

**TENNESSEE DEPARTMENT OF
MENTAL HEALTH AND SUBSTANCE ABUSE
SERVICES**

**OFFICE OF CRISIS SERVICES AND SUICIDE
PREVENTION**

MINIMAL STANDARDS OF CARE

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Department of
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Substance Abuse Services**

Tennessee Department of Mental Health and Substance Abuse Services
Office of Crisis Services and Suicide Prevention
Minimal Standards of Care
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Chapter 1 – Introduction

Executive Summary

This document contains information regarding the provision of crisis services by behavioral health service providers under contract with TDMHSAS and TennCare's Managed Care Organizations.

Workgroup participants included representatives from the following agencies:

TN Department of Mental Health and Substance Abuse Services (TDMHSAS)

Bureau of TennCare

TN Association of Mental Health Organizations (TAMHO)

Ridgeview Behavioral Health Services

Helen Ross McNabb Center

Frontier Health

Centerstone

Alliance Healthcare Services

Mental Health Cooperative

Carey Counseling Center

Professional Care Services

Volunteer Behavioral Health Care Systems

Amerigroup

United Healthcare

BlueCare Tennessee

Philosophy

Crisis response services are the preferred point of entry to a continuum of behavioral health services and supports needed by someone experiencing a behavioral health crisis. A **behavioral health crisis is defined as** any intense behavioral, emotional, or psychiatric situation perceived to be a crisis by the individual experiencing the crisis, family, or others who closely observe the individual which left untreated, could result in an emergency situation in the placement of the person in a more restrictive, less clinically appropriate setting, including but not limited to, inpatient hospitalization or at the very least, significantly reduced levels of functioning in primary activities of daily living. Phone triage and/or face-to-face assessments shall not be denied to any caller in the absence of suicidal or homicidal ideation or verbalizations.

Crisis response and intervention services offer intervention and support to individuals experiencing a crisis, seek to provide safety to the individual and the community while relieving symptoms, preventing the condition from worsening, and resolving the crisis as soon as possible. Crisis response services must be able to respond to individual needs by providing a wide range of services in a variety of settings such as homes, residential settings, jails, emergency departments, schools and outpatient settings.

A narrow focus on dangerousness alone is not a valid approach to addressing a behavioral health crisis. Situations involving behavioral health crises may follow trajectories that include intense feelings of personal distress (e.g., anxiety, depression, anger, panic, hopelessness), obvious changes in functioning (e.g., neglect of personal hygiene, unusual behavior) or catastrophic life events (e.g., disruptions in personal relationships, support systems or living arrangements; loss of autonomy or parental rights; victimization or natural disasters).

Essential Values:

- Access to supports and services is timely.
- Services are provided in the *least restrictive* manner possible.
- Peer support is available.
- Adequate time is spent with the individual in crisis.
- Plans are strengths-based.
- Emergency interventions consider the context of the individual's overall plan of services.
- Crisis services are provided by individuals with appropriate training and demonstrable competence to evaluate and effectively intervene with the problems being presented.
- Individuals in crisis are offered interventions as appropriate to include community resources and referrals.
- Crisis response staff has a comprehensive understanding of the crisis.
- Helping the individual to regain a sense of control and safety is a priority.
- Services are congruent with the culture, gender, race, age, sexual orientation, health literacy and communication needs of the individual being served.
- Rights are respected.
- Services are trauma-informed.
- Recurring crises signal problems in assessment or care.

- Meaningful measures are taken to reduce the likelihood of future emergencies.
- Early intervention is encouraged to decrease the likelihood of further need of crisis services.
- Services are coordinated with other professionals involved in the care of the individual including but not limited to case managers, primary care physicians and community mental health providers when possible.
- Crisis responders understand the dynamics of different mental health diagnoses.

Vision and Goals of Crisis Services

The Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS), in collaboration with the Bureau of TennCare and Managed Care Companies, is dedicated to achieving a consumer-oriented system that provides access to efficient, effective, quality behavioral health services through accountability and performance management. As part of the commitment to achieve behavioral health service system responsibility and accountability, standards have been developed to ensure that crisis response services reflect the goals and principles of statewide behavioral health reform. Standards set expectations for crisis response services so services across the state are consistent and incorporate evidence-based best practices. Service provision in accordance with standards will permit development of performance measures and data collection requirements for monitoring the delivery of crisis response services.

Behavioral health crisis services may be rendered to individuals with a behavioral health issue based on the behaviors and needs of the person in crisis with input from the individual, family member, law enforcement, hospital staff, outpatient providers or others who have closely observed the individual.

Crisis services are available to anyone in Tennessee regardless of ability to pay, twenty-four (24) hours a day, seven (7) days a week, 365 days per year and take into account the age, gender, race, language, etc., of the individual receiving services. Priority is given to individuals with serious behavioral health issues and those who may be at risk of causing harm to themselves or others. Services are provided in a manner that protects and respects the dignity, diversity, cultural beliefs and needs of the individual receiving services. If crisis response services determine that a face-to-face assessment is not indicated for the expressed needs, information and resources should be given on alternative options and services that assist the caller in resolving the crisis.

Crisis services include twenty-four (24) hour toll free telephone lines answered in real time by trained crisis specialists and face to face crisis services including, but not limited to: prevention, triage, intervention, evaluation/referral for additional services/treatment, and follow-up services. Peer Recovery Specialists, certified by the Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS), may be utilized (when available) in conjunction with crisis specialists to assist in alleviating and initially stabilizing crises, as well as, promoting and initiating the recovery process.

Crisis services staff are not responsible for completing the contractual obligations of an inpatient facility to obtain payment authorization for inpatient services. Behavioral health crisis service

Providers are not responsible for pre-authorizing emergency involuntary or voluntary hospitalizations.

Services are designed to reduce unnecessary hospitalization and improve quality of life for individuals experiencing a behavioral health crisis through symptom relief, referral to appropriate services and access to on-going support to prevent future crises. Efforts should be made to provide voluntary services whenever possible and consider the dignity and respect of all individuals served.

Services include:

- Assessment and Planning
- Crisis Support/Counseling
- Referrals to Medical Intervention
- Environmental Interventions and Crisis Stabilization
- Review/Referral/Follow-up
- Monitoring and Evaluation
- Referrals, Liaison, Advocacy and Consultation/Collaboration

The goals of crisis services include but are not limited to:

- 1) Promote the safety and emotional stability of individuals with a behavioral health crisis
- 2) Minimize further deterioration of individuals experiencing a crisis
- 3) Assist individuals with developing and/or enhancing coping skills and natural support systems
- 4) Help individuals obtain or retain existing behavioral health care and treatment
- 5) Encourage utilization of services in the least intensive and restrictive setting that are clinically appropriate to meet the needs of the individual

Crisis response services are not required in the absence of a contractual obligation in the following situations:

- 1) Discharge planning on behalf of a facility that has determined psychiatric inpatient hospitalization is indicated in the absence of a crisis evaluation, including but not limited to securing a bed and arranging transportation.
- 2) Assessment in ICU/medical floors in the absence of an active crisis and before a psychiatric consult has been completed by the facility
- 3) Assessment in nursing homes in the absence of an active crisis and before a psychiatric consult has been completed by the facility
- 4) Competency assessments
- 5) Assessment of an individual serving time in a prison, excludes individuals being released after completing a sentence

Contractual relationships may be sought with any existing crisis service provider or private entity to address the above needs.

Mobile Crisis Responsibilities

Crisis staff must:

- Accept and triage calls from individuals inquiring about services
- Initiate active rescue as indicated
- Determine the need for further assessment or refer to other appropriate service if further assessment is not indicated
- Conduct a face to face assessment, when indicated, and determine the most appropriate intervention needed to successfully alleviate the crisis in the least restrictive environment available to meet the needs of the individual
- Provide on-site intervention whenever possible
- Initiate referral when service referral is indicated
- Provide Means Restriction Education for individuals at risk of suicide
- Provide Safety Sweeps of the home for individuals at risk of suicide
- Develop or update Crisis Management Plans for individuals returning home
- Provide follow-up following a face to face assessment and following a non-admission decision from an RMHI

Crisis staff must screen and identify the most appropriate intervention for individuals in crisis by determining the following information:

- Degree of safety risk
- Willingness of individual to engage in services
- Availability of support systems
- Method of response (phone, face to face at home with or without law enforcement, ED visit, telehealth evaluation, face to face at walk-in center, etc.)
- Safety planning needs
- Recommendations for services that result in diversion from an inpatient setting
- Follow up needs
- Indication of the need to report (CPS, APS, DCS, duty to warn, etc.)
- Involvement of existing behavioral health service providers

Crisis service staff must perform a risk assessment utilizing the Columbia Suicide Rating Scale (C-SSRS) for evaluating individual risk for all face to face crisis contacts. The assessment must take into consideration the following current and historical risk factors:

- Specific intent, means, and plan to harm self or others
- Individual, family and community history of suicide/suicide attempts
- Observed and/or reported recent behavior threatening to the health and safety of others
- Inability to care for self
- Life threatening situation
- Identification of safety status and the specific measures in place to prevent harm
 - Domestic violence
 - Cruelty to animals
 - Environmental (access to weapons, access to means, safety of current environment)
- Current potential for or history of violent, reckless, impulsive or acting out behavior
- Demographic factors associated with high risk for suicide (i.e. marital status, gender, age, financial difficulties, family history, etc.)

- Serious impairment in functioning over the past few months including but not limited to psychosis, lack of or inconsistent treatment adherence, current or past trauma, decline in cognitive functioning etc.
- Serious impairment in health or living situation
- Current and/or history of drug and/or alcohol use including status of intoxication

Expectations for Service Delivery

The expectations for the delivery of crisis response services are outlined below:

- Compliance with all legal and ethical mandates
- Awareness of all currently available community resources and referral mechanisms and procedures to access less restrictive alternatives to hospitalization
- Adequate number of MPA's for 24/7 coverage to include a minimum of 1 MPA per crisis team per shift
- Referrals to supports and services
- Face to face assessments conducted by qualified staff and may be via walk-in triage centers or technological means including telehealth as indicated by TDMHSAS
- Partnerships with key stakeholders including but not limited to law enforcement, outpatient providers, and MCO's.

Service Delivery Responsibilities

- *Mobile crisis services are made available 24/7 to anyone regardless of race, ethnicity, or ability to pay.*
- *Mobile crisis assessments will screen and identify individuals in need of behavioral health services and include an assessment of risk using a TDMHSAS approved screening tool.*
- *Mobile crisis services will be provided in compliance with state law, rule and regulation.*
- *Crisis service providers will collaborate with stakeholders involved in the crisis service delivery system and partner to resolve service delivery concerns.*
- *When hospitalization is recommended as an outcome of the crisis assessment it is the responsibility of crisis staff, in partnership with the managed care payor source (when applicable), to: secure a bed at an inpatient psychiatric hospital, conduct required notification requirements and ensure transportation to the receiving facility is arranged. If the individual is assessed at a facility involved in the delivery of care, crisis staff will leave instructions for arranging transportation with the agency and provide assistance as needed until transportation occurs.*

Telephone and Walk-in Triage

Behavioral health crisis services can be activated by telephone contact or at a walk-in center. A toll-free number is available 24/7, 365 days a year and answered by trained crisis specialists. A triage screening determines the acuity of the crisis and determines the appropriate intervention needed to alleviate and/or stabilize the crisis. The triage screening can be completed via telephone assessment or, in the case of a walk-in service, via a face-to-face assessment (or telehealth).

The manner in which the agency's crisis telephones are answered sets the tone for each crisis call. All telephone calls are required to be answered in a uniform, courteous, and professional manner. There must be a dedicated professional answering the crisis line 24/7 with the capacity to provide screening, therapeutic counseling, and referral services. The following are a few tips to ensure requirements are met:

- Answer the telephone as soon as possible, but within at least five (5) rings and/or 30 seconds. All telephone calls not answered within 5 rings and/or 30 seconds on the statewide crisis line are routed to the State's appointed managing entity.
- All telephone calls are to be answered "live" by a qualified and trained crisis services triage personnel. If electronic devices are necessary to manage times of high call volume, "queue" messaging shall include information regarding access to emergency services. Callers shall not remain in "queue" for longer than 3 minutes before receiving assistance.
- Every crisis services triage personnel should answer the telephone in a standardized and courteous way. For example, "South Middle Crisis Services, how may I help you?"
- As soon as possible, secure the caller's name, telephone number and if possible, the caller's location. The crisis services triage personnel should state something similar to "in case we are accidentally disconnected could I have your name, telephone number and the address from which you are calling". If the caller is hesitant to share their location, do not insist they provide the location or address at that time.
- Do not place a call on hold without the caller's permission. If a caller is placed on hold, check back with the caller every minute to give him/her feedback regarding the status of the call. If you need to talk to other staff, press the mute button.
- Do not place the person on a speaker telephone. This may make them feel there is no privacy in the conversation and may prevent them from providing important information. This can also compromise the confidentiality of the caller's right to protect their private health information.
- The discounted call abandonment rate will not exceed more than 5% of the total volume of calls.

Cultural Considerations

Crisis service providers must ensure services are rendered to all individuals in a culturally competent manner. Interpreter services can be accessed by utilizing the language line, hiring multi-lingual staff persons, or making arrangements to purchase behavioral health interpreter services.

Services will consider and respect religious and cultural beliefs to the extent possible. Crisis staff shall be aware of available resources within the community when a request is made for a culturally competent provider, including those who are bilingual or provide appropriate specializations (i.e. LGBTQ services). The provision of services throughout the crisis continuum shall ensure consideration of age, race, ethnicity, gender, religion, education, etc.

Crisis Services Intervention

An intervention may be completed via telephone or face to face (which includes telehealth). Interventions include an assessment to determine the need(s) of the individual including but are not limited to active, supportive listening and the need for referrals to additional services and/or treatment. The intervention is intended to identify and provide resources specific to the needs of the caller. A face-to-face assessment shall always be conducted if there is a substantial likelihood of serious harm. All appropriate resources should be utilized in an effort to stabilize the individual and prevent escalation of the crisis. The intervention is intended to assess the need(s) of the individual for possible face to face contact with crisis services or a referral to the appropriate resource(s) in order to support and/or stabilize the individual and prevent escalation of the crisis.

Telephone Consultation

A telephone intervention or consultation occurs between crisis staff and the individual and/or the family/health care providers, as appropriate. Title 33 requires physicians and psychologists to consult with a crisis service provider before initiating a certificate of need. Telephone triage personnel must be available to provide the required consultation which includes a review of the clinical information and provision of recommended alternatives as clinically appropriate.

Consultation is intended to provide information related to available resources to a qualified professional involved in the care and or treatment of an individual experiencing a behavioral health crisis. To ensure consideration is given to all less restrictive alternatives, Emergency Department clinicians are required to complete a consult form when considering hospitalization. The form can then be faxed or read to the crisis clinician via phone during the consultation (See Appendix 1). After a review of the clinical presentation, crisis services staff should educate the caller on all available less restrictive alternatives available appropriate to the needs of the client.

Crisis services staff do not have to agree with the decision to initiate hospitalization in order for the consulting physician or psychologist to proceed. Crisis services staff are not required to facilitate hospitalization for physicians or psychologists issuing a Certificate of Need against the recommendations of the crisis services consult.

Face to face Crisis Intervention

Crisis staff completes a face-to-face assessment when the triage screening or telephone intervention deems it appropriate. Face to face assessments should not be conducted while an individual is too intoxicated to participate in the assessment process. The assessment used for completion during crisis service interventions will include standardized elements prescribed by TDMHSAS. The standardized evaluation process will be followed to ensure consistency and quality of the delivery of behavioral health crisis services. The face-to-face assessment determines the need(s) of the individual, referral(s) to additional services/treatment, and/or intervention(s) to support and/or stabilize the individual and prevent escalation of the crisis. Face to face assessments may also be needed to evaluate the risk of immediate substantial likelihood of harm. Additional face to face assessment may be required during the follow-up period to ensure the safety of an individual utilizing community supports and to prevent further crises.

For more information regarding the use of telehealth in conducting Face to face evaluations please refer to Appendix 2 for the Telehealth Guidelines for Crisis Services, also found at: http://www.tn.gov/assets/entities/behavioral-health/mh/attachments/Telehealth_Guidelines.pdf

Service Provision Responsibilities:

- *The crisis telephone line utilized by the provider and the statewide crisis number shall be answered by trained crisis specialists.*
- *Services are congruent with the culture, gender, race, age, sexual orientation, health literacy and communication needs of the individual being served.*
- *Telephone or face to face consultation by crisis staff shall be provided to physicians and psychologists issuing a CON when a MPA is unavailable within 2 hours to ensure consideration of available less restrictive alternatives.*
- *The crisis assessment triage instrument utilized in the provision of services shall adhere to the standardized elements prescribed by TDMHSAS.*
- *Face to face services are provided to individuals at risk of further deterioration in the absence of immediate care.*
- *Face to face assessments will occur within 2 hours from the time of the call for assistance.*
- *Face to face assessments conducted via telehealth are in compliance with guidelines established by TDMHSAS.*

Chapter 3 – Staffing Requirements

Trained, credentialed and/or approved behavioral health personnel and professionals who have a licensed psychiatrist or physician experienced in psychiatry available for consultation may conduct crisis assessments. Only designated Mandatory Pre-screening Agents (MPA) may execute an emergency involuntary hospitalization certificate of need.

Staffing Requirements

- Crisis Services must be staffed to provide service 24 hours a day, seven days a week and must be sufficient to permit response times in compliance with the required two-hour timeframe.
- Staff serving as Mandatory Pre-screening Agents must be available twenty-four hours a day and whenever possible are the first responders to situations likely resulting in emergency involuntary hospitalization. If hospitalization is indicated and an MPA was not available as the first responder, every attempt shall be made to utilize telehealth to expedite access to a state contracted MPA.
- Crisis services must have a licensed psychiatrist available for consultation and medication evaluation seven days a week, twenty-four hours a day, but other qualified medical staff may be available for consultation as well.
- Behavioral health personnel must be supervised by a licensed behavioral health professional with at least a master's level license in a relevant field and at least one year experience in crisis services.

The first level of response to crisis phone calls and face to face services are provided by a behavioral health professional with specialized training in crisis intervention with:

- A minimum of a bachelor's degree in a health-related field (counseling, psychology, social work or sociology) or a registered nurse with a minimum of one-year relevant experience (master's level preferred for face to face services); and
- Existing non-bachelor level staff will be grandfathered in
- At least one-year mental health experience preferred or for trainees with no mental health experience an intensive training protocol must be in place;
- Completion of all required training prior to providing services; and
- Has a licensed master's level clinician available for consultation.

Telephone Triage Staff Training Requirements

Crisis call center personnel/volunteers are required to be 18 years of age or older. In addition, crisis call center personnel/volunteers must demonstrate compassion, responsibility, active listening skills, proficiency in conveying warmth and empathy, adeptness in operating basic technology, capability to perform effectively under pressure, and proficiency in multitasking. To qualify for certification to work in a crisis call center across the state, all personnel or volunteers must successfully complete a 40-hour modular training course and demonstrate competency in, at a minimum, the following areas.

