack

Fire Definitions

Cascade of Events

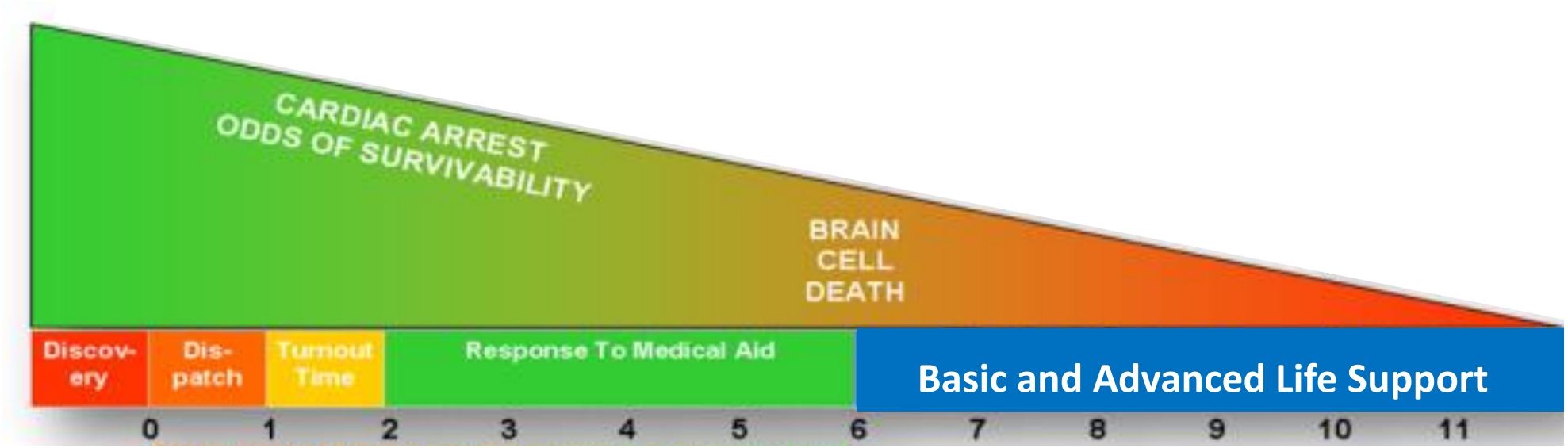




76 % EMS Calls

10% of EMS Calls are MH related. **368 for 2021**

“The shortest possible response times create the highest probabilities of resuscitation and survival”



Challenges

RCW 52.02.020
Districts authorized.
(1) Fire protection districts for the provision of fire prevention services, fire suppression services, emergency medical services, and for the protection of life and property are authorized to be established as provided in this title.

- Increased Expenditures, tax revenue is very limited
- Vehicles are aging
- Fire stations are aging, obsolete
- Understaffed
- Varying/New Missions

Strategic Plan

Community Risk Assessment

NFPA 1710 Community Risk Assessment (CRA). A systematic approach that identifies, assesses, categorizes, and classifies the probabilities and consequences of a community's fire and non-fire hazards and threats, taking into account all pertinent facts that increase or decrease risks in each first-due response zone. Also commonly referred to as Risk Sequencing and utilized to develop Community Risk Reduction (CRR) programs.

The CRA may be developed independently of the Standards of Cover (SOC) or directly integrated into the SOC process.

Strategic Plan

The Community–Driven Strategic Planning Process Outline

1. Define the services provided to the community and establish the community's service priorities.
2. Establish the community’s expectations of the department, aspects that the community views positively, as well as any concerns they may have about the department.
3. (Re) Develop the departments mission statement.
4. (Re) Establish the values of the department's membership.
5. Identify the strengths and any weaknesses of the department.
6. Identify areas of opportunity for and potential threats to the department.
7. Establish realistic goals and objectives, along with critical tasks for each objective.
8. Develop a vision of the future.

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Last Revised:	January 8, 2021	REVIEW:	
APPROVED:		Dr. David Carlbom, Medical Program Director	
APPROVED:		Laurie Tinker, E. Jefferson EMS Council Chair	

Purpose

To establish and ensure a consistent response to behavioral health emergencies throughout E. Jefferson County, emphasizing patient, provider, and community safety, while ensuring dignity for individuals experiencing behavioral challenges from mental health disorders or substance use disorders.

