SUMMIT AGENDA

3:00 – 3:15 **Welcome and Introductions**
– Dr. Carlbom and Participants

3:15 – 3:30 **Case review** – David Carlbom / Participants
Keeping Patients Safe: Unusual Cause of Abnormal Behavior

- What went well?
- What were the challenges?

3:30 – 3:50 **Agency Highlights**

- Believe In Recovery – Gabbie Caudill
- Sheriff's Office – Joe Nole

3:50 – 4:15 **EMS Behavioral Health Response Guideline**
– David Carlbom / Participants

4:15 – 4:20 **Review Action Items from 1/19/2022 Meeting**
– Facilitated by David Carlbom

4:20 – 4:30 **Summit Wrap-Up & Next Steps**
Next Meeting - Tuesday, July 26th @ 3pm?
– David Carlbom

JEFFERSON COUNTY EMS COUNCIL

CHIP

Be Healthy Jefferson

BH Summit Meeting

April 26, 3:00pm

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

JEFFERSON COUNTY EMS COUNCIL

Agenda – 4/26/22 BH Summit

- Welcome and Introductions – 15 Minutes
- Case review:
  Keeping Patients Safe: Unusual Cause of Abnormal Behavior - 15 Minutes
  - David Carlbom / Participants
- Agency Highlights - 20 Minutes
  Gabbie Caudill, Believe In Recovery / Joe Nole, Sheriff's Office
- EMS Behavioral Health Guideline Review – 25 Minutes
  - David Carlbom / Participants
- Review Action Items from 1/19/2022 Meeting – 5 Minutes
  - Facilitated by David Carlbom
- Summit Wrap-up – What Comes Next – 5 Minutes
  - David Carlbom

JEFFERSON COUNTY EMS COUNCIL

Keeping Patients Safe: Unusual Cause of Abnormal Behavior

- What went well?
- What were the challenges?

Believe In Recovery

- Regular and intensive outpatient treatment and counseling services
- Anger Management
- Alcohol and Drug Information School
- DUI Victim Impact panel
- Provide Emergency Service Patrol
- Provide Peer Support
- 24 hour Information and Crisis Services

Contracted Programs

- Serving on the Drug Court Team since 2018
- Serving on Behavioral Court Team since 2016
- Serving on Family Therapeutic Court Team since 2018
- Residential Substance Abuse Treatment (RSAT) in the Jail
  Began 2021 and is renewable yearly
- Providing in-jail assessments, case management, and relapse prevention classes since 2019

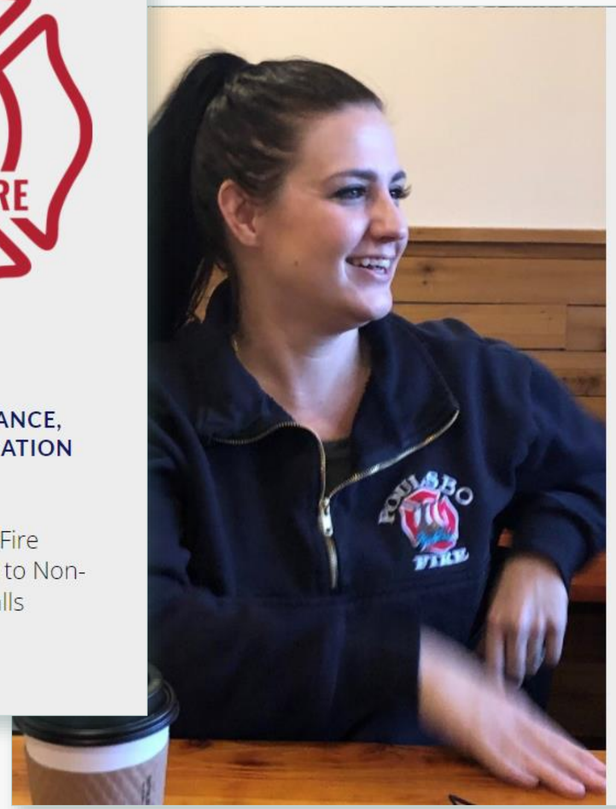
Contracted Programs – Cont'd

POULSBO FIRE CARES

CARES

COMMUNITY ASSISTANCE, REFERRAL, AND EDUCATION SERVICE

Enhancing Poulsbo Fire Department's Response to Non-Emergency 911 Calls



SUBSTANCE USE DISORDER PROFESSIONAL

GABBIE C.

