NORTH SOUND MENTAL HEALTH ADMINISTRATION
ADVISORY BOARD MEETING

North Sound Mental Health Administration
Conference Room
117 North First St., Suite 8
Mt. Vernon, WA 98273
April 6, 2004
1:00 PM

Agenda

1. Call to Order - Introductions, Chair – 5 minutes

2. Revisions to the Agenda, Chair – 5 minutes

3. Approval of the March 2004 Minutes, Chair – 5 minutes

4. Comments from the Public –5 minutes

5. Correspondence and Comments from the Chair – 5 minutes

6. Unfinished Business

   a. Executive Director's Report - Chuck Benjamin – 5 minutes
   b. Finance Committee – Mary Good – 5 minutes
   c. Planning Committee – Tom Richardson – 5 minutes
   d. Agenda Committee – Chair – 5 minutes
   e. QMOC Report – Mary Good – 5 minutes

7. Items To Be Brought Forward To The Board of Directors – Charles Benjamin, Executive Director

   a. Consent Agenda

8. New Business

9. Comments from County Advisory Board Representatives – 15 minutes

   a. Island
   b. San Juan
   c. Skagit
   d. Snohomish
   e. Whatcom

10. County Coordinator Report
    i. Consumer-Run Projects-County Reports

11. Comments from Public – 5 minutes

12. Other Business

    a. Request for Agenda Items

13. Adjournment

NOTE: The next Advisory Board meeting will be May 4, 2004 at the NSMHA Conference Room, 117 N. First Street, Suite 8, Mount Vernon.

North Sound Mental Health Administration
MENTAL HEALTH ADVISORY BOARD
March 2, 2004

Present:	John Patchamatla, Joan Lubbe, Charles Albertson, Patricia Whitcomb, Marie Jubie, Mary Good, Jim King, Patricia Little, Tom Richardson, Dean Stupke, Julian Marsh, Bruce Radtke
Absent:	James Vest
Excused:	Chris Walsh, Jack Bilsborough
Staff:	Chuck Benjamin, Sharri Dempsey, Greg Long, Wendy Klamp, Shirley Conger, Shari Downing
Guests:	Laurel Britt, Tom Sebastian

MINUTES

TOPIC	DISCUSSION	ACTION
CALL TO ORDER, INTRODUCTIONS		
Chair Jubie	Chair Jubie convened the meeting at 1:05 p.m. and welcomed those present. Introductions were made. The Advisory Board had a pre-meeting presentation by Diana Striplin NSMHA Quality Specialist and Kathy Reim from PFLAG Presenters talked about PFLAG and what they do and the GLBTQ committee in the North Sound Region. The speakers were thanked for their very educational presentation.	Informational
REVISIONS TO THE AGENDA		
Chair Jubie	Chair Jubie asked if there were any revisions to the agenda. Tom Richardson stated that he would like Chuck to speak on the changes at WCPC and how to put on the agenda a discussion on contracting with the agencies directly instead of APN. Chuck stated that it would be discussed during the Executive Director's report.	None
APPROVAL OF MINUTES		
Chair Jubie	The February 2004 minutes of the Advisory Board meeting were reviewed and passed unanimously.	Passed unanimously

COMMENTS FROM THE PUBLIC

	There was none.	Informational

CORRESPONDENCE AND COMMENTS FROM THE CHAIR

Chair Jubie	Chair Jubie stated that she has been busy in Olympia. She has been working with the DDD council and on the WMIP.	Informational

UNFINISHED BUSINESS

	Executive Director's Report	
Chuck Benjamin	Mr. Benjamin indicated that he had some sad news to relay today. Darrell Heiner is resigning from the NSMHA to go to work as an Accountant for the EMS in Skagit County. We wish Darrell well. This is an opportunity to step back and see if we need to make any changes or stay the same. Chuck indicated that we have gotten around 30 applications for the contracts manager job and have been looking at some very qualified people. He feels that he will be able to extend an offer to one of them. He would like Marie as the Advisory Board to Chair to meet the candidates for the job. Chuck advised the group that he has gotten a letter from the WCPC Board Chair Rick Sucee. In the letter it stated that they have suspended the Executive Director and the Clinical Director at WCPC. They have also retained a law firm to address other personnel issues. They are working hard with us to meet their obligations with the contract and the local community. Chuck stated that he would like to help them by working with the WCPC board on how to use the remaining 10K of the sanction to help them get on track with emergency crisis services. Chuck added that Lt. Rick Sucee is the acting Executive Director now at WCPC and he will be sending a very nice letter to his Chief Randy Carroll commending him on letting Lt. Sucee split his duties. Tom asked if we should contract with individual providers instead of APN? Chuck stated that is something that would need to go to the Board. Chuck spoke about a letter from a consumer indicating that they were not treated with dignity and respect at a California airport. Chuck wrote a letter to the Airport around this issue and got a very unsatisfactory response from them. However, he did get a very	Informational

	gracious letter back from the consumer thanking him for his advocacy. Chuck updated the committee on the WMIP. He stated that the Senate proviso going to the legislature now states that the WMIP will go forward as planned but only for medical and RX. Then take the next 3-5 years to build in mental health, chemical dependency and developmental disabilities. He gives credit to Mike Manley on finding a California model that is taking on integration but it is taking 3-5 years for them to implement. Chuck stressed that this is not in yet; the legislature is working on it this week. Committee discussion followed.	
	Finance Committee Report	
Mary Good	Ms. Good indicated that the finance committee met this morning and recommended approval to bring forth to the Board of Directors the Advisory Board expenditures. **All in favor, passed unanimously**.	Approved unanimously
	Strategic Plan Committee	
Chair Jubie	Chair Jubie informed the group that the Planning Committee met and asked Tom as the Chair of the committee to speak about it. Tom stated that the committee had consensus on three items. First, the Board of Directors Planning Committee has 4 seats for the Advisory members to sit. Currently no one from this Board is on it. Tom stated that the Chair would appoint 4 members to the Planning Committee. Jim King, Marie Jubie and Tom Richardson to be on the Planning Committee. One more member will be appointed at a later date. Second, to establish an Agenda Committee. A member from each committee will sit on this committee to advise the Chair on activities and agenda items. This committee will also be working on the Advisory Board Retreat. Third, to appoint 2 more from the Advisory Board to Executive Committee and be eligible to go to the Board of Directors Retreat coming up. Mary, Marie and Tom will be on the Executive Committee. One more member will be appointed at a later date.	Informational
	Activities and Liaison Committee	
Chair Jubie	This will be moved up to the Agenda Committee in the future.	Informational
	Site Visitations for 2004	

Sharri Dempsey	This will be moved to the Agenda Committee in the future.	Informational
	Consumer Run Projects No representative available	Informational
	QMOC Report	
Mary Good	Mary reported on the highlights of the February 2004 QMOC meeting.	

ITEMS TO BE BROUGHT FORWARD TO THE BOARD OF DIRECTORS

	Consent Agenda None	
	Action Items	
Chuck Benjamin	Chuck brought forth the following items for Advisory Board approval: To review and approve the North Sound Mental Health Administration's 2004-2005 Quality Management Plan. It is the intent of NSMHA to develop a quality management program in conformance with the Washington State Mental Health Division, (MHD) and Federal Requirements as well as with the Standards of the Health Insurance Portability and Accountability Act, (HIPAA). The NSMHA Quality Management Plan is a regional document, focusing on the integrated review components that include NSMHA contracted service provider's roles and responsibilities concerning quality assurance/improvement issues. **Motion made, seconded, passed unanimously**.	Motion passed unanimously
	Tom Richardson indicated that he had a motion to make "That before the APN cartel becomes a monopoly, the Advisory Board recommend to the NSMHA Board of Directors that it begin a deliberate process to formally reconsider that Board's long standing decision to contract most services to the APN and rather consider contracting such services directly with new or remaining individual provider agencies." Motion seconded. Committee discussion followed. Tom Sebastian addressed the group and acknowledged everyone's point of view. He also expressed that Compass has not gone into any	

	geographical area with out being invited. He stated that there have been changes at the administrative level at APN. It came down to changes at the administrative level or at service delivery. They made the changes at the administrative level. Tom indicated that it never hurts to take a step back and look at the system**. Motion passed unanimously.**	Motion passed unanimously.
	Chuck urged the committee to move the introduction items into action items. They are amendments to extend the consumer project funding for one year to three counties that had not yet spend their money.	
	To introduce NSMHA-Whatcom-04-05 Amendment 1 (one). The contract between the North Sound Mental Health Administration (NSMHA) and Whatcom County is hereby amended as follows: Effective January 1, 2004, the Consumer Oriented Projects Funding shall be extended through December 31, 2004. Maximum consideration for this amendment shall not exceed $36,068.00.	
	To introduce NSMHA-Skagit-04-05 Amendment 1 (one). The contract between the North Sound Mental Health Administration and Skagit County is hereby amended as follows: Effective January 1, 2004, the Consumer Oriented Projects Funding shall be extended through December 31, 2004. Maximum consideration for this amendment shall not exceed $12,936.00.	
	To introduce NSMHA-Island-04-05 Amendment 1 (one). The contract between North Sound Mental Health Administration and Island County is hereby amended as follows: Effective January 1, 2004, the Consumer Oriented Projects Funding shall be extended through December 31, 2004. The maximum consideration for this amendment shall not exceed $9,634. **Motion made, seconded, passed unanimously**.	Motion passed unanimously
	Emergency Action Items	
Chuck Benjamin	There are no Emergency Action Items	
	Introduction Items	
Chuck Benjamin	Moved to action items.	

NEW BUSINESS

Beckie Bacon	Beckie handed out the QRT Quarterly Report for October – December, the Summary of the Quality Review Team for 2003, and the Provider Survey of the Quality Review Team. Beckie went over the reports with the committee. A question and answer period followed. The committee thanked Beckie for her excellent report.	Informational

COMMENTS FROM COUNTY ADVISORY BOARD MEMBERS

Island	Patricia Whitcomb indicated that the Senior-to-Senior outreach program is being implemented in her county.	Informational
San Juan	Dean stated that his county is very pleased with the San Juan Compass Health.	
Skagit	Jim stated that they heard from Compass Health about opening a day drop in center in Skagit County. They are also discussed Mental Health Court and a Detox Center. Originally they tried United General for the detox but now are looking at other options.	Informational
Snohomish	Marie stated that Chris Glans from corrections came and talked to the Snohomish County Advisory Board about WMIP. Mark Doidge came and did a presentation. Bridgeways is opening a new facility on 112th Street. There are now 2 methadone clinics in Snohomish County.	Informational
Whatcom	Julian Marsh stated that this was his first NSMHA Advisory Board meeting and all welcomed him. He stated that the Whatcom Advisory Board is trying to recruit a former sheriff onto their Board. Rainbow Center had their annual recognition dinner for all of the members that work so hard. They had over 100 people attend. There was a presentation of "Proud to be Mental" at the dinner. Julian recognized how hard Charles Albertson has worked on the production. Rainbow Center has also been given a Lilley Grant for 20K. They will be using the money to do a consumer voice electronic newsletter to share with other clubhouses around the state. Tom Richardson	Informational

	added that Ward Nelson has been called to active duty in Tacoma.