Individuals Impacted

- EMS Response Personnel
- E. Jefferson County Law Enforcement
- Behavioral Health Providers
- Receiving Medical Facilities

Policy

E. Jefferson County EMS providers will safely and appropriately assist patients experiencing behavioral health crises. This assistance includes on-scene assessment, interventions, triage, transport to appropriate facilities, and specialized follow-up care where available. This policy is not intended to replace individual agency response policies and procedures but to provide guidance to member agencies and field providers.

Definitions

- Alternate Destination A transport destination other than an emergency department. See Alternate Destination Policy (Find 3/14/2011 Procedure directing txp to hospitals)
- Behavioral Health The connection between physical health and the well-being of the mind.
- Behavioral Health Crisis Any situation in which a person's behavior puts them at risk of hurting themselves or others.
- Behavioral Health Navigator An individual who works with a multidisciplinary team to support patients and address the social determinants that impact the patient's health by linking the patient with resources.
- Behavioral Health Report A supplement to ESO patient care report documenting a behavioral health patient incident.
- CARES Community assistance referral and education services.
- Crisis Intervention Officer/team A community-based approach to intervene with incidents involving individuals with mental illness and/or substance use disorders.
- Designated Crisis Responder County designated individual identified by statute to evaluate if a person represents harm to self/others, or is gravely disabled and is at imminent risk, or if there is a nonemergent risk due to a substance use disorder or mental disorder.
- Force Protection Force protection refers to the concept of protecting fire/EMS personnel, civilians, facilities, equipment, and operations from threats or hazards in order to preserve operational effectiveness.
- Grave Disability A person is a threat to self or others based on their expressed thoughts, beliefs, actions, or inability to care for themselves.
- Implied Consent Implied consent is consent that is not expressly granted by a person but rather implicitly granted by a person's actions and the facts and circumstances of a particular situation.
- Involuntary Transport Transport from one location to the next without informed consent and under the intent of implied consent.
- Mental Health Professional A psychiatrist, psychologist, physician assistant working with a supervising psychiatrist, psychiatric advanced registered nurse practitioner, psychiatric nurse, or social worker, and such other mental health professionals as may be defined by rules adopted by the Secretary of Health pursuant to RCW 71.05.
- Order of Apprehension to Detain RCW 71.05.153- A DCR may issue an order of apprehension to detain (also known as a "custody authorization" or "custody order") specifying a patient be taken to an emergency department, crisis triage, or crisis center.
- Safety Plan A plan and contract between a patient and healthcare provider for safety. It will include names of two individuals and phone numbers the patient can contact for help, two safe activities to use as a diversion, and a safe location to go to in order to avoid stressors.
- Voluntary Transport Transport from one location to the next under informed consent.
- Vulnerable Person/Population Those by race/ethnicity, age, or socioeconomic status are disadvantaged by inadequate healthcare.

Procedures

Pre-arrival Goals

If safe, begin scene safety determination & other On-Scene Goals (below). Consider:

1. Determination if scene is safe to enter.
2. Request additional resources for patient & care team safety
3. Request additional resources for patient evaluation, triage, and treatment

On-Scene Goals

When arriving on scene, these general guidelines should be followed:

1. Determination if scene is safe to enter.
2. Emphasis on behavior at the time rather than known prior diagnoses, assumptions, or history.
3. When possible, contact the patient outside. Consider establishing contact with patient by phone.
4. Role of law enforcement Aiding with scene safety for EMS crews and force protection.
5. Assess patient's issues/agenda, capacity for decisions, and Behavioral Activity Rating Scale (Psychological/Emotional/Excited Delirium: page 39 patient care protocols).

General Patient Categories

Patients with Capacity Seeking Resources

1. A patient who does not request transport to hospital or crisis center. These patients are seeking resources.
2. These patients have insight and the capacity to make decisions.
3. They are NOT actively suicidal or homicidal and do not meet a definition of grave disability.
4. These patients can make a safety plan as an interim.
5. Contact specialty resources when available and look at past utilization of these resources' effectiveness:
    a. Navigators via Jeffcom dispatch
    b. DCT via Crisis Center 24/7 line: (888) 910-0416
6. Patients should sign a non-transport release and wait for resources to meet with them.
7. Providers must document the patient's safety plan in the EHR narrative.

