NORTH SOUND
MENTAL HEALTH ADMINISTRATION

QUALITY MANAGEMENT OVERSIGHT COMMITTEE

COMMITTEE MEETING PACKET

November 23, 2005

QMOC GUIDING PRINCIPLES

The QMOC charge is to guide the quality assurance and quality improvement activities of mental health services within the NSMHA region. In assessing the necessary data and making appropriate recommendations, the QMOC members agree to the following:

- **Help create an atmosphere that is SAFE.**
- **Maintain an atmosphere that is OPEN.**
- **Demonstrate RESPECT and speak with RESPECT toward each other at all times.**
- **Practice CANDOR and PATIENCE.**
- **Accept a minimum level of TRUST so we can build on that as we progress.**
- **Be SENSITIVE to each other's role and perspectives.**
- **Promote the TEAM approach toward quality assurance.**
- **Maintain an OPEN DECISION-MAKING PROCESS.**
- **Actively PARTICIPATE at meetings.**
- **Be ACCOUNTABLE for your words and actions.**
- **Keep all stakeholders INFORMED.**

Adopted: 10-27-99
Revised: 01-17-01

November 23rd, 2005
NORTH SOUND MENTAL HEALTH ADMINISTRATION
QUALITY MANAGEMENT OVERSIGHT COMMITTEE AGENDA

Date: November 23, 2005
Time: 12:30 PM-2:30 PM
Location: NSMHA Conference Room
For Information Contact Meeting Facilitator Wendy Klamp, NSMHA, 360-416-7013

Topic	Objective	ACTION NEEDED	Discussion Leader	Handout available pre-mtg	Handout available at mtg	Page	Time Allotted
Introductions	Welcome guests, presenters and new members						5 minutes
1. Review and Approval of Agenda	Ensure agenda is complete and accurate, determine if any adjustments to time estimates are needed. Meeting will start and end on time.	Approve agenda		Agenda		3	5 minutes
2. Review and Approval of Minutes of Previous Meeting	Ensure minutes are complete and accurate	Approve minutes		Minutes		4	5 minutes
3. Announcements	Inform QMOC of news, events and other important items		All				5 minutes
4. Utilization Management Dashboard	Standing Agenda Item for monthly review	Review trends, NSMHA priorities	TERRY MCDONOUGH		Dashboard		10 minutes
5. Quality Management Department Report	Standing Agenda Item for Monthly Review	Review accomplishments, data and plans of department	Wendy Klamp		QM Dept. Report		5 minutes
6. Quality Management Plan	Presentation of 2006 plan	Approve plan	TERRY MCDONOUGH	Plan		8	30 minutes
7. Complaint, Grievance, Appeal, Fair Hearing policies	Revision of policies is needed due to contract and RFQ	Approve policies	Diana Striplin	Policy drafts		59	15 minutes
8. Clinical Eligibility and Care Guidelines	Presentation of 2006 CECS	Approve CECS	Wendy Klamp	CECS Manual		87	30 minutes
9. Date and Agenda for Next Meeting	Ensure meeting date, time and agenda are planned.		ALL				5 minutes
10. Review of Meeting	Were objectives accomplished? How could this meeting be improved?		ALL				5 minutes

Next meeting December 28, 2005

North Sound Mental Health Administration
Quality Management Oversight Committee
NSMHA Conference Room
October 26, 2005
12:30 – 2:30
DRAFT MINUTES

Present:
Gary Williams, QMOC Chair, Board of Directors, Human Services Supervisor, Whatcom County
Wendy Klamp, NSMHA Quality Manager
Terry Clark, Compass Health
Russ Hardison, Sea Mar

June LaMarr, The Tulalip Tribes
Joan Dudley, Lake Whatcom Center
Terry McDonough, Snohomish County Mental Health ITA
Janet Lutz-Smith, Whatcom County Advisory Board
Dan Bilson, NSMHA Advisory Board
Linda Carlson, Volunteers of America
Chuck Davis, Skagit County Mediation Services
Joan Lubbe, NSMHA Advisory Board
Susan Ramaglia, NAMI Skagit

Excused:
Mary Good, NSMHA Advisory Board
Mike Manley, Snohomish County Human Services

Not Present:
Maile Acoba, Skagit County Coordinator

Nancy Jones, Snohomish County Human Services
Janelle Sgrignoli, Snohomish County Human Services

Others Present:
Debra Jaccard, NSMHA
Julie de Losada, NSMHA
Greg Long, NSMHA
Margaret Rojas, NSMHA

1. Open the Meeting & Comments from the Chair

The meeting was convened at 12:34 p.m.

The QMOC Roster was briefly reviewed - Heather Fennel has been replaced by Terry Clark as the Compass Health representative, Mike Manley has replaced Preston Hess as the representative for Snohomish County, and Linda Carlson has replaced Karen Kipling as the Volunteers of America representative..

2. Agenda

Wendy noted that a new style of agenda for QMOC is being trialed at this meeting and noted that feedback was welcome on the change. Linda asked who to contact when you are unable to attend this meeting, and Wendy stated to email and notify her (wendy_klamp@nsmha.org).

3. Approval of September 2005 Minutes

Gary made a motion to accept the minutes. Deborah noted that she and Chuck Davis should be listed as employees of Skagit County Mediation Services, not Skagit County Human Services. Joan asked that last names be used to specify between similar first names.

Dan Bilson asked for a list of phone numbers for the information available from other sources as stated in section E on page 2 of the previous minutes. Terry Clark noted that what was meant was that more information is available to the receiving clinician in transferring the client. The person who wanted a transfer would initially contact their clinician. If what the individual asked for is not happening, they can speak to the clinician's supervisor, and Ombuds can also help them at any time.

A motion was made to approve the minutes as amended, seconded, motion carried.

4. Announcements

Terry Clarke announced that Compass Health has scheduled a number of community forums to explain to people the changes that are coming their way. Terry Clarke will email the list of the forums to Shannon to forward to the rest of the committee.

5. Utilization Management Dashboard

Terry McDonough passed out the dashboard, which for the first time had an attached breakout by county. Gary thanked RSN staff for that breakout. Terry M. noted that the current census at WSH is 105. Linda gave VOA statistics to add to the dashboard on total calls for August (7185) total crisis line calls (4764) and total calls to the triage line (2426). For September, total calls (7548) total crisis line calls (5015) total calls to the triage line (2533). Terry M. noted that in October, at least 1100 people will disappear from the dashboard as they go into Molina Healthcare.

Gary informed the group that Pierce County had sued the state of Washington over admissions to the State hospital and asked if more was known about this. Greg noted that much was unclear at this point, and he will update when he knows more about it.

6. Quality Management Department Report

Wendy noted that the RSN's response to the EQRO is complete. Greg has completed the Strategic Plan and presented it to the Board of Directors. The Inpatient Certification transition to VOA has gone well, Compass Health has been very supportive throughout the change. Julie de Losada was hired as NSMHA's new Quality Specialist three weeks ago. Wendy noted that all at the RSN's are doing work to prepare for the RFQ. A state-sponsored disaster behavioral health training was held last month. Diana is currently working on a disaster plan. Greg noted that Washington State has received a FEMA project grant and Compass Health will be hiring 2 FTE's as a part of this. Terry noted that the employees would be based in Skagit County. Dan asked if the 22 individuals denied services under the UM review were informed, Terry M. answered that the consumers receive a two-page certified letter (notice of action) informing them of the denial, which also states that they can receive Ombuds help with doing an appeal. The client has 30 days to appeal after the notice of denial is issued, but the 30 days is going to be shortened to 15 days. Wendy noted that there was a change made in the denial process from last year, and North Sound is now responsible for issuing the denial to the consumer.

7. Training – MHD Request for Qualifications

Wendy informed the group that when legislature passed the 1290 bill, one part of it was for RSN's to go through a qualifying process (RFQ) to make sure that they meet qualifications (from BBA, WAC, etc). The RFQ has been received and is found to be much more requirements than ever before, extending beyond current contracts, and it gives a very short time frame to be written and sent back. If qualifications are met, we can remain an RSN, if they are not, the region will be opened up to bidders, including for-profit companies.

Our RSN has a good track record, some strengths being our Advisory Board, organization and leadership, Finance department, Compliance, Critical Incident policy and procedure, Disaster Response programs, Ombuds, and Tribal relationships. The RFQ has greatly increased administrative costs for RSN's by asking for things such as implementation of 14 Evidence-based practices, which are very expensive and require much planning and preparation to carry out. Other requirements are coordination plans with 8 systems, development of clubhouses, with hours of access for the clubhouses adding great costs. Customer service requirements are that we answer phones within 5 rings with a 3% abandonment rate, 90% of calls must be answered within 30 seconds. The RSN will have to buy a new phone system to accommodate this. The RFQ also required the RSN to begin doing billing with the hospitals, which will be very expensive. The RSN will have to hire more staff, with no more money to do it, so money will have to be taken away from care. Access needs to go somewhere else (to a non-CMHA) before the RFQ is sent to the MHD procurement department by Dec. 1.

Wendy noted that all RSN's presented questions to the State at a conference last week, but many were not answered, they hope to receive some answers in the mail. Mike Shelton spoke at legislature about these problematic issues. Wendy noted that Senator Hargrove, who initiated the 1290 bill, sent a letter to the legislature stating that MHD's RFQ has gone way outside what 1290 asked for. If any are interested, the MHD website has a tab for procurement with more information. NAMI needs to pay attention as these requirements will affect the funding now going to direct care.

8. Ombuds Report

Along with a slide presentation, Chuck passed out a percentage breakout of complaint data as well as the Ombuds analysis of the data and recommendations for change. Gary asked for a breakout by county. Consumer rights are the number one cause for complaints, and Access complaints were the second, often because people who call Access have just been turned away from DDD. Chuck noted concern with what is happening with children's issues, DDD will wash people out quickly if their IQ is too high and if its difficult to find help for these people. Julie stated that she would like to have a discussion with Chuck about her experiences with children in the region.

Chuck stated there needs to be one regional parent group such as Pierce County has. Wendy stated that the RFQ requires care coordination for children, and we could try to develop something in the parent arena. Gary noted in his experience putting in work with the Whatcom NAMI chapter, a small amount of funding goes very far. Gary asked if the five points in the Ombuds summary were recommendation for action items and Chuck affirmed that they were.

A motion to take the recommendations to QMC was made, seconded, and carried. Greg noted that the planning committee has just made certain recommendations that would affect this, and the motion was amended to take the recommendations to the Planning committee as well as QMC.

Deborah Moskowitz voiced concern that older adults are underserved, and made a motion to take this issue to QMC as well. Motion was seconded and carried.

9. Performance Improvement Project – Restraint and Seclusion at the Freestanding E&T's

Wendy explained that our contract mandates that the RSN must have four ongoing PIP's which are currently: consumer satisfaction and treatment planning, improving data quality, The mortality review, and decreasing utilization of restraint seclusion at the E&T's.