COUNTY COORDINATOR REPORT

County Coordinator not available	None

COMMENTS FROM PUBLIC

None	None

OTHER BUSINESS

Chair Jubie	Chair Jubie welcomed Mr. Radtke to the Advisory Board.
	Request for Agenda Items
Chair Jubie	None

ADJOURNMENT

Chair Jubie	Meeting adjourned at 2:53.m.

MEMORANDUM

DATE: March 17, 2004

TO: NSMHA Advisory Board

FROM: Chuck Benjamin, Executive Director

RE: April 8, 2004 Board of Director's Agenda

Please find for your review and comment the following that will be discussed with the Board of Directors and brought forth at the April 8, 2004 NSMHA Board Meeting.

All items referred to below are accessible on the NSMHA website by visiting:
http://www.nsrsn.org/Boards/A_Board_Packet.htm

Consent Agenda
None

Action Items

Emergency Action Items
None

Introduction Items
To introduce the revised NSMHA Clinical Eligibility and Care Standards. We have had requests from our Ombuds and providers regarding the need for clarification within the Residential Section. This section will be brought into closer alignment with the related licensing WAC's (388-76, 388-78A and 246-325). MHD has made changes to diagnoses in the Access to Care Standards and we are now aligning our CECS document with the MHD's Exhibit C.

To introduce NSMHA-MCPP-03-04 amendment 01. Snohomish County has been selected to be the pilot site for the demonstration project for Washington State without its agreement. The NSMHA is concerned about the project and is requesting additional funding for analysis of the Washington State Medicaid Integration Project and the five model/prototype Integration Projects currently underway in other states. This agreement will be in effect December 1, 2003 through June 30, 2004. Maximum consideration for this amendment shall be $ 25,000.

cc: Charles R. Benjamin
County Coordinators
NSMHA Management Team

North Sound Mental Health Administration

Clinical Eligibility and Care Standards

For

Publicly-Funded Mental Health

Community Outpatient (Non-Emergent) Services

Table of Contents

Introduction

This document, Clinical Eligibility and Care Standards for Community Outpatient (Non-emergent) Services, was developed in a collaborative process with NSMHA providers. It defines NSMHA service standards and represents one clinical component of the NSMHA/Provider contract(s). It is to be read and utilized in conjunction with the contract, NSMHA Core Values and Principles, Voluntary and Involuntary Crisis Response Services, and all pertinent State and Federal Requirements, Washington State Administrative Codes, particularly WAC 388-865 or its successor. As State and Federal regulations change, the NSMHA will again offer collaborative opportunities to revise existing contracts, as per the Quality Management Charter. Also incorporated in this contract attachment are the Mental Health Division's State-wide Access to Care Standards, which are the minimum eligibility requirements for individuals with Medicaid funding.

The NSMHA Clinical Eligibility and Care Standards replace former Level of Care Manuals. This establishes regional standards that meet and/or exceed Federal and State requirements. Regional Support Networks have been given responsibility by the State's Department of Social and Health Services Mental Health Division to establish standards that can be expected to improve outcomes. Such enhanced requirements are defined herein and will be measured against during various system reviews as indicators of the quality of service provision and contractual compliance. The standards emphasized in this document are not an exhaustive listing. All services must meet medical necessity criteria and will be reviewed in accordance with State quality assurance, quality improvement and quality management definitions.

It is the responsibility of provider agencies to further operationalize the expectations set forth in this contract with policies and procedures that define service provision standards and evidence-based practices in detail for their staff. In general, the WACs and NSMHA standards do not dictate methodology. It is the responsibility of provider agencies to provide individualized care that is tailored to the needs and strengths of each consumer while working within the guidelines and standards contained herein. Although specific interventions are not generally prescribed, the NSMHA does expect continuous movement toward treatment methodologies and evidence-based practices that demonstrate the highest (research-based) likelihood of positive outcomes and movement toward recovery. It is the responsibility of provider agencies to embrace a wellness/recovery-oriented system of care that evaluates, treats and supports eligible consumers at all levels of need while recognizing that recovery is a highly personalized and unique process. Research shows that achieving the highest degree of wellness/recovery possible, i.e., improvements in function and/or outlook, correlates as closely with supportive environment and relationships as it does with more traditional, clinic–based, mental health services. Therefore, services that offer community-based approaches and are highly collaborative with family, natural and formal support systems are a baseline expectation.

In a responsive system of care, standards are tools that are refined over time. Quality assurance and improvement for a system of care that includes more than 100,000 potential customers requires the scrutiny and hard work of all stakeholders, consumers, families, advocates, researchers, providers and administrators. It is incumbent on all of us to complain and applaud, to speak up and to voice our findings and opinions about the quality of mental health services within the NSMHA. Improvement of our system of care is an ongoing process.

This document, the contract, and pertinent Federal and State requirements, establish a base of NSMHA's standards against which service provision will be measured for the next two-year period. Analysis of data obtained from our informational systems, various quality review and research studies, advisory committees, consumer complaints, grievances and all other sources will continue to reshape our system to better meet the needs of consumers within our region.

CRISIS SERVICES

(EMERGENT CARE)

The Clinical Eligibility and Care Standards for Crisis Services are now detailed in Provider Contracts 2004 - 2005, Voluntary and Involuntary Crisis Response Services

OUTPATIENT SERVICES
(NON-EMERGENT CARE)

OUTPATIENT SERVICES
(Non-emergent Care)

Access

Individuals/families seeking mental health services within the NSMHA will be assisted by mental health clinicians who are adept at triage and screening functions and responsive to the caller's identified needs. The first level of screening will be for safety concerns. If a crisis response is needed, the caller will be immediately connected to crisis services where Mental Health Professionals and Child Specialists are available for consultation. The next level of screening will be for Medicaid coverage, or financial eligibility. Individuals who have a current medical coupon (meet financial eligibility) will be offered either information/referral to community services or an assessment appointment with a NSMHA provider agency (to determine clinical eligibility) within 10 working days. Individuals without financial eligibility will be offered community referral options, as they apply. Response to access calls will be timely, friendly and helpful.

If eligibility for outpatient (non-crisis) services is met, the consumer will be connected by phone to the agency providing those services to schedule an appointment. At this time, they will be asked about any special accommodations that might be needed at the assessment appointment and advised that they are encouraged to bring a friend or family member to the assessment appointment, if desired.

Consumers/families who, by the nature of their mental health disability, are identified during this initial screening as needing assistance to obtain their Medicaid entitlements will be assisted, as needed.

Assessment for Determination of Clinical Eligibility

In an effort to increase statewide continuity/consistency of care and data integrity, Washington State's Mental Health Division has adopted State-wide Access to Non-Emergency Care Standards as included in Exhibit B CMS Waiver, as per their Strategic Plan 2004-2009 (pg. 21) The State-wide standards have been incorporated into all NSMHA provider contracts for the next two-year period.

Outpatient Services (non-emergent)

Minimum Clinical Eligibility Requirements for Authorization for Services for Individuals with Medicaid

Please note: The following guidelines reflect the most restrictive eligibility criteria that can be applied. RSN's may choose to expand coverage based on availability of local resources. The guidelines are not intended to be applied as continuing stay criteria.

State-wide Access Standards

<table>
<tr><td colspan="3">An individual must meet all of the following before being considered for a level of care assignment</td></tr>
<tr><td colspan="3">• The individual is determined to have a mental illness. The diagnosis must be included as a covered diagnosis in the list of Covered Disorders.
• The individual's impairment(s) and corresponding need(s) must be the result of a mental illness.
• The intervention is deemed to be reasonably necessary to improve, stabilize or prevent deterioration of functioning resulting from the presence of a mental illness
• The individual is expected to benefit from the intervention.
• The individual's unmet need would not be more appropriately met by any other formal or informal system or support.</td></tr>
<tr><td>Functional Impairment</td><td colspan="2">Must demonstrate moderate functional impairment in at least one life domain requiring assistance in order to meet the identified need AND <u>impairment is evidenced by CGAS or GAF of 60 or below.</u>

Domains include:
• Health and Self Care, including ability to access medical, dental and mental health care to include access to psychiatric medications;
• Cultural factors;
• Home and family life;
• Safety and stability;
• Work, school, daycare, pre-school or other daily activities;
• Ability to use community resources to fulfill needs.</td></tr>
<tr><td rowspan="2">Supports and Environment</td><td>Children /Youth</td><td>Natural support network is experiencing challenges, i.e., multiple stressors in the home; family or caregivers lack resources or have difficulty accessing entitlements (food, income, coupons, transportation) or available community resources, language and/or cultural factors may pose barriers to accessing services. May be involvement with one or more child serving systems requiring coordination.</td></tr>
<tr><td>Adults</td><td>May have limited social supports and impaired interpersonal functioning due to mental illness. Individual and natural supports may lack resources or have difficulty accessing entitlements (food, income, coupons, transportation) or available community resources; language and/or cultural factors may pose barriers to accessing services. May be involved with one or more additional formal systems requiring coordination. Requires treatment to develop supports, address needs and remain in the community</td></tr>
</table>

State-wide Access Standards (continued)

Covered Diagnoses	Assessment is provided by a mental health professional and determines the presence of a covered mental health diagnosis. Consultation with a children's mental health specialist is required. **Diagnosis "A" + CGAS/GAF of 60 or below = covered** **Diagnosis "B" + Additional Criteria (p. 11-12) + CGAS/GAF of 60 or below = covered**

DSM-IV-TR CODE	DSM-IV-TR DEFINITION	A = Covered B = Covered with Additional Criteria Diagnostic Rating	
		Children	Adults
	ATTENTION-DEFICIT AND DISRUPTIVE BEHAVIOR DISORDERS		
314.01	Attention-Deficit/Hyperactivity Disorder, Combined type	B	B
314.00	Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type	B	B
314.01	Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulsive Type	B	B
314.9	Attention-Deficit/Hyperactivity Disorder DOS	B	B
312.81	Conduct Disorder, Childhood-Onset Type	B	
312.82	Conduct Disorder, Adolescent-Onset Type	B	
312.89	Conduct Disorder, Unspecified Onset	B	
313.81	Oppositional Defiant Disorder	B	
312.9	Disruptive Behavior Disorder NOS	B	
	OTHER DISORDERS OF INFANCY, CHILDHOOD, OR ADOLESCENCE		
309.21	Separation Anxiety Disorder	A	
313.23	Selective Mutism	B	
313.89	Reactive Attachment Disorder of Infancy or Early Childhood	B	
307.3	Stereotypical Movement Disorder	B	
313.9	Disorder of Infancy, Childhood, or Adolescence NOS	B	
	DEMENTIA		
294.10	Dementia of the Alzheimer's Type, With Early Onset Without Behavioral Disturbance		B
294.11	Dementia of the Alzheimer's Type, With Early Onset With Behavioral Disturbance		B
294.10	Dementia of the Alzheimer's Type, With Late Onset Without Behavioral Disturbance		B
294.11	Dementia of the Alzheimer's Type, With Late Onset With Behavioral Disturbance		B
290.40	Vascular Dementia Uncomplicated		B
290.41	Vascular Dementia With Delirium		B
290.42	Vascular Dementia With Delusions		B
290.43	Vascular Dementia With Depressed Mood		B
294.10	Dementia Due to HIV Disease Without Behavioral Disturbance		B
294.11	Dementia Due to HIV Disease With Behavioral Disturbance		B
294.10	Dementia Due to Head Trauma Without Behavioral Disturbance		B
294.11	Dementia Due to Head Trauma With Behavioral Disturbance		B
294.10	Dementia Due to Parkinson's Disease Without Behavioral Disturbance		B
294.11	Dementia Due to Parkinson's Disease With Behavioral Disturbance		B
294.10	Dementia Due to Huntington's Disease Without Behavioral Disturbance		B
294.11	Dementia Due to Huntington's Disease With Behavioral Disturbance		B