Patients with Capacity Seeking Transport

1. These patients have some capacity and insight and are experiencing suicidal or homicidal ideation or exacerbation of their chronic mental health disorders.
2. In their capacity, they are requesting transport for treatment.
3. Their consent is informed, and their decision is voluntary.
4. Transport to:
    a. ED
    b. Alternate destination (Crisis Center or Withdrawal Management)
5. EMS providers must document the patient's informed consent and transport decision in the EHR narrative.

Patients without Capacity & Gravely Disabled

1. These patients are gravely disabled by their suicidal/homicidal ideation, intoxication, or exacerbation of their chronic mental health disorder.
2. They will lack the capacity and insight to make decisions.
3. Their consent for treatment is implied, and their transport will be involuntary.
4. EMS providers can gain access to the patient, and the scene is safe.
5. These patients can be transported against their will as
    a. they lack the capacity to make decisions, AND
    b. leaving them on the scene would lead to an imminent threat to their health and safety.
6. Contact Mobile Crisis Outreach (DCR) 1-888-910-0416 for on-scene evaluation OR consultation to describe the patient's grave disability.
7. If DCR is unavailable or unable to respond, contact base station for orders.
8. Contact of a DCR or base station should not delay actions necessary to prevent the patient from causing further harm, when safe to do so.
9. EMS providers may physically restrain the patient AS INDICATED and document the reason and method appropriately.
10. EMS providers may use medications to treat severe agitation that are impeding timely & safe evaluation of life-threats.
11. Request law enforcement response.
12. A patient who cannot safely be restrained or medicated should be dispositioned as “Patients Threatening Violence / Unsafe Scene”

Patients Threatening Violence / Unsafe Scene

1. These patients are violent, or proclaim/threaten violence, or possess a weapon, or EMS providers are unable to gain safe and sustained access to the patient, and/or the scene is unsafe.
2. EMS shall perform a determination if scene is safe for EMS to enter (see below).
3. If scene is unsafe, do not enter the scene. Stage and contact dispatch for law enforcement and a DCR to respond to the scene.
4. If law enforcement does not respond or will not engage in the incident:
    a. Request Dispatch of a Battalion / Duty Chief
        i. The incident commander, or supervisor, will review and confirm risk assessment and use this review to guide further agency actions and requesting additional resources
        ii. The incident commander, or supervisor, will be responsible for coordinating communication with law enforcement and DCR
    b. Whenever feasible, communicate directly with a LE officer about the case (options include face-to-face, via radio, MDT group chat, or cell phone). Confirm their intentions regarding their response.
    c. When appropriate, ask dispatch to request the patient to come outside or meet EMS personnel at a location that provides a greater margin of safety. Any contact with the patient (e.g., phone, verbal, etc.) will be documented.
    d. If patient contact is attempted, consider requesting a contact timer from JeffCom (at 3- or 5-minute intervals)

e. If the supervisor identifies that the fire or EMS agency may not safely enter (or remain on) the scene or safely contact the patient, the supervisor will attempt to update the reporting party.

5. The absence of Law Enforcement or DCR response will not increase the level of risk EMS personnel take. EMS personnel will have no obligation to provide patient care in an unsafe scene or situation.
6. Contact by dispatch with the reporting party will be attempted prior to leaving the scene if no patient contact can be attempted. Dispatch should be notified upon implementation of the decision to leave the scene.

Determination if a scene is safe for EMS to enter

Consider starting this process prior to arrival if safe.

Prior to entering the scene, EMS should conduct a preliminary risk assessment based on known information. If any of the below is encountered, stage and contact law enforcement as appropriate.

1. Is the patient harming or threatening harm to people?
2. Is the patient threatening to harm themselves with a weapon?
3. Are there bystanders that appear to present a threat to the patient or responders?
4. Is there an identifiable risk factor that presents an unusual or extraordinary threat to the health & safety of responders?
5. Does the physical environment appear safe?