Wendy noted that the this committee needs to formally adopt the fourth PIP, which originated due to a death that occurred at one of the E&T's earlier in the year and intends to reduce injury and the possibility of death at the E&T's. A motion to accept this PIP for submission to EQRO was made, seconded, approved.

Terry Clarke discussed the E&T seclusion and restraint PIP at the last Compass Health quality meeting and noted that there were rave reviews about the it and Debra Jaccard's involvement. Internal complaints have reduced from E&T's and complaints from consumers about E&T's are very rare.

Wendy acknowledged the work of Susan Ramaglia and other providers when they had earlier made requests to the State WAC around seclusion and restraint which the state had denied.

Wendy noted that we will have to choose which two PIP's to keep, and which two to drop at a later date

10. QM Plan workgroup Update

Terry M. noted that the next meeting will be on Oct. 31st from 9:00 a.m.-12:00 p.m. He asked that as many that could attend the meeting could come. Recommendations from QMOC will be examined. Terry M. stated that he hopes to bring the 06/07 QM Plan to the next QMOC meeting.

11. Complaint, Grievance, Appeal, Fair Hearing Policies

Wendy noted that these policies are not easy to read but this is the required format. Wendy asked that committee members read over them. Diana will be back next month with updates to these policies.

Debra stated that she would like to approve, if possible, the critical incident policy. Debra noted that the latest changes to the policy have been highlighted. A motion to accept the revised critical incident policy was made, seconded, carried.

12. Trauma Workgroup

Terry M. passed out the attachments to the trauma workgroup recommendations. He will be developing a training module for the next training committee meeting. The trauma tool was developed to be used by outpatient/inpatient (E&T) staff when they sense that trauma is an issue with an individual. WCPC has used the tool in a pilot study and it was found to be very helpful. Wendy noted that in the attachment, number 7 from the

Treatment Guidelines should be stricken. The committee requested that WCPC be invited to present their findings on the tool; to the committee. who is actually implementing it. June noted that Native people have a side issue of multi-generational trauma that needs to be addressed. Terry Clarke agreed, and noted she has also seen this with families outside of Native culture. Gary noted that other cultures such as that of Pacific Islanders, deal with trauma in very different way.

A motion to approve the trauma committee recommendations to go forward to the Board of Directors (with the changes of striking item #7 in the trauma guidelines and adding the two points on multi-generational trauma) was made, seconded, carried.

13. Review of Meeting

Wendy noted that there are many things that need to be approved for the RFQ, so attendance at forthcoming QMOC meetings is imperative.

The committee requested that the QMOC packet have page numbers, be three-hole punched, and have the agenda items numbered. Wendy asked who would like a packet mailed to them, Dan and Joan asked to receive the packet in the mail, everyone else will review the packet online.

Gary brought up the question from last meeting on whether calls coming from out of state should be given to the 1-800 Access and Crisis lines. Terry Clarke will check for the Access Line, Linda Carlson will check for the Crisis Line and answer at the next meeting.

14. Adjourn

Chair adjourned the meeting at 2:36 pm. The next QMOC meeting is scheduled for November 23rd , 2005, 12:30-2:30 pm.

Respectfully submitted,

Shannon Solar

Please Note:
The attachments referenced herein are part of the official record and attached to the file copy. Please contact the NSMHA at 1-800-684-3555 if you have any questions, comments, or concerns.

NORTH SOUND MENTAL HEALTH ADMINISTRATION

2006-2007 QUALITY MANAGEMENT PLAN

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Section 1

PROGRAM DESCRIPTION

Purpose

As the public mental health authority for five Counties in Washington State (Island, San Juan, Skagit, Snohomish, and Whatcom), it is the purpose of the North Sound Mental Health Administration (NSMHA) to ensure the provision of quality and integrated mental health services for the five counties (San Juan, Skagit, Snohomish, Island, and Whatcom) served by the NSMHA Prepaid Health Plan (PIHP). Services are provided to Medicaid and non-Medicaid recipients, in accordance with the State of Washington Mental Health Contracts, using monies available through Federal and State funding sources.

A. NSMHA Mission Statement

We join together to enhance our community's mental health and support recovery for people with mental illness served in the North Sound region, through high quality culturally competent services.

The NSMHA is committed to:

1. Ensuring that the mental health system of the five counties is "consumer-driven."
2. Ensuring that consumers receive services that meet their individual needs appropriately.
3. The development and management of an Integrated Delivery System.
4. Ensuring that services are accessible and locally available 24 hours a day, 7 days per week.
5. Ensuring that services are culturally sensitive, appropriate and built on recipient strengths.
6. Treating people with mental illness with respect and dignity.
7. Providing services that are community based and designed to assist the individual maintain an optimal level of functioning.

Principles for Quality Management in the North Sound System

Quality Management's overall goal is the best possible service delivery system within our financial resources. Our system will;

- Maintain quality management capabilities on a Regional basis through a single, integrated model at the NSMHA
- Hold administrative costs to a minimum in order to maximize resources available for direct consumer services
- Demonstrate the NSMHA Mission, Values and Principles, which include consumer voice, choice and ownership, as well as recovery and resilience.
- Be responsive to consumers and advocates through a system that listens to their needs and offers appropriate services and support.
- Meet state and federal requirements, to include requirements mandated by the State of Washington Mental Health Division (MHD), Centers for Medicare/Medicaid Services (CMS), the Balanced Budget Act (BBA) and the State of Washington's External Quality Review Organization (EQRO)
- Implement a shared vision of quality services and a system that is effective, coherent, transparent and easy to navigate for all stakeholders
- Engage line staff and their perspectives regarding service delivery
- Assure consistency and focus over time in our service delivery models
- Acknowledge successful delivery models
- Achieve the right balance between resources devoted to service delivery and quality management activities to assure minimal impact on delivery of services, and
- Create a culture of measurement, with data driven decisions

The region-wide Quality Management system will measure, report, and make recommendations on the efficiency of NSMHA and the provider organizations quality management activities. Development of these measures is part of the Quality Management Work Plan. Quality management activities for NSMHA and provider staff will be conducted so as to include the following principles:

- Create a collaborative approach and a "no blame" environment that minimizes overlap
- Acknowledge where we cannot be collaborative due to our roles
- Work at understanding one another's perspectives
- Honor one another's intrinsic roles and responsibilities
- Acknowledge the dynamic tensions in the system and seek ways to manage these
- Develop mechanisms for accountability at all levels of the system
- Celebrate successes as well as focusing on areas for improvement
- Involve consumers and advocates in the process
- Involve line staff and their perspectives regarding the quality management process
- Keep things simple and doable, don't add complexity to what we must do to meet state and federal requirements
- Maintain a sustained focus over time that balances service delivery with quality management
- Prioritize tasks and when adding something, look at what can be taken away
- Track information reliably, with data that has integrity
- Make decisions based on data

The NSMHA Coordinated Quality Improvement Program

The NSMHA Quality Management Plan has been developed in conformance with 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 system review components that identify the NSMHA and roles and responsibilities concerning quality assurance/improvement issues. To assist in this process, the NSMHA has been certified as a Coordinated Quality Improvement Program (CQIP), in accordance with State of Washington Department of Health. CQIP is a voluntary program, which provides protection of information and documents created specifically for, and collected and maintained by an approved program as stated in RCW 43.70.510. The protected information and documents may not be subpoenaed or used in court proceedings as discovery evidence.

NSMHA has implemented CQIP status in order to facilitate and protect information exchange between NSMHA and providers. CQIP status for the NSMHA allows for information to be divulged and reviewed in a "no blame" culture, which promotes a frank, open exchange between NSMHA and providers that engenders prompt, professionally responsible interventions designed to assure delivery of services that meet quality and appropriateness of care issues addressed in the NSMHA Quality Management Plan.

The coordination of quality improvement activities by NSMHA is implemented through monthly meetings of the NSMHA Internal Quality Management Committee. All documents reviewed by this Committee contain a statement in the "footer" indicating that they are being reviewed under the protected CQIP status of NSMHA and may not be used for purposes of disclosure or subpoena to any outside entity.

The CQIP Committee is a vital, integral part of the ongoing quality management process of NSMHA. It is supported by several NSMHA committees, including the Critical Incident Review Committee and the Utilization Review Sub-Committee. Information gathered by NSMHA Administrative Audits and NSMHA Ombuds and Quality Review Team activities is also reviewed. Information from these multiple sources is compiled in the CQIP External Monitors Matrix, which tracks scheduled quality management activities, department wide, for the two-year Quality Management Plan duration. The Matrix details the results of quality management activities, including required follow up findings, recommendations or corrective action requests. It provides a timeline for completion of required follow up action and identifies NSMHA and provider staff responsible for such action. The CQIP External Monitors Matrix provides NSMHA quality management staff with a centralized database, by which to track all NSMHA quality management activities on an ongoing basis, with accountability and consistency. The CQIP External Monitors Matrix allows NSMHA quality management staff to track the status of all requested follow-up activities related to quality management issues in a single document and to document the effectiveness of the measures implemented. It affords quality management staff the ability to "close the loop" on identified quality management issues.

NSMHA internal quality management standards are based upon the "Design, Measure, Analyze and Improve" model. This model incorporates the ongoing, multi-departmental review of quality issues that the NSMHA Internal Quality Management Committee (IQMC) demonstrates. The IQMP continually reviews and revisits issues cogent to quality management throughout the region as well

as investigating quality issues at the level of individual providers. CQIP decisions and actions are based on standards and principles mandated by the Balanced Budget Act (BBA) and the External Quality Review Organization (EQRO) that contracts with the State of Washington Mental Health Division (MHD). The NSMHA quality management system is data driven, works collaboratively with providers and consumers, incorporates evidence based practices in reviews performed and uses review instruments that have scientific validity.

Scope of Services

The NSMHA Quality Management Plan addresses outpatient and crisis mental health services for both children and adults who are enrolled with contracted NSMHA providers only. Outpatient mental health services include Brief Intervention Treatment, Crisis Services, Day Support, Family Treatment, Inpatient Evaluation and Treatment, Group Treatment Services, High Intensity Treatment, Individual Treatment Services, Intake Evaluation, Inpatient Certification for Voluntary Hospitalization, Medication Management, Medication Monitoring, Mental Health Services Provided in residential Settings, Peer Support, Psychological Assessment, Rehabilitation Case Management, Special Population Evaluation, Stabilization Services, Therapeutic Psychoeducation, Supported Employment, Respite Care, Mental Health Clubhouse Services and Advocacy provided by the Ombuds staff and/or others, as needed. Services are provided to eligible Medicaid-covered enrollees, and, as funds allow, to non-Medicaid enrollees. Any person in the North Sound five-county area, regardless of funding source, is eligible for crisis services.