		Children	Adults
294.10	Dementia Due to Pick's Disease Without Behavioral Disturbance		B
294.11	Dementia Due to Pick's Disease With Behavioral Disturbance		B
294.10	Dementia Due to Creutzfeldt-Jakob Disease Without Behavioral Disturbance		B
294.11	Dementia Due to Creutzfeldt-Jakob Disease With Behavioral Disturbance		B
294.10	Dementia Due to... (*Indicate the General Medical Condition not listed above)* Without Behavioral Disturbance		B
294.11	Dementia Due to... (*Indicate the General Medical Condition not listed above)* With Behavioral Disturbance		B
---.--	Substance-Induced Persisting Dementia (*refer to Substance-related Disorders for substance specific codes)*		B
---.--	Dementia Due to Multiple Etiologies		B
294.8	Dementia NOS		B
	OTHER COGNITIVE DISORDERS		
294.9	Cognitive Disorder NOS		B
	SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS		
295.30	Schizophrenia Paranoid Type	A	A
295.10	Schizophrenia Disorganized Type	A	A
295.20	Schizophrenia Catatonic Type	A	A
295.90	Schizophrenia Undifferentiated Type	A	A
295.60	Schizophrenia Residual Type	A	A
295.40	Schizophreniform Disorder	A	A
295.70	Schizoaffective Disorder	A	A
297.1	Delusional Disorder	A	A
298.8	Brief Psychotic Disorder	A	A
297.3	Shared Psychotic Disorder	A	A
293.81	Psychotic Disorder Due to *(Indicate the General Medical Condition)* With Delusions	A	A
293.82	Psychotic Disorder Due to *(Indicate the General Medical Condition)* With Hallucinations	A	A
298.9	Psychotic Disorder NOS	A	A
	MOOD DISORDERS **DEPRESSIVE DISORDERS**		
296.21	Major Depressive Disorder Single Episode, Mild	A	A
296.22	Major Depressive Disorder Single Episode, Moderate	A	A
296.23	Major Depressive Disorder Single Episode, Severe Without Psychotic Features	A	A
296.24	Major Depressive Disorder Single Episode, Severe With Psychotic Features	A	A
296.25	Major Depressive Disorder Single Episode, In Partial Remission	A	A
296.26	Major Depressive Disorder Single Episode, In Full Remission	A	A
296.20	Major Depressive Disorder Single Episode, Unspecified	A	A
296.31	Major Depressive Disorder Recurrent, Mild	A	A
296.32	Major Depressive Disorder Recurrent, Moderate	A	A
296.33	Major Depressive Disorder Recurrent, Severe Without Psychotic Features	A	A
296.34	Major Depressive Disorder Recurrent, Severe With Psychotic Features	A	A
296.35	Major Depressive Disorder Recurrent, In Partial Remission	A	A
296.36	Major Depressive Disorder Recurrent, In Full Remission	A	A
296.30	Major Depressive Disorder Recurrent, Unspecified	A	A
300.4	Dysthymic Disorder	A	B
311	Depressive Disorder NOS	A	B
	BIPOLAR DISORDERS		
296.01	Bipolar I Disorder Single Manic Episode, Mild	A	A
296.02	Bipolar I Disorder Single Manic Episode, Moderate	A	A
296.03	Bipolar I Disorder Single Manic Episode, Severe Without Psychotic Features	A	A
296.04	Bipolar I Disorder Single Manic Episode, Severe With Psychotic Features	A	A

		Children	Adults
296.05	Bipolar I Disorder Single Manic Episode, In Partial Remission	A	A
296.06	Bipolar I Disorder Single Manic Episode, In Full Remission	A	A
296.00	Bipolar I Disorder Single Manic Episode, Unspecified	A	A
296.40	Bipolar I Disorder Most Recent Episode Hypomanic	A	A
296.41	Bipolar I Disorder Most Recent Episode Manic, Mild	A	A
296.42	Bipolar I Disorder Most Recent Episode Manic, Moderate	A	A
296.43	Bipolar I Disorder Most Recent Episode Manic, Severe Without Psychotic Features	A	A
296.44	Bipolar I Disorder Most Recent Episode Manic, Severe With Psychotic Features	A	A
296.45	Bipolar I Disorder Most Recent Episode Manic, In Partial Remission	A	A
296.46	Bipolar I Disorder Most Recent Episode Manic, In Full Remission	A	A
296.40	Bipolar I Disorder Most Recent Episode Manic, Unspecified	A	A
296.61	Bipolar I Disorder Most Recent Episode Mixed, Mild	A	A
296.62	Bipolar I Disorder Most Recent Episode Mixed, Moderate	A	A
296.63	Bipolar I Disorder Most Recent Episode Mixed, Severe Without Psychotic Features	A	A
296.64	Bipolar I Disorder Most Recent Episode Mixed, Severe With Psychotic Features	A	A
296.65	Bipolar I Disorder Most Recent Episode Mixed, In Partial Remission	A	A
296.66	Bipolar I Disorder Most Recent Episode Mixed, In Full Remission	A	A
296.60	Bipolar I Disorder Most Recent Episode Mixed, Unspecified	A	A
296.51	Bipolar I Disorder Most Recent Episode Depressed, Mild	A	A
296.52	Bipolar I Disorder Most Recent Episode Depressed, Moderate	A	A
296.53	Bipolar I Disorder Most Recent Episode Depressed, Severe Without Psychotic Features	A	A
296.54	Bipolar I Disorder Most Recent Episode Depressed, Severe With Psychotic Features	A	A
296.55	Bipolar I Disorder Most Recent Episode Depressed, In Partial Remission	A	A
296.56	Bipolar I Disorder Most Recent Episode Depæssed, In Full Remission	A	A
296.50	Bipolar I Disorder Most Recent Episode Depressed, Unspecified	A	A
296.7	Bipolar I Disorder Most Recent Episode Unspecified	A	A
296.89	Bipolar II Disorder	A	A
301.13	Cyclothymic Disorder	B	B
296.80	Bipolar Disorder NOS	A	A
296.90	Mood Disorder NOS	A	B
	ANXIETY DISORDERS		
300.01	Panic Disorder Without Agoraphobia	A	B
300.21	Panic Disorder With Agoraphobia	A	B
300.22	Agoraphobia Without History of Panic Disorder	A	B
300.29	Specific Phobia	B	B
300.23	Social Phobia	B	B
300.3	Obsessive-Compulsive Disorder	A	B
309.81	Posttraumatic Stress Disorder	A	A
308.3	Acute Stress Disorder	A	A
300.02	Generalized Anxiety Disorder	A	B
300.00	Anxiety Disorder NOS	A	B
	SOMATOFORM DISORDERS		
300.81	Somatization Disorder	B	B
300.82	Undifferentiated Somatoform Disorder	B	B
300.11	Conversion Disorder	B	B
307.80	Pain Disorder Associated With Psychological Factors	B	B
307.89	Pain Disorder Associated With Both Psychological Factors and a General Medical Condition	B	B
300.7	Hypochondriasis	B	B
300.7	Body Dysmorphic Disorder	B	B
300.82	Somatoform Disorder NOS	B	B

		Children	Adults
	FACTITIOUS DISORDERS		
300.16	Factitious Disorder With Predominantly Psychological Signs and Symptoms	B	B
300.19	Factitious Disorder With Predominantly Physical Signs and Symptoms	B	B
300.19	Factitious Disorder With Combined Psychological and Physical Signs and Symptoms	B	B
300.19	Factitious Disorder NOS	B	B
	DISSOCIATIVE DISORDERS		
300.12	Dissociative Amnesia	B	B
300.13	Dissociative Fugue	B	B
300.14	Dissociative Identity Disorder	B	B
300.6	Depersonalization Disorder	B	B
300.15	Dissociative Disorder NOS	B	B
	SEXUAL AND GENDER IDENTITY DISORDERS		
	EATING DISORDERS		
307.1	Anorexia Nervosa	B	B
307.51	Bulimia Nervosa	B	B
307.50	Eating Disorder NOS	B	B
	ADJUSTMENT DISORDERS		
309.0	Adjustment Disorder With Depressed Mood	B	B
309.24	Adjustment Disorder With Anxiety	B	B
309.28	Adjustment Disorder With Mixed Anxiety and Depressed Mood	B	B
309.3	Adjustment Disorder With Disturbance of Conduct	B	B
309.4	Adjustment Disorder With Mixed Disturbance of Emotions and Conduct	B	B
309.9	Adjustment Disorder Unspecified	B	B
	PERSONALITY DISORDERS		
301.0	Paranoid Personality Disorder	B	B
301.20	Schizoid Personality Disorder	B	B
301.22	Schizotypal Personality Disorder	B	B
301.7	Antisocial Personality Disorder	B	B
301.83	Borderline Personality Disorder	B	B
301.50	Histrionic Personality Disorder	B	B
301.81	Narcissistic Personality Disorder	B	B
301.82	Avoidant Personality Disorder	B	B
301.6	Dependent Personality Disorder	B	B
301.4	Obsessive-Compulsive Personality Disorder	B	B
301.9	Personality Disorder NOS	B	B

State-wide Access Standards (continued)

Additional Criteria – Children and Youth	Child is under six years of age and there is a severe emotional abnormality in the child's overall functioning as indicated by one of the following: a. Atypical behavioral patterns as a result of an emotional disorder or mental illness (odd disruptive or dangerous behavior which is aggressive, self injurious, or hypersexual; display of indiscriminate sociability/excessive familiarity with strangers) b. Atypical emotional response patterns as a result of an emotional disorder or mental illness which interferes with the child's functioning (e.g. inability to communicate emotional needs; inability to tolerate age-appropriate frustrations; lack of positive interest in adults and peers or a failure to initiate or respond to most social interaction; fearfulness or other distress that doesn't respond to comfort from caregivers). (Please note: CGAS is generally not considered valid for children under the age of six. Children under six are exempted from Axis V scoring. A DC03 diagnosis and PIR-GAS may be substituted. Very young children in need of mental health care may not readily fit diagnostic criteria. The degree of functional impairment related to the symptoms of an emotional disorder or mental illness should determine eligibility. Functional impairment for very young children is described above. **The child/youth with a "B" diagnosis must meet at least one of the following criteria to be considered for a level of care placement decision. Behaviors/Symptoms must be the result of a mental illness.** a. High-risk behavior demonstrated during the previous ninety days – aggressive and/or dangerous, puts self or others at risk of harm, is at risk of severe functional deterioration, is at risk of hospitalization or at risk of loss of current placement due to mental illness or at risk of out of home placement due to the symptoms of an emotional disorder or mental illness b. At risk of escalating symptoms due to repeated physical or sexual abuse or neglect and there is significant impairment in the adult caregiver's ability to adequately address the child's needs. c. Two or more hospital admissions due to a mental health diagnosis during the previous two years. d. Psychiatric hospitalization or residential treatment due to a mental health diagnosis of more than six months duration in the previous year OR is currently being discharged from a psychiatric hospitalization. e. Received public mental health treatment on an outpatient basis within the PIHP system during the previous ninety days and will deteriorate if services are not resumed (crisis intervention is not considered outpatient treatment).