If law enforcement is present, perform direct communication prior to entering scene to confirm their intentions regarding the response & safety plan.

If law enforcement is unable to respond, consider the following:

1. Request additional resources early (such as additional fire/EMS unit(s), behavioral response unit, social worker, designated crisis responder (DCR), and/or other county specific resources).
2. Contact the EMS service leadership, if available, to assist with risk assessment and additional guidance.
3. Consider all personal protective equipment available to EMS providers.
4. When appropriate, ask the person/patient to meet EMS outside of their house/building or meet EMS personnel at a location that provides a greater margin of safety.
5. Request status checks on responding EMS providers from dispatching entity.
6. Identify process to disengage from the scene to include notification of dispatching entity.
7. Dispatching entity should be notified when EMS disengages from the response and leaves the scene.

Assessment of the risk the person presents to themself, the public, and responders

Patients exhibiting agitated or violent behavior due to other or co existing medical conditions including, but not limited trauma, head injury, bleeding, electrolyte abnormality, metabolic disorder, hypoxia, toxidrome (substance use), or infection will be treated by the appropriate treatment guideline in addition to any behavioral health needs.

1. Observe scene for medications/substances that may contribute to the agitation or uncooperative behavior, or may be relevant to the treatment of a contributing medical condition
2. Approach the patient in disarming manor, consider sitting down, avoid postured arms.
3. Assess airway patency and support as needed
4. Note respiratory rate and effort – If possible, monitor pulse oximetry and/or capnography
5. Assess circulatory status:
    a. Skin color, appearance
    b. If patient will permit contact: Measure pulse rate and quality, assess capillary refill time, skin temperature and obtain blood pressure
    c. Assess neurological status including orientation to self, events, place and time
    d. Check blood glucose (if possible)
6. Assess for evidence of traumatic injuries or toxidromes (substance use patterns)
7. Use a validated risk assessment tool such as BARS (Behavioral Activity Rating Scale), RASS (Richmond Agitation Sedation Score), or AMSS (Altered Mental Status Score) to risk stratify violent patients to help guide interventions

Situational Awareness and Mitigation/De-escalation Tools

Signs of Impending Violence
Clenched fists
Display or threat of weapon
Staring & non-blinking
Threatening Posture & Gestures
Clenched Jaw
Red face
Bulging neck veins

De-Escalation Strategies
Remove irritating stimuli
Discuss situation calmly
Active Listening
Explore Patient's Feelings
Normalize Feelings
Convey Respect
Ask: What helped in the past? What will help now?

Determination of an individual's decision-making capacity

To decline care, a patient must demonstrate decision-making capacity. To have decisional capacity, a patient must fulfill the following criteria.

Patient/caregiver is:

1. 18 years old or believed to be an emancipated minor.
2. Oriented (GCS 15) and understands the situation and consequences
    a. can weigh risk/benefit options
    b. rationally/logically processes information before making a decision
    c. can demonstrate understanding using teach-back method
    d. communicates their desires
3. Neither physically, nor cognitively impaired by the use of alcohol, drug(s), or other substances.
4. Neither suspected of brain trauma, nor hypoxia as evidenced by pulse oximetry > 85%.

5. Absent of dementia, mental illness, or other medical disease that impairs the patient's decision-making.
6. Absent of attempted suicide, verbalized suicidal intent, or other factors suggesting suicidal intent.

Patients with decision-making capacity

To refuse care and/or transport against medical advice (AMA), a patient (or a person authorized to speak on their behalf) must be oriented and understand the situation and consequences; and be able to weigh risk/benefit options; and rationally/logically process information before making a decision; and communicate their desires.

This statement should be read by the patient who is refusing care and or transport against medical advice or have it read to them by the EMS professional caring for them.