"I have always had a heart to help those struggling with homelessness and behavioral health disorders.

I'm a substance use disorder professional (SUDP) and have been working in this field for over 10 years. I am one of the owners of Believe in Recovery which has locations in Port Townsend and Yakima. I have a Master of Science degree in forensic psychology and am currently a doctoral student in the field of psychology, specializing in addictions and co-occurring disorders. I am also a veteran, which has given me firsthand experience in the struggles that veterans deal with regularly.

It feels great to contribute my experience and knowledge to the North Kitsap community. My background working with individuals struggling on so many different levels provides a solid foundation for the work I do as a Community Support Specialist with the Poulsbo Fire CARES program."

Poulsbo Cares Program
Link

Innovation Highlights

- Mobile Harm Reduction Unit

  Licensed to provide all the same services as provided in-office

- Provide transportation, clothing, tents, toiletries

- Collaboration with Law Enforcement

Opportunity Highlight

- Expanding the Emergency Patrol Services currently offered at no cost to agencies
- Mobile Unit up and running

Request of this Group

- Continued collaboration in the field

Jefferson County Sheriff's Office

- Law Enforcement agency that serves the public 24/7/365 –
- Have a jail – 56 beds
- Responsible for all law enforcement in county and on the water
- 24 deputies (including Sheriff and Undersheriff)
- 2 Deputies living on the West End of the County
- Currently 10 Corrections Officer, Need 15
- Responsible for Civil Service – 3 Civil Deputies
- 1 Animal Control Officer
- 1 Navigator

Contracted Programs

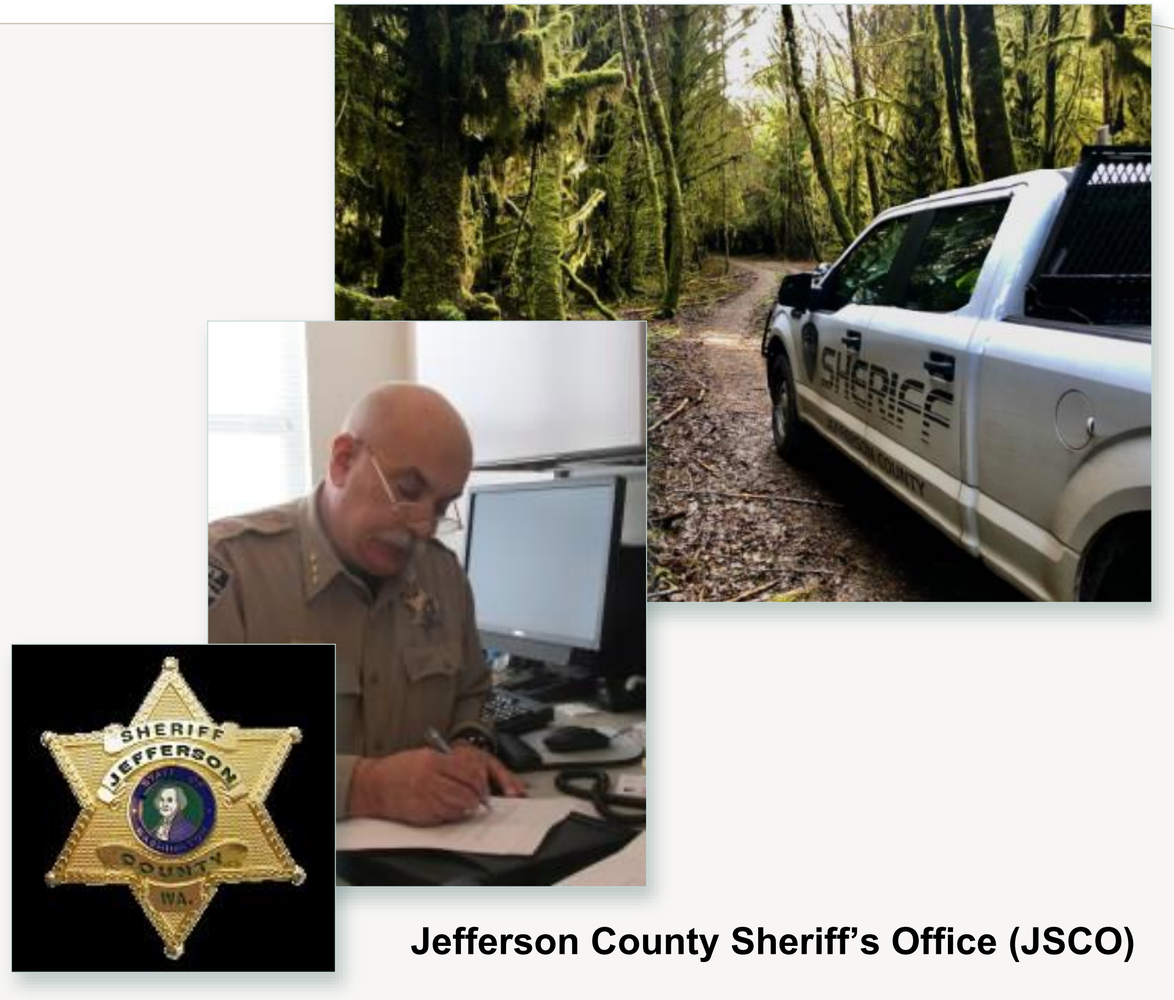
- Navigator program is contracted to DBH w/ State Funding
- Residential Substance Abuse Treatment (RSAT) Program – State Grant
- Jail Medical services are contracted to private entity
- Food services are contracted to private entity
- Marine Program is supported by State grant funding
- State-funded Sex Offender Registration Program