State-wide Access Standards (continued)

Additional State-wide Criteria for Diagnosis B - Adults	**An adult with a "B" diagnosis must meet at least one of the following criteria to be considered for a level of care placement decision. Behaviors/symptoms must be the result of a mental illness.** a. High Risk Behavior demonstrated during the previous ninety days – aggressive and/or dangerous, puts self or others at risk of harm, is at risk of severe functional deterioration, is at risk of hospitalization or at risk of loss of current placement due to mental illness or at risk of out of home placement due to the symptoms of an emotional disorder or mental illness b. Two or more hospital admissions due to a mental health diagnosis during the previous two years c. Psychiatric hospitalization or residential treatment due to a mental health diagnosis of more than six months duration in the previous year OR is currently being discharged from a psychiatric hospitalization. d. Received public mental health treatment on an outpatient basis within the PIHP system during the previous ninety days and will deteriorate if services are not resumed (crisis intervention is not considered outpatient treatment)
	Children and Adults
Dual Diagnosis	Individuals who have both a covered and a non-covered diagnosis are eligible for service based on the covered diagnosis
Exclusionary Criteria	Substance abuse, alcoholism, mental retardation, pervasive development disorders, autism, learning disorders, sexual disorders, impulse control disorders, v-codes and organic brain syndrome are not considered psychiatric illnesses under the Washington State Medicaid Program and are not covered.

Regional Outpatient (non-emergent) Access Service Requirements

All medically necessary services to include but are not limited to:

Requirement	Source of Requirement
All Federal and State Requirements pertaining to access, as well as other pertinent sections of NSMHA contract	Current CFRs and CMS waiver, BBA, and WACs
Access phone will be answered by live voice within 30 seconds	NSMHA Requirement
Risk Assessment (i.e., assessment of the consumer's risk for lethality and/or decompensation based on current functioning, current & historical risk factors and current availability of support/resources)	NSMHA Requirement
Screening per State-wide standards	State Wide Standards
Access staff will identify individuals for whom the severity of their mental illness or other disabilities may prevent them from successfully applying for state or federal entitlement programs and to reduce this barrier to service, will offer them an assessment	WAC 388-865-0415

Access staff will inform individuals that they are encouraged to bring family and/or natural supports to initial assessment, if desired	MHD Contract
An appointment is offered to occur for a face-to-face contact within seven days of discharge from community inpatient care and state hospitals	State-wide Performance Indicator
An initial face-to-face full multi-axial assessment will be offered to occur within ten working days of completed request for services by consumers with Medicaid funding.	MHD Contract
Access staff will seek information from the consumer requesting services regarding age, culture, language, gender, and physical condition, and/or special requests	Exceeds WAC 388-865-0415: NSMHA requirement
Engagement (Outreach) services – locating and engaging those needing services	WAC 388-865-0310
Information and assistance, referral and/or service appointment.	NSMHA Requirement

Outpatient Assessments

Assessment is an on-going process throughout a consumer's involvement with services. Service providers use every contact to assess for risk, needs, strengths and change and make necessary adjustments to treatment/crisis plans. Formal multi-axial assessments, which take place at intake, determine the consumer's clinical eligibility and "level" of care. Formal mental health assessments may be augmented with related evaluations, consultations, and specialist involvement, etc. depending upon medical necessity.

State-wide Standard:
Assessment is provided by a mental health professional and determines the presence of a covered mental health diagnosis. Consultation with a children's mental health specialist is required (for all children/youth). Special Populations consultation should be considered.
Regional Clarification (standard): Special population consultations will be provided as needed. (WAC 388-865-0405)

Reassessments trigger a mutual (consumer and provider) process of reconsideration of service plan, service provision and outcomes. For consumers in long-term outpatient services reassessments/reviews will occur every 180 days, with subsequent changes to treatment and crisis plans, as indicated

Consumers are encouraged to bring natural supports to the initial assessment appointment to assist with the provision of support and information and to establish the format for consumer-driven support teams and continued involvement of natural supports. If consumers are unable to get to a clinic-based assessment due to the client's mental illness, disability, lack of transportation, incarceration or other barriers, assessments can be established at other locations, including community-based detention facilities. Accommodations will be made for barriers of language or disability.

Assessments for outpatient (non-emergent) services will determine:

1. Clinical Eligibility - based on State-wide Standards: a combination of diagnosis, current level of functionality (GAF or CGAS) and specific "Additional Criteria"
2. Level of Care – based on regional and State-wide Standards

Regional Service Requirements – related to Assessment:

Regional Requirement	Source of Requirement
All Federal and State Requirements, as well as NSMHA contract	Current CFRs, CMS waiver, BBA, & WACs
Non-urgent assessments will be offered within 10 working days of completed request for services	MHD 2003-5
Urgent Assessments – will be completed with the consumer within 24 hours of the initial screening for urgent referral. Referrals for assessment initiated by NSMHA, ICRS staff, or hospital staff shall be performed within 24 hours, if needed	See Attachment - Voluntary and Involuntary Crisis Response Services
Assessments will be conducted by MHPs	
Assessments must be completed within fourteen calendar days of first face to face appointment.	WAC 388-865-0420
Assessors will be culturally competent and have linguistic supports, as needed	WAC 388-865-0420
Provider will seek information from the consumer regarding age, culture, language, gender, sexual orientation and physical condition.	NSMHA Standard WAC 388-865-0415 (exceeds)
As needed to reduce barriers to service, assessment staff will assist individuals for whom the severity of their mental illness or other disabilities may prevent them from successfully applying for state or federal entitlement programs in obtaining benefits for which they are eligible, including Medicaid.	WAC 388-865-0415
Culturally competent services emphasizing consumer voice/choice	WAC 388-865-0420, WAC 388-865-0405. NSMHA 7.01 plan
Assessments shall address/evaluate all life domains including safety and risk of decompensation	WAC 388-865-0425 (4)
Assessments shall be conducted at locations in the community, as needed	WACs 388-865-0415 (1); 388-865-0310 In the NSMHA contract
Routine mental health services are offered to occur within 14 calendar days of the determination of eligibility	MHD 2.2.2.2 – Contract 2003-05
Reassessments will occur at 180-day intervals (180-day Reviews) or more often at the request of the consumer, with updates and changes noted in the consumer's treatment and/or crisis plan, as needed.	WAC 388-865-0425

Consumer complaints/concerns regarding Assessment services will be documented and staffed with supervisor. Consumers will receive copies of Client Rights at time of Admission into services, when complaints are voiced and upon request. (WAC 388-865-0410)

OUTPATIENT LEVELS OF CARE

ALL AGES

Children and Youth Outpatient Services

Consumer complaints/concerns regarding services will be documented and staffed with supervisor. Consumers will receive copies of Client Rights at time of Admission into services, when complaints are voiced and upon request. (WAC 388-865-0410)

The NSMHA 7.01 Plan will be implemented as currently written. Other source documents will be referenced as they are updated and approved.

Level One

	State-wide Standard	Regional Service Requirement	Source Of Requirement
Goal and period of Authorization	Brief intervention Treatment/short term crisis resolution is necessary for the purpose of strengthening ties within the community, identifying and building on innate strengths of the family and/or other natural supports and preventing the need for long term treatment OR Long-term low intensity treatment for the purpose of allowing a person who has previously received treatment at a higher level of care to maintain their (level of) recovery. The period of authorization may be up to six months of care OR may be up to twelve months of care when an individual is receiving long-term, low intensity treatment.	All Federal and State Requirements. Safety/risk assessment Crisis planning as needed. Culturally competent, strength-based service plan and services, utilizing consumer voice and choice The authorization period for all consumers meeting clinical eligibility requirements for Level One services in this region will be up to 15 service hours over the course of one year. The equivalent group service hours would be up to 45. (3x 15).	

Children and Youth Outpatient Services

Level One (continued)

	State-wide Standard	Regional Service Requirement	Source Of Requirement
Functional Impairment	Must demonstrate moderate functional impairment in at least one life domain requiring assistance in order to meet the identified need AND impairment is evidenced by CGAS of 60 or below. **Domains include**: • Health and Self Care, including ability to access medical, dental and mental health care to include access to psychiatric medications; • Cultural factors; • Home and family life; • Safety and stability; • Work, school, daycare, pre-school or other daily activities; • Ability to use community resources to fulfill needs.	A CGAS score of 60 or below OR symptomatology consistent with DC-03 diagnostic criteria and PIR-GAS score of 50 or below. Health Screening Referrals (EPSDT) as required. Concurrent focus on enhancing natural supports. Assisted/facilitated referrals to other systems of care and community supports, as needed	
Supports and Environment	Natural support network is experiencing challenges, i.e., multiple stressors in the home; family or caregivers lack resources or have difficulty accessing entitlements (food, income, coupons, transportation) or available community resources; language and/or cultural factors may pose barriers to accessing services. May be involvement with one or more child serving systems requiring coordination.	Assisted referrals to other system of care, medical professionals and state and federal entitlements programs, as needed. Special population consultation(s) as required, by WAC 388-865-0405	
***EPSDT Plan**	Level One Services are defined as short-term mental health services for children/families with less severe need. An ISP should be developed and appropriate referrals made.	*Health screenings as required. Strength-based, individualized treatment plan	

Children and Youth Outpatient Services

Level One (continued)

	State-wide Standard	Regional Service Requirement	Source Of Requirement
Minimum Modality Set	Access to the following modalities is based on clinical assessment, medical necessity and individual need. Individuals may be referred for the following treatment: • Brief Intervention Treatment • Medication management • Psychoeducation • Group Treatment • Family Supports The full scope of available treatment modalities may be provided based on clinical assessment, medical necessity and individual need.	The full scope of available treatment modalities may be provided based on clinical assessment, medical necessity and individual need. Coordination of services with other formal/informal support systems as needed to obtain positive outcomes.	
Dual Diagnosis	Individuals who have both a covered and a non-covered diagnosis may be eligible for service based on the covered diagnosis.	Same as State Requirement	
Exclusionary Criteria	Substance abuse, alcoholism, mental retardation, pervasive dev. disorders, autism, learning dis., sexual disorders, impulse control disorders, v-codes and organic brain syndrome are not considered psychiatric illnesses under the WA State Medicaid Program and are not covered.	Same as State Requirement	

*EPSDT Plan: Since 1992, the mental health system has been required in the EPSDT State Plan to provide at least 10% of all EPSDT children statewide with an individual team. Cross-system professionals should staff the team with active participation by the child, parent or caregiver, family and natural support system. Please see the current Washington state EPSDT Updated Plan from 2002 for more information. The EPSDT Plan is included in the MHD/RSN contract as exhibit H.