"This form has been given to you because you do not want treatment and/or transport by EMS. Your health and safety concerns us, even though you have decided not to accept our advice. In doing so, please remember the following:

1. Your condition may not seem as bad to you as it may actually be. Without treatment your condition or problem could become worse. If you are planning to get medical treatment, a decision to refuse treatment or transport by EMS may result in a delay of care, which could make your condition or problem worse.
2. The evaluation and/or treatment offered to you by EMS cannot replace treatment by a doctor. You should obtain medical evaluation and/or treatment by going to any hospital Emergency Department in this area, or by calling your doctor if you have one.
3. If you change your mind or your condition becomes worse, do not hesitate to call 9-1-1. Don't wait. When medical treatment is needed, call 9-1-1; it is better to get help immediately."

Patients without decision-making capacity

If the patient does not have decision-making capacity, the patient cannot refuse care against medical advice per established protocols. In such an instance, EMS should proceed in efforts to safely engage the patient using considerations for unsecured scenes.

Law enforcement should be contacted to attempt to get assistance in managing the patient.

If EMS has made the determination to not engage or disengage with the uncooperative patient and that they should remove themselves from the scene due to safety concerns, online medical control will be contacted.

When EMS providers disengage from a scene with or without patient interaction, they should document the risk they perceive in engaging the patient, their perception that the scene is unsafe, and that law enforcement is unable to assist in the call.

General Considerations for Physical and Pharmacological Management Devices

EMS providers are primarily responsible to develop and implement patient care plans tailored to the scene and patient scenario and to provide emergency medical care in accordance with their training, scope of practice, and protocols. The method of physical and/or pharmacologic management shall not restrict the adequate monitoring of applicable physiology including vital signs or otherwise prevent appropriate and necessary therapeutic measures. It is recognized that medical evaluation and treatment requires patient cooperation and thus, may be difficult or impossible.

Sufficient personnel should be available to provide the safest environment for patient, EMS providers, and others. Request additional resources early.

EMS professionals must remember that uncooperative behavior may be a symptom of medical conditions such as:

- Head trauma
- Alcohol/drug related problems (e.g. combative agitation)
- Metabolic disorders (i.e., hypoglycemia, hypoxia, etc.)
- Psychiatric/stress related disorders

Physical Management Considerations

- Soft physical management devices are to be used when necessary in situations where the patient is potentially violent and may be a danger to themselves, EMS personnel, or others.
- All physical management devices should have the ability to be quickly released.
- EMS personnel shall check for circulation in extremities that are restrained on regular intervals.
- Restrain the patient in a lateral or supine position. Do not restrain the patient in a prone position.
- No devices such as backboards, splints, or other devices will be placed on top of the patient.
- The patient must always be under constant observation by EMS. Use continuous multimodal monitoring such as ECG, end tidal CO2 (EtCO2), and pulse oximetry, when indicated, available, and able to be performed.
- Hard physical management devices should be transitioned to soft physical management devices as soon as possible.
- The person who was responsible for applying a physical management device that requires a key (such as handcuffs) or special releasing device should physically remain with the patient regardless of the vehicle of transport in the interest of the patient's safety or an alternative appropriate physical management device must be used.

Pharmacologic Management Recommended Practices

- EMS providers may administer an appropriate dose of a pharmacologic management measure as directed by patient care protocols.
- Online medical direction may be contacted at any time for advice or for pharmacological orders.
- The patient must always be under constant observation by EMS. Use continuous multimodal monitoring to include ECG, end tidal CO2 (EtCO2), and pulse oximetry, when indicated, available, and able to be performed.
- Refer to local MPD patient care protocols for guidance on appropriate medical instances to administer pharmacologic management measures.

EMS Refusal to Treat and/or Transport

EMS providers may determine that they should remove themselves from the scene due to safety concerns. This removal may result in EMS not engaging or disengaging from a violent or uncooperative person or patient. EMS providers should include items identified in documentation standards for unsecured scenes and uncooperative patients.

1. If scene is unsafe, do not enter the scene. Stage and contact dispatch for law enforcement and a DCR to respond to the scene.
2. If law enforcement does not respond or will not engage in the incident:
    a. Request Dispatch of a Battalion / Duty Chief
        i. The incident commander, or supervisor, will review and confirm risk assessment and use this review to guide further agency actions and requesting additional resources
        ii. The incident commander, or supervisor, will be responsible for coordinating communication with law enforcement and DCR

b. Whenever feasible, communicate directly with a LE officer about the case (options include face-to-face, via radio, MDT group chat, or cell phone). Confirm their intentions regarding their response.
c. When appropriate, ask dispatch to request the patient to come outside or meet EMS personnel at a location that provides a greater margin of safety. Any contact with the patient (e.g., phone, verbal, etc.) will be documented.
d. If patient contact is attempted, consider requesting a contact timer from JeffCom (at 3- or 5-minute intervals)
e. If the supervisor identifies that the fire agency may not safely enter (or remain on) the scene or safely contact the patient, the supervisor will attempt to update the reporting party.