- Customer service
- Conflict resolution
- Active listening
- Empathetic communication
- Verbal de-escalation techniques
- Appropriate service referral
- Emergency protocols
- Knowledge of community resources
- Suicide Assessment
- Risk Assessment
- Confidentiality & Ethics
- Cultural Competency
- Trauma Informed Care

Training will incorporate components on knowledge acquisition and skills development that include lecture, role play/call simulation, and mentoring. Crisis call center personnel/volunteers are evaluated throughout the onboarding process via testing and trainer assessment. Center specific role play will then be scheduled after completion of core training for in-person simulations. At the end of successful completion, crisis call center personnel/volunteers are certified to work on the crisis lines, but all personnel/volunteers must continue to receive annual refreshers on specified topics and must participate in at least 2 in-service training opportunities per year. In addition to annual refreshers, crisis call center personnel/volunteers will receive ongoing supervision and evaluation from leadership.

Face To Face Staff Training Requirements

Face to face crisis response services are provided by professionals with appropriate training and demonstrable competencies in, at least, the following:

- Assessment of suicidal/homicidal risk using standardized crisis assessment tool mandated by TDMHSAS
- Mandatory Pre-Screening Agent (MPA) certification training. Recommended even for those not eligible to become designated.
- Crisis intervention and resolution, including safety procedures; screening for inpatient hospitalization; stress management skills for behavioral health case managers and other behavioral health service providers; rules, regulations, standards, policies and procedures governing the provision of TennCare/TDMHSAS funded behavioral health services
- All Crisis Services Provider staff successfully completes the State's Crisis Training Manual (or on-line training module) prior to working independently in a crisis. Refresher training or any subsequent updates should be taken every three years.

Additional required training for crisis face to face response staff:

- *Safety Standards*
- *Conflict Management*
- *Client/Patient's Rights*
- *Cultural Diversity*
- *Crisis Management*
- *Behavioral Health/Substance Use Disorders and Associated Medical Conditions and Care*
- *Research-Based Practices*
- *Law, Ethics*
- *Overview of Psychopharmacology*
- *TDMHSAS Best Practice Guidelines*
- *Treatment Considerations for Children and Adolescents*
- *Age Appropriate Developmental Principles and Early Periodic Screening, Diagnosis and Treatment (EPSDT) Requirements for Children and Adolescents. - <http://www.tn.gov/tenncare/topic/provider-information>*
- *Crisis De-Escalation and Crisis Management*
- *Trauma informed care*
- *Overview of Suicide Assessment/Overview of Suicide Screening*
- *Counseling Access to Lethal Means (CALM)*
- *Columbia Suicide Severity Rating Scale*
- *Crisis Support/Counseling*
- *First Aid Refresher*
- *Environmental Interventions and Crisis Stabilization*
- *Empowerment and Advocacy in Information and Referral*
- *Monitoring and Evaluation*
- *Information, Liaison, Advocacy and Consultation/Collaboration*
- *Law enforcement and Emergency Department interface*
- *Co-occurring Complexities; Signs of detox and suicidal tendencies in individuals with substance abuse issues.*
- *Training relative to Intellectual Disabilities (including differentiating between behavioral and psychiatric symptoms, Cross System Crisis Planning, System of Support)*
- *Comprehensive Crisis Management/comparable program*
- *APS/DCS referrals*
- *Duty to warn*
- *Identifying and Preventing Abuse and Neglect*
 - *Disaster Mental Health Intervention*
 - *Therapeutic Communication*
 - *Emergency Preparedness*

Consultation

Each crisis service provider will provide a 24/7 consultative process for crisis response staff involved in the delivery of services that will provide guidance and feedback and includes support for:

- Clinical psychiatric support,
- Medical concerns, and
- Special needs such as those with intellectual disabilities.

Supervision Requirements

Clinical supervision of all telephone and face to face crisis specialists will be provided by a licensed, master's level professional with experience in crisis services. Clinical supervision may be provided through a variety of mechanisms including, but not limited to, real time consultation, review of clinical assessments, case review and discussion, competency checklists, etc.

At a minimum, clinical supervision and/or peer review will be provided to all crisis staff involved in the delivery of crisis services weekly. Supervision will include a review of the appropriateness of the clinical decision to either refer for inpatient hospitalization or not and documentation of the crisis episode.

Staffing Responsibilities

- *A licensed psychiatrist, physician or other qualified staff must be available for consultation to crisis services staff. (e.g. if treatment recommendations have to be provided when crisis is unable to locate an inpatient provider willing to accept the person)*
- *Crisis services staff must meet professional education requirements established above.*
- *Crisis services staff must complete all required training within 3 months of hire.*
- *Mandatory Prescreening Agents must pass the required refresher training course every two years.*
- *Staffing of mobile crisis services must be sufficient to ensure no more than 10% of all face to face assessments are seen outside of the required 2 hour response time.*
- *A licensed master's level clinician must be available to provide consultation and supervision to mobile crisis staff 24/7.*
- *A process for the provision of clinical supervision by a licensed master level professional no less than weekly must be provided.*
- *A process for conducting periodic quality assurance reviews of the crisis services documentation must be provided.*

Peer and Recovery Support

The use of Certified Peer Recovery Specialists (CPRS's) in the provision of crisis services can help alleviate anxiety and frustrations encountered by individuals receiving services and improve engagement in recovery. Individuals served in the crisis service delivery system shall be afforded an opportunity to receive peer support from a Certified Peer Recovery Specialist.

Choosing the best Certified Peer Recovery Specialist in the delivery of crisis services is imperative to the success of these programs. The CPRS must adhere to the code of ethics listed below regardless of certification and if certified, to the requirements and code of ethics outlined at:

<http://www.tennessee.gov/behavioral-health/topic/certified-peer-recovery-specialist-program>

CPRS Code of Ethics

- 1) The primary responsibility of Certified Peer Recovery Specialists is to help peers achieve their own needs, wants, and goals.
- 2) Certified Peer Recovery Specialists will maintain high standards of personal and professional conduct.
- 3) Certified Peer Recovery Specialists will conduct themselves in a manner that fosters their own recovery.
- 4) Certified Peer Recovery Specialists will openly share with peers, other CPRS's and non-peers their recovery stories from mental illness, substance abuse, or co-occurring disorders as appropriate for the situation in order to promote recovery and resiliency.
- 5) Certified Peer Recovery Specialists at all times will respect the rights and dignity of those they serve.
- 6) Certified Peer Recovery Specialists will never intimidate, threaten, harass, use undue influence, use physical force, use verbal abuse, or make unwarranted promises of benefits to the individuals they serve.
- 7) Certified Peer Recovery Specialists will not practice, condone, facilitate, or collaborate in any form of discrimination or harassment based on ethnicity, race, color, pregnancy, creed, veteran's status, sex, sexual orientation, age, religion, national origin, marital status, political belief, mental or physical disability, or any other category protected by state and/or federal civil rights laws.
- 8) Certified Peer Recovery Specialists will promote self-direction and decision making for those they serve.
- 9) Certified Peer Recovery Specialists will respect the privacy and confidentiality of those they serve.
- 10) Certified Peer Recovery Specialists will promote and support services that foster full integration of individuals into the communities of their choice.
- 11) Certified Peer Recovery Specialists will be directed by the knowledge that all individuals have the right to live and function in the least restrictive and least intrusive environment.

- 12) Certified Peer Recovery Specialists will not enter into dual relationships or commitments that conflict with the interests of those they serve.
- 13) Certified Peer Recovery Specialists will never engage in sexual or other inappropriate activities with peers they serve.
- 14) Certified Peer Recovery Specialists will not use illegal substances, misuse alcohol, or other drugs (including prescription medications).
- 15) Certified Peer Recovery Specialists will keep current with emerging knowledge relevant to recovery and will share this knowledge with other Certified Peer Recovery Specialists.
- 16) Certified Peer Recovery Specialists will not accept gifts of significant value from those they serve.
- 17) Certified Peer Recovery Specialists will not provide services, either for employment or on a volunteer basis, without supervision from a behavioral health professional.
- 18) Certified Peer Recovery Specialists will not provide services beyond their qualifications. This includes diagnosing an illness, prescribing medications, or providing clinical services.
- 19) Certified Peer Recovery Specialists shall only provide services and support within the hours, days and locations that are authorized by the TDMHSAS-approved agency with which they work.

Direct peer-to-peer services can include a variety of support services, such as:

- assisting in the development of strengths-based individual goals
- serving as an advocate, mentor, or facilitator for resolution of issues that a peer is unable to resolve on their own
- assisting in the development of rehabilitation goals
- developing community support
- providing education on ways to maintain personal wellness and recovery
- providing education on behavioral health system navigation

Certified Peer Recovery Specialist responsibilities may include but are not limited to:

- Empathetic listening for individuals calling the crisis line
- Sitting and/or riding with an individual accessing services
- Explaining the hospitalization process
- Assisting with the development of a Crisis Management Plan, such as the Wellness Recovery Action Plan (WRAP®)
- Sharing their own personal story of recovery, when appropriate
- Conducting follow-up calls

Training Requirements for Certified Peer Recovery Specialists working within the Crisis Continuum

Certified Peer Recovery Specialists shall receive pertinent training related to crisis services in the crisis service delivery system to include but not limited to:

- Customer service
- Conflict resolution
- Active listening/Empathetic communication
- Verbal de-escalation techniques
- Emergency protocols
- Confidentiality
- Ethics
- Establishing Boundaries
- Motivational Interviewing

Peer Support Responsibilities:

- *Crisis service providers, with Crisis Stabilization Units (CSUs), will ensure a Certified Peer Recovery Specialist is available to assist in the care of an individual receiving crisis services.*
- *Crisis service providers, with Mobile Crisis Services and/or Respite Services, will ensure that crisis specialists have access to Certified Peer Recovery Specialists (CPRSs), and/or Certified Family Support Specialists (CFSSs) for children and youth, to be utilized in conjunction with crisis specialists.*
- *Utilize a Certified Peer Recovery Specialist in the provision of mobile crisis services when appropriate.*
- *Ensure that Certified Peer Recovery Specialists utilized in crisis services have received the required training.*
- *If not currently certified, Peer Recovery Specialists must be certified within one year of hire.*

Chapter 4 – Coordination of Care with Other Providers

Services must be integrated and coordinated with the broader behavioral health system to meet differing needs, including those of individuals currently accessing behavioral health services as well as those accessing the behavioral health system for the first time.

Partnership development and coordination of care with law enforcement, emergency departments, psychiatric inpatient facilities, conservators, and others involved in the person's care are essential to the success of mobile crisis services.

Law Enforcement Involvement

Involving law enforcement officers and other emergency services personnel in the care of an individual in crisis is often essential to ensuring the safety of crisis responders; however, law enforcement officers are not behavioral health professionals and are unable to clinically determine whether behavioral health services are indicated. To ensure law enforcement involvement does not criminalize behavioral health services or lead to a lack of resolution of the behavioral health condition, behavioral health professionals must develop effective partnerships that promote coordinated systems of care.

Crisis service providers shall offer training to both Crisis Intervention Team (CIT) law enforcement personnel as well as non-CIT officers. The TDMHSAS standardized training curriculum shall be utilized in the provision of training to all non-CIT officers to ensure all officers receive the same information and are informed of the laws and processes that affect access to services.

If available, CIT trained officers shall be utilized in situations involving suspected behavioral health issues whenever possible.

Partnerships with local emergency response systems which may include 911 dispatch and ambulance services will be documented in writing and include agreements for data sharing, communication procedures, and coordinated community responses.

Use of Wellness Checks

A "Wellness Check" or "Welfare Check" is a request made to law enforcement to check on a particular person whose well-being is of concern.

"Wellness checks" can often be an appropriate response particularly when it is unclear whether a person has caused harm to themselves; however, there are times when a wellness check in the absence of a behavioral health professional is ineffective in alleviating the crisis and fails to meet the behavioral health needs of the individual involved. Law enforcement officers are not equipped to make decisions regarding the need for treatment.

The initiation of a wellness check for a behavioral health condition should not be conducted in the absence of behavioral health professional involvement without imminent risk. If law enforcement has determined the presence of imminent risk further responsibilities for accessing service remain with the involved officer. If law enforcement is requested by a crisis service provider to perform a wellness check on an individual with a suspected behavioral health condition, there will be a coordinated response with a behavioral health professional and/or a mechanism for ensuring follow-up by a clinician.

When working with law enforcement the following information should be obtained during the "Wellness Checks":

- Are there weapons in the home?
- How is the person behaving?
- Is the individual present in the residence?
- For children and youth, is there adult supervision present?

Law Enforcement Partnership Responsibilities:

- *Establish written agreements by county, with local emergency response systems to ensure adequate exchange of information and provide a process for responding to the behavioral health needs of individuals in the community.*
- *Coordinate with law enforcement to provide a coordinated community response to assess individuals with behavioral health needs when indicated.*
- *Partner with the appropriate law enforcement representative to provide standardized law enforcement training curriculum to new and existing officers annually.*
- *Partner with law enforcement when responding to individual residences to ensure safety of the responder and ensure the best outcomes for the client in crisis.*
- *Provide a process for following up on identified behavioral health needs when utilizing wellness checks.*

Emergency Department Interface

Medical conditions frequently contribute to and/or exacerbate the symptoms of a behavioral health condition necessitating the need for a medical screening prior to accessing behavioral health care. However, in certain situations, efforts should be made to prevent the unnecessary use of an emergency department (ED) as it is costly and creates additional delays in access to emergency behavioral health care.

Consideration of the following will be given when determining whether to direct an individual in crisis to an ED for access to behavioral health services:

- Does the individual have an acute medical condition?
- Did the individual overdose on substances (whether intentional or not)?
- Has the individual attempted to commit suicide?
- Has the individual been using alcohol or substances to the extent that there is a risk of withdrawal symptoms?

- Is the individual a well-known behavioral health service recipient?
- Can vital signs be obtained and reported to a receiving psychiatric facility?

Information regarding alternative access points for behavioral health services will be provided to ED staff as well as individuals seeking behavioral health care when serving those who presented in the ED simply for access to behavioral health services.

Relationship development with ED staff promotes the involvement of behavioral health experts in the disposition of an individual in need of behavioral health services. To reduce unnecessary utilization of emergency involuntary hospitalization, ED physicians must have a certain level of trust in the recommendations being provided. Key hospital staff should be contacted periodically to ensure an adequate understanding of available services and to discuss any barriers encountered by crisis staff when working with ED staff. Crisis responders must be able to demonstrate professional, respectful, and courteous communication skills and tactfully advocate for the most appropriate and least restrictive services appropriate for the needs of the individual in need of services.

Extended Wait Time Protocols

A case is considered to have placement difficulty when the crisis-assessed client has been referred for inpatient psychiatric treatment, and the referral attempts have resulted in at least 1 declined (or refused) referral from all inpatient facilities for which the client is eligible for admission.

The crisis team shall remain engaged with the case until the referral is accepted for admission by an inpatient treatment facility or until appropriate alternative services are established, and transportation arrangements are confirmed.

Communication Expectations

- As soon as it has been determined that there are barriers to placement, the crisis clinician (or other designee) shall inform the MCO and/or DCS (for C&Y providers only, when applicable) as well as the client and support systems* (for all providers) of the circumstances, including the need to anticipate an extended wait time.
*Support systems may include, but are not limited to: family and/or other support persons; conservator; staff and/or personnel of the location of assessment; school faculty and/or officials; mental health case manager; DPOA; DIDD; criminal justice liaison
- If the declined referral is for a reason *other than* having no beds (e.g., acuity), seek consult with upper management personnel of the proposed admitting facilities for placement reconsideration.
- If the declined referral is due to no beds, then a bed availability status check shall be conducted no less than every 24 hours until the client is accepted by an inpatient treatment facility, or until alternative services are established.

- While taking efforts to locate an available placement, ongoing communication of efforts shall be provided to the MCO and/or DCS (for C&Y providers only, when applicable) as well as to the client and support systems (for all providers) no less than daily to ensure all involved parties are aware of efforts taken to find placement and if known, how much longer before placement might occur. During each contact, information regarding the client's status and ongoing need for inpatient placement shall be obtained. If at any time the client's status improves and inpatient care is no longer required, then efforts shall be made to pursue a less restrictive level of care. To prevent an influx of phone calls to prospective admitting hospitals, advise ER's, DCS and other support systems to contact mobile crisis for an update if needed.

Aiding the Facility Required to Hold the Patient Pending Placement

- Efforts shall be made to encourage immediate intervention whenever possible (such as, advocate for medication management or psychiatric consult, a visit from an agency med prescriber to a JDC, or other) to initiate treatment in order to either stabilize the individual or to manage the individual's needs pending availability of an inpatient bed.
- Provide guidance related to management of the individual's needs to staff or primary support at the location of the client to aid the support systems involvement during the wait period.

Ongoing Assessment of Client Needs

- A new face to face assessment is recommended at any time there is a change in the original disposition recommendation.

Follow-up

- Continued engagement with the case involves follow-up contacts (either by phone or face to face) with the client and/or interested parties every 24 hours during the pending/hold period to ascertain whether the original recommendation for inpatient care is still valid. The determination for conducting a phone versus face-to-face follow-up should be based on the clinical needs of the client and/or the need to maintain harmonious community relations.
- If a bed becomes available for the client and 24 or more hours have elapsed since the last face-to-face follow up contact, a new follow up contact must be completed before transportation is arranged to confirm that less drastic alternatives continue to be unsuitable and/or unavailable.

Documentation Expectations

- Documentation should be maintained for each follow up contact, whether contact is conducted via phone or face-to-face. Documentation should include the names of support persons contacted, their affiliation, and the contact dates/times. Only those follow-up

assessments that required a new face-to-face assessment shall be entered into the state crisis tracking system database.

RMHI Medical Clearance Requirements

In today's mental health system, there has been an increase of utilization of community-based mental health services. This has resulted in more Regional Mental Health Institutes (RMHI) referrals coming directly from the community.

RMHIs are structured to deal with chronic and persistent mental illness in a population that is presumed to be relatively medically stable. While, RMHIs have a physician available on-site, twenty-four hours a day, seven days a week, to deal with both medical and behavioral issues, they are limited in the medical services they can provide. Most serious illnesses demand expertise beyond the capabilities of the clinical staff. Therefore, when determining the medical stability of individuals referred to State RMHIs, they continue to rely on the local emergency room as our primary resource. They recognize that these same emergency rooms are under increase pressure to avoid inappropriate referrals and reduce the provision of routine healthcare service.

The RMHIs are committed to reducing needless referrals to these emergency rooms. In an attempt to do this, they have identified certain individuals that can be referred directly to the RMHIs for assessment without medical screening. Please see below.