MHD/NSMHA Contractual Expectations Regarding Quality Management

The contractor (NSMHA) must;

1. Participate with MHD in the implementation, updates and evaluation of the Quality Strategy, located on the MHD website
2. Maintain a system that uses data collected, results of monitoring, and verification of services to review its ongoing quality management program. Ensure continued assessment and improvements to the quality of public mental health services in its services area and determine the effectiveness of overall regional system of care.
3. Assess the degree to which mental health services and planning is driven by and incorporates enrollee and family voice
4. Assess the degree to which mental health services are age, culturally and linguistically competent
5. Assess the degree to which mental health services are provided in the least restrictive environment
6. Assess the degree to which uninterrupted linkages occur from the time services are authorized that move the enrollee toward recovery and resiliency
7. Assess the continuity in service linkages and integration with other formal/informal systems and settings
8. Assess the strengths and barriers of resource management mechanism, assess standards, and the utilization management activities
9. Ensure relevant grievance, fair hearing, reported critical incidents, and appeal results are incorporated into system improvement

10. Ensure the interpretation of quality improvement feedback is conveyed to Community Mental Health Agencies, the advisory board and other interested parties
11. Provide all available information necessary to respond to inquiries from MHD within the time frames specified in the written request by the MHD Director, an Office Chief or their designee
12. Participate with MHD in the development and implementation of a standard set of performance indicators to measure access, quality and appropriateness. Participation must include;
    a. Provision of all necessary data
    b. The analysis of results and development of system improvements based on the analysis on a local and statewide basis, and
    c. Incorporation of the results into quality improvement activities
13. Participate with MHD in completing annual Mental Health Statistics Improvement Project (MHSIP) surveys. The schedule will rotate annually between adults and youth/families. Participation must include at a minimum:
    a. Provision of enrollee information to MHD
    b. Involvement in the analysis of results and development of system improvements based on that analysis on a statewide basis; and
    c. Incorporation of results into PIHP specific quality improvement activities
14. Monitor and increase the number of enrollees receiving outcome assessments who complete an intake assessment. The Contractors goal for completed or attempted outcome surveys is 85%. This includes completed and attempted outcome assessments as recorded by the TeleSage outcome system database
15. Continue two statewide Performance Improvement Projects (PIPs) and the addition of two new PIP during the Agreement period. The Contractor must maintain four PIPs at all times. These projects must include two clinical projects and two non-clinical projects, which shall:
    a. Sustain demonstrated improvements in the Performance Improvement Project measures. Where improvement is indicated, the PIHP will plan and initiate activities to improve Performance Improvement Project measures
16. Participate with MHD in review activities. Efforts will be made to combine review activities whenever possible to reduce duplicative site visits. Participation will include at a minimum:
    a. The submission of deliverables and other materials necessary prior to the site visit
    b. Completion of site visit protocols; and
    c. Assistance in scheduling interviews and agency visits

NSMHA/Providers Contractual Expectations Regarding Quality Management

NSMHA contracts with the following service providers;

- The Associated Provider Network (*bridgeways*, Catholic Community Services, Compass Health, Lake Whatcom Residential and Treatment Center, and Whatcom Counseling and Psychiatric Clinic)
- Sea Mar Behavioral Health
- Snohomish County
- The Tulalip Tribes, and
- The Volunteers of America

The NSMHA contract with each of these providers contains a core, constant set of expectations regarding quality management activities that include requiring providers comply with the NSMHA Quality Management Plan. NSMHA Quality Management staff monitor each providers quality

management activities during Administrative, Fiscal and Quality Assurance/Improvement Audits. Other NSMHA quality management review activities of providers include case reviews, clinical record review and Utilization Management reviews, as appropriate. All subcontracts awarded by NSMHA are also reviewed by NSMHA staff to verify compliance with NSMHA quality management expectations.

NSMHA contract requirements regarding quality management specify that the providers participate with the Mental Health Division (MHD) in the implementation of the MHD Quality Strategy. Requirements of the quality management participation are;

- APN shall ensure Quality Assurance and Quality Improvement data is analyzed, reported and acted upon by its members and affiliates. This shall be demonstrated by written records maintained by APN.
- Sea Mar shall participate with the NSMHA in the implementation, updates and evaluation of the MHD Quality Strategy located on the MHD website that is hereby incorporated by reference.
- VOA shall participate with the NSMHA in the implementation, updates and evaluation of the MHD Quality Strategy located on the MHD website that is hereby incorporated by reference.
- SNOHOMISH COUNTY's County Coordinator shall assist NSMHA in conducting quality management programs and activities, in accordance with Attachment V. Activities include regularly participating in NSMHA's Quality Management Oversight Committee and other quality management processes as appropriate.

Accountability regarding the NSMHA Quality Management Plan

The NSMHA is the managed care entity accountable to the State of Washington Mental Health Division (MHD) for oversight of the mental health services delivered by its contracted providers to eligible Medicaid enrollees and, as funds allow, to non-Medicaid recipients as well. NSMHA has an obligation to insure that the care and services delivered by service providers meet the standards of the NSMHA provider contracts, NSMHA Clinical Eligibility and Care Standards Manual, the State of Washington Center for Medicaid Services (CMS) Waiver, relevant State of Washington Administrative Codes (WACs), and the Revised Codes of Washington (RCWs). When NSMHA quality review activities indicate the need for a corrective action from providers to address quality management activities, the corrective action plans are reported to the regional Quality Management Oversight Committee and to the NSMHA Board of Directors.

Specific MHD Quality Management Plan expectations of the NSMHA are;
"The regional support network must implement a process for continuous quality improvement in the delivery of culturally competent mental health services. The regional support network must submit a quality management plan as part of the written biennial plan to the mental health division for approval. All changes to the quality management plan must be submitted to the mental health division for approval prior to implementation. The quality management plan must include:

- Roles, structures, functions and interrelationships of all the elements of the quality management process, including but not limited to the regional support governing board, clinical and management staff, advisory board, Ombuds service and quality review teams
- Procedures that ensure that the quality management activities are effectively and efficiently carried out with clear management and clinical accountability, including methods to:
    - Collect, analyze and display information regarding:
        - The capacity to manage resources and services, including financial and cost information and compliance with statutes, regulations and agreements
        - System performance indicators
        - Quality and intensity of services
        - Incorporation of feedback from consumers, allied service systems, community providers, Ombuds and quality review team
        - Clinical care and service utilization including consumer outcome measures; and
        - Recommendations and strategies for system and clinical care improvements, including information from exit interviews of consumers and practitioners
- Monitor management information system data integrity
- Monitor complaints, grievances and adverse incidents for adults and children
- Monitor contract with contractors and to notify the MHD of observations and information indicating that providers may not be in compliance with licensing or certification requirements
- Immediately investigate and report allegations of fraud and abuse of the contractor or subcontractor to the MHD
- Monitor delegated administrative activities
- Identify necessary improvements
- Interpret and communicate practice guidelines to practitioners
- Implement change
- Evaluate and report results
- Demonstrate use of all corrective actions to improve the system
- Consider system improvements based on recommendations from all on site monitoring, evaluation and accreditation/certification reviews
- Review, update and make plan available to community stakeholders
- Targeted improvement activities, including
    - Performance measures that are objective, measurable and based on current knowledge/best practice including at least those defined by the mental health division in the agreement with the regional support networks
    - An analysis of consumer care covering a representative sample of at least ten percent of consumers or five hundred consumers, whichever is smaller
    - Efficient use of human resources, and
    - Efficient business practices

Advocacy

The NSMHA values the input and perspectives of individual consumers, advocates and stakeholders, as well as from consumer and family member organizations such as the National

Alliance on Mental Illness (NAMI).The NSMHA Office of Consumer Affairs supports and solicits input from these groups. The NSMHA believes that the voice of consumer, family and advocates is an essential component of the quality management process, providing vital input regarding important aspects of care from those most directly affected by such care. The NSMHA feels that the Quality Management plans of all contracted providers should emphasize and incorporate consumer, family members and advocates into their ongoing quality assurance and quality improvement processes.

Remedial Action, Recommendations and Sanctions

NSMHA is responsible to the MHD for any remedial action required of NSMHA by the MHD. Contracted NSMHA providers are responsible to NSMHA for any remedial action required by NSMHA. Any remedial action required of providers by NSMHA is reported to the regional Quality Management Oversight Committee and to the NSMHA Board of Directors.

NSMHA may require the APN and CMHAs to plan and execute corrective action. Corrective action plans developed by the APN and CMHAs must be submitted for approval to the NSMHA within 30 calendar days of notification. Corrective action plans must be provided in a format acceptable to NSMHA. The NSMHA may extend or reduce the time allowed for corrective action depending upon the nature of the situation as determined by the NSMHA.

The full information detailing provider responsibilities and requirements regarding remedial actions may be found in each provider's contract with NSMHA, in the Section F, "Oversight, Remedies and Termination" portion of the contract.

Delegation/Delegated Functions

Delegation is defined as a formal process by which the NSMHA gives another entity the authority to perform certain functions on its behalf, such as credentialing, inpatient authorization, outpatient authorization and quality management. Although the NSMHA can delegate the authority to perform a function, it cannot delegate the responsibility for assuring that the function is performed appropriately. The NSMHA shall assure that delegated functions are performed appropriately through the monitoring of all such functions. Any function delegated to a provider requires the submission of a formal plan by NSMHA to MHD detailing how the delegated function will be monitored.

Structure of the NSMHA Quality Management Program

The NSMHA Quality Management (QM) Program is an open, inclusive process through which NSMHA collects and analyses information received from multiple sources throughout the region. The function of the NSMHA QM Program is to implement the quality management strategies identified in the current NSMHA Quality Management Plan. Input from providers, consumers, advocates and NSMHA staff is integrated into the NSMHA quality management process on a regular, ongoing basis. Reports and recommendations from committees involved in quality management activities, including provider and NSMHA staff, consumers and advocates are presented to the NSMHA Board of Directors, the NSMHA Advisory Board and the NSMHA Quality Management Oversight Committee monthly. Briefly, the roles of these groups are as follows;

- The NSMHA Board of Directors is the governing body of NSMHA. It is comprised of elected officials (or their delegates) from Island, San Juan, Skagit, Snohomish and Whatcom counties, Tribal representatives and the Chair and Vice Chair of the NSMHA Advisory Board. The Board meets monthly throughout the year. In regard to the NSMHA QM Program, the Board is responsible for the adoption and oversight of NSMHA's annual Quality Management Plan and for acting upon all quality management recommendations forwarded by NSMHA's Quality Management Oversight Committee (QMOC).

- The NSMHA Advisory Board is comprised of consumers, advocates and other interested parties from throughout the Region. It meets monthly to review issues of concern and relevance to mental health consumers and their families/support sources. The purpose of the NSMHA Advisory Board is to provide independent advice and input to the NSMHA Board of Directors as well as to local jurisdictions and service providers. Reports from the NSMHA Advisory Board are a standing item at the monthly NSMHA Board of Directors meetings.