Innovation Highlight

- The Navigator Program
  - Better for the people we encounter on calls
  - Relieves Deputies of the time commitment needed (thinking of wording)
  - The follow-up service JSCO is able to provide
- BODY Cams
  - Protects citizens and deputies from false claims
  - Gives picture of the scene and what occurred

Opportunity Highlight

- Continue to explore ways to link people to the services



Jefferson County Sheriff's Office (JSCO)

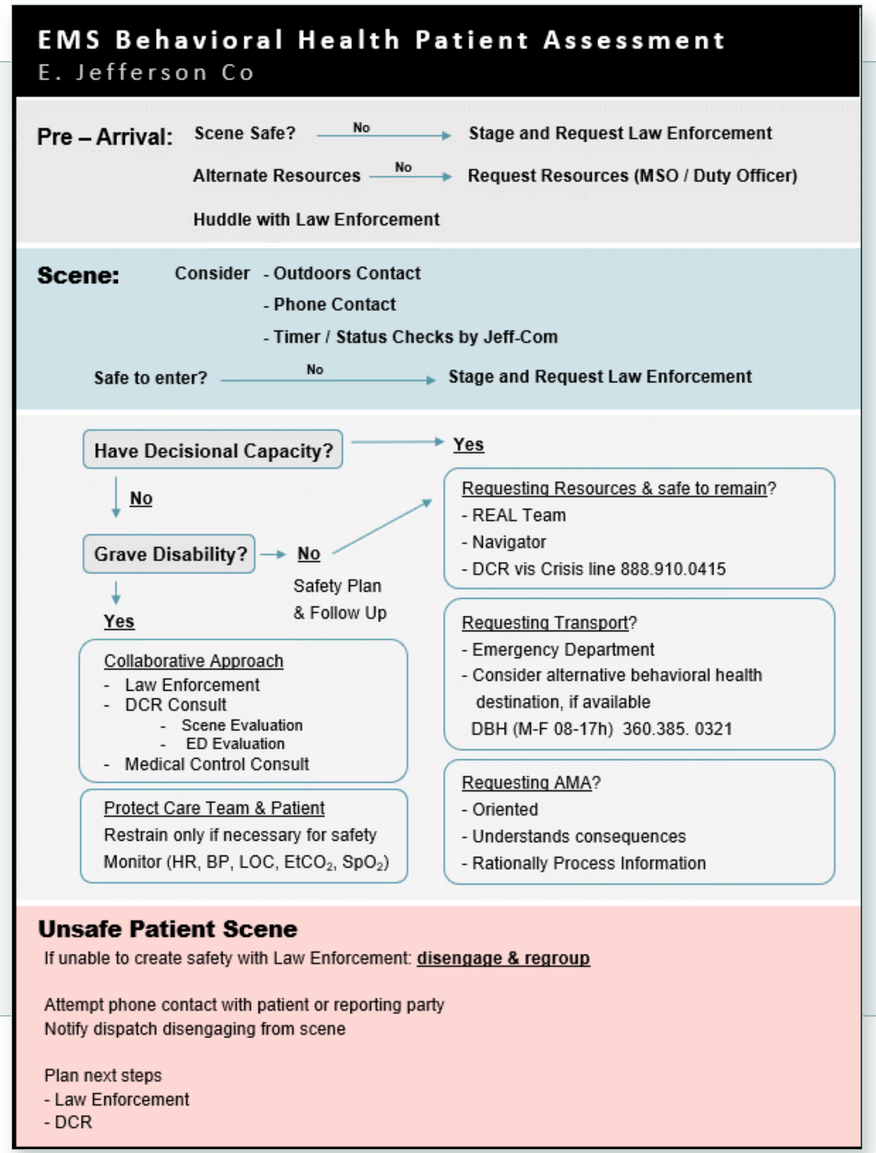
EMS Behavioral Health Guideline Review

- Jefferson County

  EMS Behavioral Health Response

  - Adopted 4/5/2022

- Draft Behavioral Health Flow Chart



EMS Behavioral Health Patient Assessment
E. Jefferson Co

Pre – Arrival:
Scene Safe? — No → Stage and Request Law Enforcement
Alternate Resources — No → Request Resources (MSO / Duty Officer)
Huddle with Law Enforcement

Scene:
Consider - Outdoors Contact
- Phone Contact
- Timer / Status Checks by Jeff-Com

Safe to enter? — No → Stage and Request Law Enforcement

Have Decisional Capacity? → Yes

No

Grave Disability? → No

Yes

Safety Plan & Follow Up

Requesting Resources & safe to remain?
- REAL Team
- Navigator
- DCR vis Crisis line 888.910.0415

Collaborative Approach
- Law Enforcement
- DCR Consult
  - Scene Evaluation
  - ED Evaluation
- Medical Control Consult

Requesting Transport?
- Emergency Department
- Consider alternative behavioral health destination, if available

DBH (M-F 08-17h) 360.385. 0321

Protect Care Team & Patient
Restrain only if necessary for safety
Monitor (HR, BP, LOC, $EtCO_2$, SpO_2)

Requesting AMA?
- Oriented
- Understands consequences
- Rationally Process Information

Unsafe Patient Scene
If unable to create safety with Law Enforcement: **disengage & regroup**

Attempt phone contact with patient or reporting party
Notify dispatch disengaging from scene

Plan next steps
- Law Enforcement