Individuals Eligible for Direct Referral to RMHIs

- Under Age 55
 - No known health issues or medical complaint and prior history of psychiatric treatment
 - Patients transferring from a Crisis Stabilization Unit (CSU) with or without chronic medical conditions that have been stable for more than 48 hours.
 - No report or indication of alcohol or Benzodiazepines use within twenty-four (24) hours of the referral and absence of any withdrawal symptoms
 - No recent history of head trauma or loss of consciousness
 - No history of recent drug overdose

Individuals with a Known Mental Health and a Known Chronic Health Condition

- Who May Be Eligible for a Direct Referral;
 - Based on a known history of compliances with treatment
 - Vital signs within normal limits
 - Blood glucose level for diabetics within the last hour
 - Individual with known history of substance abuse would require urine drug screening and breathalyzer

Individuals Referred from Jails

- Breathalyzers can be used as an alternative for blood alcohol testing when patients are referred from a non-ER setting
- Referrals from correctional settings should not be routinely referred for medical clearance, but should be done on an individual basis. Utilize same criteria used for those coming from the community

Individuals referred for medical clearance should receive diagnostic testing based upon the emergency provider's determination of need. In order for the RMHIs to expedite the referral process, it would be helpful if the following were obtained:

- Vital Signs
- Urine Drug Screen
- Complete Blood Count
- Comprehensive Metabolic Panel (CMP)
- Pregnancy Test
- Blood Alcohol
- Drug Levels i.e., Lithium, Depakote, etc.

The requesting RMHI will provide in writing upon request, the rational for any other diagnostic testing which crisis services staff can then provide to the emergency department to explain the need for additional testing (see Appendix 3). Crisis services staff are encouraged to request a doctor to doctor conversation anytime disagreement occurs regarding required medical testing.

Please see Appendix 4 for a list of conditions that the RMHIs are unable to accommodate. Alternative resources will need to be identified for individuals in need of psychiatric hospitalization with a co-occurring medical condition as listed in Appendix 4.

ED Interface Responsibilities:

- *Establish relationships with key staff of the medical facilities within your agency's service area.*
- *Consider the medical necessity of directing an individual in crisis to an emergency department.*
- *Promote the use of walk-in centers, mobile crisis and other behavioral health access points to reduce unnecessary use of an ED.*
- *Establish trusting and collaborative relationships with ED physicians.*
- *Communicate professionally, respectfully and courteously with all involved in the crisis.*

Regional Disaster Planning

The State of Tennessee Disaster Mental Health Response Committee relies heavily on the crisis response system to meet the behavioral health needs of individuals affected by an environmental disaster. A representative from the local crisis service provider will attend and participate in regional disaster planning activities and report needs to the State of Tennessee Disaster Planning Committee regularly.

Disaster Planning Responsibilities:

- *Attend and participate in regional disaster planning activities.*
- *Maintain communication with the State of Tennessee Disaster Mental Health Response Committee.*

Stakeholder Engagement/Providers and MCO's/TennCare

Crisis responders shall determine whether the person is receiving CMHC case management services and involve case managers in the resolution of the crisis as clinically appropriate. An attempt to notify existing providers that the person has required crisis services will be made in order to improve long term outcomes and ensure continuity of care for the individuals served. Documentation of contact attempts will be maintained in the medical record.

Crisis services providers shall discuss the kind of services the person may need with either existing providers or new providers during and/or following a person being seen in crisis. The views of existing providers (where appropriate, reasonable, and practicable) and consideration of their capacity to cope are to be taken into account, always in observance of the service user rights to confidentiality and their wishes. Providers responsible for picking up the care of an individual following a crisis should be provided access to information regarding medication changes and potential side effects where appropriate.

Information obtained from advocates involved in the care of the individual in crisis will be considered when determining the level of care an individual may need. Crisis service providers will explain recommendations, what to expect during the process and any limitations of those services with both the advocate and the person being served.

Crisis services staff are not responsible for completing the contractual obligations of an inpatient facility to obtain payment authorization for inpatient services. Behavioral health crisis service providers are not responsible for pre-authorizing emergency involuntary or voluntary hospitalizations.

Crisis service provider representatives are encouraged to participate in quarterly meetings as requested by TennCare's MCO's whenever possible.

Interface Responsibilities:

- *If involvement of a CMHC case manager is known by the crisis service provider, an attempt to engage the case manager in crisis resolution shall be made.*
- *Communicate with any known service providers during and/or as soon as possible following a crisis episode.*
- *Consider information obtained from friends and family of the individual as well as other sources during the assessment process and identification of service needs*
- *Provide the required notifications and/or prior authorizations to the individual's Managed Care Organization.*
- *Engage the individual's TennCare MCO or private insurance carrier to assist with care coordination when the situation cannot be resolved independently.*

Cross Systems Crisis Plans and Training

Individuals with intellectual or developmental disabilities receiving crisis services can present some difficult challenges. Crisis responders must have adequate knowledge of the systems serving these

individuals and any special precautions, considerations or interventions that should be used. Cross systems crisis plans can assist both caregivers and service providers to manage behavior that frequently leads to the need for crisis intervention.

Cross Systems Responsibilities:

- *Crisis services staff will participate in the development of cross systems crisis plans for individuals with intellectual disabilities identified as a frequent user of services.*
- *Crisis services staff will provide and participate in cross training opportunities with the intellectual and developmental disability system of care.*
- *Crisis services staff shall contact the assigned MCO liaison to request a referral to the SOS program when a need is identified.*
- *Crisis staff may consult with SOS staff to aid disposition planning for individuals with intellectual disability whom are not currently enrolled in the program.*

I/DD Behavioral Health Systems of Support:

The I/DD Behavioral Health Stabilization Systems of Support (SOS) is a comprehensive, person-centered approach to the delivery of behavioral health crisis prevention, intervention, and stabilization services for individuals with intellectual and developmental disabilities (I/DD) who experience challenging behaviors that place themselves and others at risk of harm. The model is designed to provide a full array of necessary behavioral services and supports for individuals with I/DD and co-occurring mental health and/or behavior disorders including behavioral health crisis prevention, intervention, stabilization and when necessary, inpatient services.

This proactive model is designed to improve quality of life by promoting behavioral crisis planning and prevention. Behavioral health crisis prevention includes person-centered assessment. Planning will require the development of an individualized crisis plan that includes linkage, coordination, and collaboration with current State crisis teams.

The contracted I/DD Systems of Support provider will be the first point of contact in crisis events for members that have been enrolled into the Systems of Support program. The provider will assess the member for the purpose of stabilization in the individual's environment, however, should the member need further assessment for potential hospitalization; the provider will collaborate with our state crisis service teams.

Currently, referrals for the SOS program are directed by the appropriate Managed Care Organization (MCO). If the mental health crisis system encounters an individual believed to be in need of services through the System of Support program, please contact the appropriate MCO and advocate for inclusion.

When making referrals to the SOS program, providers need to contact the member's appropriate MCO.

Crisis Respite Services will continue to be utilized to provide immediate shelter to I/DD members with emotional/behavioral problems who are in need of emergency respite in the event that the

member cannot be stabilized in the current living environment. These services are delivered by contracted providers in community locations approved by the health plan.

Chapter 5 – Alcohol & Drug Services

Individuals with co-occurring mental health and substance use disorders represent a significant proportion of clients that appear in the crisis services system. The presence of this group should therefore be treated as an expectation, rather than an exception and should be addressed accordingly.

Competencies

The following competencies are to be demonstrated by crisis responders working with the co-occurring population:

1. Welcoming, Empathic and Hopeful Stance
Demonstrate a welcoming, empathic, and hopeful attitude in the provision of services to persons with co-occurring disorders.
2. Co-occurring Population Needs and Barriers
Demonstrate a working knowledge of the needs and concerns of persons with co-occurring disorders as a special population
3. Mental Health and Addiction Clinical Knowledge and Best Practices
Demonstrate basic knowledge of etiology for mental health and substance use disorders and best practices in treatment/rehabilitation for co-occurring disorders.
4. Change and Recovery Models
Demonstrate an understanding of change and recovery models used in the treatment/rehabilitation of mental health and substance use disorders.
5. Crisis Response
Demonstrate practical knowledge on a range of crisis prevention, intervention, and resolution approaches.
6. Screening and Assessment
Demonstrate ability to complete basic screening for co-occurring disorders and an integrated, longitudinal, strength-based assessment.
7. Coordination of Services
Demonstrate knowledge and skills to facilitate the client's experience of integrated, continuous, and coordinated service.

To further promote and develop co-occurring services for both mental health and substance use/abuse providers, cross training of staff should be offered and received whenever possible. Crisis service providers shall offer training related to the C-SSRS and managing individuals with mental health issues while alcohol and drug service providers will offer A&D training to crisis services staff.

Crisis assessments should not routinely be completed with individuals too impaired to participate in the evaluation. Crisis response services should not be initiated for an intoxicated individual until the individual can participate in the assessment process. Individuals under the influence of intoxicating substances, not uncommonly, experience mood swings and suicidal thoughts which resolve in the absence of the substance. Except in the presence of imminent risk, it is preferred that assessment occur after the effects of intoxicating substances have worn off. The legal limit for a blood alcohol level is 0.08; anything higher than this may impair judgment.

An individual's blood pressure, pulse and temperature can provide valuable information regarding physical stability and risk of withdrawal. Withdrawal symptoms typically occur between 24 and 72 hours from the time cessation occurred. Vital signs should be obtained and provided to the receiving facility whenever possible. Blood pressure, pulse and temperature can be obtained using digital equipment in order to provide a reading. Interpretation of vital sign readings shall only be made by appropriately qualified medical staff.

Responsibilities:

- *Crisis responders will identify individuals with co-occurring disorders.*
- *Crisis responders will be familiar with treatment resources and referral mechanisms.*

Chapter 6 – Crisis Management Planning and Safety Planning

As part of a crisis intervention service, the crisis services provider must develop a crisis management plan during a crisis encounter whenever possible. The plan must address the needs and problems noted during assessment and provide information to assist with the reduction or elimination of the crisis.

If a person has developed a Wellness Recovery Action Plan (WRAP), cross system crisis plan or crisis management plan prior to the current crisis situation and/or has a Declaration for Mental Health Treatment (see Appendix 5; also found at http://www.tn.gov/assets/entities/behavioral-health/attachments/Declaration_for_Mental_Health_Treatment-Form.pdf), the crisis service provider should attempt to locate and follow the plan to the extent possible, including bringing in those people identified to assist with the plan.

The collaboration that occurs when the crisis service provider is intervening in a crisis will depend largely on the person being served. Asking the person about his or her support network is a very important piece of the crisis intervention process. However, individuals may choose not to involve family, friends, or service providers at the time of the crisis. He or she may choose not to involve others at all, or it may be something that he/she chooses after the crisis has stabilized. Others may wish to have family or friends directly involved. Such support aids the provider in developing a crisis management plan and/or a safety plan that allows an individual to remain within their natural environment.

For individuals at risk of suicide, safety planning and means restriction education must be provided to the individual and/or support system at the time of the face-to-face assessment.

Whenever possible, individuals should be supported to actively and positively participate in decision-making within individual support plans and have opportunities to contribute to the planning and development of the service to the extent possible.

Crisis Management Planning

A crisis management plan is a documented intervention tool that itemizes and describes information and actions intended to sustain resolution of the recent crisis episode and reduce the potential for a subsequent crisis episode. When possible, the crisis management plan should be a collaborative product between the crisis professional and the person in crisis and/or their designated support person(s). Information within a crisis management plan may include, but is not limited to: willing and available persons of support and their contact information; phone numbers of the mental health provider(s) and the local mobile crisis team; list of current medications and dosages; list of treatments used in the past; list of calming and de-escalation techniques that have worked; list of trigger items and subjects to avoid; preferred treatment facilities; copy of advanced psychiatric directives. In addition, the crisis management plan should include a safety plan when necessary. The crisis management plan should evolve as necessary, with updated information whenever there is a change in diagnosis, medication, treatment, provider, support persons, etc.

The following items should be considered when determining crisis management planning needs:

- Where are they going?
- Client's phone number
- Does phone number work and are minutes available for calls?
- Is someone going to be with the client?
- Name / Relationship
- Friend / Family member's phone number
- Does phone number work?
- Does client have alternative support system?
- Name / Relationship
- Friend / Family member's phone number
- Does phone number work?
- Is location secure for:
 - Guns
 - Knives
 - Medications
 - Other:_____
- Will client accept a follow-up appointment?
- Appointment date? (if applicable)

See Appendix 6 for crisis management planning considerations, and Appendix 7 for a sample crisis management plan template.

Safety Planning

Safety planning refers to a documented protocol or set of action steps that specifically outlines pertinent information and concrete strategies to implement in order to address and reduce the potential risk of harm or danger due to a behavioral health condition. The safety plan should be a collaborative product between the crisis professional and the person in crisis and/or their designated support person(s). While a safety plan may be included in a crisis management plan, it should be structured in such a way that it can function independently. Action steps within a safety plan include, but is not limited to: recognizing warning signs of an impending behavior that induces self-harm, harm to others or imminent danger; using identified coping strategies; contacting identified person(s) of support to distract from thoughts of harm to self or others, or endangerment; contacting identified person(s) to support who may help to resolve the crisis; contacting behavioral health providers; safety sweeps in residential setting; removing and reducing accessibility of means for self-harm, harm to others or endangerment.

See Appendix 8 for a sample safety plan template.

Safety Planning Responsibilities:

- *Access to means for self-harm, harm to others, or endangerment and availability of support shall be considered in the development of a safety management plan.*
- *Crisis responders shall determine if an individual with intellectual disabilities has a system of support and/or a cross systems crisis plan and follow the plan to the extent possible.*

Chapter 7 – Administrative Requirements

Crisis service providers will provide policies and procedures, data collection methods, and quality assurance/improvement processes within the crisis delivery system. Regional meetings with delivery system stakeholders should be conducted quarterly to provide a venue for discussion of service delivery barriers, gaps and needs whenever possible.

Policies and Procedures

Policies and procedures will be designed to ensure all crisis response staff follows appropriate protocol in the performance of their jobs. Policies and procedures will include but are not limited to the following:

- Client rights and the grievance procedures to be followed when a suspected violation of client rights has been reported;
- Consent and release of information in a crisis evaluation (Title 33, when consent not required)
- Confidentiality of client information which comply with applicable confidentiality laws and regulations (e.g., T.C.A. § 33-3-104(10); federal alcohol and drug regulations found at 42 CFR, Part 2);
- A medication administration policy and control procedures for facilities involved in the administration of medication to clients;
- Fire evacuation and natural disaster emergencies which include provision for emergency transportation of clients, emergency medical care, and staff coverage in such events;
- Accessibility (include inclement weather operations)
- Contingency plans for continued phone line and/or computer operations;
- Reporting and investigation of suspected or alleged abuse, neglect of clients, or other critical incidents. The procedures must include provisions for corrective action, if any, to be taken as a result of such reporting and investigation;
- Use of volunteers, interns or other non-paid staff, if used by the facility
- Client behavior, management techniques
- Quality assurance and improvement procedures
- Provision of non-emergency transportation
- Emergency medical procedures
- Involuntary commitment process
- Risk assessment and management of suicide and homicide risk
- Safety of staff and individuals receiving services
- Referral coordination and procedures
- Documentation requirements
- Employee Code of Conduct
- Credentialing/Re-credentialing
- Written procedures to guide access to inpatient services or less restrictive alternatives including MCO interface requirements.
- Procedures for the involvement of family members, identified legal representatives, or others, with legal right or the consent of the persons served

Mobile Crisis Documentation Requirements

A log or EHR report of all contacts with crisis telephone services will be maintained by the crisis service provider and includes, whenever possible, the name of the caller, client's date of birth, social security number, gender, race/ethnicity (when available), the name of the crisis telephone worker, the time and duration of the call, time of face to face dispatch, if applicable, and final disposition of the call. Call documentation shall include a description of the presenting problem.

A service record will be maintained for each crisis face-to-face (or telehealth) encounter which minimally includes the following information:

- The client's
 - name;
 - address;
 - telephone number (primary and secondary);
 - gender;
 - date of birth;
 - race and ethnicity;
 - marital status
 - residential status;
 - county of residence;
 - employment status;
 - annual gross household income (when possible);
 - veteran status;
 - number of arrests past 30 days;
 - school attendance past 3 months;
 - current or highest grade completed;
 - payor source;
 - presenting problem;
 - assessment of risk to self and others to include suicidal ideation/other self harm, violent/threatening/homicidal behavior, psychosis)
 - diagnosis if known;
 - Issues since last stabilization, when applicable;
 - Medical conditions/stability;
 - Use of alcohol and drugs, including presence of detox symptoms;
 - History of previous response and results;
 - The date and time of assessment;
 - Location of the individual being assessed;
 - Type of face to face conducted (in person or telehealth)
 - The source of the client's referral to the service;
 - The name, address, and telephone number of an emergency contact person, if known;
 - Any known past trauma;
 - Any known or suspected intellectual or developmental disability;
 - Current or recent prescription or over the counter medications and related compliance issues;
 - Any known history of prior mental health and/or drug abuse treatment episodes;
 - Any known current treatment providers and date of last service;

- Clinical intervention activities, if applicable;
- Existence of MOT obligation if known;
- Existence of conservator, Durable Power of Attorney or guardian, if known;
- Existence of Declaration for Mental Health Treatment, if known;
- Alternative services available and offered to the individual if appropriate;
- Recommended final disposition and rationale; and
- Results of follow-up contact.

Quality Assurance/Patient Satisfaction

The use of meaningful data will inform the quality assurance and improvement process. Crisis service providers will ensure quality assurance/improvement processes are in place to guide program development and ongoing improvement. Processes may include but are not limited to: record reviews, peer review processes, patient satisfaction surveys, stakeholder interviews, and data analysis.

Patient satisfaction surveys will be utilized whenever possible within the crisis services continuum. For individuals receiving mobile crisis services, an attempt will be made to solicit feedback on the usefulness of the service will be made during the follow-up attempt unless involuntary hospitalization was recommended. Information obtained from survey results will help inform improvement needs. Crisis service providers will periodically reach out to the systems that use the service to request feedback useful in identifying potential service improvement opportunities.

Quality Assurance/Improvement Responsibilities:

- *Ensure quality assurance/improvement processes guide program development and improvement.*
- *Conduct patient satisfaction surveys or stakeholder interviews to seek information about potential improvements regularly.*

Critical Incidents

A critical incident is any actual or alleged event that may potentially result in criminal action, media interest, serious physical injury, or major interruption to services in the crisis services delivery system.

Critical incidents will be reported to the TDMHSAS Director of Crisis Services as soon as possible after the incident by phone, e-mail, or text. Notification requirements will be considered fulfilled as long as a voice or written message has been provided.

Critical incidents include but are not limited to the following:

- Life threatening or debilitating staff injury that occurred while fulfilling work duties,
- Known completed suicide/homicide of individual assessed in crisis within the past 30 days,
- Fire, flood, inclement weather, or other disaster that results in an interruption to crisis service operations lasting more than 24 hours, and
- Inoperability of the crisis line

Considering the frequent tragedies occurring all across the United States, the crisis service delivery system must be available to provide support to businesses, agencies and individuals affected by such tragedies. A process for accessing critical incident debriefing services when requested by other agencies shall be provided by the crisis service delivery system. If the agency intends to provide critical incident debriefing, all training requirements must be satisfied.

Additionally, crisis service providers shall ensure access to internal debriefing processes for staff affected by traumatic and/or stressful events while fulfilling the requirements of their job.