- The NSMHA Quality Management Oversight Committee (QMOC) is a standing committee of the NSMHA Board of Directors. It is responsible for the oversight of quality management systems throughout the region and for reviewing all quality management activities conducted throughout the region. QMOC is comprised of NSMHA and provider staff, consumers, a Tribal representative, advocates and elected officials or their representatives. A member of the NSMHA Board of Directors serves as the Chair of QMOC and reports monthly to the Board of Directors regarding regional quality management activities, results and/or recommendations.

As noted above, the NSMHA Advisory Board and QMOC each report monthly to the NSMHA Board of Directors regarding quality management results and/or recommendations. The Board of Directors, acting in its role as the governing body of NSMHA, reviews the quality management recommendations and decides to either accept the recommendations from the Advisory Board and/or QMOC, or to return the matter to either the Advisory Board or QMOC for further study. If the Board does decide to accept the quality management recommendation proposed, the current NSMHA QM Plan is changed accordingly, with such changes presented to the Board for their final approval. If the Board decides to return the quality management recommendation to either the Advisory Board or QMOC for further study, the Chair of the Advisory Board or QMOC returns the matter to their respective group for further analysis and review. When this review/analysis is complete, the matter is again presented to the Board of Directors, with recommendations included.

Flow of information through the NSMHA Quality Management Program

The NSMHA QM Program is designed to constantly review, measure and assess the effectiveness of regional quality management activities throughout the region. It does this through input received from committees comprised of NSMHA and provider staff, consumers and advocates. All NSMHA committees, whether public, internal to NSMHA or composed of NSMHA and provider staff, have written Charters, describing the purpose, membership, primary objectives and expected outcomes of the committee. The committees investigate various aspects of care related to the provision of quality services region wide and prepares reports, including recommendations, regarding their activities and results.

As represented in the diagram describing the NSMHA QM Program, the multiple NSMHA committees that investigate quality management issues are all connected to the overall implementation of the NSMHA QM Plan. Some of these committees are the;

- Information Systems Committee
- Integrated Crisis Response Committee
- Medical Directors Committee
- Planning Committee
- Quality Management Committee
- Regional Management Council
- Training Committee, and
- Utilization Management Committee

These committees, as well as other ad hoc groups, review regional quality management activities on an ongoing basis and report their results and information on a regular basis to QMOC. Coordination of multiple quality management activities and committees is facilitated by the Regional Quality Management Committee, which is made up of clinical and quality management staff from NSMHA and providers. The Regional Quality Management Committee (QMC) assimilates and analyzes quality management information from multiple indicators and determines what overall trends and patterns are evident throughout the region. Based upon information received from its multiple sources, the QMC suggests areas for further study and review, as well as brings forward recommendations about quality activities currently in place that are producing positive results. The QMC reviews both strengths and weaknesses of regional quality management activities and brings consensus recommendations regarding quality management to the QMOC on a regular basis. QMOC then decides, by Committee vote, whether to bring the quality management recommendation to the Board of Directors or to return the issue to the QMC for further study.

As well as the committees listed above, two internal NSMHA committees, the Integrated Quality Management Committee and the Critical Incident Review Committee, review regional quality management information on a monthly basis. These two committees operate under the aegis of the NSMHA Coordinated Quality Improvement Program described on page 4 of this document. As such, both are able to review provider information and reports related to consumer health and safety concerns without the risk of the provider's information being subject to disclosure or court ordered subpoenas. The Integrated Quality Management Committee contains members from the entire NSMHA QM department and integrates agency data from multiple NSMHA report sources to identify any noted trends or issues in quality management. Through this ongoing review process, both the Integrated Quality Review Committee and the Critical Incident Review Committee are able to make timely, data-driven decisions and to bring these decisions forward as recommendations to the regional Quality Management Committee. The QMC in turn brings the recommendations forward to the Quality Management Oversight Committee (QMOC) who approve them as is, amend and approve them or return them for further review. When QMOC brings the quality management recommendations to the Board of Directors, the Board, like QMOC, can approve them as is, approve with amendments or return to QMOC for further study. All recommendations accepted by the Board that result in

revisions to the NSMHA QM Plan are implemented into the QM Plan by NSMHA staff. Once the QM Plan is amended to include the quality management recommendation, the final version of the amended QM Plan is brought back to the Board for their final approval.

Information regarding all quality management activities is recorded in minutes, by all committees. Reports and other information generated by committees is published on the NSMHA website, for ease of access by all interested parties. The NSMHA QM Program is responsive to ongoing quality management regionally due to its comprehensiveness, interconnections and flexibility. All contributors to regional quality management activities are given a voice in the NSMHA QM Program.

SECTION 2

Standards for Record Reviews

All review instruments developed will be based on specific sources, such as the WAC's, the contract between NSMHA/MHD, the contract between NSMHA/providers, the NSMHA Clinical Eligibility and Care Standards, the RCW's, etc. All review instruments will contain specific references to the sources that have been cited in the tool development.

All review instruments will be developed in collaboration with providers. Drafts will be shown to providers and their input will be solicited. Review instruments will be pre-tested with providers prior to their implementation at provider agencies. No review results will be reported based on instruments that have not been tested for both reliability and validity by NSMHA staff.

NSMHA Quality Specialists use the following types of review documents;

- Initial Review Instrument
- Concurrent Review Instrument
- Retrospective Review Instrument
- Crisis System Services Review Instrument
- Evaluation and Treatment Facility Review Instrument, and;
- The Outpatient Record Review Instrument from MHD

Section 3 WORK PLAN

QUALITY ASSURANCE

Goal #1: To ensure services provided throughout the Region are effective and appropriate (NSMHA Administrative Audits)

Objective #1: Provider agencies meet defined contract expectations regarding NSMHA Administrative, Fiscal and Quality Assurance/Improvement Audits

Staff responsible: NSMHA Quality Management Department

Timeline: All providers are audited once annually

Activities/Task	Output	Measure/Data Sources	Benchmarks
NSMHA Administrative, Fiscal, Quality Assurance/Improvement Audits	Reports upon completion of Audits to regional Quality Management Committee and Quality Management Oversight Committee Review of Audit data by NSMHA Internal Quality Management Committee. Recommendations to the regional Quality Management Committee, as appropriate	NSMHA Administrative, Fiscal and Quality Assurance/Improvement Onsite Monitoring document	Any Audit Findings require a Corrective Action Plan from providers.

QUALITY ASSURANCE

Goal #1: To ensure services provided throughout the Region are effective and appropriate (NSMHA Outpatient Clinical Record Reviews)

Objective #2: Provider agencies meet defined contract expectations regarding NSMHA Administrative, Fiscal and Quality Assurance/Improvement Audits

Staff responsible: NSMHA Quality Management Department

Timeline: All providers have a percentage of their clinical records reviewed annually

Activities/Task	Output	Measure/Data Sources	Benchmarks
NSMHA Outpatient Clinical Record reviews	Reports upon completion of Clinical Record Reviews to regional Quality Management Committee and Quality Management Oversight Committee Review of Clinical Record Review data by NSMHA Internal Quality Management Committee. Recommendations to the regional Quality Management Committee, as appropriate	MHD Outpatient Record Review document	90% scoring standard for the MHD Record Review document

QUALITY ASSURANCE

Goal #1: To ensure services provided throughout the Region are effective and appropriate (Crisis system record reviews)

Objective #3: Crisis services provided to consumers are in accordance with expectations defined in the NSMHA/MHD contract and all relevant WAC's

Staff responsible: NSMHA Quality Management Department

Timeline: A representative sample of all providers' crisis services clinical records are audited once annually

Activities/Task	Output	Measure/Data Sources	Benchmarks
Annual review of clinical records from providers	Reports upon completion to the NSMHA Internal Quality Management Committee and the regional Quality Management Committee Reports every six months to the regional Quality Management Oversight Committee Inclusion of data in the NSMHA six month Integrated Report.	NSMHA Crisis Service Documentation Review tool	To be determined

QUALITY ASSURANCE

Goal #1: To ensure services provided throughout the Region are effective and appropriate (Residential Services Review)

Objective #4: Residential services provided to consumers are in accordance with expectations defined in the NSMHA/MHD contract and all relevant WAC's

Staff responsible: NSMHA Quality Management Department

Timeline: Residential services are reviewed annually

Activities/Task	Output	Measure/Data Sources	Benchmarks
Clinical record review of residential services received by consumers	Reports upon completion to the NSMHA Internal Quality Management Committee and the regional Quality Management Committee Reports every six months to the regional Quality Management Oversight Committee Inclusion of data in the NSMHA six month Integrated Report.	MHD Outpatient Record Review document	90% scoring standard for the MHD Record Review document

QUALITY ASSURANCE

Goal #1: To ensure services provided throughout the Region are effective and appropriate (Evaluation and Treatment Facilities Review)

Objective #5: Services provided to consumers in both regional Evaluation and Treatment Facilities are in accordance with expectations defined in the NSMHA/MHD contract and all relevant WAC's

Staff responsible: NSMHA Quality Management Department

Timeline: Each E&T facility will be reviewed annually

Activities/Task	Output	Measure/Data Sources	Benchmarks
Review of both regional E&T's service provision records by; • A review of clinical records using the MHD Record Review document, and • A review of compliance with clinical contract elements	One-time report to the NSMHA Internal Quality Management Committee, Regional Quality Management Committee. One-time report to the regional Quality Management Oversight Committee Inclusion of information and/or recommendations in the NSMHA six month Integrated Report.	MHD Record Review document NSMHA/MHD contract	90% scoring standard on the MHD Record Review document

QUALITY ASSURANCE

Goal #2: To ensure that consumers are satisfied with the services they receive
(Customer service standards)

Objective #1 NSMHA meets all customer service standards in its own and its delegated functions; to include;

- NSMHA Customer Service
- Access Call Center
- Voluntary Inpatient Certification Program

Staff responsible: NSMHA Quality Management Department

Timeline: Reports presented monthly

Activities/Task	Output	Measure/Data Sources	Benchmarks
NSMHA will monitor their own customer services operations and all Access Call Center and Inpatient Certification operations for adherence to customer service standards	Monthly reports of Access Call Center and Inpt Cert data to the NSMHA Integrated Quality Management Committee and the regional Quality Management Committee. Monthly report and review of the data presented to the regional Quality Management Oversight Committee	Access Call Center data Voluntary Inpatient Cert data	• All calls answered within 5 rings • No more than 3% of calls end by caller hanging up • 90% of calls are answered within 30 seconds NSMHA/Volunteers of America contract

QUALITY ASSURANCE

Goal #2: To ensure that consumers are satisfied with the services they receive (Complaint and Grievance data levels)

Objective #2: Trends in complaint and grievance data are monitored and responded to