- DCR

JEFFERSON COUNTY EMS COUNCIL

Review Action Items from 1/19/2022 Summit

- Question: Where could the client have gone to get tested/vaccine? EJFR noted at one point this patient couldn't get into a local shelter for lack of vaccine/testing. Another challenge is the 10-day wait post-vaccination required for local shelter options. (It was noted anyone who comes into the jail is tested and offered a vaccine, if needed.)
  Action: LF followed up with Gabbie, who noted the Salvation Army in Bremerton, the cold weather shelter at Gateway in Poulsbo, and The Community Center in Kingston accept unvaccinated patrons, (however, they are not always open).
- Clarification of rules around local shelter vaccination: Also, clarify the rules around the local shelter – is an N95 mask acceptable, if they had a negative test is that acceptable? Per Cherish Cronmiller / Kathy Morgan: Vaccinations are required at the Legion Shelter. Patrons are encouraged to wear a mask and n95s are made available at the counter. Because of the older population they tend to not wear them. That is why we are asking for folks to be fully vaccinated. If we encounter symptoms we isolate them and test them there. We have two rooms for the isolation.

The group reviewed a draft of the Jefferson County EMS Behavioral Health Response Guideline that has been modeled in large part on the WA State DOH EMS guidance document.
Action: Dr. Carlbom invites input and will present it at the EMS Council in February for approval, then on to State DOH where it will be reviewed by EMS office and the Attorney General's Office. From there the document will be updated.

1/19/2022 Meeting Notes

BH Summit Web Page

JEFFERSON COUNTY EMS COUNCIL

Review Action Items from 1/19/2022 Summit

- Request: Create a graphic that illustrates the spectrum from REAL team, to Navigator, to DCR, and clarify who does what.