Critical incident Responsibilities:

- *Notify TDMHSAS Crisis Director of critical incidents as indicated above.*
- *Provide information regarding the availability of critical incident debriefing to businesses, agencies and/or individuals whenever possible upon request.*
- *Provide process for debriefing crisis response staff following a traumatic or stressful event.*

Chapter 8 – Involuntary Commitment Process

Philosophy

The use of emergency involuntary commitment processes will only be initiated when all less restrictive alternatives, including voluntary hospitalization are unsuitable to meet the needs of the individual in need of services. Voluntary hospitalization will be considered as a preferred alternative to involuntary hospitalization and efforts will be made to access voluntary services prior to initiating an involuntary process.

Qualified Mental Health Professionals designated as Mandatory Prescreening Agents (MPA) will be utilized whenever possible as the first responder for face-to-face assessment when hospitalization is likely.

Provide education to emergency departments and law enforcement regarding the use of TCA 33-6-401 to detain an individual pending examination for TCA 33-6-404 whenever possible.

East TN Referral Process

Beginning June 1, 2012, emergency inpatient psychiatric hospitalization for uninsured individuals in Regions 1 and 2 will be provided by Mountain States Health Alliance's (MSHA's) Woodridge Psychiatric Hospital, Peninsula Hospital or Ridgeview Psychiatric Hospital (hereinafter state contracted providers or (SCPs)) in lieu of Lakeshore Mental Health Institute. Contractual requirements for these services require that a TDMH designated crisis service provider be involved in the decision to refer for inpatient psychiatric hospitalization.

Before initiating inpatient psychiatric hospitalization of uninsured individuals to any one of the SCPs, a TDMHSAS designated crisis service provider must first consider the potential for the provision of service in a less restrictive environment and conclude that a referral for inpatient psychiatric care is necessary. Several community services have been established that are designed to reduce utilization of involuntary inpatient psychiatric services for uninsured individuals and allow for the provision of voluntary care within the community where the individual resides. TDMHSAS designated crisis service providers will be knowledgeable of these services and their potential benefits in reducing the need for inpatient psychiatric hospitalization for uninsured individuals and will be available to assist in the inpatient psychiatric hospitalization decision process.

Additionally, before referring any individual (insured or uninsured) to Moccasin Bend Mental Health Institute (MBMHI) from Region 1 or 2, placement attempts must be made at all three SCP's serving the East TN area. Upon a referral attempt, MBMHI will inquire as to why the individual was not accepted at each of the three SCPs before considering admission; however, consideration will be given to any individual meeting emergency commitment criteria that cannot be appropriately served by any of the three SCPs serving Regions 1 and 2.

Telehealth systems shall be utilized between the involved TDMHSAS designated crisis service provider and MBMHI to ensure that an admission evaluation and acceptance occurs prior to long distance transport for inpatient psychiatric hospitalization.

RMHI Non-admit Decisions

When an individual is referred to, is accepted by and transported to one of the State's Regional Mental Health Institutes (RMHIs) but is not admitted for any reason the following non-Admit process should be used.

Upon receiving notice of a Non-Admit Decision, the crisis provider shall:

- a) Document the rationale for the Non-Admit Decision provided by the notifying RMHI;
- b) Follow-up with the individual, arrange for, and/or refer the individual to other treatment options;
- c) Document in the individual's record any referrals made or arranged; and
- d) In situations involving the individual not being admitted and sent back to a supervised setting (nursing home, group home, the individual's caretaker's home; or the individual's family home), the crisis provider shall alert the supervised setting of the Non-Admit Decision.

Mandatory Prescreening Agent Responsibilities

Mandatory Prescreening Agents must comply with the following requirements:

- Have access to current information about available community resources and referral procedures to access less restrictive alternatives to hospitalization.
- Comply with county protocol(s) for designated modes of transportation.
- Pre-screen service recipients to assess eligibility for emergency involuntary admission to state-owned or operated facilities under T.C.A. § 33-6-404.
- Determine, if possible, whether the service recipient has a durable power of attorney for health care or a declaration for mental health treatment and comply to the extent possible.
- Determine, if possible, whether the service recipient is under a mandatory outpatient treatment obligation from an inpatient provider.
- Complete a certificate of need for any service recipient assessed as eligible for emergency involuntary admission under T.C.A. § 33-6-404.
- Determine and document level of security required and mode of transportation to the admitting hospital for service recipients eligible for emergency involuntary admission under T.C.A. § 33-6-404 and document level of security required, and mode of transportation needed on the CON.

When an individual is evaluated and does not meet emergency involuntary admission criteria, the MPA will:

- Assess availability of alternative services and make referral, if appropriate;
- Initiate contact with each individual not eligible for emergency involuntary admission within twelve (12) hours of evaluation and complete follow-up as necessary. By agreement, an MPA may designate another QMHP or a crisis response service to meet responsibilities for follow-up as defined in 0940-3-8-.03(5);
- Maintain documentation of at least the following information:
 - Reason/justification for diversion;
 - Clinical intervention activities, if applicable;

- Alternative services available and offered to the service recipient, if appropriate;
- Results of follow-up contact and actions taken.

MPAs will be knowledgeable of all applicable TN statutes regarding the involuntary commitment process.

MPAs are required to complete a refresher course every two years and maintain a current TN license in order to adhere to designation requirements.

MPAs must immediately notify the Department if he or she:

- a) no longer meets the requirements for QMHP;
- b) requires or makes changes in service area location(s);
- c) no longer functions as a mandatory pre-screening agent; or
- d) has a change of name, address, and contact information.

MPA Documentation Requirements

Upon determining the need for emergency involuntary hospitalization the MPA will provide a completed Certificate of Need and copy of the crisis assessment to the receiving psychiatric facility in addition to the following:

- Acknowledgement and copy, where possible, of a durable power of attorney for health care or a declaration for mental health treatment;
- Existence of mandatory outpatient treatment obligation, if applicable, and discharging facility, if known;
- Name of person at referring service provider;
- Any known medical condition(s);
- Current or recent prescription and/or over-the-counter medication(s), if any;
- Current or recent use of alcohol and/or other substance use, if any;
- Name of current or most recent community behavioral health provider, if known; and
- Recommendations for services and/or supports following discharge.

If a service recipient requires evaluation for emergency involuntary admission to a state-owned or operated treatment resource under T.C.A. § 33-6-404 and cannot be examined by a mandatory prescreening agent within two (2) hours of the request to examine the person, a physician or psychologist may perform the evaluation and provide a certificate of need. However, the physician or psychologist must before completing a certificate of need, make a determination, in consultation with a crisis response service that serves the county where the service recipient is being evaluated, that all available and appropriate less drastic alternatives to placement in a hospital or treatment resource are unsuitable to meet the needs of the person and document the consultation. A face-to-face consultation with the crisis response service is not required.

Responsibilities:

- MPAs will adhere to all designation requirements including providing notice of change of status, maintaining a current TN professional license, and completing the required training courses.
- MPAs will be utilized as the first responder whenever hospitalization is likely whenever possible.
- MPAs will consider all less restrictive alternatives to involuntary hospitalization before initiating an involuntary process.
- MPAs will document the level of security required and mode of transportation needed.
- The crisis service provider will provide consultation to physicians or psychologists who in the absence of a MPA being available within 2 hours are issuing a certificate of need for emergency involuntary hospitalization.

Transportation

When arranging and/or providing transportation to inpatient services, consideration must be given to the level of risk that the person presents as well as whether the benefit of requiring a secure method of transport, which results in a person being handcuffed, outweighs the trauma created by such.

Title 33 requires a physician, psychologist with health service provider designation or mandatory pre-screening agent to determine the need for the level of vehicle security needed when initiating emergency involuntary hospitalization.

The following items need to be considered when determining the appropriate method of transportation for additional behavioral health services:

Individual information

- Is the current behavior or history, impulsive?
- Are there medical issues that could impact safety in transporting?
- Does the benefit of secure transport outweigh the trauma caused?
- What is the individual's history with crisis provider/MPA? Is there frequent use of crisis services?
- Has the individual carried out physical violence in the current situation?
- Is information given accurate to the best of their cognitive ability?
- Does the individual agree with need for service?
- Is the individual willing to be transported by "other" transporter?
- Is the transporter familiar with the individual?
- Has the transporter been fully informed of importance of the transporter's role?

Proposed transporter

- Is there an obvious positive connection, to family member, friend or mental health professional that will transport?

- Is the transporter willing to agree to provide immediate and direct transportation to receiving facility and understand that the receiving facility will be notified of their estimated arrival time?
- Does transporter verbalize an understanding of liability and transporting at own expense?
- Is there a need for additional riders? Would the transporter feel more comfortable with an additional person riding along?
- Does the transporter have a cell phone available during transport?
- Does the transporter have insurance?

Transportation Vehicle

- Is the vehicle clear of obvious weapons or instruments that could be harmful?
- Does the vehicle have child locks on doors and windows?
- Does the vehicle appear to be a reliable means of transportation?

Responsibilities:

- Consider the need for secure transportation when emergency involuntary hospitalization is indicated.
- Utilize less restrictive modes of transportation whenever possible.
- Provide a confirmation number with the CON to the transporting agent for individuals referred to an RMHI for an emergency involuntary admission.
- Explain the transportation process to the client whenever possible prior to initiating transport in order to reduce the individuals trauma and anxiety.

Chapter 9 – Follow-up Services

Follow-up with an individual who has been assessed face to face will provide valuable information regarding the effectiveness and appropriateness of the service recommendation. Follow-up services can be provided via phone, face to face, chat, peer support, and telehealth. Providing follow-up promotes a feeling of connectedness for the individual being served and can enhance the benefit of other behavioral health services.

At a minimum, follow-up attempts will be conducted for all individuals seen by face to face by a crisis service provider within 12-24 hours from the time the assessment was completed. Preferably, additional contacts will be attempted at 3 days and one week post crisis encounter.

At least three attempts to contact an individual will be made before determining an unsuccessful follow-up attempt. Documentation of each attempt will be maintained in the service record. For individuals still experiencing a crisis episode at the time of the follow-up contact, crisis responders will attempt to provide alternative recommendations aimed at alleviating the crisis and maintaining the safety of the individual and community. Follow-up is also a great time to ensure the individual is connected and able to engage with behavioral health services.

APPENDICES

**CRISIS CLINICAL CONSULT FORM
(FOR MENTAL HEALTH CRISIS PHONE CONSULTATION)**

DATE OF CALL: _____ TIME OF CALL: _____ REFERRING HOSPITAL: _____

CLIENT NAME: _____ SOCIAL SECURITY NUMBER: _____
FIRST MI LAST - -

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

TELEPHONE NO.: HOME () _____ WORK: () _____ DATE OF BIRTH: mm/dd/yy _____/_____/_____

HAS THE CLIENT EVER BEEN ADMITTED TO AN INPATIENT PSYCHIATRIC FACILITY OR A CRISIS STABILIZATION UNIT? ☐ NO ☐ YES ☐ UNKNOWN

WHERE AND WHEN WAS MOST RECENT ADMISSION: _____

WHAT MEDICATIONS IS THE CLIENT CURRENTLY BEING PRESCRIBED? _____

IS THE CLIENT ABUSING SUBSTANCES? ☐ NO ☐ YES ☐ UNKNOWN

NAME OF DRUG: _____ HOW OFTEN: _____ HOW MUCH: _____ LAST USE: _____ NUMBER OF YRS: _____

NAME OF DRUG: _____ HOW OFTEN: _____ HOW MUCH: _____ LAST USE: _____ NUMBER OF YRS: _____

NAME OF DRUG: _____ HOW OFTEN: _____ HOW MUCH: _____ LAST USE: _____ NUMBER OF YRS: _____

IF CLIENT IS ABUSING SUBSTANCES, DOES CLIENT HAVE A HISTORY OF DT'S, SEIZURES, BLACKOUTS DURING WITHDRAWAL? ☐ NO ☐ YES ☐ UNKNOWN

IS THE CLIENT EXPRESSING SUICIDAL IDEATION? ☐ NO ☐ YES

IF YES, DO THEY HAVE A PLAN? ☐ NO ☐ YES ☐ UNKNOWN

ARE THE MEANS AVAILABLE? ☐ NO ☐ YES ☐ UNKNOWN

HAVE THEY HAD ANY PREVIOUS ATTEMPTS? ☐ NO ☐ YES ☐ UNKNOWN

IS THERE A FAMILY HISTORY OF SUICIDE? ☐ NO ☐ YES ☐ UNKNOWN

IS THE CLIENT EXPRESSING HOMICIDAL IDEATION? ☐ NO ☐ YES OR ASSAULTIVE IDEATION? ☐ NO ☐ YES

IS THERE A SPECIFIED TARGET? ☐ NO ☐ YES (SPECIFY TARGET) _____

HAS THE TARGET BEEN CONTACTED TO WARN TARGET? ☐ NO ☐ YES

IS THE CLIENT PSYCHOTIC? ☐ NO ☐ YES

THOUGHT CONTENT: ☐ WITHIN NORMAL LIMITS ☐ PARANOIA ☐ DELUSIONS

☐ OTHER: _____

PERCEPTION: ☐ WITHIN NORMAL LIMITS ☐ AUDITORY HALLUCINATIONS ☐ VISUAL HALLUCINATIONS

☐ TACTILE HALLUCINATIONS ☐ COMMAND HALLUCINATIONS

IS THE CLIENT CURRENTLY VIOLENT? ☐ NO ☐ YES

HAS A CERTIFICATE OF NEED BEEN SIGNED PRIOR TO CONSULTATION? ☐ NO ☐ YES

IF YES, IS THE SIGNING MD WILLING TO RESCIND IF A LOWER LEVEL OF CARE IS DEEMED APPROPRIATE? ☐ NO ☐ YES

IS THE CLIENT EXHIBITING INSIGHT INTO THEIR NEED FOR ADDITIONAL MENTAL HEALTH SERVICES AND ARE THEY WILLING TO SEEK THEM VOLUNTARILY?
☐ NO ☐ YES

STAFF SIGNATURE: _____ DATE: _____



**TENNESSEE DEPARTMENT OF MENTAL HEALTH AND
SUBSTANCE ABUSE SERVICES**

OFFICE OF CRISIS SERVICES



TELECOMMUNICATION GUIDELINES

**FOR TENNESSEE DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE
ABUSE SERVICES DESIGNATED CRISIS SERVICES**

Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS)
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3. Appendix

Overview of Telehealth Systems

The Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS) conducted extensive review on the use of telehealth services. Based upon the findings, TDMHSAS believes telehealth is a viable option for access to behavioral health services and enhancing the efficiency of the crisis service delivery system.

Telehealth is the use of electronic information and telecommunication technologies to support clinical care between an individual with mental illness and/or substance abuse issues and a healthcare practitioner. The continued development of the Internet and recent reductions in the cost of technology to deliver this service have made telehealth a viable option for delivering behavioral health services to service recipients residing in rural and underserved geographic regions. As a cost-effective alternative to more traditional ways of providing behavioral health care, use of telehealth technology by providers can reduce transportation expenses, improve service recipient access to behavioral health providers, improve quality of care, and facilitate better communication between providers. Telehealth systems provide a live, interactive audio-video communication or videoconferencing connection between the individual in need of services and the crisis service delivery system.

The primary goals of the use of telehealth in the delivery of crisis services:

- 1) Enhance timely resolution of the crisis situation;
- 2) Improve efficiency in the psychiatric hospitalization process;
- 3) Reduce trauma related to unnecessary transport of an individual in psychiatric crisis;
- 4) Improve access to mental health professionals for emergency departments and jails; and
- 5) Reduce healthcare costs.

The following guidelines provide information related to the establishment and use of telehealth systems in the provision of crisis services. These guidelines are to be followed by providers using telehealth systems to render crisis related services funded in whole or in part by TDMHSAS.

Although there are general templates and guidelines for protocols, each telehealth provider should have its own protocol that is tailored to the environment, infrastructure and organizational configuration for that particular provider's location(s). These protocols should be as consistent as possible across various provider locations while adapting the protocols to address the realities of each individual provider's environment.

General Provisions

Crisis service providers may connect with a variety of community locations serving individuals with mental illness or substance abuse problems to help facilitate access to needed services. Locations may include emergency departments, jails, detention centers, and other similar locations. A telehealth connection to sites with a high volume of presentations will allow crisis providers to conduct face-to-face assessments to determine the need for emergency involuntary hospitalization, or alternatives as appropriate, more efficiently and cost effectively. These connections should improve the accessibility and timeliness of service disposition and allow improved utilization of crisis resources. Additionally, crisis providers shall seek telehealth connections with admitting psychiatric hospitals, starting with the Regional Mental Health Institutes (RMHIs). This will allow for an admitting psychiatric facility to determine the need for hospitalization prior to transporting an individual long distances.

Connectivity issues are one of the main concerns for compatibility of software and/or equipment. In order to avoid these issues, each provider should consult with the inpatient psychiatric facility, emergency departments, jails and/or other community providers to ensure that the provider software and equipment are compatible with existing community telehealth systems. It is expected that all crisis providers, at a minimum, be able to connect to the RMHI's.

As long as the community provider's telehealth system can connect with the State's RMHI and an agreement of acceptable quality is reached, the telehealth system chosen by each provider is considered acceptable. Telehealth connections to the RMHIs will only occur with the involvement of a TDMHSAS designated crisis service provider. Appointments for telehealth assessments will require that an identification (ID) number be provided by the crisis provider at the time the request for an appointment is made.

To determine if you can connect to the telehealth super highway, you must first arrange a connectivity test to a RMHI. Once connected to any one of the State RMHIs, the provider will be able to connect to all. After the crisis service provider has established a connection with a RMHI, the crisis provider service can begin establishing new connections to other interested admitting psychiatric hospitals for 2nd CON assessment and presentation points in the community for 1st CON assessments.

The IT Managers at each RMHI are as follows:

- . Middle Tennessee - Vic Hearne- 615-902-7446
- . Moccasin Bend - Mickey Williams- 423-785-3332
- . Western - Earl Bates- 731-228-2000
- . Memphis - John Hayden- 901-577-1906

Guidelines for services include but are not limited to the following:

A. EQUIPMENT

The major components include monitors, cameras, CODEC (coder/decoder), a desktop computer or laptop computer, microphones, speakers, and other audiovisual interactive technologies such as videophones. Organizational policies and procedures should be developed and followed regarding equipment quality control standards. Providers should keep all telehealth equipment in good working condition and replace equipment as necessary to ensure clinical results are comparable to on-site face-to-face clinical results.

There must be procedures in place for dealing with equipment failure. Should failure occur, the site where the individual is physically located is responsible for attempting to reestablish an adequate audio-video connection. If this is not possible, then the provider at the site where the individual is physically located should telephone the community mental health site. In emergency situations, it is essential that there be personnel at the site with the individual receiving services to assist the individual in the event of equipment failure. Whenever possible, an IT professional should be on-site and available in case something technically goes wrong.

In case of equipment failure, procedures must be in place at the crisis provider agency to ensure prompt on-site face-to-face assessment and continuity of care (e.g., redundancy- 2nd computer set-up, if available, to do a "hot-switch" on the spot, conduct an on-site face-to-face assessment, conduct an in-home visit or go to the Emergency Room). The behavioral health professional that provides direct care through telehealth is responsible for ensuring appropriate options are available for the individual receiving services.