Staff responsible: NSMHA Quality Management Department

Timeline: Reports presented every six months

Activities/Task	Output	Measure/Data Sources	Benchmarks
Gather, analyze and summarize consumer complaint and grievance data Review WIMIRT survey data and summarize conclusions from that data Gather select consumer satisfaction data from site visits to providers	MHD Exhibit N document, summarizing complaint and grievance data regionally Presented upon completion to NSMHA Internal QM Committee, regional QM Committee Data reported to regional Quality Management Oversight Committee every six months and included in the NSMHA six month Integrated Report	Ombuds/QRT staff NSMHA provider staff WIMIRT survey	To be determined

QUALITY ASSURANCE

Goal #2: To ensure that consumers are satisfied with the services they receive
(Consumer Satisfaction Surveys)

Objective #3: Consumers will report satisfaction with the treatment they receive from regional providers

Staff responsible: NSMHA Quality Management Department

Timeline: Data included in NSMHA Integrated Report

Activities/Task	Output	Measure/Data Sources	Benchmarks
NSMHA Quality Review Team Consumer satisfaction survey	Information from the data sources will be included in the NSMHA Integrated Quality Management Report.	QRT Consumer Satisfaction surveys	To be determined
Review applicable relevant Telesage survey data every six months		Telesage data	
Review WIMIRT data when available	This report will be presented to the regional QM Committee and to the regional QM Oversight Committee	WIMIRT data	

QUALITY ASSURANCE

Goal #2: To ensure that consumers are satisfied with the services they receive
(Consumers complaints settled at lowest level possible)

Objective #4: A responsive consumer complaint and grievance system exists at all levels so that consumer complaints are able to be solved at the lowest possible level

Staff responsible: NSMHA Quality Management Department

Timeline: Results reported every six months

Activities/Task	Output	Measure/Data Sources	Benchmarks
Maintain ongoing data base regarding complaints and/or grievances regionally Ombuds/QRT outreach services to consumers	MHD Exhibit N document, summarizing complaint and grievance data regionally Presented upon completion to NSMHA Internal QM Committee, regional QM Committee Data reported to regional Quality Management Oversight Committee every six months and included in the NSMHA six month Integrated Report	NSMHA Consumer Complaint and Grievance Policy Ombuds/QRT reports every six months NSMHA provider staff WIMIRT survey	100% reporting and tracking of complaints and/or grievances received

QUALITY ASSURANCE

Goal #3: To ensure that stakeholders and providers are satisfied with the services they receive from NSMHA (Stakeholder/Provider satisfaction with NSMHA services)

Objective #1: Stakeholders and provider agencies report satisfaction with the services they receive from NSMHA

Staff responsible: NSMHA Quality Management Department

Timeline: Results included in NSMHA Integrated Report

Activities/Task	Output	Measure/Data Sources	Benchmarks
Conduct annual provider survey Sponsor annual provider forum to collect input re: RSN	QRT report annually	Provider surveys by QRT staff	To be determined

QUALITY ASSURANCE

Goal #3: To ensure that stakeholders and providers are satisfied with services they receive from NSMHA (Stakeholder/Provider satisfaction with NSMHA services))

Objective #2: Cross-system linkages report satisfaction with the services they receive from NSMHA

Staff responsible: NSMHA Quality Management Department

Timeline: Results included in NSMHA Integrated Report at a minimum annually

Activities/Task	Output	Measure/Data Sources	Benchmarks
Annual survey of cross-system partners to include hospitals, jails, DSHS staff, drug/alcohol system, etc.	QRT report annually	Cross-system satisfaction survey	To be determined

QUALITY ASSURANCE

Goal #4: To ensure that all state services are available to consumers who need them (Availability of Services)

Objective #1: Services defined in the NSMHA/MHD contract are available regionally for consumers who need them

Staff responsible: NSMHA Quality Management Department

Timeline: Results reported every six months

Activities/Task	Output	Measure/Data Sources	Benchmarks
NSMHA Administrative Audits NSMHA review of all provider Out-of-Network services Review of complaint and grievance data re: availability issues Review of regional Residential Service and High Intensity Service authorization requests	Data reviewed monthly by NSMHA Internal QM Committee Reported to regional QM Committee and regional Quality Management Oversight Committee every six months Data included in six month NSMHA Integrated Report	NSMHA Administrative Audit document NSMHA/MHD contract NSMHA report on all provider out-of-network services Residential Services Review document NSMHA Utilization Reviews	Per contract and P&P requirements

QUALITY ASSURANCE

Goal #5: To ensure services are provided in a safe manner
(Safety)

Objective #1: Trends in risk management and consumer safety are responded to

Staff responsible: NSMHA Quality Management Department

Timeline: Results reported every six months

Activities/Task	Output	Measure/Data Sources	Benchmarks
NSMHA Critical Incident Review Committee NSMHA Critical Incident reporting system NSMHA Critical Incident Review Committee Coordinator reports all reportable critical incidents to MHD	Data reported to MHD per Critical Incident Data reviewed monthly at NSMHA Internal QM Committee Reported to regional QM Committee and r\Regional Quality Management Oversight Committee at a minimum every six months Data included in six month NSMHA Integrated Report	NSMHA Critical Incident reports	Reports from providers are received per contract requirements and NSMHA Critical Incident Policy and Procedure standards

QUALITY ASSURANCE

Goal #6: Quality services are provided by well trained staff (Training)

Objective #1: Identified staff training needs are addressed

Staff responsible: NSMHA Quality Management Department

Timeline: Training activities are ongoing throughout the year

Activities/Task	Output	Measure/Data Sources	Benchmarks
Ensure compliance with NSMHA Regional Training Plan All provider staff are trained in compliance with the NSMHA Regional Training Plan Bi-monthly NSMHA Training Committee meetings	Staff records indicate they have received all appropriate, necessary training as per NSMHA Administrative, Fiscal and Quality Assurance/Improvement Audits	NSMHA Training Plan	90%

QUALITY IMPROVEMENT

Goal #1: To ensure consumers are satisfied with their participation in treatment planning process **(Consumer satisfaction with treatment planning participation)**

(Performance Improvement Project #1, begun on 01-01-2004, measured thru 01-01-2005)

Objective #1: Increase or maintain the level of consumer satisfaction with their participation in their treatment planning process

Staff responsible: NSMHA Quality Management Department

Timeline: Results reported every six months

Activities/Task	Output	Measure/Data Sources	Benchmarks
MHD Record Review document, analysis of specific document questions assessing consumer satisfaction	Report comparing current level of consumer satisfaction with previous levels.	MHD Record Review tool	90% scoring standard on MHD Record Review tool
WIMIRT survey		WIMIRT survey	To be determined

QUALITY IMPROVEMENT

Goal #2: To provide quality data regarding regional service provision to MHD
(Quality data provision to MHD)

(Performance Improvement Project #2, begun on 01-01-2004, measured thru 12-31-2005)

Objective #1: Improve the quality of NSMHA data submitted to the Mental Health Division (MHD)

Staff responsible: NSMHA Quality Management Department

Timeline: Quarterly review of data quality submission trends/patterns

Activities/Task	Output	Measure/Data Sources	Benchmarks
NSMHA will monitor the timeliness of data reporting by the provider agencies by implementing the following procedure; On weekly basis, NSMHA will generate a report that calculates these statistics; • Service Month/Year • # of records received • # of consumers identified • Total minutes of service reported • # of records submitted after 45 days # of records submitted after 60 days	Each week the data report generated is distributed to the provider agencies by NSMHA. NSMHA will download and monitor the timely submission of data to MHD via the reports that are available on the MHD Intranet	Data reports received from provider agencies	90% of data is submitted without errors

QUALITY IMPROVEMENT

Goal #3: To ensure services are effective and appropriate
(Mortality Review)

(Performance Improvement Project #3, begun on 01-01-2005, measured thru 12-31-2006)

Objective #1: Trends in consumer mortality are identified and addressed

Staff responsible: NSMHA Quality Management Department

Timeline: Reported upon completion of Review

Activities/Task	Output	Measure/Data Sources	Benchmarks
Review cluster unexpected deaths of consumers under age 50 where homicide/suicide was not the cause of death. Explore access to primary care and coordination between medical and mental health care for consumers who died unexpectedly.	Mortality Review Study Report presented to NSMHA Internal QM Committee, regional QM Committee and regional QM Oversight Committee upon completion. Data from Mortality Review included in appropriate NSMHA six month Integrated Report.	NSMHA Critical Incident database, review of information in the National Institute of Health's grant program researching Health Behavior Change in People with Mental Health Disorders (2004)	To be determined

QUALITY IMPROVEMENT

Goal #4: To ensure services are effective and appropriate
(Seclusion and Restraint Reduction Review)

(Performance Improvement Project #4, begun on 01-01-2005, measured thru 12-31-2006)

Objective #1: Reduce the use of seclusion and physical restraints at both regional Evaluation and Treatment Facilities (E&T's)

Staff responsible: NSMHA Quality Management Department

Timeline: Reported upon completion of Review

Activities/Task	Output	Measure/Data Sources	Benchmarks
Review current standards regarding the use of restraints and seclusion at both regional Evaluation and Treatment Facilities (E&T's) Development of a collaborative improvement project involving NSMHA and E&T staff Review of all relevant WAC's Review of current P&P's re: seclusion and restraint at the E&T's Review of E&T Admission Criteria and Medical Clearance requirements Review of physical assessments done by nursing staff at admission	Ongoing review of E&T medical records Final Report upon completion of the project	Restraint and seclusion reports from both regional E&T's Critical Incident reports regarding injury or deaths from both regional E&T's Regional review of both E&T's Exhibit N re: consumer complaints and grievances	Decrease the overall use of seclusion and physical restraints at both E&T's by 10%

UTILIZATION MANAGEMENT

Goal #1: To ensure consumers receive care in the least restrictive environment (Care in the least restrictive environment)

Objective #1: Consumers receive medically necessary level of care services

Staff responsible: NSMHA Quality Management Department

Timeline: Reports reviewed monthly

Activities/Task	Output	Measure/Data Sources	Benchmarks
Review of all voluntary Inpatient Authorizations	Monthly reports by NSMHA QM staff	IS reports re: Inpatient Authorizations	90% scoring standard
Review of regional data re: length of stay for Inpatient Authorizations	Review of data/trends by NSMHA Utilization Management Committee	IS reports re: Inpatient Authorizations and length of stay	90% scoring standard
Review of hospital diversion strategies and resources	Report by NSMHA QM Staff	Initial, Concurrent Retrospective Utilization Reviews	
Focused Utilization review of repeat Inpatient admissions	Reports by NSMHA QM Dept	CLIP/CHAP reports	90% scoring standard
CLIP/CHAP Resource Management reviews	Reports by NSMHA QM Dept	Monthly Inpatient Certification Reports	Per contract requirements

UTILIZATION MANAGEMENT

Goal #1: To ensure consumers receive care in the least restrictive environment (Reduction in inpatient bed days))