Program	**REAL (Recovery Empowerment Advocacy and Linkages)**	**Sheriff's Navigator**	**PTPD Navigator**	**Mobile Crisis Outreach (DCR)**
Service Offered	Pre-Crisis outreach, light touch and intensive case management	Service linkage	Service linkage	Crisis Intervention BH triage ITA
Referral Source	Governing Board representing Community interests	Sheriff's Dept	PTPD	All
Anchor Point	Service linkage	DBH	PTPD	DBH

JEFFERSON COUNTY EMS COUNCIL

Summit Wrap-Up – Next Steps

- Next Meeting – Tuesday, July 26th @ 3pm?

JEFFERSON COUNTY EMS COUNCIL

Acronym Sheet

BH – Behavioral Health

BHC – Behavioral Health Consortium

CAP – Communication Action Plan

CHA – Community Health Assessment

CHIP – Community Health Improvement Plan

DCR – Designated Crisis Responder

DUI – Driving Under the Influence

ED – Emergency Department

EJFR – East Jefferson Fire Rescue

EMS – Emergency Medical Services

JCPH – Jefferson County Public Health

JeffCo – Jefferson County

JHC – Jefferson Healthcare

HFPD – Health Facilities Planning & Development Consultants

HRSA – Health Resources and Services Administration

ITA – Involuntary Treatment Assessment

MAT – Medically Assisted Treatment

MH – Mental Health

MOUD – Medications for Opioid Use Disorder

OUD – Opioid Use Disorder

PTPD – Port Townsend Police Department

PWUD – People Who Use Drugs

RHNDP-P – Rural Health Network Development Program – Planning (HRSA Grant Awarded 2018-2019)

RCORP-P – Rural Community Opioid Response Program – Planning (HRSA Grant Awarded 2019-2020)

RCORP-I – Rural Community Opioid Response Program – Implementation (HRSA Grant Awarded 2020-2023)

R.E.A.L. – Recovery, Empowerment, Advocacy, Linkage

SUD – Substance Use Disorder

TBH – To Be Hired

VOA – Volunteers of America – Crisis Line

Vol - Voluntary

Invol – Involuntary

Thank You

EMS Behavioral Health Patient Assessment

E. Jefferson Co

Pre – Arrival:

- **Scene Safe?** — No → **Stage and Request Law Enforcement**
- **Alternate Resources** — No → **Request Resources (MSO / Duty Officer)**
- **Huddle with Law Enforcement**

Scene:

Consider
- **Outdoors Contact**
- **Phone Contact**
- **Timer / Status Checks by Jeff-Com**

Safe to enter? — No → **Stage and Request Law Enforcement**

Have Decisional Capacity? → **Yes**

↓ **No**

Grave Disability? → **No** → Safety Plan & Follow Up

↓ **Yes**

Collaborative Approach
- Law Enforcement
- DCR Consult
  - Scene Evaluation
  - ED Evaluation
- Medical Control Consult

Protect Care Team & Patient

Restrain only if necessary for safety

Monitor (HR, BP, LOC, $EtCO_2$, SpO_2)

Requesting Resources & safe to remain?
- REAL Team
- Navigator
- DCR vis Crisis line 888.910.0415

Requesting Transport?
- Emergency Department
- Consider alternative behavioral health destination, if available

DBH (M-F 08-17h) 360.385. 0321

Requesting AMA?
- Oriented
- Understands consequences
- Rationally Process Information

Unsafe Patient Scene

If unable to create safety with Law Enforcement: **disengage & regroup**

Attempt phone contact with patient or reporting party
Notify dispatch disengaging from scene

Plan next steps
- Law Enforcement
- DCR

E. Jefferson County EMS Behavioral Health Response Patient Care Protocol

Last Revised:	March, 2022	REVIEW:	
APPROVED:	**Signed 4/5/22**	Dr. David Carlbom, Medical Program Director	
APPROVED:	**Signed 4/5/22**	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 within their scope and training level. This assistance includes collaborating with Behavioral Health professionals and Law Enforcement to provide on-scene assessment, interventions, triage, transport to appropriate facilities, and specialized follow-up care where available.

This policy is not intended for use in the wilderness setting where resources are unavailable.

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
- 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 (DCR) 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.
- Electronic Health Record (EHR) The electronic record of patient care events completed by medical team.
- 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.
- Mobile Data Terminal (MDT) Computer in EMS or LE vehicle that affords asynchronous typed communication.
- 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 Establishing scene safety for EMS crews.
5. Assess patient's issues/agenda, capacity for decisions, and Behavioral Activity Rating Scale (Psychological / Emotional / Excited Delirium: page 39 NW Region Patient Care Protocols).