Special considerations for laptop use:

Laptop technology will allow crisis providers to connect to the admitting psychiatric inpatient facilities from the presentation point, without the need for transport to a remote telehealth site. **However**, the use of laptop technology presents special challenges that would not be an issue with stationary equipment and requires extra steps to ensure safety and security of the equipment.

The following **must** be considered with the use of laptop technology:

Appendix 2 (cont'd)

- The site must provide for the confidentiality of the assessment;
- The quality of the connection must provide adequate sound and image; and
- The individual must be able to be left alone with the equipment without the risk of injury to the individual or equipment.

Listed below are minimal specifications for the use of telecommunications for Crisis Services:

Audio

High quality microphones and speakers ensure effective audio communication and should be used in telehealth consultations to ensure accurate interpretation of the individual's and provider's spoken communication. High- quality audio is essential to the success of telehealth services, capturing the nuances of conversation that are often vital in making appropriate diagnoses. Microphone type and placement are extremely important, as are the acoustical properties of the room used. Most flat "conference-style" microphones are adequate to pick up sounds around a table or in a room, as long as the microphones are placed on a hard, flat surface at desk or table-top level. Many will also work well if placed on a flat wall at about head level for a seated person. If no flat surface is available, or if individuals are active or agitated, an omni-directional microphone can be hung from the center of the ceiling. "Quiet" rooms (those with carpeting, soft furniture, acoustical treatments, or other sound absorbing characteristics) allow for better intelligibility of transmitted speech.

Transmission Speed and Bandwidth

Transmission speed shall be the minimum necessary to allow the smooth and natural communication pace necessary for clinical encounters. Most telehealth programs use systems that transmit data at a minimum of 384 Kbps.

Image Storage, Retrieval and Transmission

- Security:* The United States Health Insurance Portability and Accountability Act (HIPAA), Alcohol and Drug Confidentiality Regulations in 42 CFR, Part 2 and Tennessee privacy requirements shall be followed at all times to protect individual privacy. Network and software security protocols to protect privacy and confidentiality shall be developed as well as appropriate user accessibility and authentication protocols. Measures to safeguard data against intentional and unintentional corruption shall be in place during both storage and transmission.
- Encryption:* Within the U.S., HIPAA requires that Electronic Protected Health Information is encrypted.
- Resolution:* The resolution of the display monitor should match as closely as possible the resolution of the acquired image being displayed, or the originally acquired image resolution should be accessible using zoom and pan functions.
- Interoperability:* Most telecommunications standards are established by the International Telecommunications Union (ITU), an agency of the United Nations. Equipment shall be based on these standards which allow successful conferencing regardless of platform or manufacturer. The ITU standards that shall be used comprise the H (video), G (audio) and T (data) series.

Video units the RMHIs of Tennessee have successfully connected to:

- Polycom VSX-7000series

Appendix 2 (cont'd)

- Polycom VSX-8000series
- PolycomHDX-7000
- PolycomHDX-8000
- Tandberg-Cisco 770MXP
- Tandberg-Cisco 880MXP
- Tandberg-Cisco 3000MXP
- Tandberg-Cisco 6000MXP
- Tandberg-Cisco Edge 95
- HD Web Cam with Cisco Jabber Video (MOVI)

Security

Steps must be taken to ensure the security of the equipment, such as keeping the equipment in a locked room with limited access and securing equipment while the individual is being evaluated to prevent injury and/or damage to the equipment. In addition, mobile networks should have secure username and password protections. Mobile units shall never be left unattended without restricting access by unintended users. When transmission of identifiable individual data is required, it should occur over secure networks or appropriate encryption protocols must be used.

C. Credentialing

Psychiatric inpatient facilities may require that staff performing crisis assessments, whether in person or via telehealth, be credentialed within their organization. If this is required, the crisis provider shall follow the protocols outlined by the psychiatric inpatient facility and/or its parent organization.

D. Privacy/Confidentiality

Service recipient privacy and confidentiality must be maintained at all times while receiving telehealth services, in accordance with, but not limited to, Tennessee Code Annotated Title 33, HIPAA standards and the Alcohol and Drug Confidentiality Regulations in 42 CFR, Part 2. This includes privacy provisions at the service recipient's location, as well as the location receiving the service recipient's information.

The physical location in which the telehealth assessment takes place should be one which provides the most privacy available. While this may sometimes be challenging, given that some locations may not be conducive to ensuring privacy, the professional doing the assessment must use his/her best judgment to determine whether the telehealth assessment setting is appropriate. Staff must be available at all times in close proximity to the room at the telehealth site in which the individual is being evaluated. Depending on the condition of the individual being evaluated via telehealth, staff may be needed in the room with the individual, particularly if the individual is impulsive. The determination of whether staff should be present in the room with the individual being evaluated shall be made jointly by the agency where the individual is located and staff at the community telehealth site. Significant concerns regarding whether the individual would be safe being alone in the room during the assessment may be an indicator that the assessment should be conducted in person, not by telehealth.

Privacy policies must be reviewed with the individual *before* beginning a telehealth assessment and the review shall be documented in his/her record.

- A) The individual will be informed that privacy policies contain standards that will protect the individual receiving services from being monitored through the video and/or through audio by unauthorized third parties without the individual's prior knowledge.
- B) The individual will be introduced to all persons involved in the assessment. The individual will be notified immediately if other personnel involved in the delivery of telehealth services, or other individuals as applicable, enter the transmitting and receptor sites during the assessment.
- C) The individual will be given the opportunity to request that the assessment be completed in person rather than by telehealth.

E. Right to Object

The individual being evaluated via telehealth must be informed of the process and given an opportunity to request an in-person face-to-face assessment **before** conducting a telehealth assessment. This should be documented in his/her record.

- A) Explanation of the process shall include a statement that services will not be withheld if the telehealth encounter is refused, and the individual may terminate the telehealth assessment at any time.
- B) Documentation must contain a statement that the telehealth process was explained to the individual and whether or not an objection was raised.

F. Disclosing Information

It is essential that necessary information be shared between the agency requesting an assessment (if applicable), the medical facility (if applicable), crisis service provider and the admitting psychiatric facility (when indicated) to ensure seamless transition and continuity of care for the individual being served. Sharing information is authorized in T.C.A. §33-3-105. (See Appendix)

G. Physical Location

All telehealth sites shall ensure that telehealth equipment is located in a space conducive to a clinical environment and provides adequate comfort and privacy for the individual being evaluated. Both visual and audio privacy are important, and placement and selection of the rooms used for conducting telehealth assessments should consider this. Proper lighting is required to keep shadows off the faces of the participants.

H. Licensure

All behavioral health professional licensure requirements are the same for telehealth as for on-site face-to-face services. However, licensing requirements vary from state to state thus if a professional is providing direct care services across state lines, the behavioral health professional must adhere to the requirements of each state's licensing authority.

I. Training

All professionals involved in telehealth assessments must be trained in how to use telehealth equipment properly and in accordance with the individual employer's organizational policies. Telehealth training procedures should include familiarity with the equipment, its operation and limitations, emergency backup procedures and means of safeguarding confidentiality and privacy at both the transmission and receptor sites. Each organization must have training for all personnel using telehealth to ensure competency prior to initial use. This training must be documented in the personnel records.

J. Inclusion/Exclusion Criteria

A determination must be made whether telehealth is a viable means of conducting the assessment based on the individual's behavior and psychiatric condition. If the individual's presenting condition is inappropriate for a telehealth assessment or if visual or sound quality is inadequate, the professional should proceed with an on-site, face-to-face assessment. Assessment of an individual via telehealth may not be viable if:

- The individual is too agitated to focus;
- The individual is violent, if the violence would potentially result in injury to staff or damage to equipment;
- The individual's delusional system would prevent him/her from engaging in the process; or
- The individual has an untreated acute medical condition.

Additional Considerations:

Transportation to a telehealth location is not necessary if:

- the ER already has a telehealth connection with the admitting psychiatric facility and a crisis service provider is on-site or if an on-site crisis service provider has a laptop connection with the admitting facility,
- the admitting psychiatric facility is located closer to the presenting location than the telehealth site,
- the telehealth location already has too many individuals to manage at once (thus the requirement to involve Walk-In Center (WIC) staff in the decision to choose telehealth).

K. Right to Terminate

For any reason and at any time during the process, the individual being evaluated via telehealth or the professional conducting the assessment (or other staff located where the individual is located) can request the assessment be terminated and be conducted on-site, face-to-face instead. Reasons might include but are not limited to: poor audio or visual quality, connectivity interruptions, and/or unstable mental health symptoms.

L. Service Records

Each telehealth encounter must be documented and information obtained during the telehealth encounter collected according to individual employer's organizational policy. The provider maintaining the record and

the location of the record (e.g.-receptor site, transmitter site) must be clearly stated in the organizational policy. If the record is kept at the site where the individual is physically located, then arrangements should be made to also have a copy of the record at the site of the treating crisis service provider. Privacy and confidentiality will apply to all sites where records are located. For optimal continuity of care, while adhering to the privacy and confidentiality laws, the site requesting the telehealth assessment should provide the necessary information from the record for staff to properly conduct the telehealth assessment.

Documentation must reflect that the assessment was conducted via telehealth, the names and roles of staff present during the telehealth assessment (if applicable), and whether staff were present with the individual at the telehealth site where the individual is located. If staff were present with the individual at the telehealth site, documentation should reflect their roles (such as admitting physician, emergency room staff, security staff), if known.

The record must comply with organizational standards and federal and state laws for documentation of crisis encounters. Documentation for a service rendered through telehealth should include, at a minimum, the same information as an on-site face-to-face contact. Additionally, it should include the following information:

- That the individual was informed of the telehealth process and confidentiality requirements;
- The location of the behavioral health personnel providing the service;
- The location of the service recipient (e.g. town, facility where physically located, etc.);
- Any malfunction that may have affected clinical assessment or care being rendered by telehealth, such as the quality of a transmission being poor and how this was addressed;
- A list of all personnel and others present during the telehealth services and their role(s) and
- The final outcome of the assessment.

The Certificate of Need (CON) may be transmitted electronically when indicated via encrypted email or other electronic transmission. It is recommended that admitting psychiatric facilities check with local court systems to determine whether electronic records will be accepted.

M. Use of Telehealth to Conduct a Crisis Assessment

1) General Considerations:

- a. The facility where the individual is located must call to schedule a time to conduct the telehealth assessment to ensure crisis staff availability. A Mandatory Pre-screening Agent should conduct the assessment if inpatient psychiatric hospitalization is likely.
- b. Assessment via telehealth should not be attempted without the support of staff present at the site where the individual is being evaluated if the individual being evaluated is: suicidal, homicidal, dissociative, having significant cognitive limitations including mental retardation, or acutely psychotic.
- c. The same criteria (e.g.-risk assessment, documentation, and response time) apply to crisis assessments via telehealth as to on-site face-to-face crisis assessments. (See Adult Mobile Crisis Grant Contract)
- d. Assessment of an individual via telehealth should not be attempted if there are technical problems with the telehealth equipment or connection or if the individual's psychiatric condition does not warrant a telehealth assessment.

Appendix 2 (cont'd)

- e. The individual being evaluated and the crisis staff conducting the assessment must be able to see and hear each other without delays or distortion and either may decide an in person face to face should be conducted.
- f. The site where the individual is located and the crisis staff involved in telehealth assessments must establish a procedure to be utilized in case an emergency situation develops during the telehealth assessment.

2) Prior to Initiating a Telehealth Assessment:

- a. The agency where the individual is located must contact crisis staff to verify availability to conduct the assessment **prior to** initiating a telehealth assessment.
- b. A discussion must occur between crisis staff and the agency where the individual is located regarding whether telehealth is a viable means of conducting the assessment, based on the individual's behavior and psychiatric condition.
- c. If either the agency where the individual is located or crisis staff determines that telehealth is **not** a viable means of conducting the assessment, crisis service provider shall dispatch staff to conduct the face-to-face assessment on site.
- d. If both agencies agree that the assessment can be conducted by telehealth, then the individual being evaluated must be given the choice to have the assessment via telehealth or on-site, in person.
- e. The agency requesting the telehealth assessment shall provide the following information, if available, to the crisis staff either verbally, via encrypted email or FAX. Additional information relative to the assessment may also be provided.
 - i. Basic information (individual's name, reason for assessment, date of birth, social security number, and insurance status) and whether the individual is considered medically stable and ready for a crisis assessment;
 - ii. Whether the individual has a durable power of attorney for health care that includes mental health care or a declaration for mental health treatment;
 - iii. Whether the individual is on mandatory outpatient treatment, if known;
 - iv. Any known medical conditions;
 - v. Current or recent prescription and over-the-counter medications, if any;
 - vi. Current or recent use of alcohol and/or other substance use, if any; and
 - vii. The name of the current or most recent community mental health provider, if known.
- f. Upon receiving the clinical and demographic information, crisis staff will call the agency where the individual is located to confirm that the information was received. The crisis staff will provide a time that he or she will be ready to begin the assessment via telehealth. The crisis staff

Appendix 2 (cont'd)

will inform the agency where the individual is located of any known delays (including technical problems or if other assessments are to be completed ahead of this one).

- g. The agency requesting the telehealth assessment must provide crisis staff with the name and phone number of a contact person at the site where the individual is located who is to be notified by crisis staff when the assessment has been completed or if it is interrupted. This contact person must be located in close proximity to the room in which the individual is being evaluated via telehealth and immediately accessible by phone during the assessment.
- h. After testing the telehealth equipment and connectivity, the community telehealth site and the site where the individual is located, the scheduled assessment can begin.

3) Conducting the Assessment via Telehealth:

- a. At the beginning of the telehealth assessment, the crisis staff shall explain the purpose of the assessment to the individual being evaluated (i.e., to determine service needs).
- b. The crisis staff shall inform the individual if other staff are present in the room where the telehealth equipment is located or enter the room at any point during the assessment.
- c. The telehealth assessment conducted by the crisis staff shall be identical to the assessment that would be conducted on-site, with the addition of the initial determination that assessment via telehealth is a viable option.
- d. All of the documentation required for crisis services for an on-site assessment is required for an assessment conducted via telehealth, regardless of whether the outcome of the assessment is to issue a Certificate of Need (CON) or not.
- e. If, during the telehealth assessment, it becomes obvious that the individual is not able to participate to the extent that the telehealth assessment cannot be completed, or if the individual being evaluated requests to terminate the telehealth assessment, the individual must be assessed in-person, face-to-face.
- f. Staff must be available at all times in close proximity to the room at the site where the individual is located. Depending on the condition of the individual being evaluated via telehealth, staff may be needed in the room with the individual, particularly if the individual is impulsive. The determination of whether staff should be present in the room with the individual being evaluated shall be made jointly by the agency requesting the telehealth assessment and the crisis staff. Significant concerns regarding whether the individual would be safe being alone in the room during the assessment may be an indicator that the assessment should be conducted on site, not by telehealth.
- g. The crisis staff conducting the assessment via telehealth shall not be interrupted during the assessment except in the event of an emergency that cannot be managed by any other staff or an emergency requiring evacuation of the telehealth location. If the crisis staff must be interrupted during the assessment, other staff members must be assigned to: 1) immediately communicate the interruption to the site where the individual being evaluated is located; and 2) keep the individual under visual observation until the crisis staff returns and the assessment resumes or staff at the telehealth location where the individual is located assumes responsibility for the individual.

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- h. If at the conclusion of the telehealth assessment the individual meets criteria for admission on an emergency involuntary basis under T.C.A. §33-6-404, the crisis Mandatory Pre-Screening Agent (MPA), MD or PhD shall complete a Certificate of Need (CON) and shall refer the individual for an admission assessment to an inpatient psychiatric facility.

If admission to a State RMHI is indicated and a MPA is not available to complete the CON then the physician or psychologist with health service provider (HSP) designation at the agency where the individual is located may issue the CON in consultation with the crisis staff conducting the assessment.

If the referral is being made to one of the private psychiatric hospitals that contracts with TDMHSAS, crisis staff must be involved in the decision to issue the 1st CON and a certification form must be provided to the admitting psychiatric facility by the crisis staff involved in the decision.

If the referral is being made to a private psychiatric hospital that does not contract with TDMHSAS, a non-crisis physician, psychologist with HSP designation or MPA may issue the 1st CON without consulting with the crisis service provider.

- i. As soon as the crisis MPA has made a decision regarding whether or not the individual meets criteria for emergency involuntary admission, crisis staff shall communicate this decision to the agency staff where the individual is located.
- j. If the crisis MPA, physician or psychologist determines that the individual meets criteria for emergency involuntary admission, the crisis staff will make needed telephone calls to potential admitting psychiatric facilities to secure a bed. In addition, crisis staff will complete the required pre-authorizations with insurance providers for voluntary admissions or required notification for emergency involuntary inpatient psychiatric hospitalization. The crisis staff will again contact the agency where the individual is located to request medical information as needed to be provided to potential admitting facilities.
- k. The crisis staff shall arrange for the transportation to the admitting psychiatric facility or telehealth location designated for the 2nd CON examination to complete the admission process for the individual who was evaluated.
- l. For referrals to the RMHIs, a confirmation number will be provided when a suitable bed becomes available. Confirmation numbers are required for transportation to a RMHI to occur.
- m. The 1st CON completed by the crisis MPA, physician or psychologist with HSP designation and confirmation numbers, if applicable, shall be provided to the agency where the individual is located, the transporting authority and to the admitting psychiatric facility and/or telehealth location designated to perform 2nd CON assessments. Additionally, any information received by the crisis service provider from the agency requesting the telehealth assessment shall be provided to the admitting psychiatric facility.
- n. If the 1st CON is completed by a qualified mental health professional at the site where the individual is located, crisis staff shall arrange for an inpatient psychiatric bed and transportation to the admitting psychiatric facility or telehealth location designated to conduct 2nd CON examinations and the original CON shall be sent with the individual being admitted.

Appendix 2 (cont'd)

- o. If the admitting psychiatric facility determines that the individual requires immediate medical treatment that cannot be provided by the admitting psychiatric facility, additional testing or transportation to a medical facility may be requested.
- p. If inpatient psychiatric hospitalization is not indicated, the MPA or crisis staff shall provide service linkage information to staff at the telehealth site where the individual is located and/or arrange for admission to an alternative treatment resource.
- q. Crisis staff shall send electronically a copy of consultative outcomes to the agency requesting the telehealth assessment for the individual's record.
- r. Requirements for follow-up are the same as for on-site, face-to-face assessments.

N. Use of Telehealth in an Assessment for Emergency Admission by an Inpatient Psychiatric Facility via Laptop or Connection at Presenting Site

1) General Considerations:

- a. Laptop connections must provide adequate visual and audio quality.
- b. The individual being evaluated via telehealth with the use of laptop technology must be able to be safely left alone with the equipment.
- c. The use of telehealth to conduct the admission assessment may not be feasible if the admitting inpatient psychiatric facility is located within close proximity to the location requesting the telehealth assessment.
- d. The community telehealth site (ED, MHC, jail, etc.) must provide a safe environment for the individual being evaluated, with equipment secured so as to minimize potential for damage or injury. This environment must also be comfortable in regard to temperature and lighting, with minimal distractions.
- e. Technical staff must be available (even if by phone) to both the admitting psychiatric facility and the community telehealth site to address technical problems with the telehealth equipment or connection that might arise during the assessment. If the assessment cannot be completed due to technical problems with the telehealth equipment or connection, the individual must be transported to the admitting psychiatric facility for a face-to-face on-site assessment.