Objective #2: Decrease inpatient usage by 10% of current bed day totals)

Staff responsible: NSMHA Quality Management Department

Timeline: Reports produced quarterly

Activities/Task	Output	Measure/Data Sources	Benchmarks
Oversight/review of voluntary inpatient authorization data to determine that consumers authorized for voluntary inpatient care meet NSMHA standards for medical necessity and eligibility	Monthly reports of inpatient data, reports to UM Sub, quarterly reports to regional QM Committee and regional QM Oversight Committee	VOA Inpatient Authorization reports	Decrease utilization by 10% of current bed days total
Monitor the number of hospitalized consumers receiving outpatient full time care within 7 days of hospital discharge	Monthly reports of inpatient data, reports to UM Sub, quarterly reports to regional QM Committee and regional QM Oversight Committee	NSMHA IS reports	90% of consumers receive outpatient full time services within 7 days of hospital discharge

UTILIZATION MANAGEMENT

Goal #1: To ensure consumers receive care in the least restrictive environment
(Reduction in regional inpatient utilization overall)

Objective #3: Decrease the utilization of inpatient level of care throughout the region

Staff responsible: NSMHA Quality Management Department

Timeline: Reports produced monthly

Activities/Task	Output	Measure/Data Sources	Benchmarks
Provide ongoing NSMHA Care Management to high risk consumers, people frequently re-hospitalized and those who remain inpatient for long stays	Monthly reports of inpatient data, reports to UM Sub, quarterly reports to regional QM Committee and regional QM Oversight Committee	NSMHA IS data	NSMHA/MHD contract, relevant WAC's and RCW's
Monitor inpatient hospitalization patterns through ongoing utilization reviews	Reports upon completion to UM Sub, NSMHA Internal QM Committee, quarterly reports to regional QM Committee and regional QM Oversight Committee	NSMHA UR documents re: Initial, Concurrent and/or Retrospective reviews	90% scoring standard on UR documents

UTILIZATION MANAGEMENT

Goal #1: To ensure services provided throughout the region are effective and appropriate
(Outpatient services provided according to contract expectations)

Objective #1: Outpatient services provided to consumers are in accordance with expectations defined in the NSMHA/MHD contract and all relevant WAC's

Staff responsible: NSMHA Quality Management Department

Timeline: Reports produced monthly

Activities/Task	Output	Measure/Data Sources	Benchmarks
Monthly scheduled routine Utilization reviews of selected clinical records	Ongoing feedback to the NSMHA Internal Quality Management Committee Quarterly reports to regional Quality Management Committee and regional Quality Management Oversight Committee Inclusion of information and/or recommendations in the NSMHA six month Integrated Report	NSMHA Utilization Management Review tools for Initial, Concurrent and Retrospective Reviews, relevant WAC's and/or RCW's	90% scoring standard

UTILIZATION MANAGEMENT

Goal #1: To ensure services provided throughout the region are effective and appropriate (Consistent application of eligibility standards by all age groups and service levels)

Objective #2: Consistent application of eligibility standards across the region, by all age groups and all levels of care, to include outpatient, residential, and High Intensity Treatment services

Staff responsible: NSMHA Quality Management Department

Timeline: Reports produced monthly

Activities/Task	Output	Measure/Data Sources	Benchmarks
Review service authorizations and denials for compliance with established eligibility criteria	Monthly reports regarding service authorization and denials to Um Sub Committee and regional QM Committee	NSMHA UR document re: Initial Services	90% scoring standard
Review clinical records for compliance with ongoing eligibility criteria defined in the MHD Access to Care Standards and the NSMHA Clinical Eligibility and Care Standards, or its successor	Reports to regional QM Oversight Committee every six months Data included in NSMHA six month Integrated Report	NSMHA UR document re: Concurrent and Retrospective Monthly Authorization/Denial Report	90% scoring standard

UTILIZATION MANAGEMENT

Goal #1: To ensure services provided throughout the region are effective and appropriate (NSMHA delegated functions)

Objective #3: Consistent application of NSMHA standards in functions delegated by NSMHA

Staff responsible: NSMHA Quality Management Department

Timeline: Information reviewed monthly and included in NSMHA Annual Report

Activities/Task	Output	Measure/Data Sources	Benchmarks
Monitoring and oversight of the following functions delegated to provider; • Access Call Center • Inpatient Authorization	Ongoing reviews of delegated functions with monthly reports to UM Sub Committee Quarterly reports to regional QM and QM Oversight Committees Inclusion of data in NSMHA six month Integrated report	Monthly and Annual Audits Data Reports	Per contract expectations with providers

UTILIZATION MANAGEMENT

Goal #1: To ensure services provided throughout the region are effective and appropriate (Regional Medicaid penetration rate)

Objective #4: The regional Medicaid Penetration Rate is maintained at 10% or above

Staff responsible: NSMHA Quality Management Department

Timeline: Information reviewed monthly

Activities/Task	Output	Measure/Data Sources	Benchmarks
Ensure data collection to determine current level	Monthly reports to UM Sub Committee, quarterly reports to regional QM and QM Oversight Committees	NSMHA IS data reports	Comparison to state-wide averages to determine if NSMHA meets or exceeds the minimum requirements
Review NSMHA IS data reports	Inclusion of data in NSMHA six month Integrated Report		

UTILIZATION MANAGEMENT

Goal #1: To ensure services provided throughout the region are effective and appropriate (Time from intake to first non-crisis appt. does not exceed 14 days)

Objective #5: Time from intake to first non-crisis appointment does not exceed 14 days

Staff responsible: NSMHA Quality Management Department

Timeline: Information reviewed monthly

Activities/Task	Output	Measure/Data Sources	Benchmarks
Ensure data collection to determine current interval from intake to first non-crisis appointment	Monthly reports to UM Sub Committee, quarterly reports to regional QM and QM Oversight Committees	NSMHA IS data reports	Contract expectations with providers
Review NSMHA IS data reports	Inclusion of data in NSMHA six month Integrated Report		
Ongoing UR's by NSMHA QM staff		NSMHA Initial, Concurrent and Retrospective UR documents	90% scoring standard

UTILIZATION MANAGEMENT

Goal #1: To ensure services provided throughout the region are effective and appropriate (Western State Hospital (WSH) bed utilization)

Objective #6: NSMHA utilization of WSH beds remains at or below the current capacity allotment

Staff responsible: NSMHA Quality Management Department

Timeline: Information reviewed monthly

Activities/Task	Output	Measure/Data Sources	Benchmarks
Review WSH daily/monthly census reports	Monthly reports to UM Sub Committee, quarterly reports to regional QM and QM Oversight Committees Inclusion of data in NSMHA six month Integrated Report	NSMHA WSH daily/monthly census reports	NSMHA bed allocation number for WSH

UTILIZATION MANAGEMENT

Goal #1: To ensure services provided throughout the region are effective and appropriate (Connection to outpatient services after hospital discharge)

Objective #7: Outpatient services are provided within 7 days of hospital discharge

Staff responsible: NSMHA Quality Management Department

Timeline: Information reviewed monthly

Activities/Task	Output	Measure/Data Sources	Benchmarks
Review NSMHA IS data reports re: connection to outpatient services following hospital discharge	Monthly reports to UM Sub Committee, quarterly reports to regional QM and QM Oversight Committees	NSMHA IS data reports	Contract expectations with providers
Ongoing UR's by NSMHA QM staff	Inclusion of data in NSMHA six month Integrated Report	NSMHA Initial, Concurrent and Retrospective UR documents	90% scoring standard

UTILIZATION MANAGEMENT

Goal #1: To ensure services provided throughout the region are effective and appropriate (Increase services to Older Adults regionally)

Objective #8: Increase the penetration rate of services to Older Adults regionally from the 2004 Performance Indicator Report (2003 data) level

Staff responsible: NSMHA Quality Management Department

Timeline: Information reported every six months

Activities/Task	Output	Measure/Data Sources	Benchmarks
Review regional data, compare regional numbers to the statewide averages Analyze regional data for trends	Review of available data monthly, reports on a quarterly basis to UM Sub-Committee and regional QM Committee Reported every six months to regional QM Oversight Committee Data included in the NSMHA six month Integrated Report	NSMHA IS reports MHD statewide performance indicator reports	Comparison to state-wide averages to determine if NSMHA meets or exceeds the 2004 Performance Indicator Report (2003 data) levels level for this indicator of service

UTILIZATION MANAGEMENT

Goal #1: To ensure services provided throughout the region are effective and appropriate (Increase services to Adults regionally)

Objective #10: Increase the outpatient penetration rate for services provided to Adults regionally from the 2004 Performance Indicator Report (2003 data) levels
levels

Staff responsible: NSMHA Quality Management Department

Timeline: Information reported every six months

Activities/Task	Output	Measure/Data Sources	Benchmarks
Review regional data, compare regional numbers to the statewide averages Analyze regional data for trends	Review of available data monthly, reports on a quarterly basis to UM Sub-Committee and regional QM Committee Reported every six months to regional QM Oversight Committee Data included in the NSMHA six month Integrated Report	NSMHA IS reports MHD statewide performance indicator reports	Comparison to state-wide averages to determine if NSMHA meets or exceeds the 2004 Performance Indicator Report (2003 data) levels level for this indicator of service

UTILIZATION MANAGEMENT

Goal #1: To ensure services provided throughout the region are effective and appropriate (Increase services to children in their homes and schools regionally)

Objective #11: An overall increase in services provided to Children in their homes and schools regionally from 2004 Performance Indicator Report (2003 data) levels

Staff responsible: NSMHA Quality Management Department

Timeline: Information reported every six months

Activities/Task	Output	Measure/Data Sources	Benchmarks
Review regional data, compare regional numbers to the statewide averages Analyze regional data for trends	Review of available data monthly, reports on a quarterly basis to UM Sub-Committee and regional QM Committee Reported every six months to regional QM Oversight Committee Data included in the NSMHA six month Integrated Report	NSMHA IS reports MHD statewide performance indicator reports	Comparison to state-wide averages to determine if NSMHA meets or exceeds the 2004 Performance Indicator Report (2003 data) levels level for this indicator of service

UTILIZATION MANAGEMENT

Goal #1: To ensure services provided throughout the region are effective and appropriate (Monitoring/Oversight of projects using State-only dollars)

Objective #12: Outpatient services using state-only dollars are monitored for over/under utilization

Staff responsible: NSMHA Quality Management Department

Timeline: Information reported every six months

Activities/Task	Output	Measure/Data Sources	Benchmarks
NSMHA will monitor projects regionally that use state-only dollars	Review of available data, reports on a quarterly basis to UM Sub-Committee and regional QM Committee Reported every six months to regional QM Oversight Committee Data included in the NSMHA six month Integrated Report	NSMHA IS reports Initial, Concurrent, and Retrospective Reviews	Compliance with contractual expectations