General Patient Categories

1. Patients with Decisional 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. DCR 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.

2. Patients with Decisional Capacity Seeking Transport

1. These patients have some decisional 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.

3. Patients without Decisional 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 decisional capacity and insight to make decisions.
3. Their consent for treatment is implied, and their transport will be involuntary.
4. 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.
5. Request law enforcement response.
    a. 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.
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 for patient & provider safety; document the reason and method appropriately.
10. EMS providers may use medications to treat severe agitation that is impeding timely & safe evaluation of life-threats. (see NW Region 2020 Protocols: Psychological / Emotional / Excited Delirium, p39.)
11. A patient who cannot safely be restrained or medicated should be dispositioned as “Patients Threatening Violence / Unsafe Scene”

4. Patients without Decisional Capacity & Threatening Violence or 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 priority traffic (& 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 establish a safe staging area and attempt to update the reporting party.
5. The absence of Law Enforcement or DCR response does not mean EMS personnel should take any additional risk. 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 able. Do not enter unsafe scenes.

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 unsafe?

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 priority traffic (& timer) from JeffCom (at 3- or 5-minute intervals).
6. Request status checks on responding EMS providers from dispatching entity.
7. Identify process to disengage from the scene to include notification of dispatching entity.
8. Dispatching entity should be notified when EMS disengages from the response and leaves the scene; clear priority traffic.

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. (see NW Region 2020 Protocols: Psychological / Emotional / Excited Delirium, p39.)

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 priority traffic (& 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 does not mean EMS personnel should take any additional risk. 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 decisional capacity & gravely disabled.
    b. Physical restraint or any medication used in patients threatening violence or unsafe 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.

ATTENDEES

Tim Manley, Brinnon Fire; Andy Pernsteiner, JSCO; Tim McKern, Quilcene Fire; Jim Novelli, DBH; Steven Eckles, DBH/JSCO Navigator; Tammy Ridgway, EJFR; Sheriff Nole, JCSO; Bret Black, EJFR; Kent Smith, JHC-ED; Laurie Tinker, EMS Council; Gabbie Caudill, Believe In Recovery; David Carlbom, JeffCo EMS; Lori Fleming, CHIP/BHC.

CASE STUDY – OBSERVATIONS & INSIGHTS

What went well:

- A lot of Law Enforcement and EMS aid was brought to bear on this situation – everyone wanted to help. There was compassion, and the desire to help this client.
- The ED did a thorough workup on this client in spite of the barriers noted.

Of note, questions and opportunities:

- Of note: EDs are under-resourced and under duress. Having someone board in the ED was a foreign concept six months ago, now people are staying 2-3 days on a regular basis for lack of beds and shelter. In this situation ED had too many patients already, and the client enters the scene toward the end of the shift, when the ED team is exhausted
- Question: A person who is not described as suicidal or homicidal – at what point are they detained? Housing isn't an option for a client that isn't stable. Was Telepsych consulted? Answer: Using the telepsych service turns the ED into a defacto psych ward - because of the extended timeline it often takes for Telepsych to return the call.
- Question: Where could the client have gone to get tested/vaccine? EJFR noted at one point this patient couldn't get into a local shelter for lack of vaccine/testing. Another challenge is the 10-day wait post-vaccination required for local shelter options. (It was noted anyone who comes into the jail is tested and offered a vaccine, if needed.)
  Action: LF followed up with Gabbie, who noted the Salvation Army in Bremerton, the cold weather shelter at Gateway in Poulsbo, and The Community Center in Kingston accept unvaccinated patrons, (however, they are not always open).
- Clarification of rules around local shelter vaccination: Also, clarify the rules around the local shelter – is an N95 mask acceptable, if they had a negative test is that acceptable? Per Cherish Cronmiller / Kathy Morgan: Vaccinations are required at the Legion Shelter. Patrons are encouraged to wear a mask and n95s are made available at the counter. Because of the older population they tend to not wear them. That is why we are asking for folks to be fully vaccinated. If we encounter symptoms we isolate them and test them there. We have two rooms for the isolation.
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- Opportunity: Would having a DCR come and evaluate the client have been appropriate, and if so, at what point in the timeline? Clarifying the boundaries of gravely disabled vs challenging personality is worthwhile. **DBH offered their availability of a DCR consult by phone** in cases like this.
- Opportunity for Homelessness Case Management: While Navigator coverage is unavailable during the early morning hours, which contributes to a sense of dearth of resources for Homeless Case Management, the **JSCO Navigator will follow up on situations/questions** that are called, emailed etc. when he comes on shift.