2) Prior to Initiating a Telehealth Assessment:

- a. A determination must be made whether telehealth is a viable means of conducting the assessment, based on the individual's behavior and psychiatric condition.
 - i. Assessment of an individual via telehealth may **not** be viable if:
 - The individual is too agitated to focus;

Appendix 2 (cont'd)

- The individual is violent, if the violence would potentially result in injury to staff or damage to equipment;
- The individual's delusional system would prevent him/her from engaging in the process; or
- The individual has an untreated acute medical condition.

Additional Considerations:

Transportation to a telehealth location is not necessary if:

- the ER already has a telehealth connection with the admitting psychiatric facility and a crisis service provider is on-site or if an on-site crisis service provider has a laptop connection with the admitting facility,
 - the admitting psychiatric facility is located closer to the presenting location than the telehealth site,
 - the telehealth location already has too many individuals to manage at once (thus the requirement to involve Walk-In Center (WIC) staff in the decision to choose telehealth).
- b. If the agency where the individual is located determines that telehealth is **not** a viable means of conducting the admission assessment, the individual shall be transported to the admitting psychiatric facility for a face-to-face on-site assessment.
- c. If the agency where the individual is located believes that telehealth is a viable means of conducting the assessment, the agency where the individual is located (or other community staff involved with the referral) shall contact staff at the admitting inpatient psychiatric facility to establish a time for the assessment to occur.
- d. If the admitting inpatient psychiatric facility staff questions the viability or appropriateness of conducting the assessment via telehealth based on the referral information, staff shall participate in the decision to transport directly to the admitting psychiatric facility based on the referral information provided.
- e. The individual must be informed by the agency where the individual is located (the professional completing the first CON for emergency involuntary psychiatric hospitalization) or other community staff involved with the referral (such as a crisis worker or staff at an emergency room) that the assessment is to be conducted by telehealth and the individual must be given the option to request that the assessment be conducted by face-to-face on-site admitting psychiatric facility instead.
- f. The agency where the individual is located must send electronically (scan and secure e-mail or fax) to the admitting inpatient psychiatric facility the first Certificate of Need (CON) and all referral information. This information includes, but is not limited to, the following:
- I. Copies of assessments completed in the community (by the agency where individual is located and crisis service provider, if applicable) utilized in making the determination to complete the first CON;
 - II. Whether the individual has a general durable power of attorney that specifically includes powers related to decisions about mental health care; or a durable power of attorney for health care that specifically includes powers related to decisions about mental health care; or a declaration for mental health treatment;

Appendix 2 (cont'd)

- III. Whether the individual is on mandatory outpatient treatment, if known;
 - IV. Any known medical conditions;
 - V. Current or recent prescription and/or over-the-counter medications, if any;
 - VI. Current or recent use of alcohol and/or other substance use, if any;
 - VII. The name of the current or most recent community mental health and substance abuse service provider, if known; and
 - VIII. Recommendations for services and/or supports following discharge.
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- g. The agency where the individual is located (or other community staff involved with the referral) should discuss the individual's current behavior, any medications or medical issues, inpatient psychiatric bed availability and lack of available less restrictive alternatives with the receiving staff prior to initiating a telehealth assessment.
 - h. If, at any point, questions arise regarding whether the individual has a medical condition that requires **immediate** medical treatment that the admitting psychiatric facility cannot provide, either staff from the agency where the individual is located or involved crisis staff should contact the admitting psychiatric facility to discuss the individual's medical condition prior to transport to the admitting inpatient psychiatric facility.
 - i. If a physician is available at the location where the individual is located, a physician to physician discussion should occur to determine whether additional medical intervention is indicated prior to conducting the telehealth assessment (via mobile or stationary unit). All medical concerns should be addressed prior to conducting an admission decision to the psychiatric facility.
 - j. The community telehealth site must test the telehealth equipment and connectivity with the admitting psychiatric facility prior to initiating the admission assessment. Assessment of an individual via telehealth should not be attempted if there are technical problems with the telehealth equipment or connection. The individual being evaluated and the admitting psychiatric facility physician conducting the assessment must be able to see and hear each other without delays or distortion.
 - k. The community telehealth location staff must provide the admitting psychiatric facility with the name and phone number of a contact person at the community telehealth site where the individual will be evaluated via telehealth who is to be notified by admitting psychiatric facility when the assessment has been completed or if it is interrupted. This contact person must be located in close proximity to the room in which the individual is being evaluated via telehealth and immediately accessible by phone during the assessment.
 - l. The admitting psychiatric facility physician **cannot** order medications to be administered at the community telehealth site or order use of seclusion or restraint at the community telehealth site.

3) Conducting the Assessment via Telehealth:

- a. At the beginning of the telehealth assessment, the admitting physician shall explain the purpose of the assessment to the individual being evaluated (i.e., to determine whether the individual meets criteria for emergency involuntary psychiatric hospitalization).
- b. The admitting physician shall inform the individual if other hospital staff are present in the room where the telehealth equipment is located or enter the room at any point during the assessment.
- c. The telehealth assessment conducted by the admitting psychiatric facility physician shall be identical to the assessment that would be conducted on-site at the admitting psychiatric facility, with the addition of the initial determination that assessment via telehealth is a viable option.
- d. All of the documentation required by the admitting psychiatric facility for an on-site assessment is required for an assessment conducted via telehealth, regardless of whether the outcome of the assessment is admission or not.
- e. Documentation must also reflect that the assessment was conducted via telehealth, the names and roles of other inpatient psychiatric facility staff present during the telehealth assessment (if applicable), and whether staff were present with the individual at the community telehealth site. If staff were present with the individual at the community telehealth site, documentation should reflect their roles (such as crisis worker, emergency room staff, security staff), if known.
- f. If, during the telehealth assessment, it becomes obvious that the individual is not able to participate to the extent that the telehealth assessment cannot be completed, or if the individual being evaluated requests to terminate the telehealth assessment, the individual must be transported to the admitting psychiatric facility to complete the assessment by face-to-face on-site at the admitting psychiatric facility.
- g. Staff must be available at all times in close proximity to the room at the community telehealth site in which the individual is being evaluated via telehealth. Depending on the condition of the individual being evaluated via telehealth, staff may be needed in the room with the individual, particularly if the individual is impulsive. The determination of whether staff should be present in the room with the individual being evaluated shall be made jointly by the admitting psychiatric facility physician and staff at the community telehealth site. Significant concerns regarding whether the individual would be safe being alone in the room during the assessment may be an indicator that the assessment should be conducted at the admitting psychiatric facility, not by telehealth.
- h. If the connection at the telehealth location must be interrupted during the assessment for emergency purposes, staff must be assigned to: 1) immediately communicate the interruption to the site where the individual is being evaluated; and 2) keep the individual under visual observation until the connection can be re-established and the assessment resumes or staff at the admitting psychiatric facility site assume responsibility for the individual.
- i. If the connection at the admitting psychiatric facility must be interrupted during the assessment for emergency purposes, admitting psychiatric facility staff must immediately communicate the interruption to the site where the individual is being evaluated and may request that someone at the telehealth location be assigned to keep the individual under visual observation until the connection can be re-established and the assessment resumes.

Appendix 2 (cont'd)

- j. If the conclusion of the admitting psychiatric facility physician, based on the assessment conducted via telehealth, is that the individual meets criteria for inpatient psychiatric admission on an emergency involuntary basis under T.C.A. §33-6-404, the physician shall complete a Certificate Of Need (CON) and shall order the individual's admission to the inpatient psychiatric facility.
- k. As soon as the admitting psychiatric facility physician has made a decision regarding whether or not the individual meets criteria for emergency involuntary admission, inpatient psychiatric facility staff shall communicate this decision to staff at the location where the individual is being evaluated via telehealth and to the original agency where the individual presented, if not at the telehealth location.
- l. If the admitting psychiatric facility physician determines that the individual meets criteria for emergency involuntary admission to an inpatient psychiatric facility, the individual may then be transported to the inpatient psychiatric facility to complete the admission process. The original CON (or electronically sent CON, if the first CON was completed via telehealth) and the confirmation number, if applicable, shall be transported with the individual. If the accepting inpatient psychiatric facility contracts with TDMHSAS to provide inpatient psychiatric services for uninsured adults, the crisis staff shall also electronically provide the required certification form to the admitting psychiatric facility.
- m. If the admitting psychiatric facility physician determines the individual does not meet criteria for emergency involuntary admission to an inpatient psychiatric facility, the telehealth location staff shall determine the next most appropriate level of care.

O. Use of a Telehealth Site in an Assessment for Emergency Admission by an Inpatient Psychiatric Facility

4) General Considerations:

- a. The qualified professional issuing the Certificate of Need (CON) for emergency involuntary hospitalization shall consider whether the individual can be safely transported to a local telehealth location for a psychiatric admission decision at a telehealth location and indicate this in Section D of the Certificate of Need.
- b. In conjunction with the emergency involuntary psychiatric admission process outlined in Title 33, the sheriff (or non-secure transport if appropriate) shall transport the individual to the telehealth location for the admission assessment and remain at the location for up to one hour and forty- five minutes pending the decision. If the outcome of the assessment is to admit, the sheriff may then transport to the admitting facility without any further waiting requirements.
- c. Assessment via telehealth by an admitting psychiatric facility may be conducted only when the admitting psychiatric facility has available suitable accommodations (i.e., when staff or a psychiatric bed is available) and a confirmation number has been provided, if applicable.
- d. The telehealth location must have staff available to conduct the assessment and a time for transport to the site must be established.

Appendix 2 (cont'd)

- e. Admitting psychiatric facility physicians conducting assessments via telehealth, Admissions Office staff, and staff at the community telehealth site must be trained in the use of the telehealth equipment and all related policies and procedures prior to conducting an assessment via telehealth.
- f. The telehealth equipment at the admitting psychiatric facility and at the community telehealth site must be located in a room with minimal distractions that will allow the telehealth assessment to be conducted in a private and confidential manner.
- g. The community telehealth site must provide a safe environment for the individual being evaluated, with equipment secured so as to minimize potential for damage or injury. This environment must also be comfortable in regard to temperature and lighting, with minimal distractions.
- h. Technical staff must be available (even if by phone) to both the admitting psychiatric facility and the community telehealth site to address technical problems with the telehealth equipment or connection that might arise during the assessment. If the assessment cannot be completed due to technical problems with the telehealth equipment or connection, the individual must be transported to the admitting psychiatric facility for a face-to-face on-site assessment.

5) Prior to Initiating a Telehealth Assessment:

- m. The agency where the individual is located must contact the telehealth location to verify that the telehealth site has available staff and accommodations to conduct the telehealth assessment. The agency where the individual is located shall discuss the psychiatric inpatient placement being recommended and rationale for the decision with telehealth location staff that will assist in determining the appropriateness of a telehealth assessment.
- n. A determination must be made whether telehealth is a viable means of conducting the assessment, based on the individual's behavior and psychiatric condition.
 - I. Assessment of an individual via telehealth may **not** be viable if:
 - The individual is too agitated to focus;
 - The individual is violent, if the violence would potentially result in injury to staff or damage to equipment;
 - The individual's delusional system would prevent him/her from engaging in the process; or
 - The individual has an untreated acute medical condition.

Additional Considerations:

Transportation to a telehealth location is not necessary if:

- the ER already has a telehealth connection with the admitting psychiatric facility and a crisis service provider is on-site or if an on-site crisis service provider has a laptop connection with the admitting facility,
- the admitting psychiatric facility is located closer to the presenting location than the telehealth site,

Appendix 2 (cont'd)

- the telehealth location already has too many individuals to manage at once (thus the requirement to involve Walk-In Center (WIC) staff in the decision to choose telehealth).
- o. If the agency where the individual is located determines that telehealth is **not** a viable means of conducting the admission assessment, the individual shall be transported to the admitting psychiatric facility for a face-to-face on-site assessment.
- p. If the agency where the individual is located believes that telehealth is a viable means of conducting the assessment, the agency where the individual is located (or other community staff involved with the referral) shall contact staff at the closest telehealth location to discuss feasibility of telehealth assessment.
- q. If the telehealth location staff questions the viability or appropriateness of conducting the assessment via telehealth based on the referral information, staff shall participate in the decision to transport directly to the admitting psychiatric facility based on the referral information provided.
- r. The individual must be informed by the agency where the individual is located (the professional completing the first CON for emergency involuntary psychiatric hospitalization) or other community staff involved with the referral (such as a crisis worker or staff at an emergency room) that the assessment is to be conducted by telehealth and the individual must be given the option to request that the assessment be conducted by face-to-face on-site admitting psychiatric facility instead.
- s. The agency where the individual is located must send electronically (scan and secure e-mail or fax) to the telehealth location the first Certificate of Need (CON) and all referral information that would normally be sent to the admitting psychiatric facility either prior to transport or with the individual when transported. This information includes, but is not limited to, the following:
 - IX. Copies of assessments completed in the community (by the agency where individual is located and crisis service provider, if applicable) utilized in making the determination to complete the first CON;
 - X. Whether the individual has a durable power of attorney for mental health care or a declaration for mental health treatment;
 - XI. Whether the individual is on mandatory outpatient treatment, if known;
 - XII. Any known medical conditions;
 - XIII. Current or recent prescription and/or over-the-counter medications, if any;
 - XIV. Current or recent use of alcohol and/or other substance use, if any;
 - XV. The name of the current or most recent community mental health and substance abuse service provider, if known; and
 - XVI. Recommendations for services and/or supports following discharge.

Appendix 2 (cont'd)

- t. The agency where the individual is located (or other community staff involved with the referral) should discuss the individual's current behavior, any medications or medical issues, inpatient psychiatric bed availability and lack of available less restrictive alternatives with the receiving staff prior to initiating a telehealth assessment.
- u. If, at any point, questions arise regarding whether the individual has a medical condition that requires **immediate** medical treatment that the admitting psychiatric facility cannot provide, either staff from the agency where the individual is located or involved crisis staff should contact the admitting psychiatric facility to discuss the individual's medical condition prior to transport for an admission determination.

If a physician is available at the location where the individual is located, a physician to physician discussion should occur to determine whether additional medical intervention is indicated prior to conducting the telehealth assessment (via mobile or stationary unit). All medical concerns should be addressed prior to conducting an admission decision to the psychiatric facility.

- v. If the individual is not already at the community telehealth site, the community telehealth site must test the telehealth equipment and connectivity with the admitting psychiatric facility before the individual is transported to the community telehealth site.
- w. Assessment of an individual via telehealth should not be attempted if there are technical problems with the telehealth equipment or connection. The individual being evaluated and the admitting psychiatric facility physician conducting the assessment must be able to see and hear each other without delays or distortion.
- x. The community telehealth site and the admitting psychiatric facility's Admissions Office shall schedule a time for the telehealth assessment to be conducted and the individual shall be transported to the telehealth location.
- y. As soon as possible after arrival at the telehealth location, the crisis MPA, physician or psychologist with HSP designation shall determine whether the individual continues to require emergency involuntary hospitalization and document the following:
 - 1. Specifically why the individual no longer meets emergency involuntary commitment criteria. If the individual no longer needs inpatient psychiatric hospitalization, the telehealth location staff shall contact the admitting psychiatric facility to inform the admitting physician and the agency that requested the telehealth assessment; and
 - 2. If the individual does continue to need inpatient psychiatric hospitalization, the telehealth assessment will be conducted as scheduled and a final disposition decision will be made.
- z. After testing the telehealth equipment and connectivity, the community telehealth site and the admitting psychiatric facility's Admissions Office shall begin the telehealth assessment.
- aa. The telehealth location staff must provide the admitting psychiatric facility with the name and phone number of a contact person at the community telehealth site where the individual will be evaluated via telehealth who is to be notified by admitting psychiatric facility when the assessment has been completed or if it is interrupted. This contact person must be located in close proximity to the room

Appendix 2 (cont'd)

in which the individual is being evaluated via telehealth and immediately accessible by phone during the assessment.

- bb. The admitting psychiatric facility physician **cannot** order medications to be administered at the community telehealth site or order use of seclusion or restraint at the community telehealth site.
- cc. Telehealth location staff shall send electronically (scan and secure e-mail) to the admitting psychiatric facility the first Certificate of Need (CON) and all referral information that would normally be sent to the admitting psychiatric facility either prior to transport or with the individual when transported. This information includes, but is not limited to, the following:
 - I. Copies of assessments completed in the community (by the agency where individual is located and the crisis service provider, if applicable) utilized in making the determination to complete the first CON;
 - II. Whether the individual has a durable power of attorney for mental health care or a declaration for mental health treatment;
 - III. Whether the individual is on mandatory outpatient treatment, if known;
 - IV. Any known medical conditions;
 - V. Current or recent prescription and over-the-counter medications, if any;
 - VI. Current or recent use of alcohol and/or other substance use, if any;
 - VII. The name of the current or most recent community mental health or substance abuse service provider, if known; and
 - VIII. Recommendations for services and/or supports following discharge.

6) Conducting the Assessment via Telehealth:

- a. At the beginning of the telehealth assessment, the admitting physician shall explain the purpose of the assessment to the individual being evaluated (i.e., to determine whether the individual meets criteria for emergency involuntary psychiatric hospitalization).
- b. The admitting physician shall inform the individual if other hospital staff are present in the room where the telehealth equipment is located or enter the room at any point during the assessment.
- c. The telehealth assessment conducted by the admitting psychiatric facility physician shall be identical to the assessment that would be conducted on-site at the admitting psychiatric facility, with the addition of the initial determination that assessment via telehealth is a viable option.
- d. All of the documentation required by the admitting psychiatric facility for an on-site assessment is required for an assessment conducted via telehealth, regardless of whether the outcome of the assessment is admission or not.
- e. Documentation must also reflect that the assessment was conducted via telehealth, the names and roles of other inpatient facility staff present during the telehealth assessment (if applicable), and whether staff were present with the individual at the community telehealth site. If staff were present with the individual at the community telehealth site, documentation should reflect their roles (such as crisis worker, emergency room staff, security staff), if known.