Children and Youth Outpatient Services

Level Two

	State-wide Standard	Regional Service Requirement	Source Of Requirement
Goal and period of Authorization	Longer-term treatment is necessary to achieve or maintain stability OR requires high intensity treatment to prevent hospitalization, out of home placement and/or decrease the use of other costly services. The period of authorization may be up to six months of care OR may be up to twelve months of care as determined by medical necessity and treatment goal(s).	All current federal and state requirements. Safety/risk assessment. Crisis planning. Culturally competent, strength-based service plan and services, utilizing consumer voice and choice Special population consultation(s) as required, by WAC 388-865-0405 In this region, the authorization period for consumers meeting clinical eligibility requirements for Level Two will be <u>one year, with service hours based on medical necessity.</u>	
Functional Impairment	Must demonstrate severe and persistent functional impairment in at least one life domain requiring assistance in order to meet identified need AND Impairment is evidenced by a CGAS score of 50 of below. **Domains include**: • Health & self care, including the ability to access medical, dental and mental health care to include access to psychiatric medications; • Cultural factors; • Home and family life; safety and stability; • Work, school, daycare, pre-school and other daily activities; • Ability to use community resources to fulfill needs.	CGAS of 50 or below or symptomatology consistent with DC-03 diagnosis and PIR-GAS score of 40 or below. Facilitated referrals to other systems of care (e.g., DDD, CA/DCFS, DASA, Early Headstart, etc), community supports and/or entitlement programs, as needed. Concurrent enhancement of natural supports	

Children and Youth Outpatient Services

Level Two (continued)

	State-wide Standard	Regional Service Requirement	Source Of Requirement
Supports and Environment	Significant stressors are present in home environment, i.e., change in custodial adult; out of home placement; abuse or history of abuse; and situation exceeds the resources of natural support system. May be involvement with one or more children serving systems requiring coordination.	Coordination of services with other formal/informal support systems and participation on cross-system child/family teams, upon specific request, or as needed to obtain positive outcomes.	
***EPSDT Plan**	Level Two EPSDT services are defined as longer term, multi-agency services designed to meet the complex needs of an individual child and family. Level Two is authorized for children with multi-system needs or for children who are high utilizers of services from multiple agencies. EPSDT children authorized for this level will be referred to and may require an individual treatment team in accordance with the EPSDT plan.	Health Screening referrals (EPSDT) as required	
Minimum Modality Set	Access to the following modalities is based on clinical assessment, medical necessity and individual need. In addition to the modalities listed in Level One, individual may be referred to the following treatment: • Individual Treatment • Medication Monitoring The full scope of available treatment modalities may be provided based on clinical assessment medical necessity and individual need	The full scope of available treatment modalities may be provided based on clinical assessment medical necessity and individual need.	

Children and Youth Outpatient Services

Level Two (continued)

	State-wide Standard	Regional Service Requirement	Source Of Requirement
Dual Diagnosis	Individuals who have both a covered and a non-covered diagnosis may be eligible for service based on the covered diagnosis.	Same as State Requirement.	
Exclusionary Criteria	Substance abuse, alcoholism, mental retardation, pervasive dev. disorders, autism, learning dis., sexual disorders, impulse control disorders, v-codes and organic brain syndrome are not considered psychiatric illnesses under the WA State Medicaid Program and are not covered.	Same as State Requirement.	

*EPSDT plan: Since 1992, the mental health system has been required in the EPSDT State plan to provide at least 10% of all EPSDT children statewide with an individual team. Cross-system professionals should staff the team with active participation by the child, parent or caregiver, family and natural support system. Please see the current WA State EPSDT updated Plan from 2002 for more information. The EPSDT Plan is included in the MHD/RSN contract as Exhibit H.

Children and Youth Outpatient Services

Level Two Plus

	State-wide Standard	Regional Service Requirement	Source Of Requirement
Goal and period of Authorization	Same as Level Two	All Level Two requirements, plus: Long term treatment with cross-system teams is required to achieve or maintain individual and/or family stability Requires highest intensity treatment to prevent hospitalization, out of home placement and/or decrease the use of other costly services. Authorization period for Level Two Plus will be one year with services hours based on medical necessity.	
Functional Impairment	Same as Level Two	CGAS of 40 or below or symptomatology consistent with DC-03 diagnosis and PIR-GAS of 30 or below and any one of the criteria below: 1. High Risk Behavior in last 90 days – aggressive and/or dangerous, puts self or others at risk of harm, is at risk of grave disability, is at risk of psychiatric hospitalization or at risk of loss of current placement due to the symptoms of a mental illness 2. Two or more psych hospitalizations in last year or one inpatient stay of more than 90 days. 3. Involvement with two or more child-serving formal systems, (special ed, DCFS/CA, JRA, DDD, etc.) 4. MH supervisor requests highest level of outpatient care	
***EPSDT Plan**	Same as Level Two	As per Level Two	
Supports and Environment	Same as Level Two	Enhanced supports to least restrictive environment, to stabilize situation prior to move to more restrictive setting	

Children and Youth Outpatient Services

Level Two Plus (continued)

	State-wide Standard	Regional Service Requirement	Source Of Requirement
Minimum Modality Set	Same as Level Two	In addition to modalities (as needed) listed in Levels One and Two Consultation and planning with ICRS staff, if needed, including the use of crisis alerts as clinically indicated. Coordination of services with other formal/informal support systems and on-going participation on cross-system child/family teams that meet with frequency needed to obtain positive outcomes Treatment modalities, intensity, frequency and duration based on medical necessity and evidence-based practice The full scope of available treatment modalities may be provided based on clinical assessment medical necessity and individual need.	
Dual diagnosis	Same as Level Two	Facilitated referrals to community support services and documented invitations to other support systems (formal and informal) to participate on cross-system treatment teams	
Exclusionary Criteria	Same as Level Two	Same as State Requirement.	

Adult Outpatient Services

Consumer complaints/concerns regarding services will be documented and staffed with supervisor. Consumers will receive copies of Client Rights at time of Admission into services, when complaints/concerns are voiced and upon request. (WAC 388-865-0410)

The NSMHA 7.01 Plan will be implemented as currently written. Other source documents will be referenced as they are updated and approved.

Level One

	State-wide Standard	Regional Service Requirement	Source Of Requirement
Goal and period of Authorization	Brief Intervention treatment/short term crisis resolution is provided OR Long-term, low intensity treatment is provided allowing a person who has previously received treatment at a higher level of care to maintain their recovery. The period of authorization may be up to six months of care for Brief Intervention Treatment OR may be up to twelve months of care when an individual is receiving long, term low intensity treatment.	All current fed and state requirements. Safety and risk assessment. Crisis planning as needed. Culturally competent, strength-based service plan and services, utilizing consumer voice and choice. The authorization period for all consumers meeting clinical eligibility requirements for Level one services in this region will be up to 15 service hours over the course of one year. The equivalent group service hours would be up to 45 (15 x 3).	
Supports and Environment	May have limited social supports and impaired interpersonal functioning due to mental illness. Individual and natural supports may lack resources or have difficulty accessing entitlements (food, income, coupons, transportation) or available community resources; language and/or cultural factors may pose barriers to accessing services. May be involvement with one or more additional formal systems requirement coordination. Requires treatment to develop supports, address needs and remain in the community.	Special population consultation(s) as required, by WAC 388-865-0405 Concurrent focus on enhancing natural supports.	

Adult Outpatient Services

Level One (continued)

	State-wide Standard	Regional Service Requirement	Source Of Requirement
Functional impairment	Must demonstrate moderate functional impairment in at least one life domain requiring assistance in order to meet the identified need AND Impairment is evidenced by a GAF sore of 60 or below. **Domains include**: • Health & Self-Care, including the ability to access medical, dental and mental health care to include access to psychiatric medications • Cultural Factors • Home & Family Life, Safety and Stability • Work, school, daycare or other activities • Ability to use community resources to fulfill needs.	A GAF score of 60 or below. Facilitated referrals to medical professionals, other systems of care (e.g. alcohol and drug services) and state and fed entitlement programs, as needed. Strength-based planning and services that emphasize consumer voice/choice	
Minimum Modality Set	Access to the following modalities is based on clinical assessment, medical necessity and individual need. Individuals may be referred for the following treatment: • Brief intervention treatment • Medication Management • Psychoeducation • Group treatment The full scope of available treatment modalities may be provided based on clinical assessment, medical necessity or individual need.	Treatment modalities, intensity, frequency and duration based on medical necessity and evidence-based practice The full scope of available treatment modalities may be provided based on clinical assessment medical necessity and individual need.	

Adult Outpatient Services

Level One (continued)

	State-wide Standard	Regional Service Requirement	Source Of Requirement
Dual Diagnosis	Individuals who have both a covered and a non-covered diagnosis are eligible for service based on the covered diagnosis.	Assisted/facilitated referrals to community services and supports. Coordination of care with other systems, as needed.	
Exclusionary Criteria	Substance abuse, alcoholism, mental retardation, pervasive dev. disorders, autism, learning dis., sexual disorders, impulse control disorders, v-codes and organic brain syndrome are not considered psychiatric illnesses under the WA State Medicaid Program and are not covered.	Same as State Requirement.	

Adult Outpatient

Level Two

	State-wide Standard	Regional Service Requirement	Source Of Requirement
Goal and period of Authorization	Needs long-term treatment to achieve or maintain stability or requires high intensity treatment to minimize highly dangerous behavior, prevent return to grave disability and/or decrease the use of other costly services. The period of authorization may be up to six months of care or may be up to twelve months of care as determined by medical necessity and treatment goal(s).	Services will meet all current fed and state requirements Safety and risk assessments. Crisis planning. Individualized strength-based treatment planning that reflects individual's culture, voice, and choice. In our region, periods of authorization are for one year, with service hours based on medical necessity.	
Functional Impairment	Must demonstrate serious functional impairment in at least one life domain requiring assistance in order to meet the identified need and Impairment is evidenced by a GAF score of 50 or below. Domains – see Level One	A GAF score of 50 or below Assistance with basic needs, as needed.	