AGENCY HIGHLIGHT

East Jefferson Fire Rescue (EJFR) (Refer to Slides on pp 9-20 in Meeting Packet)

- EJFR is a Fire District (not a Fire Dept.). Their total calls, about 76% are EMS calls – and of those, 10% are behavioral health. The EJFR team documents a BH client as one call, even if interacting with BH clients more than once to transport them to ED, then from ED to next service, etc. Every interaction reduces fire crew and equipment available for emergency.
- EJFR is in the thick of handling other priorities on a landscape where costs are rising at 4% and revenue from taxes capped at only at 1%.
- EMTs receive very little specialized training to handle mental health patients in crisis – EJFR is working to address that.
- EJFR is working on a full, independent strategic plan.
- EJFR capacity to take on an innovation like Community Paramedicine and Mobile Integrated Health is limited at this time. They look forward to exploring other models in counties that could be emulated. The ultimate goals is a fully baked proposal that identifies a program following the smart model, that is specific, measurable, has a timeline, methods of improvements and mitigations for when it doesn't go as planned, even to the point of ending the program if it doesn't achieve the metrics outlined.

Discovery Behavioral Health (DBH) (Refer to Slides on pp 4-8 in Meeting Packet)

- DBH is a state-monitored behavioral health center, mandated to serve Medicaid patients primarily. Reimbursement rates significantly limit hiring ability people at a rate that is equivalent to education and care capacity. Medicare patients require Incidental billing, which is dangerous if not done correctly.
- 4 Nurse practitioners who provide evaluations and med management treatment, including MAT; Psychiatric evaluation and medicine management patients must be willing to get therapy at the same time.

- Offering Substance use disorder services as of February 1 – using the Safe Harbor program at DBH for the counseling side and DBH Medically Assisted Treatment (MAT) services. This sets a good foundation to address dual diagnosis.
- Provide 24/7 crisis services DCRs; Case management
- DBH's Contract programs: Sheriff's Team Navigator and the Recovery, Empowerment, Advocacy and Linkage (REAL) Team.
- **Innovation:** Integration of DBH and Sheriff's Department's efforts to address calls involving mental health; Collaboration with Quilcene and Brinnon's Fire Departments is being developed.
- **DBH's Goal with the Summit Group:** To strengthen relationships with PTPD and EJFR, and use those relationships to deliver behavioral health services with intention and effectiveness.

FOLLOW-ON DISCUSSION

- **REAL Program –** Jolene Kron noted this program is being rolled out in Kitsap, Clallam and Jefferson County.
  - The SBH-ASO's Marti Anne Lewis will roll out the Jefferson County program at the BHC's February 13th meeting.
  - The SBH-ASO will form a Jefferson County REAL policy workgroup that will meet at the BHC's table. This group will act as an overarching body and identify gaps in the community that would benefit from REAL engagement.
- Request: Create a graphic that illustrates the spectrum from REAL team, to Navigator, to DCR, and clarify who does what.

Program	REAL (Recovery Empowerment Advocacy and Linkages)	Sheriff's Navigator	PTPD Navigator	Mobile Crisis Outreach (DCR)
Service Offered	Pre-Crisis outreach, light touch and intensive case management	Service linkage	Service linkage	Crisis Intervention BH triage ITA
Referral Source	Governing Board representing Community interests	Sheriff's Dept	PTPD	All
Anchor Point	Service linkage	DBH	PTPD	DBH

- Jim Novelli clarified DCR's (mobile crisis outreach) can be called by the law enforcement to a scene. If a psychiatric hospitalization is required, a medical clearance is required. A visit to the ED is required for a medical clearance.

EMS BEHAVIORAL HEALTH GUIDELINE REVIEW

(Refer to Slides on pp 21-30 in Meeting Packet)

The group reviewed a draft of the Jefferson County EMS Behavioral Health Response Guideline that has been modeled in large part on the WA State DOH EMS guidance document.
Action: Dr. Carlbom invites input and will present it at the EMS Council in February for approval, then on to State DOH where it will be reviewed by EMS office and the Attorney General's Office. From there the document will be updated.

Next Meeting Scheduled for Tuesday, April 26th, 3-4:30pm