Crises/Hospital Workgroup Report
Co-facilitated by Diane Dietz (DHFS/CII) and Sharon Locklin (NE Regional Crisis Grant)

### Crisis Planning (Prevention)

The group chose to look at this topic as crisis prevention and community support planning. The following were identified as integral in prevention of crisis situations.

1) Provide comprehensive medical and dental evaluations at regular intervals.
2) Develop a good social history on the person and use person-centered planning techniques.
3) Create non-punitive behavioral support plans.
4) Match the person to the environment most optimal for the person.
5) Workforce development is important (staff philosophy, training and skill-building)
6) Address power/control issues with staff (who’s crisis is it?)
7) Integration of systems (crisis and long-term support)
8) Create support teams using direct care providers and extending to others in the community such as neighbors, law enforcement, county staff, family, and others
9) Early identification of people “at risk” and providing additional resources, support up front.
10) Environmental modifications that address safety and sensory issues.
11) Create shared values and mission from management on down.
Crisis Response

Diversion, maximizing community resources is the key to good crisis response for this population. Hospitalization may be necessary, but should be viewed as the last resort.

1) Good medical and dental evaluation and plan to address identified issues.

2) Good collaboration with the county crisis teams (HFS34).

3) Providers should be made to feel confident and secure to report behavioral issues and get support.

4) Some crises are predictable and should be planned for (ie, dying friends and family members, changes in placement, etc).

5) Training of provider network on crisis funding and support for additional resources during times of crisis.

6) Create wrap services to bring to person in crisis and use "crisis homes" if person does need to be removed temporarily—send staff with the person to these homes.

7) Trauma-informed care—need for staff debriefing and support following crisis situations, recognition of PTSD in consumers and staff.

8) Good communication and exchange of information between providers at times of crisis.
Coordination of Care (Hospitals, ER’s, other Health-care Providers)

Communication, information sharing and cross-training of providers is essential to good coordination of care.

1) Medical, dental, mental health communities need training on dealing with DD (and other) populations.

2) Share information with medical, dental and mental health providers using a standardized tool such as a “health log.”

3) Get pre-signed consents when possible. Remember that HIPPA allows information sharing in crisis situations on a “need to know” basis.

4) Request information back from other health-care providers upon return—don’t assume they will send it and if they don’t, follow-up

5) Create standardized transfer form—so that agencies, counties are sharing the same types of information.

6) Where there are resources or expertise lacking, use telehealth to connect to these resources.

7) The team should follow the person (even when person is temporarily away from primary placement).

8) Promote consistency in coordination with out-of-county placements and contracts.

9) Attempt to get all services within the same healthcare system or HMO—it’s much harder when there is a need for info sharing between different systems.

10) Establish good communication and working relationships with medical, dental, mental health staff during times when there isn’t a crisis.

11) Recognize that in spite of good communication and coordination there will be some “non-responders” as some issues related to DD are difficult to treat.

12) Improve the process for medical clearance when needed—meet with police, ER staff and treatment providers to develop protocols that meet standards and make the process more efficient.

13) Educate ER staff that medical and dental problems may be underlying behavioral problems and people need to be assessed accordingly.
Police/Legal

Much of what was discussed in Coordination of Care applies to this topic. In addition, the following recommendations were made:

1) Training for Law Enforcement (ie, CIT), EMT’s and Judges.

2) Inclusion of Law Enforcement in Behavioral and Crisis Response Plans (make them part of the team).

3) Provide crisis protocol reference cards that can be carried by officers and EMT’s in the field for quick reference.

4) Improve communication between Court system and other systems—the systems don’t speak the same language (ie, competency).

5) Educate Judges that while jail may not be appropriate for a DD person, legal consequences may be necessary at times to support the plan for the person.

6) Work with legal system on differentiating between a DD person with sexuality issues and sexual predators.

Conclusion

A paradigm shift is needed to effect change in the way the DD Population is handled in crisis situations. In order for this to occur, there is a need for individuals with much commitment and enthusiasm for providing quality support services to persons with DD to educate and assist others in making the necessary systems changes.