Adult Outpatient Services

Level Two (continued)

	State-wide Standard	Regional Service Requirement	Source Of Requirement
Supports and Environment	May have lack of or severely limited natural supports in the community due to mental illness. May be involved with one or more formal systems requiring coordination in order to achieve goals. Active outreach may be needed to ensure treatment involvement. Situation exceeds the resources of the natural support system.	Enhancement of natural supports Special population consultation(s) as required, by WAC 388-865-0405 Coordination of services with other formal/informal support systems and participation on cross-system teams, upon specific request, or as needed to obtain positive outcomes. Facilitated referrals to other systems of care and/or state and fed entitlement programs. Residential supports	
Minimum Modality Set	Access to the following modalities is based on clinical assessment, medical necessity and individual need. In addition to the modalities listed in Level of Care one, individual may be referred for the following treatment; • Individual Treatment • Medication Monitoring • Peer Support The full scope of available treatment modalities may be provided base don clinical assessment, medical necessity and individual need.	In addition to modalities available to consumer at Level One and the State-wide Level Two Standard: Coordination of and participation on cross-system teams Treatment intensity, frequency, duration and interventions based on medical necessity and evidence-based practices The full scope of available treatment modalities may be provided based on clinical assessment medical necessity and individual need.	
Dual Diagnosis	Individual who have both a covered and a non-covered diagnosis are eligible for service based on the covered diagnosis.	Facilitated referrals to community services and supports, as needed. Coordination of cross-system services as needed.	

Adult Outpatient Services

Level Two (continued)

	State-wide Standard	Regional Service Requirement	Source Of Requirement
Exclusionary Criteria	Substance abuse, alcoholism, mental retardation, pervasive dev. disorders, autism, learning dis., sexual disorders, impulse control disorders, v-codes and organic brain syndrome are not considered psychiatric illnesses under the WA State Medicaid Program and are not covered.	Same as State Requirement.	

Adult Outpatient

Level Two Plus

	State-wide Standard	Regional Service Requirement	Source Of Requirement
Goal and period of Authorization	See Level Two	Services meet or exceed all federal and state requirements. All Level One and Two service requirements. Period of authorization will be one year.	
Functional impairment	See Level Two	GAF of 40 or below and any one of the criteria listed below: High Risk Behavior in last 90 days – aggressive and/or dangerous, puts self or others at risk of harm, is at risk of grave disability, is at risk of psychiatric hospitalization or at risk of loss of current placement due to the symptoms of a mental illness. Two or more psych hospitalizations in last year or one inpatient stay of more than 90 days. Involvement with two or more formal systems, (DOC, DVR. DASA, etc. etc.) MH supervisor requests highest level of outpatient care.	
Supports and Environment	See Level Two	Enhanced supports as needed to maintain the consumer in the least restrictive environment or prior to moving to more restrictive setting Coordination of services with other formal/informal support systems and on-going participation on cross-system child/family teams that meet with frequency needed to obtain positive outcomes	

Adult Outpatient Services

Level Two Plus (continued)

	State-wide Standard	Regional Service Requirement	Source Of Requirement
Minimum Modality Set	Same as Level Two	Consultation and planning with ICRS staff, if needed, including the use of crisis alerts as clinically indicated. Treatment intensity, frequency, duration and interventions based on medical necessity and evidence-based practices The full scope of available treatment modalities may be provided based on clinical assessment medical necessity and individual need.	
Dual Diagnosis	Same as Level Two	Facilitated referrals to community services and supports.	
Exclusionary Criteria	Same as Level Two	Same as State Requirement	

Involuntary Outpatient Services (LRA)

Post-Inpatient Services

NSMHA consumers who leave a psychiatric inpatient setting on a Less Restrictive Alternative Court Order are entitled to the following services in additional to service requirements associated with their Level:

Requirements following involuntary, for consumers on LRA's	**Source of Requirement**
All State and Federal Requirements	Waiver, BBA, RCW, WAC's, etc. etc.
Development and implementation of an individual service plan which addresses the conditions of the less restrictive alternative court order and a plan for transition to voluntary treatment	WAC 388-865-0466 (c)
The consumer's crisis plan will be re-evaluated and revised	
Outreach efforts as needed to assure safety and continuity of care must be documented in the clinical record. If safety concerns arise, a documented plan will be developed with supervisory staff and other County authorities to assure continuity of care and safety for the consumer, staff and community.	WAC 388-865-0310
The consumer receives psychiatric treatment including medication management for the assessment and prescription of psychotropic medications appropriate to the needs of the consumer. Such services must be provided: (i) Monthly or as needed during the ninety-day and one-hundred eighty day periods of involuntary treatment unless the attending physician determines another schedule is more appropriate and they record the new schedule and the reasons for it in the consumer's clinical record.	WAC 388-865-0466 (d)
During the course of the LRA, agency staff is expected to coordinate with the CDMHPs regarding issues related to the consumer's ability to remain in the community and successfully complete the LRA.	
During the course of the LRA, agency staff is expected to incorporate the discharge recommendations from the inpatient facility, e.g. hospital or E&T that the consumer was in prior to the implementation of the LRA. Or document clinical status changes that have occurred since discharge that may warrant a change in treatment approach.	
During the course of the LRA, an "MHP" will review and update the consumer's treatment plan at least monthly. If a monthly update is not done, the clinical record must contain documentation explaining the absence of such.	
Consumers on court order to continue services (LRA/LRO) cannot be closed.	

Consumer complaints regarding voluntary/involuntary services will be documented and staffed with supervisor. Consumers will receive copies of Clients Rights at time of Admission into services, when complaints are voiced and upon request.

Post-Inpatient Services – Voluntary

For voluntary clients, see level of care service requirements appropriate to the client's age and current status. See also post hospitalization service requirements on page 50.

RESIDENTIAL, HOUSING AND SHELTER SUPPORT SERVICES

NSMHA Residential Access Standards:

An individual must meet all of the following before being referred for (non-emergent) adult residential placement:

- Is 18 or older
- Meets eligibility criteria for publicly-funded outpatient mental health services, at Level Two or Two Plus (and has completed or is scheduled for MH intake assessment)
- Requires 24-hour supervision to live successfully in community settings
- Is medically stable and free of physical condition(s) requiring medical or nursing care beyond what the residential facility can provide* (246-325-030) (388-78A-0100, 388-78A-0050)
- Is ambulatory
- Has cognitive and physical abilities to enable response to fire alarms
- Has not required physical restraint in the past 30 days.
- Meets WAC requirements for resident characteristics (246-325-030) (388-78A-0050) and (388-76)

* Please see facility-specific Policies and Procedures

Residential Outpatient Options

Option and Authorization Period	**Description**
Adult Residential Rehabilitation Center Six months or one year	This residential option provides 24-hour service to a range of highly disabled consumers, including those with multiple function and behavioral impairments, but who do not require, extensive medical care. These consumers typically have a history of not being able to live independently in community settings. Treatment and rehabilitation services are largely facility-based and stays are relatively short-term. (This is not a permanent residential option.)
Supervised Living One year	This residential service is for consumers who require 24-hour supervision. Length of stays may be either short or long-term with an emphasis placed on transitioning clients to more independent settings or maintaining them in their current settings. Based on consumer needs and abilities, treatment can be provided in-facility or in the community.
Adult Family Home with Mental Health Specialty One year	This residential option is designed for consumers who need 24-hour supervision for physical disabilities as well as MH issues in a home-like setting to maintain their residence in the community. For example, the consumer may have more success with the lower level of stimulation of an AFH as opposed to that in an ARRC or Boarding Home. This service is long-term as long as the consumer meets the criteria for the level of care.

Residential Exclusionary Criteria:

1. The consumer has a psychiatric condition that qualifies for a more intensive/restrictive residential option.
2. The consumer is actively suicidal or homicidal.
3. The consumer is chemically dependent on alcohol and/or drugs and is in need of detoxification.
4. The consumer has a primary diagnosis of DD/Mental Retardation or autism.
5. The consumer has a recent history of arson, serious property damage or infliction of bodily injury on self or others. (This exclusion can be waived based upon the accepting facility's evaluation of the consumer's functioning.)
6. For Supervised Living Only: The consumer does not meet acceptance criteria of the facility as stated in the facility's disclosure information. (WAC: 388-78A-0050)

Residential Admission Criteria:

Admission Criteria	**ARRC**	**Supervised Living**	**AFH – with mental health specialty**
Consumer received a multi-axial assessment by a mental health professional and is eligible to receive on-going mental health services from a community based mental health provider, at level 2 or 2-Plus.	yes	yes	yes
Residential Authorization Form has been completed and approved by NSMHA designee	yes	yes	yes
Case Manager has been assigned	yes	yes	yes*
Preliminary ITP/Negotiated Service Plan has been developed. A completed Negotiated Service Plan or ITP is signed/ approved by consumer within 30 days of admission. (WAC 388-865-0425)	yes	yes 388-78A-0130	yes
Cross-system (fee) agreements have been approved when necessary	n/a	n/a	as needed
Functionality is within the (NSMHA-approved) range of Mental Health Residential Placement Guidelines (see page 40 – 41): Behavior Problems Self-Care Social Functioning Reasons for exceptions are well documented	 2.0 – 5.5 2.0 – 3.5 2.0 – 3.5	 5.5 – 6.5 3.0 – 6.5 2.0 – 6.5	 4.0 – 7.0 1.0 – 7.0 1.0 – 6.5
Consumer meets WAC standards for admission per WAC 388-865-0235 and licensing WAC's:	WAC 246-325	388-78A	388-76-61020
Consumer receives/signs Client Rights, as per 388-865-0410	yes	yes	yes
Consumer receives/signs facility's disclosure information before admission to facility	n/a	388-78A-0690	388-76-60030

* There can be no discontinuation of mental health services in a co-funded placement. If placement is disrupted the case manager continues to provide services with an emphasis on meeting residential needs.

Care/Recovery Standards for Consumers in Residential Facilities:

A consumer receiving any level of NSMHA residential service is eligible and entitled to the full range of services described in the Outpatient Assessment and Outpatient Level of Care: Adults Level Two and Level Two Plus Sections of this document.

Treatment/recovery services and goals are established in the consumer's Negotiated Service Agreement or ITP.

Continuing Care Criteria:

The residential facility will continue to provide services as long as the consumer's condition continues to meet admission criteria at this residential level and no less intensive options would be adequate.

In the event that the consumer is discharged from the facility, continues to need services, and is no longer receiving residential services, the outpatient service responsibilities remain with the residential provider agency.

Discharge Criteria:

Any of the following criteria are sufficient for discharge from this residential level:

1. The consumer's documented treatment plan goals and objectives have been substantially met.
2. The consumer no longer meets admission criteria or meets criteria for less/more intensive residential or inpatient option.
3. Consent for treatment is withdrawn.
4. Support systems, which allow the consumer to be maintained in a less restrictive environment, have been secured.
5. The consumer is noncompliant in treatment not willing to sign or follow negotiated and/or renegotiated agreements in the Treatment/Service Plan (despite documented provider attempts to address such issues in other ways). WAC 388-78A-0140
6. Continuing to serve this consumer will put the facility in conflict with WAC standards for residential licensing.

Additional Residential and Housing Support Services

Service Requirements for any consumer in need of housing supports and/or assistance.