3. The absence of Law Enforcement or DCR response will not increase the level of risk EMS personnel take. EMS personnel will have no obligation to provide patient care in an unsafe scene or situation.
4. Contact by dispatch with the reporting party will be attempted prior to leaving the scene if no patient contact can be attempted. Dispatch should be notified upon implementation of the decision to leave the scene.

Documentation Standards for Unsecured Scenes / Uncooperative Patients Refusal to Treat and/or Transport

In addition to standard documentation that is traditionally completed by EMS providers to document the care and decisions made by EMS personnel, EMS should also complete documentation that supports assessment and determination of scene safety, physical or pharmacological management, medical care, transport or no transport decisions made by the EMS personnel for these types of calls.

1. Personnel will use the Unusual Incident form on all patients threatening violence or unsafe scene.
2. There will be a 100% agency QI review of:
    a. Transports of patients without capacity & gravely disabled.
    b. Physical restraint or any medication used in patients threatening violence nsafe Scene.
    c. Unusual Incident forms on all patients threatening violence or unsafe scene responses.

Documentation should include:

1. Descriptive overview of physical characteristics of the scene.
    a. Example: Responded to an unconscious person in a car in a parking lot.
2. Description of the danger or safety elements involved.
    a. Example: Person is in a vehicle; crew cannot see the persons hands or if there are weapons.
    b. Example: The person will not engage with providers attempt to contact.
    c. Example: The person indicates they do not want help, approached, bothered.
3. List and describe measures used to attempt to engage the patient.
    a. Example: Attempted to call out to the person from a distance.
    b. Example: Attempted to use the public address system to contact the person.
    c. Describe other specific mitigation measures.
4. List and describe measures used to attempt to create safety.
    a. Example: Requested law enforcement and/or DCR.
    b. Example: Attempted to evaluate the scene from a distance.
    c. Describe other specifically identified hazards.

5. Describe why safety could not be established.
    a. Example: Unable to gain reasonable cooperation from person. Because the person was threatening EMS personnel/firefighters.
    b. Example: Law Enforcement could/would not respond or engage.
6. Document exposure to violence or threats of violence in personnel module if available on platform.
7. Document medical care, including:
    a. Describe the reason for physical and/or pharmacologic management.
    b. Identify who applied the physical management device (i.e., EMS, police).
    c. Document any medical screening attempts.
    d. Document vital signs including serial cardio-respiratory status and peripheral neurovascular status.
8. Document other agencies that interacted or attempted to interact with the person.
9. Document information acquired about the situation that resulted in EMS being called:
    a. Describe what prompted EMS to be called to the scene.
    b. Identify if law enforcement engaged the person prior to EMS arrival and what actions were taken.

Acronym Sheet

BH – Behavioral Health
BHC – Behavioral Health Consortium
CHIP – Community Health Improvement Plan
DUI – Driving Under the Influence
ED – Emergency Department
EJFR – East Jefferson Fire Rescue
EMS – Emergency Medical Services
JeffCo – Jefferson County
JHC – Jefferson Healthcare
MAT – Medically Assisted Treatment
MH – Mental Health
OUD – Opioid Use Disorder
PTPD – Port Townsend Police Department
REAL Program – Recovery, Empowerment, Advocacy, and Linkages Program
RHNDP-P – Rural Health Network Development Program – Planning
RCORP-P – Rural Community Opioid Response Program – Planning
RCORP-I – Rural Community Opioid Response Program – Implementation
SUD – Substance Use Disorder
TBH – To Be Hired
VOA – Volunteers of America – Crisis Line
Vol - Voluntary
Invol – Involuntary

Thank You