UTILIZATION MANAGEMENT

Goal #1: To ensure services provided throughout the region are effective and appropriate
(Number of consumers diagnosed with co-occurring disorders)

Objective #13: Increase the accurate identification and data reporting of the number of consumers diagnosed with co-occurring disorders regionally from the 2004 Performance Indicator Report (2003 data) levels

Staff responsible: NSMHA Quality Management Department

Timeline: Information reported every six months

Activities/Task	Output	Measure/Data Sources	Benchmarks
NSMHA will analyze data collection methods to determine that all co-occurring disorder diagnoses are entered appropriately in the Management Information System	Review of available data, reports on a quarterly basis to UM Sub-Committee and regional QM Committee Reported every six months to regional QM Oversight Committee Data included in the NSMHA six month Integrated Report	NSMHA IS reports	Comparison to state-wide averages to determine if NSMHA meets or exceeds the 2004 Performance Indicator Report (2003 data) levels level for this indicator of service

UTILIZATION MANAGEMENT

Goal #1: To ensure services provided throughout the region are effective and appropriate (Number of adult consumers employed regionally)

Objective #16: Increase the number of adult consumers employed regionally from the 2004 Performance Indicator Report (2003 data) levels

Staff responsible: NSMHA Quality Management Department

Timeline: Information reported every six months

Activities/Task	Output	Measure/Data Sources	Benchmarks
NSMHA will analyze data collection methods to determine that employment is entered appropriately in the Management Information System	Review of available data, reports on a quarterly basis to UM Sub-Committee and regional QM Committee Reported every six months to regional QM Oversight Committee Data included in the NSMHA six month Integrated Report	NSMHA IS reports	Comparison to state-wide averages to determine if NSMHA meets or exceeds the 2004 Performance Indicator Report (2003 data) levels level for this indicator of service

Effective Date: 10/9/2003, BOD Approved, Motion #03-053; 6/20/2004, BOD Approved, Motion #04-027
Revised Date: November 17, 2005
Review Date:

North Sound Mental Health Administration

Section 1000 – Administrative: Complaint, Grievance, Appeal & Fair Hearing – General Requirements

Authorizing Source: 42 CFR 438-214

Cancels:		
See Also:	Approved by Board of Directors	Date:
Responsible Staff: Quality Manager	Motion #:	

B. POLICY# 1001.00

SUBJECT: COMPLAINT, GRIEVANCE, APPEAL, and FAIR HEARING – GENERAL REQUIREMENTS

C. PURPOSE

The purpose of the North Sound Mental Health Administration (NSMHA) Complaint, Grievance, Appeal, and Fair Hearing Policy is to outline the NSMHA complaint, grievance, appeal and fair hearing policy for both Medicaid enrollees and state funded consumers in the North Sound Region and ensure that the policy is used consistently throughout the North Sound Region.

The NSMHA policy will also outline the rights, responsibilities, and requirements of the NSMHA, consumers, providers, and other involved parties at all levels of the complaint, grievance, appeal, and fair hearing system.

In addition, the policy will outline the use of customer service, complaint, grievance, appeal, denial and fair hearing information for continuous quality improvement.

Consumers will be informed of NSMHA customer services, independent Ombuds services, and other supports available to them at each level of the process. (See 1002 NSMHA Complaint and Grievance Policy, 1003 NSMHA Appeals Policy, 1004 NSMHA Fair Hearing Policy and NSMHA Customer Services Policy for additional requirements.)

D. GENERAL POLICY

It is the policy of the NSMHA to resolve complaints, grievances and appeals at the lowest possible level, in a confidential manner and without retaliation. The NSMHA policy is to resolve or rule upon, if necessary, consumers (see definition of "consumer" below) complaints, grievances, or appeals honoring consumer's voice, choice, and rights while considering the most effective clinical practices, State wide Access to Care Standards, medical necessity, laws and Federal/State/NSMHA contractual requirements.

Throughout the complaint, grievance, appeal and fair hearing policies the term consumer will include both state funded consumers and Medicaid enrollees. When the policies refer only to state funded consumers or Medicaid enrollees these terms will be used. (See the definition section below.)

The NSMHA encourages the resolution of complaints and grievances at the lowest possible level. Consumers may pursue a complaint or grievance with a provider, provider network, formal designee, or with the NSMHA.

Medicaid enrollees may request appeals of actions by the NSMHA or formal designee and state funded consumers may request grievances regarding authorization decisions by the NSMHA or designee. Appeals of actions and grievances regarding service authorization by the NSMHA or designee are pursued at the NSMHA.

Consumers or their representatives may request a fair hearing at any time if they believe there has been a violation of the Washington Administrative Code. Consumers may also request a fair hearing if they are dissatisfied with the NSMHA resolution of a grievance. Medicaid enrollees may also request a fair hearing if they are dissatisfied with the NSMHA decision regarding an appeal. Consumers may also, under certain circumstances, request additional consideration of a grievance from the state Mental Health Division if they are dissatisfied with the NSMHA decision about a grievance. (See 1004 -NSMHA Fair Hearing Policy.)

1. Consumers will be informed of their right to initiate a complaint, expedited grievance, grievance, or request a fair hearing. Medicaid enrollees will also be informed of their right to initiate an appeal or expedited appeal. This policy will be published and made available to all current and potential users of publicly funded mental health services, and advocates in language that is clear and understandable to the individual.

State funded consumers will receive information about their complaint, grievance, and fair hearing rights through NSMHA produced materials and Medicaid enrollees will receive information about their complaint, grievance, appeal, and fair hearing rights through the Medicaid Benefits Booklet and NSMHA produced materials. The Medicaid benefits booklet will also be provided to Medicaid enrollees in the NSMHA service area on an annual basis and be provided to enrollees within 15 days of enrollment.

These materials will be in easily understood language and format, including alternative formats, will be available to consumers prior to intake evaluation. (See NSMHA policies 4505 – Enrollee Rights and 4506 – Enrollee Rights – Compliance with Federal and State Laws for complete information regarding consumer rights.)

2. Medicaid enrolled consumers will receive written notice of action that outlines their rights to appeal actions including service determination or authorization by the NSMHA or their formal designee and the process to appeal these actions with the NSMHA. State funded consumers will receive written communication that outlines their right to grieve decisions about service determination or authorization by the NSMHA or their formal designee and the process to grieve these decisions with the NSMHA.
3. The NSMHA will provide customer services that are customer friendly, flexible, proactive, and responsive to consumers, families, and stakeholders. NSMHA customer service staff is available 8:00 a.m. to 5:00 p.m. Monday through Friday (excluding holidays) at 1-800-684-3555 or 1-360-416-7013 to assist callers with customer service inquires including those about access, benefits and claims. NSMHA customer service staff is also available to assist callers with complaints and will assist in distinguishing between a complaint, Third Party Insurance issue, appeal, grievance, or request for information. NSMHA customer service staff will assist callers to triage their concern to the appropriate party.

4. Independent, confidential Ombuds services are available to provide advocacy, assistance, and investigation to consumers, family members and other interested parties throughout the complaint, grievance, appeal and fair hearing process in accordance with Washington Administrative Code (WAC). Ombuds services may be reached toll free, at 1-888-336-6164. Ombuds services may also be reached at 1-360-419-3391 or 1-360-419-3455. Ombuds services will be offered to assist consumers at all levels of the process.
5. Provider, provider network, formal designee and NSMHA staff are also available to provide consumers with assistance in completing forms and taking other procedural steps. This includes but is not limited to provision of Ombuds services, interpreter services and toll-free numbers with adequate TTY/TTD capability. All providers, provider networks, and formal designees will appoint a complaint and grievance contact person to assist with the process.
6. Consumers may have participation of others of their choice throughout the process. Consumers may also have a representative who acts on their behalf (with written permission) throughout the process.
7. Previously authorized services will continue or be reinstated during the complaint and grievance process at the consumer's request. Medicaid enrollees may request their previously authorized services continue or be reinstated during the appeals process under certain circumstances. When grievances or appeals are not resolved in consumers' favor, in certain circumstances, they may be asked to pay for these services.
8. Complaints, grievances, and appeals will be handled in a confidential manner. The NSMHA Notice of Privacy Practices will contain a statement that individuals may complain to the NSMHA and to the Secretary of Health and Human Services if they believe their privacy rights have been violated, a brief description of how the individual may file a complaint with the covered entity, and a statement that the individual will not be retaliated against for filing a complaint.
9. Individuals may also initiate complaints concerning noncompliance with the requirements for advance directive for psychiatric care with the Mental Health Division (MHD) at 1-888-713-6010.
10. The NSMHA customer service, complaint, grievance, appeal, and fair hearing process will be age, culturally and linguistically competent. The NMHA will provide toll free numbers that have adequate TTY/TDD, and oral or manual interpreter services. Oral or manual interpreter services may be reached at 1-800 684-3555 and TTY/TDD services at 1-800 833-6388 or by dialing 711. In-person interpreter services are also available. Providers, networks, and formal designees will also provide toll free numbers that have adequate TTY/TDD, and oral or manual interpreter services. In person interpreter services will also be available through providers, networks, and formal designees. Mental health specialists are also available throughout the process to assist in providing culturally competent processes.
11. Complaints, grievances, and appeals will be followed up on even if consumers are no longer receiving services.
12. There will be no retaliation or punitive action of any kind against a consumer who initiates a complaint, expedited grievance, grievance, appeal, expedited appeal, or request for fair hearing. There will be no retaliation against providers who initiate appeals or grievances on behalf of consumers. Ombuds services, providers, and the NSMHA staff are available to assist if concerns about retaliation occur. Consumers may also contact the NSMHA director if concerns about retaliation occur (see NSMHA policy 4503-Retaliation Policy).

13. Aggregate information about types of customer service calls, complaints, grievances, appeals, fair hearing requests and denials and other actions will be used to analyze patterns or trends, identify system implications, identify areas for quality improvement, outline plans to address system implications or trends, and improve the RSN system. Information will also be used as part of the NSMHA's quality strategy. Information about individual complaints, grievances, appeals, or fair hearings that have system implications may also be used for quality improvement.
14. The following definitions will apply to – 1001 NSMHA Complaint, Grievance, Appeal, and Fair Hearing Policy General Policy Requirements, 1002 NSMHA Complaint and Grievance Policy, 1003 NSMHA Appeals Policy, and 1004 NSMHA Fair Hearing Policy.

E. DEFINITIONS

ACTION

Actions apply to Medicaid enrollees and are defined as:

1. NSMHA (or formal designee) decisions to:

    a. Deny or limit authorization of a requested service, including type or level of service;
    b. Reduce, suspend, or terminate a previously authorized service; or
    c. Deny in whole or in part, payment for a service.