Requirements	**Source of Requirement**
All federal and state requirements regarding independent housing supports	CFR's, BBA, WAC's and CMS waiver,
Active promotion of consumer access to and choice in safe and affordable independent housing that is appropriate to the consumer's age, culture and residential needs	WAC 388-865-0235
Provision of services to families of eligible children and to eligible consumers who are homeless or at imminent risk of becoming homeless as defined in Public Law 100-77, through outreach, engagement and coordination or linkage to services with shelter and housing	WAC 388-865-0235
The availability of community support services, with an emphasis supporting consumers in their own homes or where they live in the community, with residences and residential supports prescribed in the consumer's treatment plan. This includes a full range of residential services as required in RCW 71.24 (7) and (14) and chapter 71.24.025 (14) RCW including Section 8 applications, assistance with rental subsidy applications, etc.	WAC 388-865-0235
The active search of comprehensive resources to meet the housing needs of consumers.	WAC 388-865-0235
Flex funding availability	WAC 388-865-0456

Adult Residential Level of Functioning

Behavior Management

Instructions: From the list below, find the "cluster" of behaviors that best describes the client's present behaviors. The score for that "cluster" is the client's score for Behavior. If the client appears to fall between two "clusters" assign an intermediate score. For example, if a client has behaviors that fall in both cluster score 3 and cluster score 4, assign a Behavior Score of 3.5.

Represents a potential danger to self, others or property Score= 1.0

- Committed recent (1 month) violent or life threatening act
- Actively makes suicide attempts/gestures or engages in self-mutilating behaviors or threatens suicide
- Inflicts extensive damage on property (e.g. breaking windows, destroying furniture)

Represents minimal danger to self, others or property, but presents severe behavior management problems Score= 2.0

- Frequently exhibits intense emotional outbursts or temper tantrums (yelling, screaming, etc.)
- May inflict minor damage on property (marring, denting, scratching)

Presents persistent and difficult behavior Management problems Score=3.0

- Frequently verbally abusive (threatens, uses profane/demeaning language toward others)
- Frequently socially disruptive (interrupts, harasses others, excessive laughing/crying, refuses to respect rights/property of others)
- Frequently makes sexually inappropriate advances/gestures (undressing/exposing self, excessive solicitations, inappropriate touch)

Periodically presents difficult behavior Management problems Score= 4.0

- Sometimes exhibits intense emotional outbursts or temper tantrums
- Sometimes verbally abusive or socially disruptive
- Sometimes makes sexually inappropriate advances or gestures
- Frequently refuses to complete assigned tasks or participate in treatment/activities

Presents persistent, but moderate behavior Management problems Score= 5.0

- Generally uncooperative and resistant
- Frequently refuses to follow facility rules about smoking, TV/radio, unauthorized leaves, etc.)
- Frequently refuses to complete assigned tasks or to participate in treatment or other scheduled activities

Presents persistent, but mild behavior Problems Score= 6.0

- Dresses bizarrely, inappropriately or peculiarly in public (draws negative attention to self)
- Engages in repetitive, stereotypical behavior (rocking, hand wringing, etc.)

Periodically presents behavior Management problems Score= 7.0

- Sometimes uncooperative or resistant
- Sometimes refuses to follow facility rules, or participate in treatment or other scheduled activities

Generally presents no behavior Management problems Score= 8.0

- Generally presents no behavior management problems
- Usually possesses emotional control
- Cooperative about facility rules
- Participates in treatment or facility activities
- Respects the rights and privacy of others
- Behaves appropriately toward others and in public

PROVIDER Adult Residential
Behavior Management Assessment

CLIENT BEHAVIOR SCORE _____

Mental Health Residential Placement Guidelines

Residential Placement	Treatment and Placement History		Client Behavior Problems		Self-Care and Practical Living Skills		Communication and Social Functioning
Inappropriate for Community Mental Health Residential Programs. Requires ongoing hospitalization	Meets one of the following: -Primary diagnosis of mental retardation, alcoholism, drug abuse or anti-social personality disorder -Severe organic etiology -Multiple physical problems -Physical or mental deterioration	OR	1.0 to 1.9	OR	1.0 to 1.9	OR	1.0 to 1.9
Intensive Care and Rehabilitation / Adult Residential Rehabilitation Center	Meets two of the following: -Unable to maintain self in community -Resistant to community mental health treatment efforts -Unable to reintegrate into community living	AND	2.0 to 5.5	OR	2.0 to 3.5	OR	2.0 to 3.5
Congregate Care Facility / Supervised Living	Must meet the following: -History of failure in independent living -Potential for reintegrating into community living -Cooperative with community mental health treatment efforts	AND	5.5 to 6.5	AND	3.0 to 6.5	AND	2.0 to 6.5
Adult Family Home	Must meet the following: -History of failure in independent living -AFH will enable consumer to stay in community -Consumer is enrolled in community mental health services	AND	4.0 to 7.0	AND	1.0 to 7.0	AND	1.0 to 6.5
Add-On to Assisted Living	Must meet the following: -Add-on to assisted living will enable consumer to stay in community -Consumer is enrolled in community mental health services	AND	6 to 8	AND	1 to 4	AND	1 to 8
Transitional Housing Vouchers	Must meet the following: -Voucher will enable consumer to stay in community -Consumer is enrolled in community mental health services -Housing crisis can be resolved in one to four weeks	AND	5 to 6.5	AND	3 to 6.5	AND	3 to 6.5

EMPLOYMENT and EDUCATION SUPPORT SERVICES

Employment Support Services

Eligibility:

Any consumer who is age sixteen or older and has any of the following characteristics:

1. Expressed interest in employment
2. Employment has been prioritized by either the clinician or the consumer.

Requirements	Source of Requirement
All Federal and State Requirements, as well as full contract requirements	CFR's and CMS/HCFA waiver RCW's and WAC's
Assist consumers to achieve the goals in their individualized service plan and provide access to employment opportunities and support/advocacy, if needed to existing employment sites.	388-865-0464(1)
A vocational assessment of work history, skills, training, education, and personal career goals	WAC 388-865-0464(1)(a)
Information about how employment will affect income and benefits the consumer is receiving because of their disability	WAC 388-865-0464(1)(b)
Active involvement with consumers in creating and revising individualized job and career development plan, emphasizing consumer's goals and strengths	WAC 388-865-0464(1)(c)
Assistance in locating employment opportunities that are consistent with the consumer's skills, goals, and interests	WAC 388-865-0464(1)(d)
Integrated supported employment, including outreach/job coaching and support in a normalized or integrated work site.	WAC 388-865-0464(1)(e)
Coordinate efforts with other rehabilitation and employment services such as DVR and state employment services	WAC 388-865-0464(3)
Employment supports including flexible funding availability for transportation, and job-related expenses	NSMHA WAC 388-865-0456

Consumer complaints/concerns regarding services will be documented and staffed with Supervisor. Consumers will receive copies of Client Rights at time of Admission into services, when complaints are voiced and upon request. (WAC 388-865-0410)

Education Support Services

Eligibility:

Any level consumer who expresses interest in furthering education obtaining GED and/or seeking post secondary degree(s) and education has been prioritized by either the consumer or the clinician.

Requirements	Source of Requirement
Individualized educational plan, based on consumer's goals, strengths and needs, history and interests	WAC 388-865-0456
Educational supports may include, but are not limited to: (a) information and referrals to specialized and general education programming, (b) Information regarding funding and scholarships, (c) Mentors and coaches, (d) transportation information and assistance	WAC 388-865-0456
Advocacy and consultation	WAC 388-865-0456
Assistance in locating and entering programs that encourage advocacy and support in natural educational settings	WAC 388-865-0456

Consumer complaints regarding services will be documented and staffed with supervisor. Consumers will receive copies of Client Rights at time of Admission into services, when complaints are voiced and upon request. (WAC 388-865-0410)

INPATIENT SERVICE COORDINATION BY OUT-PATIENT CLINICIANS

Information Related to Inpatient Services

Inpatient Eligibility:

Voluntary	Individuals who are Medicaid eligible and meet certification/medical necessity criteria regardless of age.
Involuntary	Any individual detained by within NSMHA by County-designated MHP under RCW 71.05 (poses significant danger to self, others, property or is gravely disabled).

Inpatient Admission and Certification Criteria:

1. Individual demonstrates symptomology consistent with DSM-IV (AXES I-V) diagnosis
2. Less restrictive, outpatient care resources available in the community have been attempted and do not meet the treatment needs of the individual.
3. Proper treatment of the consumer's psychiatric condition requires services on an inpatient basis under the direction of a physician.
4. Acute inpatient services can reasonably be expected to improve the client's level of functioning or prevent further regression of functioning

Inpatient Options:

Consumers of the NSMHA utilize inpatient services of our regional psychiatric Evaluation and Treatment Facilities (E&Ts), as well as various local and statewide psychiatric inpatient units, in addition to Western State Hospital for adults and the various Children's Long-term Inpatient program (CLIP) services for children. The NSMHA maintains memoranda of agreement with local psychiatric inpatient facilities.

NSMHA has delegated responsibility for authorization and certification of voluntary inpatient services for Medicaid eligible recipients and for certification of involuntary inpatient services to the Associated Provider Network.

NSMHA has contracted with the Associated Provider Network for two fifteen-bed adult Evaluation and Treatment facilities, one in Snohomish County and one in Skagit County.

Inpatient Continuing Care Criteria:

ALL requests for hospital extensions beyond the initial authorization period will be reviewed by the NSMHA contracted provider.

- The following criteria are necessary for continued treatment at this level of care:
    - Individual's condition continues to meet admission criteria for this level of care and no less intensive care would be adequate.

Inpatient Discharge Criteria:

1. Individual no longer meets medical necessity for acute inpatient level of care.
2. Individual is no longer a danger to self, others or property.

OUTPATIENT SERVICE REQUIREMENTS RELATED TO INPATIENT UTILIZATION

Pre-Hospitalization

All medically necessary services including, but not limited to:

Pre-Hospitalization Requirements for Voluntary Services	Source of Requirement
Assess for need for intensifying services.	
Primary Care Clinician/Team has seen consumer or crisis services staff within past twenty-four hours.	
For enrolled consumers: During business hours, primary care provider/team must be consulted prior to decision to admit for psychiatric hospitalization or document reasons for not doing this consult.	
Decision to use inpatient services has been reviewed and approved by MHP	
Alternative community-based options have been attempted and did not meet the needs of the consumer, or were ruled out and rationale documented.	
Support and assistance securing inpatient placement, as needed, i.e., there is a bed and hospital will accept this consumer at this time.	
Assistance arranging transportation, as needed.	
Certification (from NSMHA contracted provider) for inpatient utilization has been obtained (800-707-4656)	
Pre-Hospitalization Requirement for Involuntary Services (in addition to above requirements):	
Primary care clinician/team shall request evaluation by CDMHP for any consumer (13 and older) who has been evaluated as needing inpatient level of care to assure safety, but is refusing voluntary inpatient services.	

