MID-WILLAMETTE REGIONAL ACUTE CARE UNITS AND MID-WILLAMETTE COMMUNITY MENTAL HEALTH PROGRAMS 2005 - 07 LINKAGE AGREEMENT

This agreement is between Good Samaritan Hospital (GSH) Psychiatric Unit and Salem Hospital Psychiatric Medicine Center (SHPMC), thereafter referred to as Regional Acute Care Units (RACUs), and the Mid-Willamette Region Community Mental Health Programs including Benton, Linn, Lincoln, Marion, Polk, Tillamook, and Yamhill Counties, hereafter referred to as CMHP/Agency. This agreement is effective October 1, 2005 through June 30, 2007 contingent on the renewal of agreements between the Regional Acute Care Units, the Mid-Willamette Community Mental Health Programs, and the Office of Mental Health and Addiction Services. Amendments to this agreement are valid only when they are submitted in writing and approved in writing by RACUs and CMHP/Agencies. Disputes arising from this agreement will be resolved whenever possible at the lowest appropriate level, followed by consultation between the CMHP/ Agency/ Director and the Administrative Director at Good Samaritan Hospital or Salem Hospital. During resolution or dispute, the consumer's care is uninterrupted. If resolution is not reached at this level, the dispute will be referred to the Mid-Willamette Acute Care Regional Directors Group for development of a negotiation plan.

1. PURPOSE:

The purpose of this agreement is to provide guidelines and procedures to ensure coordination and continuity of inpatient treatment from pre-intake through post-discharge including appropriate and timely inpatient admissions, sharing and use of treatment information, planned and timely discharges, and timely access to appropriate outpatient mental health services.

2. ADMISSION PHASE:

Admissions to the RACUs regional beds is a cooperative venture to provide a continuum of care employing the least restrictive approach to adequately meet each consumer's individual mental health needs.

A. Screening:

The resident CMHP/Agency screens all admissions to RACUs prior to admission. If a consumer arrives at a RACU without a prior screening by the resident county, the resident county is notified and asked their preference for screening prior to consideration for hospitalization. If the resident county cannot screen, the host county (Benton for GSH and Marion for SHPMC) performs the screening prior to the client being admitted to the RACU. The host county conducting a screening for a resident county notifies the resident county at the time of screening prior to plans for hospitalization or, if unable to get a response at the time of screening, as soon as possible after the screening. The host county makes every reasonable effort to contact the resident county. Should attempts to contact be unsuccessful, the resident county accepts recommendation of the host county. If hospitalization is not approved the host county screener is responsible for making appropriate arrangements for alternative placement.

B. Mid-Willamette Régional Hospital Pre-Admission Record:

Part of the screening process will include completing a Mid-Willamette Regional Hospital Pre-Admission Contact Record (MWRHPACR), which documents admission criteria, and when signed, authorizes payment to the RACU when an indigent or MVBCN consumer is admitted. The Mid-Willamette Regional Hospital Pre-Admission Contact Record form is a part of the chart for all admissions.

C. Sharing of Information :

Information is shared as a means to facilitate treatment. To the extent the law allows, the resident CMHP/Agency performing the screening facilitates the delivery of the most recent community treatment documents to the hospital on the same day if the admission is during normal business hours and by the next business day following admission if the admission is after hours or on weekends. The minimum information includes the most recent evaluation, the last 4 progress notes including the last 2 medicaton management notes, the medication sheet, an Advanced Directive if available and if the consumer chooses, information related to coordinating care with family members. To facilitate continuity of care between providers, when possible, a telephone call from the attending outpatient licensed medical practitioner or therapist/case manager is made – particularly in complicated cases. Whenever possible, contact by the LMP, CMHP/Agency liaison, or therapist/case manager will be made prior to admission to gather the most curent clinical information. Information can be faxed to Good Samaritan Hospital at 541-768-5278, or to Salem Hospital at 503-561-4787.

D. Financial Information/Support:

The RACU Social Worker/Admissions Staff assists the consumer in filling out the financial statement form for the purpose of assessing appropriate billing, including family members if available. If appropriate, including when other insurance benefits are exhausted, assistance is initiated by RACU Social Worker/Admissions Staff. The status of the assistance application is provided to the CMHP/Agency/Liaison staff.

E. Regional Coordinator(s):

To ensure the most appropriate use of available resources, when possible, notification of the Regional Coordinator or designee is attempted prior to contacting the RACU.