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- f. If, during the telehealth assessment, it becomes obvious that the individual is not able to participate to the extent that the telehealth assessment cannot be completed, or if the individual being evaluated requests to terminate the telehealth assessment, the individual must be transported to the admitting psychiatric facility to complete the assessment by face-to-face on-site at the admitting psychiatric facility.
- g. Staff must be available at all times in close proximity to the room at the community telehealth site in which the individual is being evaluated via telehealth. Depending on the condition of the individual being evaluated via telehealth, staff may be needed in the room with the individual, particularly if the individual is impulsive. The determination of whether staff should be present in the room with the individual being evaluated shall be made jointly by the admitting physician and staff at the community telehealth site. Significant concerns regarding whether the individual would be safe being alone in the room during the assessment may be an indicator that the assessment should be conducted at the admitting psychiatric facility, not by telehealth.
- h. If the connection at the telehealth location must be interrupted during the assessment for emergency purposes, staff must be assigned to: 1) immediately communicate the interruption to the site where the individual is being evaluated; and 2) keep the individual under visual observation until the a connection can be re-established and the assessment resumes or staff at the admitting psychiatric facility site assume responsibility for the individual.
- i. If the connection at the admitting psychiatric facility must be interrupted during the assessment for emergency purposes, admitting psychiatric facility staff must immediately communicate the interruption to the site where the individual is being evaluated and may request that someone at the telehealth location be assigned to keep the individual under visual observation until the connection can be re-established and the assessment resumes.
- j. If the conclusion of the admitting physician, based on the assessment conducted via telehealth, is that the individual meets criteria for inpatient psychiatric admission on an emergency involuntary basis under T.C.A. §33-6-404, the physician shall complete a Certificate Of Need (CON) and shall order the individual's admission to the inpatient psychiatric facility.
- k. As soon as the admitting physician has made a decision regarding whether or not the individual meets criteria for emergency involuntary admission, inpatient psychiatric facility staff shall communicate this decision to staff at the location where the individual is being evaluated via telehealth and to the original agency where the individual presented, if not at the telehealth location.
- l. If the admitting physician determines that the individual meets criteria for emergency involuntary admission to an inpatient psychiatric facility, the individual may then be transported to the inpatient psychiatric facility to complete the admission process. The original CON (or electronically sent CON, if the first CON was completed via telehealth) and the confirmation number, if applicable, shall be transported with the individual. If the accepting inpatient psychiatric facility contracts with TDMHSAS to provide inpatient psychiatric services for uninsured adults, the crisis staff shall also electronically provide the required certification form to the admitting psychiatric facility.

Appendix 2 (cont'd)

- m. If the admitting physician determines the individual does not meet criteria for emergency involuntary admission to an inpatient psychiatric facility, the telehealth location staff shall determine the next most appropriate level of care.

P. Assessment of Effectiveness:

Agencies participating in telehealth crisis assessments shall continuously evaluate the effectiveness of conducting crisis assessments via telehealth. Reporting is required by Grant Contract as outlined in the Crisis Management Tracking System; however, the assessment components outlined below shall also be maintained by the crisis service agency and made available to TDMHSAS upon request. Questions that should be considered in evaluating the effectiveness include:

Key Questions for 1st CON assessment:

1. What percent of assessments were conducted by telehealth?
2. Of the assessments that were not conducted by telehealth, what were the reasons for not using telehealth?
3. What percentages of assessments were not conducted via telehealth due to individual objection?
4. What percent of assessments conducted by telehealth were not completed?
5. If a telehealth session was stopped, what were the reasons for stopping?
6. Are wait times for face-to-face assessments decreased via telehealth compared to in-person?
7. Is the percent of decisions to write a CON vs. not the same for telehealth assessments and in-person assessments?
8. What percent of decisions to issue a CON vs. not by telehealth assessment occurred by telehealth location?
9. What is the impact of the telehealth assessments on local procedures?
10. How much travel time and mileage were saved by decisions to utilize telehealth?
11. What is the crisis service provider rating of the efficacy of telehealth assessment?
12. What is law enforcement's rating of the telehealth cost savings?
13. What is the agency where the individual is located ratings of the efficacy of the assessment by telehealth?

Key Questions for 2nd CON assessment:

1. What percent of admitting psychiatric facility examinations determining the need for inpatient psychiatric hospitalization were conducted by telehealth?
2. If the assessment was not conducted by telehealth, what were the reasons for not using telehealth?
3. What percent of admitting psychiatric facility examinations conducted by telehealth were not completed?
4. If a telehealth session was stopped, what were the reasons for stopping?
5. Is the percent of decisions to admit or not admit the same for telehealth assessments and in-person assessments?
6. What percent of decisions to conduct the assessment via telehealth assessment occurred by admitting psychiatric facility location?
7. What percent of admitting psychiatric facility exams were completed using laptop technology vs. stationary telehealth units?
8. Is the percent of people sent out for medical treatment within 24 hours the same for telehealth assessments and in-person assessments?
9. Are discharge lengths of stay the same for people evaluated by telehealth and in-person?
10. How much travel time and mileage were saved by decisions to not admit by telehealth?

Appendix 2 (cont'd)

11. What is the impact of the telehealth assessments on local procedures?
12. What is the crisis service provider rating of the efficacy of telehealth assessment?
13. What is law enforcement's rating of the telehealth cost savings?
14. What is the physician's rating of the efficacy of the assessment?

Q. Tennessee Department of Mental Health and Substance Abuse Services Designated Crisis Agencies' Contact Numbers:

- Carey Counseling Center- 731-641-0626
- Centerstone Community Mental Health Center- 615-463-6600
- Cherokee Health Systems- 423-586-5074 or 855-602-1082
- Frontier Health- 423-467-3600
- Helen Ross McNabb Center- 865-637-9711
- Mental Health Cooperative- 615-726-3340
- Pathways of Tennessee- 800-587-3854
- Professional Care Services- 901-476-8967
- Quinco Community Mental Health Center- 731-658-6113
- Ridgeview Psychiatric Hospital & Center- 865-482-1076
- Southeast Mental Health Center- 901-369-1400
- Volunteer Behavioral Health- 877-567-6051
- Youth Villages- 615-250-7200

APPENDIX A

T.C.A. §33-3-105 - Information may be shared between the providers involved in the care of the individual without consent if:

- (1) Disclosure is necessary to carry out duties under this title;
- (2) Disclosure may be necessary to assure service or care to the service recipient by the least drastic means that are suitable to the service recipient liberty and interests;
- (3) As a court orders, after a hearing, upon its determination that disclosure is necessary for the conduct of proceedings before it and that failure to make the disclosure would be contrary to public interest or to the detriment of a party to the proceedings;
- (4) It is solely information as to a residential service recipient's overall medical condition without clinical details and is sought by the service recipient's family members, relatives, conservator, legal guardian, legal custodian, guardian ad litem, foster parents, or friends;
- (5) A service recipient moves from one service provider to another and exchange of information is necessary for continuity of service; or
- (6) A custodial agent for another state agency that has legal custody of the service recipient cannot perform the agent's duties properly without the information.

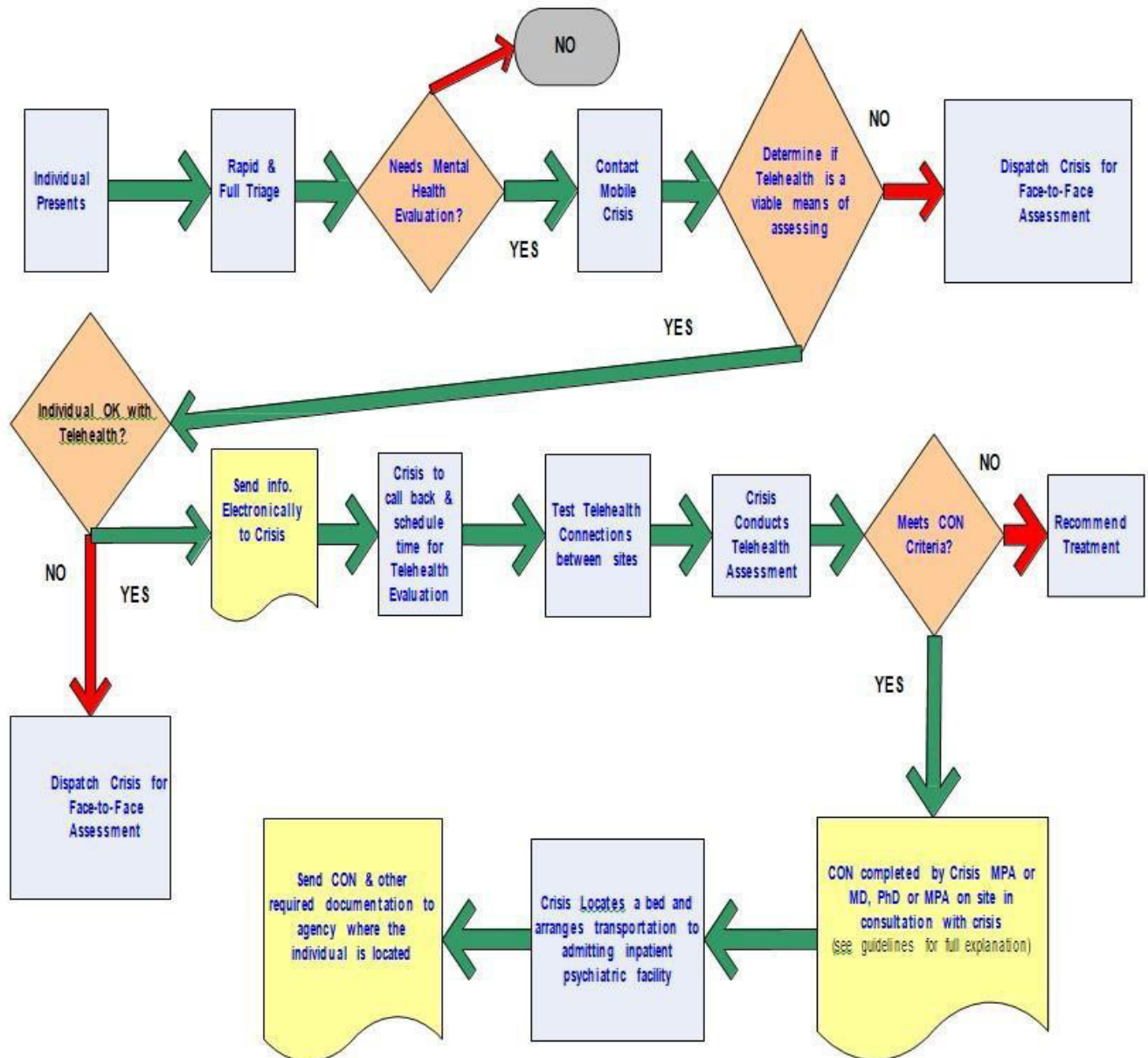
T.C.A. §47-10-107 - Legal recognition of electronic records, electronic signatures, and electronic contracts.

- (a) A record or signature may not be denied legal effect or enforceability solely because it is in electronic form.
- (b) A contract may not be denied legal effect or enforceability solely because an electronic record was used in its formation.
- (c) If a law requires a record to be in writing, an electronic record satisfies the law.
- (d) If a law requires a signature, an electronic signature satisfies the law.

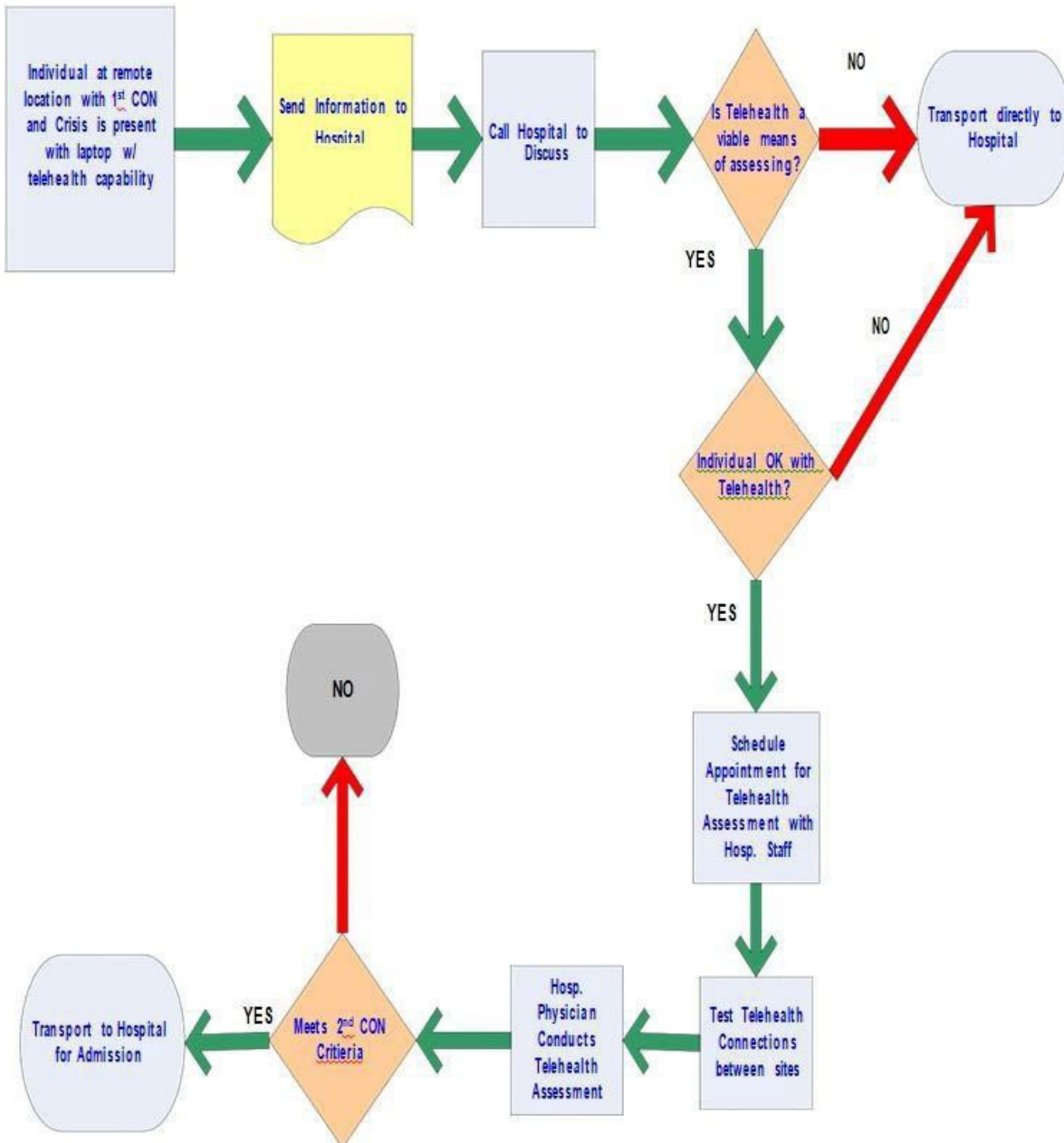
An electronic signature is defined as an electronic sound (e.g., audio files of a person's voice), symbol (e.g., a graphic representation of a person in JPEG file), or process (e.g., a procedure that conveys assent), attached to or logically associated with a record, and executed or adopted by a person with the intent to sign the record. An electronic signature is easy to implement, since something as simple as a typed name can serve as one. Consequently, e-signatures are very problematic with regards to maintaining integrity and security, as there is nothing to prevent one individual from typing another individual's name. Due to this reality, an electronic signature that does not incorporate additional measures of security is considered an insecure way of signing documentation.

A digital signature takes the concept of traditional paper-based signing and turns it into an electronic "fingerprint." This "fingerprint," or coded message, is unique to both the document and the signer and binds both of them together. The digital signature ensures the authenticity of the signer. Any changes made to the document after it is signed invalidate the signature, thereby protecting against signature forgery and information tampering. Digital signatures help organizations sustain signer authenticity, accountability, data integrity and non-repudiation of electronic documents and forms. Digital signatures are required for signing the Certificate of Need.

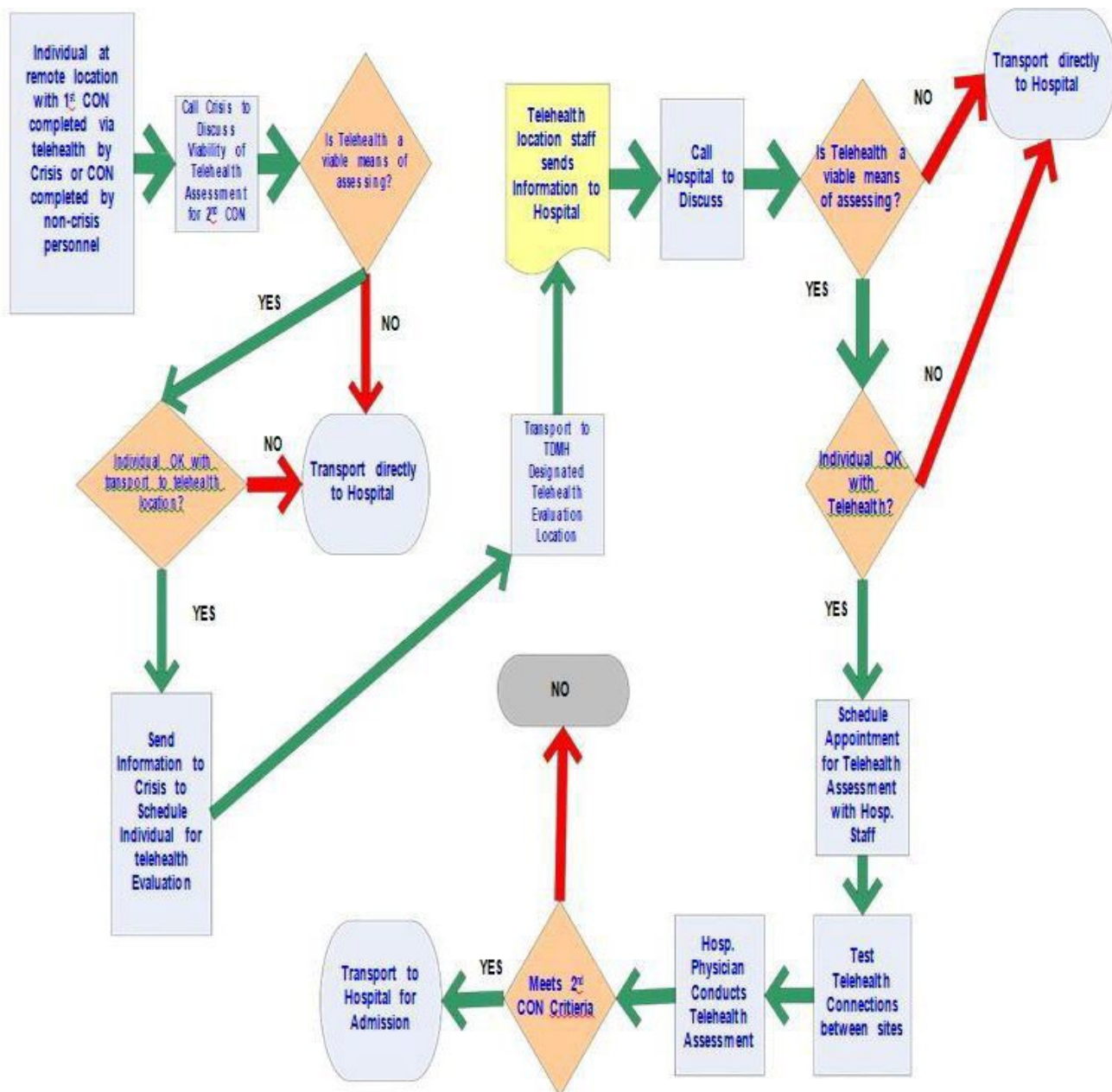
USE OF TELEHEALTH FOR A CRISIS ASSESSMENT



Conducting an Admission Evaluation via Laptop Technology



Conducting an Admission Evaluation via Telehealth Location



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REQUEST FOR ADDITIONAL LABORATORY STUDIES

DATE/TIME OF MEDICAL CLEARANCE REQUEST: _____

NAME OF PATIENT: _____

REFERRAL SOURCE: _____

PLACE OF INITIAL ASSESSMENT: _____

INDICATORS FOR QUESTIONING THE NEED FOR MEDICAL CLEARANCE:

SPECIFIC MEDICAL TESTS/LAB RESULTS REQUESTED: _____

ADDITIONAL COMMENTS (IF ANY): _____

FORM COMPLETED BY: _____

SIGNATURE OF REQUESTING M.D.: _____

Reviewed 02/22/2016

Medical Conditions that RMHIs are Unable to Accommodate

- | | | |
|--|--|-----------------------------------|
| 1. Acute (medical) trauma | 12. Critical care condition requiring continuous nursing assessments | 22. Open wound |
| 2. Acute abdomen condition | 13. Deep vein thrombosis (DVT) | 23. Pneumothorax |
| 3. Acute coronary syndromes | 14. Head trauma (recent) | 24. Pulmonary embolism |
| 4. Acute intoxication (due to substance abuse) | 15. History of recent bleeding or anemia | 25. Respiratory isolation |
| 5. Acute respiratory distress | 16. Infusion pumps | 26. Sepsis |
| 6. Asthmatic (unstabilized) | 17. Intracerebral bleeding | 27. Surgical procedure conditions |
| 7. Burns | 18. Intravenous therapy | 28. Tube feeding |
| 8. Cardiac monitoring | 19. Mechanical ventilation | 29. Uncontrolled hypertension |
| 9. Chemotherapy (Administration of) | 20. Meningitis | 30. Unstable bone fracture |
| 10. Continuous oxygen | 21. Neuroleptic malignant syndrome | 31. Unstable diabetes |
| 11. Continuous pulse oximetry | | |

No.	Medical Condition	Narrative
1.	Acute (medical) trauma	If in pain, the patient must be off parenteral narcotics.
2.	Acute abdomen condition	Must be cleared by referral of medical authority.
3.	Acute coronary syndromes	Must be cleared by referral of medical authority.
4.	Acute intoxication (due to substance abuse)	Blood alcohol should be <300.
5.	Acute respiratory distress	The presence of shortness of breath for any cause should be weighed.
6.	Asthmatic (unstabilized)	02 sat < 90%.
7.	Burns	When sterile dressing changes are required.
8.	Cardiac monitoring	
9.	Chemotherapy (Administration of)	This would only apply if given IV.
10.	Continuous oxygen	When 02 sat is consistently < 90%.
11.	Continuous pulse oximetry	When 02 sat consistently < 90%.
12.	Critical care condition requiring continuous nursing assessments	When equipment is not available for treatment and there is no in-house physical therapy or respiratory therapy available.
13.	Deep vein thrombosis (DVT)	

No.	Medical Condition	Narrative
14.	Head trauma (recent)	Less than 24 hours with recent head trauma with loss of consciousness.
15.	History of recent bleeding or anemia	Hemoglobin < 8.
16.	Infusion pumps	Excluding insulin pumps from this category.
17.	Intracerebral bleeding	When inherently medically unstable.
18.	Intravenous therapy	
19.	Mechanical ventilation	
20.	Meningitis	When the condition is inherently medically unstable.
21.	Neuroleptic malignant syndrome	When the condition is inherently medically unstable.
22.	Open wound	When stage II and III decubitus ulcers are evident.
23.	Pneumothorax	The condition is inherently medically unstable.
24.	Pulmonary embolism	When the condition is inherently medically unstable.
25.	Respiratory isolation	When active TB is evident.
26.	Sepsis	When the condition is inherently medically unstable (applies if active sepsis and requiring <i>N</i> therapy are present).
27.	Surgical procedure conditions	If there is a requirement for dressing changes > 2 times daily or under sterile procedure, draining or contaminated.
28.	Tube feeding	
29..	Uncontrolled hypertension	Systolic BP> 180 or <60. Diastolic BP> 110 or < 60.
30.	Unstable bone fracture	When the condition is inherently medically unstable.
31.	Unstable diabetes	BS > 500.

The DMHT in Tennessee

What Is a DMHT?

For those of us with mental illness, our commitment to recovery includes making a plan for keeping well. Many of us use the Wellness Recovery Action Plan (WRAP[®]) by Mary Ellen Copeland to list what we need to stay well, to identify our triggers, and to create a crisis plan. But there are times when, despite our commitment to recovery, we get worse. Perhaps something big happens in our lives and it's just more than we can cope with. Sometimes our symptoms get the better of us.

Tennessee has created a legal document that can help. It's called a Declaration for Mental Health Treatment (DMHT). And when we find ourselves in a crisis, it can give us peace of mind. The DMHT is a legal document where we can write down our wishes in case of a mental health crisis. We can write down mental health treatments and medications that are okay with us and any that are not okay with us. We can write down what it looks like when we are in a mental health crisis and need help. Some people like to write down which hospitals they prefer and which mental health agencies they prefer, too.

Here's how to fill out your DMHT:

1. Read the entire DMHT form first.
2. Some sections of the DMHT form ask you to choose at least one option. In those sections, you will have to pick one of the options.
3. When you write down your wishes on the form, be as specific as you can.
4. There is a place at the bottom of each page where you need to put your initials and the date.
5. When you are ready to sign, get two adults to be your witnesses.
6. Pick two people who already know you. You cannot pick anyone who works for a mental health facility. That's against the rules for the DMHT because the people who wrote the DMHT rules want to make sure you aren't pressured to write down anything you don't want to.
7. Before you sign in front of the witnesses that you picked, tell them about what you wrote in your DMHT.
8. Be sure to talk with the friends and family members of your choice about what you wrote in your DMHT so they can be there for you in the way you want.

Important Legal Information

The Tennessee Department of Mental Health and Substance Abuse Services developed this form based on Tennessee Code Annotated, Title 33, Chapter 6, Part 10.

Tennessee Code Annotated, Title 33, Chapter 6, Part 10, gives the right to individuals, 16 years of age and older, to be involved in decisions about their mental health treatment. The law also recognizes that, at times, some individuals are unable to make treatment decisions. A “Declaration for Mental Health Treatment” allows people receiving services to plan ahead; it may also assist service providers in giving appropriate treatment.

This “Declaration for Mental Health Treatment” form describes what a service participant wants to occur when receiving mental health treatment. It describes mental health services that a service participant might consider, the conditions under which a declaration may be acted upon, and directions on how a service participant can revoke/cancel a declaration.

For example, completion of a “Declaration for Mental Health Treatment” form allows a service participant to state:

- Conditions or symptoms that might cause the declaration to be acted upon;
- Medications you are willing to take and medications you are not willing to take;
- Specific instructions for or against electroconvulsive or other convulsive treatment;
- Mental health facilities and mental health providers which you prefer;
- Treatments or actions which you will allow or those which you refuse to permit; and
- Any other matter pertaining to your mental health treatment which you wish to make known.

You must sign the form in front of two (2) competent adult witnesses (18 years or older) who know you. You must discuss the contents of this form with the witnesses prior to them signing it. It is important to note that restrictions exist on who may witness the declaration. The following parties may not act as witnesses:

- o The service participant’s mental health service provider;
- o An employee of the service participant’s mental health service provider;
- o The operator of a mental health facility; or
- o An employee of a mental health facility.

This declaration may include consent to, or refusal to, permit mental health treatment and other instructions and information for mental health service providers.

Declaration for Mental Health Treatment for:

(Print Your Full Name)

This DMHT says what my wishes are for mental health treatment when I am in a mental health crisis and can't make decisions for myself.

I understand that sometimes I cannot make decisions about mental health treatment because of the symptoms of my mental illness. This is when I am in a mental health crisis.

Here are my symptoms when I am having a mental health crisis:

Initials Date_____

Appendix 5 (cont'd)

This DMHT gives me the right to say what medications I am okay with, how I feel about ECT (electroconvulsive therapy), and which psychiatric hospital I prefer (for up to 15 days).

Medication (*Psychoactive and other Medications*)

If I am in a mental health crisis and cannot make my own mental health treatment decisions, here are my wishes about medication:

You must check one:

I do not have a preference about medications.

I do not want the following medications:

Name of medication: _____

Reason I don't want it: _____

Name of medication: _____

Reason I don't want it: _____

Name of medication: _____

Reason I don't want it: _____

Name of medication: _____

Reason I don't want it: _____

Initials Date_____

These medications have worked for me in the past:

Name of medication: _____

How it worked for me: _____

Name of medication: _____

How it worked for me: _____

Name of medication: _____

How it worked for me: _____

Additional medication concerns:

_____.

Initials Date_____

Going to the Hospital

*(Admission to and Remaining in a Hospital for Mental Health Treatment)**

If I am in a mental health crisis and not able to make decisions, these are my preferences about going to the hospital:

You must check one:

I do not have a preference about being admitted to a hospital for mental health treatment.

I am okay with being admitted to a hospital for mental health treatment. I consent.

I do not want to go voluntarily to a hospital for mental health treatment. I do not consent.

If I have to go to a hospital for mental health treatment, then I want the following to happen:

You must check one:

I will remain voluntarily in the hospital for mental health treatment. I consent.

I do not want to remain voluntarily in the hospital for mental health treatment. I do not consent.

Additional hospitalization concerns:

*Psychiatric hospital authorization in a DMHT is limited to 15 days.

Initials____Date_____

Mental Health Services from Other Places

Tennessee has places other than the hospital where you can receive help for your mental illness. These are places like a Crisis Stabilization Unit (CSU), a respite facility, and others.

If I am in a mental health crisis and not able to make decisions, these are my preferences about receiving mental health services from places other than a hospital:

You must check one:

I do not have a preference about receiving mental health services from places other than a hospital.

I am okay with receiving mental health services from places other than a hospital. I consent.

I do not want to receive mental health services from places other than a hospital. I do not consent.

Additional concerns about mental health services from other places:

Initials Date_____

Specific Mental Health Agencies, Hospitals, and Other Places for Treatment

If I am in a mental health crisis and not able to make decisions, these are my preferences about certain mental health agencies, specific hospitals, and other places for mental health treatment:

Check all that apply:

I do not have a preference about any specific mental health agencies, specific hospitals, and other places for mental health treatment.

I do not prefer the following specific mental health agencies, specific hospitals, and other places for mental health treatment.

I do prefer the following specific mental health agencies, specific hospitals, and other places for mental health treatment.

Names of hospitals, mental health agencies, and other places for mental health treatment that I...	
DO NOT CONSENT TO:	PREFER:

Additional concerns about specific mental health agencies, hospitals and other places for treatment:

_____.

Initials____Date_____

ECT (Electroconvulsive Therapy) and Other Convulsive Therapies*

If I am in a mental health crisis and not able to make decisions, these are my preferences about receiving ECT (electroconvulsive therapy) and other convulsive therapies:

You must check one:

I do not have a preference about receiving ECT (electroconvulsive therapy) and other convulsive therapies.

I do not want to receive ECT (electroconvulsive therapy) or other convulsive therapies.
I do not consent.

I am okay with ECT (electroconvulsive therapy). If I have any conditions, I have written them below.

I am okay with other convulsive therapies. If I have any conditions, I have written them below.

**Your decision to consent to electroconvulsive therapy may be limited if you are considered to be a child under certain provisions of the law. Your decision to consent to electroconvulsive therapy may be limited if you are a child in the state's custody under certain provisions of the law.*

Initials Date_____

Other Preferences

If I am in a mental health crisis and not able to make decisions, here are some additional things I prefer:

Here are the people I want to be called if I am in a mental health crisis:

Name _____

Home Phone (with area code) _____

Work Phone (with area code) _____

Cell Phone (with area code) _____

Name _____

Home Phone (with area code) _____

Work Phone (with area code) _____

Cell Phone (with area code) _____

Name _____

Home Phone (with area code) _____

Work Phone (with area code) _____

Cell Phone (with area code) _____

Initials Date_____

My Affirmation

I am sixteen (16) years of age or older. I am capable of making informed mental health treatment decisions. I make this "Declaration for Mental Health Treatment" to be followed if I become unable to make informed mental health treatment decisions. The determination that I am unable to make an informed decision about my mental health treatment must be made by (1) a court in a conservatorship or guardianship proceeding, or (2) two examining physicians, or (3) a physician with expertise in psychiatry and a doctoral level psychologist with health service provider designation.

I know that I may cancel this DMHT, in whole or in part, at any time, by word or in writing, when I am able to make informed treatment decisions.

This declaration will expire two years from the day it is signed by me and two witnesses or a shorter period specified by this date:_____/_____/_____or until revoked.

My Name (printed) _____

My Signature_____Date _____

Address _____

City, State, ZIP _____

Phone (with area code) _____

Date of Birth _____

Initials Date_____

Affirmation of the First Witness

I affirm that _____ is personally known to me; that he or she signed this “Declaration for Mental Health Treatment” in my presence; that he or she talked to me about the document and its contents and the reasons for preparing and wanting the document to be effective. He or she appears to be able to make informed mental health treatment decisions and is not under duress, fraud or undue influence. The declaration was not signed on the premises of a mental health service provider.

I affirm that I am an adult and that I am not:

The service participant's mental health services provider

An employee of the service participant's mental health services provider

The operator of a mental health facility

An employee of a mental health facility.

You must check one:

I am a relative by blood, marriage, or adoption.*

Yes No

You must check one:

I am likely to be entitled to a portion of this person's estate in the event of his/her death.**

Yes No

First Witness Name (print) _____

_____ First Witness Signature

Date _____

Address _____

Phone (with area code)

*Only one of the two witnesses can be a relative by blood, marriage, or adoption.

****Only one of the two witnesses can be a person likely to benefit from the death of the person completing the declaration.**

Initials Date

Affirmation of the Second Witness

I affirm that _____ is personally known to me; that he or she signed this "Declaration for Mental Health Treatment" in my presence; that he or she talked to me about the document and its contents and the reasons for preparing and wanting the document to be effective. He or she appears to be able to make informed mental health treatment decisions and is not under duress, fraud or undue influence. The declaration was not signed on the premises of a mental health service provider.

I affirm that I am an adult and that I am not:

The service participant's mental health services provider

An employee of the service participant's mental health services provider The operator of a mental health facility

An employee of a mental health facility.

You must check one:

I am a relative by blood, marriage, or adoption.* Yes No

You must check one:

I am likely to be entitled to a portion of this person's estate in the event of his/her death.** Yes No

Second Witness Name (print) _____

Second Witness Signature _____ Date _____

Address _____

Phone (with area code) _____

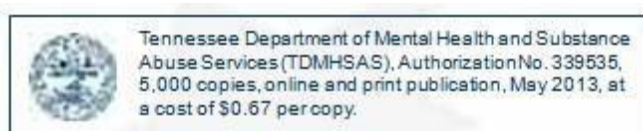
*Only one of the two witnesses can be a relative by blood, marriage, or adoption.

**Only one of the two witnesses can be a person likely to benefit from the death of the person completing the declaration.

Initials Date _____

For additional information about the
Declaration for Mental Health Treatment, contact the
TDMHSAS Office of Consumer Affairs and Peer Support Services
At 1-800-560-5767
Or by email to
OCA.Tdmhsas@tn.gov

For questions about information on our Website,
Contact the Publication Editor c/o the
Tennessee Department of Mental Health and Substance Abuse Services
Office of Communications
at (615) 253-4812
or by email to OC.Tdmhsas@tn.gov



The Tennessee Department of Mental Health and Substance Abuse Services is committed to the principles of equal opportunity, equal access and affirmative action. Contact the TDMHSAS EEO/AA Coordinator at (615) 532-6580, Office of Human Resources; the Title VI Coordinator at (615) 532-6510; or the ADA Coordinator at (615) 532-6700 for further information. Persons with hearing impairments should contact the department by email at OC.Tdmhsas@tn.gov

CRISIS MANAGEMENT PLANNING REQUIREMENTS

BEFORE SENDING SOMEONE HOME:

- WHERE ARE THEY GOING? _____
- CLIENT'S PHONE NUMBER _____
- DOES PHONE NUMBER WORK? YES _____ NO _____
- IS SOMEONE GOING TO BE WITH CLIENT? YES _____ NO _____
- NAME/RELATIONSHIP _____
- FRIEND/FAMILY MEMBER'S PHONE NUMBER _____
- DOES PHONE NUMBER WORK? YES _____ NO _____
- DOES CLIENT HAVE ALTERNATE SUPPORT SYSTEM? YES _____ NO _____
- NAME/RELATIONSHIP _____
- ALTERNATE SUPPORT SYSTEM'S PHONE NUMBER _____
- DOES PHONE NUMBER WORK? YES _____ NO _____
- IS LOCATION SECURE FROM:
 - GUNS YES _____ NO _____
 - KNIVES YES _____ NO _____
 - MEDICATIONS YES _____ NO _____
 - OTHER: _____ YES _____ NO _____
- WAS MEANS RESTRICTION EDUCATION PROVIDED TO FAMILY/SUPPORT SYSTEM/CONSUMER?
YES _____ NO _____
- WILL CLIENT ACCEPT A FOLLOW-UP APPOINTMENT? YES _____ NO _____
- APPOINTMENT DATE? (IF APPLICABLE) _____
- WAS CRISIS MANAGEMENT PLAN PROVIDED TO THE CLIENT? YES _____ NO _____

CRISIS MANAGEMENT PLAN

THINGS THAT CAN CAUSE A CRISIS / TRIGGERS

- 1) _____
- 2) _____
- 3) _____

WARNINGSIGNS:

☐ _____	☐ _____
☐ _____	☐ _____
☐ _____	☐ _____
☐ _____	☐ _____
☐ _____	☐ _____

WHAT TO DO / COPING:

- 1) _____
- 2) _____
- 3) _____

WHAT NOT TO DO / TECHNIQUES TO AVOID:

- 1) _____
- 2) _____
- 3) _____

SUPPORT SYSTEM:

CALL FAMILY / FRIEND: _____ PHONE _____ NUMBER: _____

CALL FAMILY / FRIEND: _____ PHONE _____ NUMBER: _____

CALL FAMILY / FRIEND: _____ PHONE _____ NUMBER: _____

ROUTINE PROVIDER: _____ PHONENUMBER: _____

CALL 911

CALL CRISIS: _____

STATEWIDE CRISIS NUMBER: 1-855-CRISIS-1 (274-7471)

NEXT APPOINTMENT DATE / TIME: _____

Patient Safety Plan Template

Step 1: Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing:

1. _____
2. _____
3. _____

Step 2: Internal coping strategies – Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity):

1. _____
2. _____
3. _____

Step 3: People and social settings that provide distraction:

1. Name _____ Phone _____
2. Name _____ Phone _____
3. Place _____ 4. Place _____

Step 4: People whom I can ask for help:

1. Name _____ Phone _____
2. Name _____ Phone _____
3. Name _____ Phone _____

Step 5: Professionals or agencies I can contact during a crisis:

1. Clinician Name _____ Phone _____
Clinician Pager or Emergency Contact # _____
2. Clinician Name _____ Phone _____
Clinician Pager or Emergency Contact # _____
3. Local Urgent Care Services _____
Urgent Care Services Address _____
Urgent Care Services Phone _____
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

Step 6: Making the environment safe:

1. _____
2. _____

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The one thing that is most important to me and worth living for is:



Department of General Services.
Authorization No. 339544,
November 2017. This Document was
promulgated for Electronic use only