During Hospitalization

Service Requirements During Hospitalization	Source of Requirement
Contact must be established with hospital staff for purposes of consultation with three working days following admit.	
Information including the following (medical, medication history, service history, initial treatment plan and current treatment plan) must be faxed to hospital staff, as quickly as possible, if available, (i.e., consumer is "known" or enrolled)	
For enrolled consumers in hospital within the region who exceed a seven day length of stay: Primary care clinician/team will have at least one direct contact (conference call, face to face or phone contact) with the consumer and hospital staff prior to discharge.	
For enrolled consumers who have been hospitalized, there must be documented good faith prescriber-initiated request with inpatient staff/psychiatrist for consultation regarding medication changes. If the out-patient prescriber is unavailable, the consultation can be initiated by other clinical staff. The underlying rationale shall be documented.	
For eligible consumers who are not enrolled, there will be contact by NSMHA contracted provider staff within 3 working days	
For enrolled consumers, Level Two and Two Plus, primary care clinician/team will be responsible for notifying team members (including other formal systems) of hospitalization and will engage team in discharge planning process	In compliance with HIPAA and other confidentiality laws.
Discharge planning assistance including: 1. community-based follow-up appointment with community support clinician within seven days of discharge (in non-urgent situations), 2. community provider/clinician will advocate for adequate medication supplied to be dispensed in a manner that assures safety, 3. a follow-up psychiatric appointment is established within 7 business days of discharge, or as needed to assure continuity of medications and care, 4. the primary care clinician/team and consumer have reassessed the adequacy of the basic community supports for all life domains, 5. the crisis plan has been updated	

Post-Hospitalization (involuntary services)

Please see service requirements on page 33.

Post-Hospitalization (voluntary services)

Service Requirements following voluntary hospitalization	Source of Requirement
Assess for needed intensity of services.	
Risk Assessment (i.e., assessment of the consumer's risk for lethality and/or decompensation based on current functioning, current & historical risk factors and current availability of support/resources)	
Updated crisis planning, as needed	WAC 388-865-0430
Re-evaluation of pre-hospitalization level of care, with consideration of Two Plus services, if necessary	NSMHA
Updated and reviewed individual Service Plan, with changes as needed	WAC 388-865-0425
Follow-up appointments with clinical staff and psychiatrist within required timelines, ongoing appointments as needed	
Implementation of mechanisms that promote rapid and successful reintegration of consumers back into the community from long-term placements from state psychiatric hospitals and children's long-term inpatient psychiatric facilities	MHD 2003 – 05
Treatment intensity, frequency, modality and interventions that have the highest (research-based) likelihood of achieving positive outcomes	
See appropriate "level" for additional, specific information re: service requirements	

Consumer complaints regarding services will be documented and staffed with supervisor. Consumers will receive copies of Client Rights at time of Admission into services, when complaints are voiced and upon request. (WAC 388-865-0410)

ADDITIONAL SERVICE REQUIREMENTS

Safety

Safety of consumers, provider staff and the general public is of paramount importance and concern. When safety concerns arise, case-specific clinical supervision will be documented. Consultation with NSMHA's Integrated Crisis Response System and the most current Crisis Alert systems will be utilized. Crisis plans will be updated. CDMHP and/or local police evaluations and/or interventions will be documented.

Criteria for Continuing or Discontinuing Services

Criteria for Continuing Services

Services shall continue if any of the following criteria is met:

1. Consumer's condition continues to meet admission and clinical criteria
2. Ending episode of care at this time would not be in the consumer's best interests and consumer is requesting that services continue.
3. Continued service is court ordered
4. Consumer has history of chronic mental health needs and needs on-going mental health services (or psychiatric services) to maintain high-level functioning.
5. Other community-based services are not available.

Criteria for Closing an Episode of Care/Discontinuing Services

(When ending an episode of care is encouraged/allowed)

For purposes of this document, the preferred term for ending an episode of care is "closure" or for the consumer to move to "inactive status" rather than "discharge" which is used to describe the end of psychiatric inpatient stays.

NSMHA requires the titration of services with "step downs" to lower levels of care, if applicable, on-going planning for the end of the service episode and an **updated crisis plan** when requested by consumer or whenever clinically indicated prior to discontinuation of services.

1. The consumer no longer meets clinical admission criteria.
2. The consumer has substantially met treatment goals and has adequate support systems in place.
3. The consumer is not at risk, and has missed consecutive appointments and is not responding to clinician's attempts to re-engage in services.
4. The consumer is psychiatrically stable and is requesting discharge.
5. The consumer (13 years and older) or the parent/guardian is refusing further treatment. Treatment goals have not been achieved. A CPS/APS referral has been made or was not indicated.
6. After facilitated referral to DASA services, consumers who have been assessed as having low mental health needs and high chemical dependency needs (Please see Appendix A), can be discharged from community support services if their mental health treatment and progress is compromised by the abuse/addiction issues and they have not engaged in DASA treatment services. (See also "facilitated referral" in Glossary).
7. When a consumer is decompensating and not showing for appointments he/she cannot be discharged from services until outreach/re-engagement services have been provided, as per approved protocols.
8. When a consumer is at imminent risk of harm, he/she cannot be discharged from services until ongoing efforts to re-engage consumer in services and consultation with supervisory staff and Crisis Services have been provided, as per approved protocol.

Closure Exclusionary Criteria

(When ending an episode of care is not allowed)

1. Any consumer receiving mental health care in a State treatment facility (Western State Hospital or one of the CLIP facilities) will remain "open" during the treatment period, with on-going support and planning services from the primary clinician/team.
2. Consumer is on a court order to continue services (LRO).

Service Authorizations

Authorization of service levels shall be done according to a standardized, region-wide protocol developed by the PROVIDER and approved by the NSMHA. The service level shall be documented in the consumer's record with justification for the service level authorized. Levels will be assigned based on the criteria in this manual.

Facilitated Transfers

(Defined as individuals transferred to other contracted mental health providers within the NSMHA)

NSMHA service providers are responsible for facilitating all transferring individuals to other contracted mental health providers within the NSMHA.

1. The current consumer's primary care clinician shall be responsible for coordinating and confirming the transfer process between Region III agencies with the consumer's new primary care clinician following consumer request.
2. Time from initial consumer request (which must be documented in the consumer's clinical record by the clinician receiving the request) to the time of first offered appointment at receiving agency is not to exceed 30 days.
3. The transferring agency remains responsible for the consumer's care until the transfer is completed. Services should be continued at needed intensity and without interruption until transfer is completed. Transfers are "completed" when the consumer has his/her first face-to-face appointment with primary care clinician at the receiving agency.
4. Transferring agency shall enter transfer data into the NSMHA information system within seven (7) business days of confirmed transfer date.

Changes in Consumer's Level of Care

1. All changes in consumer's level of care, whether higher or lower, shall be based upon changes in the individual's functionality and need.
2. A change of status in consumer's level of care shall be noted on the consumer's updated Individual Service Plan.
3. A change in Level of Care shall be entered into the NSMHA Information System (IS) by the provider within ten (10) business days. Both the provider and the NSMHA shall use this information, to assess the provider's case mix and the accuracy of the provider's level of care assessments.
4. Changes of status are subject to concurrent review by QM/UM staff.

Crisis Services

For NSMHA providers who do not hold a crisis service contract, the primary care provider/team shall interface with the contracted crisis services provider to facilitate access to crisis respite services, community-based behavioral treatment aides, acute diversion services and emergency psychiatric, prescription and medical services.

Assistance with Complaints, Appeals, Grievances and Fair Hearings

Consumer complaints regarding services will be documented and staffed with Supervisor. Consumers will receive copies of Client Rights at time of admission into services, and/or at time complaints are voiced and upon request.

Providers shall make a good faith attempt to give 15 day notice of change in PCP and 30 days notice of changes in benefit package, residential, and/or housing capacity that result in decreased access to care. Notifications shall include criteria used in making the determination.

Consumers may initiate a complaint or grievance, appeal any denial, suspension, reduction, or termination of services, request disenrollment, or fair hearing. Consumers have the right to continue receiving services through this process.

Staff will assist consumers in initiating complaints, appeals, grievances, or fair hearings in accordance with the NSMHA grievance policy. Staff will also offer Ombuds services for further assistance.

Exception Policy

A provider who is receiving a NSMHA capitated payment shall not refuse to provide medically necessary level of care service to individuals referred by NSMHA and/or Provider Acute Care Team, regardless of their funding source. These cases are subject to concurrent review by NSMHA. If there is a disagreement, the provider may appeal to the NSMHA Medical Director. However, services shall be provided at the requested level during the appeal process.

Service Requirements Supporting Team Approaches

Providers of mental health services will work in coordination with other service providers, the consumer, the consumer's family and/or natural support system whenever possible. Team meetings will be held at times and locations that are most convenient for team members. Teams will meet at a frequency needed to keep team members involved and engaged in accomplishing the tasks developed by and for the team.

NSMHA PHILOSOPHICAL FOUNDATIONS and VALUES

Recovery Model

The NSMHA embraces the Recovery Model that has been well documented by many authors including Wilma Townsend of the Ohio Department of Mental Health. It is the expectation of the NSMHA that our providers will promote this vision of hope and recovery with our consumers. Recovery is not necessarily a cure, but rather is the process by which a person with mental illness can recover self-esteem, self-worth, dreams, pride, choice, dignity and life-meaning.

Team Approaches to Services that Enhance Recovery Processes for Most Consumers

As our system evolves, we are learning from research and from experience that team approaches to service provision are highly effective for most consumers. The NSMHA supports the development of child/family teams, cross-system teams, clinician teams, etc. for all consumers with moderate to high level needs.

Individualized and Tailored Care

The NSMHA endorses the principals and practices put forth in the individualized and Tailored Care (ITC) model of care. Individualized and tailored care is a proactive and holistic approach to providing mental health services that began as a children's model, but has since been successfully applied to adult consumers as well. ITC supports the belief that children/consumers who are seriously emotionally disturbed with other complex presenting needs, including organic and developmental disabilities, can live and have their needs met in their community, given appropriate resources and community interaction.

ITC focuses on the strengths of individuals and families, rather than focusing on deficits. Consumers and families tend to report that ITC feels supportive, whereas services in their past histories may have felt more blaming. ITC values the consumer's most natural support system and encourages the consumer to invite all support systems (natural and more formal) to join their "team" of people who work together to meet the consumer's needs in the least restrictive community setting. (Gosney, 1994)

Each child/consumer (individual) and family served by a system of care has unique and changing needs, related to age developmental stages, level of functioning or degree of impairment and special needs resulting from physical handicaps, racial or ethnic background or many other factors. Thus, the type, mix and intensity of services must be determined for each individual. Consumer and families should not be expected to conform to the service system, but that services should be designed and configured to fit the individual/family needs. (Stroul and Friedman, 86)

The process of providing individualized and tailored care for consumers with complex needs in their communities is workable within current resources and settings. The elements involved in this process are now well publicized and can be easily replicated. (Whitbeck, 1993)

Child/Family Teams or Individual Service Teams

The NSMHA supports the ITC (Individual, tailored care) service model – (Appendix D) particularly in rehabilitative work with children and families. In this model, the family and their support network, drives the planning for the child. Teams meet at a frequency that keeps positive outcomes and accomplishments at a good pace. Goals and tasks for all members of the team are small accomplishments are noted and celebrated. Teams

meetings are held at times and locations that accommodate parental work schedules and are convenient to the team members.

Cross-System Teams

Many of our consumers are (or should be) receiving services from other systems, (DASA, DCFS, DDD) in addition to their mental health services. Evidence shows that services are most effective when they are coordinated to include all informal and formal support systems. It is a NSMHA service requirement that provider clinicians will participate/facilitate on cross system teams, as needed. Cross-system teams frequently encompass the child/family team.