On work weekdays between 8:00 a.m. and 5:00 p.m., the Regional Coordinator for Linn, Marion, Polk, Tillamook and Yamhill Counties is to be notified of all admissions to RACUs by calling 503-361-2694 (desk) or 503-551-7847 (cell). Regional Coordinator for Benton and Lincoln Counties is available 8:00 a.m. to 5:00 p.m. weekdays and is to be notified of all admissions by calling 541-322-7447 (desk) or 541-602-1663 (cell).

3. TREATMENT PHASE:

A. CMHP/Agency Representative (Liaison/Case Manager):

Each CMHP/Agency identifies and makes known to each RACU an individual who will serve as CMHP/Agency liaison and serves as an initial point of contact with the

CMHP/Agency and RACU. Liaisons or treating clinicians make contact with consumer from the Region within one business day from hospital admission and notify Social Worker/Treatment Team by voice mail or email. The RACU staff contacts and consults with the hospital liaison within one business day of admission, if during normal work hours, if admission is on the weekend the contact is made on Monday, to share information and begin the discharge planning process.

B. Treatment:

The treatment phase is a cooperative effort between the RACU staff, the consumer, (and family members and/or significant others when the consumer chooses) and the CMHP/Agency where the consumer resides. This treatment team's goal is effective treatment and efficient use of resources to facilitate a rapid stabilization and preparation for treatment at the next (lower) level of care.

The CMHP/Agency representative/liaison is involved in the treatment process and available by phone or in person whenever possible for treatment and discharge planning meetings when notified one day in advance of the meeting time.

C. Disability Services:

The RACU staff assigned to the consumer's case notifies the Disability Services Office within twenty-five days, whenever possible, of the admission of a consumer who receives Social Security benefits and request that they notify Social Security Administration.
When appropriate the assigned social worker/discharge planner assists the consumer in applying for and obtaining available entitlements.

D. Treatment Progress:

The RACU Social Worker assigned to the consumer while an inpatient of the RACU initiates discussions of treatment progress with the CMHP/Agency/Liaison staff involved in the consumer's outpatient treatment and with family members and others as appropriate for continuity of care. Each consumer needs to give written consent for RACU staff to discuss treatment progress with anyone other than CMHP/Agency staff, Office of Mental Health and Addiction Services staff, or State Hospital staff.

The RACU staff notifies the Regional Coordinator and the identified CMHP/Agency liaison immediately to report the occurrence of any major consumer events such as sudden and acute illness, death, or elopement.

4. DISCHARGE PHASE:

The Regional Coordinator assists the RACU and CMHP/Agency/liaison staff to effect timely discharges and provide for appropriate and timely aftercare. The Regional Coordinators will accomplish this by maintaining knowledge of regional services and assisting the RACUs and CMHP/Agency (ies)/liaison in linking consumers to available, appropriate services. In order to facilitate this the Regional Coordinator meet weekly with the RACUs for clinical review and authorizing funds for appropriate step-down placements.

A. Discharge Planning:

The assigned RACU Social Worker/Discharge staff coordinates the discharge planning with the unit's interdisciplinary staff, CMHP/Agency, community providers and family members, as identified by the consumer, integral to the consumer's post-hospital care. At the time of discharge, the discharge instructions identify and specify roles of parties responsible for outpatient mental health treatment, caregivers, and significant supports, such as family members. The RACU staff promptly notifies all involved parties of changes to the discharge plan that develop over the course of the inpatient stay.

The discharge instructions include current medications, a plan for continuity post-discharge, significant problems needing treatment, treatment and support services provided, and providers and caregivers. The instructions address the means by which the consumer is transported from the hospital to post-discharge residence/placement. All scheduled appointments will be included. The consumer and the RACU staff sign the plan. The assigned RACU staff provides a legible copy of the discharge instructions to the CMHP/Agency/Liaison and it is faxed to the outpatient provider on the day of discharge. The discharge instructions include the amount (days) of medications provided as a link to the outpatient appointment. The physician's discharge instructions are available to the outpatient physician at the time of or prior to the follow-up appointment, if an outpatient physician is identified.

The assigned RACU staff is responsible for notifying involved family and the CMHP/Agency liaison of a consumer's readiness for discharge and the anticipated date of discharge. This notification occurs at least 24 hours prior to the anticipated discharge time whenever possible.

B. Financial Assistance:

For persons eligible, an application for OHP is submitted to the local DSO branch 2 (two) days prior to discharge. The RACU staff assists the consumer in contacting the local AFS/DSO office issuing their medical card to report a change of address. RACU and county liaison/case manager responsibilities with the local agency (Disability Services, AFS, Senior Service Division) office include assisting consumers in preparing applications for entitlements and support.

C. Trial Visit:

When a trial visit is agreed upon through discussion with the consumer and involved family/support systems, the hospital, and county staff, the CMHP/Agency liaison/treatment clinician obtain approval from the CMHP/Agency Director or designee and develop the conditions of trial visit. Information from the consumer, Pre-commitment Investigator, the Regional Coordinator, the consumer's treating physician, staff of the RACU, and others such as consumer's care givers, family, and significant others are considered in the planning. The RACU staff and County staff partner will educate and explain the conditions of a trial visit to the consumer, when possible, have the consumer sign the agreement to conditions of a trial visit, and give a copy of the conditions of a trial visit to the consumer. The original agreement will be forwarded to the CMHP/Agency liaison.

D. Extended Care Management Transfer

Extended Care referrals are made in consultation with RACU staff, CMHP/Agency liaison staff and Regional Coordinator. RACU staff makes ECMU referrals. ECMU referrals need to meet the criteria set by the Office of Mental Health and Addiction Services. Upon acceptance for ECMU placement the current rules for payment set by Office of Mental Health and Addiction Services apply.

A consumer has the right to grieve the proposed transfer to a State Hospital. The procedure is for the consumer to express, either verbally or in writing, a desire to grieve the transfer. The resident county CMHP/Agency liaison or Regional Coordinator meets with the consumer within one business day to hear their reasons for not wanting the proposed transfer. The CMHP/Agency liaison will then consult with the Regional Coordinator. A decision will be made within one business day of the discussion with the consumer. The CMHP/Agency liaison will fax the decision to the consumer at the RACU. This decision is final.

E. Referrals:

If a referral is needed for Adult Foster Care, Residential Care, Respite Care, or other support services, the assigned RACU Social Worker staff coordinates all referrals with the CMHP/Agency liaison and/or Regional Coordinator.

Prior to a determination that a consumer requires a nursing home placement the RACU Social Worker staff consults with the CMHP/Agency/Regional Coordinator DSO if the consumer is under age 62. All referrals to a nursing home are coordinated with the CMHP/Agency liaison and Senior Services (if the consumer is over age 62). Assigned RACU Social Worker/Discharge Planner requests a PASSR Level I screen as soon as the Treatment Team determines nursing home placement is necessary.

F. Transportation:

The CMHP/Agency liaison and RACU Discharge Planner are jointly responsible for arranging transportation for the consumer from the RACU in a timely manner. If the transportation plan includes the family transporting the client, 24-hour notice needs to be provided to the family whenever possible.

G. Prescriptions:

Planning for medication access post-discharge occurs as part of the discharge plan development and includes consideration of the consumer's access to a pharmacy, ability to purchase, and date of the next outpatient appointment so that the plan achieves uninterrupted medication access, whenever possible.

The RACUs provides discharged consumer with medication by providing a supply of medications or prescriptions that will last until the first appointment with their outpatient prescriber (not to exceed 10 days post discharge unless agreed to by the discharging psychiatrist).

In order to avoid a lapse in medication availability the RACUs may agree to contract with the CMHP/Agency separately for additional prescriptive services on a case-by-case basis in those situations when adequate outpatient coverage cannot be established.

H. Discharge Instructions:

Legible discharge instructions, provided by the RACU, including discharge address, referrals, appointments, axis I diagnosis discharge medications are given to the consumer at time of discharge and are faxed to the CMHP/Agency in the County of residence within 24 hours of the discharge. An involved family member/support person, with appropriate consent, can also receive discharge information including medication education, possible side effects, appointment schedules, and who to call if problems arise. The discharge instructions includes amount (days) of medications provided as a link to outpatient appointment. 10 (Ten) days of medications or prescription is provided as a link to outpatient appointments whenever possible and clinically appropriate. These appointments include contact with an outpatient provider within 7 days and an appointment with a Licensed Medical Practitioner within 10 working days of discharge, whenever possible.

Discharge Instructions are completed, and copies are sent to the CMHP/Agency in the county of residence and the Regional Coordinator. Fax numbers for the counties are: Benton, 541-766-6899; Lincoln, 541-265-4194; Linn 541-928-3020; Marion, 503-585-4098; Polk, 503-623-2731; Tillamook, 503-815-1870; Yamhill, 503-434-9846. Fax numbers for the Regional Coordinators are: MVBCN, 503-585-4989 ABHA, 541-322-7429.

If the CMHP/Agency with designated responsibility for the consumer is different from the CMHP/Agency in the county of residence of the consumer, appropriate discharge information is sent to both programs.

AGREEMENT RELATED TO SERVING THOSE WITH DEVELOPMENTAL DISABILITIES

These guidelines are to be utilized in addition to the above parts of the Linkage Agreement to facilitate linkage of Office of Mental Health and Addiction Services, Seniors and People with Disabilities Office, and support for Regional Acute Care Units. (RACUs)

1. PURPOSE:

The purpose of this section is to provide guidelines and suggested procedures for County programs for persons with Developmental Disabilities to coordinate with the Regional Acute Care Units. (RACUs)

2. CONSULTATION AND TECHNICAL ASSISTANCE:

Local DD programs for persons with developmental disabilities, acting individually, in cooperation, or through the Regional Acute Care Council, provide training on the needs of persons with developmental disabilities in an inpatient setting. Training is developed in collaboration with the RACUs. A primary goal of the training is to assist the RACUs to identify needs, make reasonable accommodation and provide quality mental health care to consumers with

developmental disabilities within the hospital milieu, and includes training on consumer specific behavior and treatment planning. When typical psychiatric treatment measures do not work in the best interest of a specific DD consumer, the DD Regional Crisis worker is available for consultation and/or assistance in devising alternative appropriate care. DD regional Crisis Worker and admitting or treating physician determine need for additional assistance.

3. SCREENING PHASE:

A. County crisis staff (QMHP/crisis screener) conducts an evaluation to determine appropriateness for acute psychiatric care.

B. County crisis staff (QMHP/crisis screener) have a means of identifying enrolled clients in the appropriate DD program.

C. County crisis staff (QMHP/crisis screener) have a means of contacting the responsible DD case manager or individual within the appropriate county who is responsible for DD client crises as soon as possible but no later than the next business day.

D. The DD Case Manager or DD Regional Crisis Worker is contacted, if necessary, to arrange a diversion, and in all cases when an emergency hold to an RACU is planned.

E. The DD Case Manager or DD Regional Crisis Worker assesses the need for division funds for enhanced services within the hospital setting for individuals with Developmental Disabilities upon approval from the county of residence Program Manager and this assessment is re-evaulated as the consumer improves, determined by the treatment team.

F. County crisis staff (QMHP/crisis screener) arranges for the client's community licensed medical practitioner to consult with the hospital-treating psychiatrist on all DD consumers admitted to the RACUs.

G. County crisis staff (QMHP/crisis screener) have access to assistance from County DD staff when screening persons suspected to have a developmental disability, but not enrolled in a County program for persons with developmental disabilities.

4. TREATMENT PHASE:

A. The DD Regional Crisis Worker the next working day after an enrolled client is admitted contacts the DD Case Manager.

B. The DD Case Manager contacts the RACU where an enrolled client is admitted on the first scheduled working day after the admission and each working day thereafter.

C. The DD Case Manager or designee coordinates treatment needs of the client with hospital needs for client specific training and direct staff assistance, and identify community resources which are available to ensure that the hospital is adequately prepared to address client needs. The hospital makes reasonable accommodation for persons who have developmental disabilities.

D. The DD Case Manager coordinates communication and treatment planning and establish linkage with the RACU staff, residential providers, vocational providers, licensed medical practitioner, and family and other supports.

5. DISCHARGE PHASE:

A. The RACU Social Worker/Discharge Planner coordinates discharge-planning activities with the resident DD Case Manager to facilitate an expeditious return to the most appropriate setting.

B. The local DD Case Manager may use any of the following resources, as appropriate:

- Return to home or residential placement with support;
- Use DD diversion funds for enhanced services;
- Use specialized consultants including the State DD diversion team for residential and treatment options;
- Access Eastern Oregon Training Center for extensive evaluations when determined to be the most appropriate setting by DD professionals.

6. GRIEVANCES:

A. Grievances are handled at the lowest possible level and not at the consumers' expense. If resolution is not reached at this level, concerns are submitted to the Regional Coordinator in the form of a Statement of Concern.

MID-WILLAMETTE REGIONAL ACUTE CARE UNITS AND
MID-WILLAMETTE COMMUNITY MENTAL HEALTH PROGRAMS

2003-2005 LINKAGE AGREEMENT

In witness whereof, the parties hereto have caused this agreement to be executed by their officers, thereunto duly authorized.

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Good Samaritan Hospital Date

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Marion County Date

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Salem Hospital Date

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Polk County Date

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Benton County Date

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Tillamook County Date

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Lincoln County Date

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Yamhill County Date

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Linn County Date