2. The failure to:

    a. Provide services in a timely manner as defined by the state
    b. Act within timeframes provided in 42CFR438.408 (b), including the disposition of and resolution of grievances within 30 days from receipt of the grievance at the Community Mental Health Agency (provider), provider network, or formal designee, 30 days from receipt at the NSMHA; and 30 days at the Mental Health Division (MHD) if the grievance can be brought to the MHD according to policy, unless extended by mutual agreement with the Medicaid enrollee.

3. Or the failure of the NSMHA to:

    Dispose of and resolve an appeal within 45 days from the receipt of the appeal, unless extended by the NSMHA or the Medicaid enrollee.

The denial, suspension, reduction, and termination of services are defined as follows:

Denial – The decision not to offer an intake is a denial. The decision by the NSMHA, or their formal designee, not to authorize covered Medicaid mental health services that meet medical necessity is a denial.
Suspension – The decision by the NSMHA, or their formal designee, to temporarily stop an enrollee's previously authorized covered Medicaid mental health services described in the Level of Care Guidelines. The decision by a Community Mental Health agency to temporarily stop or change a covered service in the Individualized Service Plan is not a suspension.

Reduction – The decision by the NSMHA to decrease an enrollee's previously authorized covered Medicaid mental health services described in our Level of Care Guidelines. The decision by a Community Mental Health Agency to decrease or change a covered service in the Individualized Service Plan is not a reduction.

Termination – The decision by the NSMHA, or their formal designee, to stop an enrollee's previously authorized covered Medicaid mental health services described in our Level of Care Guidelines. The decision by a Community Mental Health Agency to stop or change a covered service in the Individualized Service Plan is not a termination.

APPEAL

An **appeal** is a request by a Medicaid enrollee, provider, or representative on behalf of the enrollee and with the enrollee's written permission to the NSMHA for review and reconsideration of an action outlined in a written notice of action. For appeals that involve inpatient services, inpatient providers may also request an appeal on behalf of the consumer, with the enrollee's written permission.

An **expedited appeal** is a request by a Medicaid enrollee, provider, or representative on behalf of the enrollee and with the enrollee's written permission to the NSMHA for expedited review and reconsideration of an action outlined in a written notice of action. For appeals that involve inpatient services, inpatient providers may also request an expedited appeal on behalf of the enrollee, with the enrollee's written permission.

COMPLAINT

A **complaint** is a verbal statement of dissatisfaction with any aspect of mental health services covered under the NSMHA PHIP and SMHC Program Agreements, including provider, provider network, formal designee or the NSMHA. If a complaint is initiated in writing, assistance will be provided to clarify whether the intension is to initiate a complaint or grievance.

CONSUMERS/STATE FUNDED CONSUMERS/MEDICAID ENROLLEES

Consumers are people, who have applied for, are eligible for, enrolled in, or who have received publicly funded mental health service from the NSMHA service network. This definition includes Medicaid enrollees and state funded consumers.

The definition of "consumers" also includes parents or legal guardians for children under the age of 13, parents or legal guardians who are involved in the treatment plan for children 13 and older. Representatives who act on a consumer's behalf with the consumer's signed written permission including providers, family members and other interested parties can also utilize this process. An authorization will be needed from the consumer to share Protected Health Information to a family member or other interested party who does not have written permission to act on behalf of the consumer.

*Throughout the policy, the term **"Consumer"** will be used to describe the above group.*

Medicaid enrollees are Medicaid recipients with a mental health benefit who are currently enrolled in the NSMHA. **Potential Medicaid enrollees** are Medicaid recipients with a mental health benefit who are not currently enrolled in the NSMHA.

Throughout the policy, the term ***"Medicaid enrollee"*** *or "****enrollee"*** *will be used to describe the above group.*

State funded consumers are people, who have applied for, are eligible for, enrolled in, or who have received publicly funded mental health service from the NSMHA service network who are not Medicaid enrollees.

Throughout the policy, the term ***"State funded consumer"*** *will be used to describe the above group.*

FAMILY

Family is those the consumer defines as family or those appointed/assigned (e.g., parents, foster parents, guardians, siblings, caregivers, and significant others).

FAIR HEARING

A **fair hearing** is a hearing conducted through the auspices of the state Office of Administrative hearings in accordance with Washington Administrative Code (WAC) 388-02. The term "fair hearing" is synonymous with administrative hearing.

GRIEVANCE

For Medicaid enrollees **grievances** are an expression of dissatisfaction about any matter other than an "action" as defined in the NSMHA Policy. For state funded consumers **grievances** are an expression of dissatisfaction about any matter. (Possible subjects for grievances include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness).

A **Grievance** is a more formal way to express dissatisfaction than a complaint and may be pursued at the provider level or the NSMHA level. **Grievances** may be initiated orally but are followed up with a signed written request. **Grievances** regarding authorization decisions by the NSMHA or designee for state funded consumers will be pursued directly with the NSMHA. An **Expedited grievance** is a request for a more immediate response to a grievance. Expedited grievances are not expected to be followed up on in writing. **Expedited grievances** may be pursued at the provider/network/formal designee or NSMHA level.

GRIEVANCE SYSTEM

The term **grievance** is also used to refer to the overall system that includes grievances and appeals at the NSMHA and access to the State fair hearing process.

MENTAL HEALTH CARE PROVIDER (MHCP)

The Mental Health Care Provider **is the individual with primary responsibility for implementing an individualized service plan for mental health rehabilitation services.**

NOTICE OF ACTION

Medicaid enrollees will also receive a written Notice of Action **that will outline an action the NSMHA or formal designee has taken or is planning to take concerning Medicaid funded mental health services. The notice of action will outline a Medicaid Enrollees rights to appeal these decisions. It will also outline the process for appeal of these decisions.**

OFFICE OF ADMINISTRATIVE HEARINGS

The Office of Administrative Hearings **is a part of state government that conducts fair hearings.**

COMMUNITY MENTAL HEALTH AGENCY/ PROVIDER/ INPATIENT PROVIDER/ PROVIDER NETWORK/FORMAL DESIGNEE

A **provider** is any NSMHA contracted network Community Mental Health Agency licensed to provide mental health services covered in the NSMHA PHIP and SMHC Program Agreement, and includes contracted crisis line providers, or contracted crisis providers. A **community mental health agency** is synonymous with provider. A **provider network** refers to the NSMHA contracted provider network's highest level of administration. An **inpatient provider** is any community inpatient facility or evaluation and treatment facility that may be utilized for psychiatric hospitalization. A **formal designee** is an entity contracted by the NSMHA to make authorization decisions on behalf of the NSMHA.

F. ADDITIONAL REQUIREMENTS

The NSMHA, formal designees, providers, provider networks, and any other contracted, individuals and agencies shall comply with all requirements outlined in the NSMHA Policy and in references cited below. The providers, provider networks, and formal designees' Complaint, Grievance, Appeal and Fair Hearing Policies will be congruent with the NSMHA Policy. To ensure the NSMHA policy is consistently applied throughout the region, the NSMHA will monitor these policies through the administrative audit process.

The NSMHA will oversee the provider, provider network, and formal designees' complaint and grievance process. The NSMHA, providers, provider networks, formal designees, and sub-contractors and any other contracted individuals and agencies will cooperate with and promptly abide by all complaint, appeal, grievance and fair hearing decisions. The NSMHA will require this in contracts and will monitor compliance with this requirement through the administrative audit process.

The providers, provider networks, formal designees, Ombuds, and NSMHA will assist with methods to collect information for quality improvement efforts and to assist the NSMHA in complying with reporting requirements to the Mental Health Division (MHD). The NSMHA will maintain records of complaints, grievances, appeals, and fair hearings. The NSMHA and providers will review complaint, grievance, denial, appeal, and fair hearing records and information at least annually as part of the NSMHA's quality management strategy.

The provider networks, providers, formal designees, Ombuds Services, and NSMHA will submit semi-annual reports in compliance with the NSMHA and MHD timelines. The reports will include: 1) The number and nature of complaints, grievances, and fair hearings; 2) The timeframes within which they were disposed or resolved; 3) The nature of the decisions; 4) The number and nature of appeals 5). The number and types of denials or other actions, and 6) A summary and analysis of the implications of the data, including identification of system implications, identification of areas for quality improvement and any measures that may be taken to address either quality improvement or undesirable patterns.

The providers, formal designees, provider networks, and NSMHA will utilize customer service, complaint, grievance, denial, appeal and fair hearing information to analyze trends or identify areas for quality improvement through strategies outlined in the NSMHA Quality Management Plan.

The NSMHA, providers, networks, and formal designees will keep full records of complaints, grievances and appeals during the term of the NSMHA Program Agreements with the Mental Health Division and for six (6) years following termination or expiration of the Agreement, or if any audit, claim, litigation, or other legal action involving the records is started before expiration of the six year period, the records will be maintained until completion and resolution of all issues arising there from or until the end of the six year period, whichever is later.

Records of complaints, grievances, or appeals will be kept in confidential files separate from clinical records. These records will not be disclosed without the consumer's written authorization, except as necessary, to resolve the grievance, to DSHS if a fair hearing is requested, or for review as part of the state quality strategy. Complaint and grievance records maintained by the NSMHA are included in the NSMHA defined designated record set.

The requirements outlined in 1001 Complaint, Grievance, Appeal and Fair Hearing Policy General Policy Requirements apply to – 1002 NSMHA Complaint and Grievance Policy, 1003 NSMHA Appeal Policy, and 1004 NSMHA Fair Hearing Policy.

G. REFERENCES

1. 2004-06 Federal 1915 (b) Waiver Amendment Document.
2. Waiver Renewal Submittal March 14, 2003, CMS DRAFT FORM Proposal for a Section 1915(b) Capitated Waiver Program.
3. Federal 1915 (b) MH Waiver, Medicaid State plan or any successors.
4. State Mental Health Program Agreement (SMHC) 9-1-2005-8-31-2006 and Prepaid Inpatient Health Plan Program Agreement (PIHP) 9-1-2005-8-31-2006 between The State of Washington DSHS and the NSMHA or their successors including SMHC and PIHP Exhibit Ns.
5. 45 CFR Health Insurance Portability and Accountability Act (HIPAA).
6. WAC 388-865 and 388-02.
7. NOTICE OF ACTION Medicaid-Funded Mental Health Services-Washington State Mental Health Division.
8. Benefits Booklet for People Enrolled in Medicaid Public Mental Health System, May 1, 2004 – Washington State Mental Health Division.
9. Code of Federal Regulations (CFR) – 42 CFR 438.100, 42 CFR 438.218, 228, 230, 240, 242, 42 CFR 438.210, 42 CFR 438 Subpart F, (400-424).
10. Section 1919e of the Social Security Act.

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North Sound Mental Health Administration

Section 1000 – Administrative: Complaint and Grievance

Authorizing Source: 42 CFR 438-214

Cancels:
See Also:
Responsible Staff: Quality Manager

Approved by Board of Directors Date: 06-29-04
Motion #: 04-027

H. POLICY # 1002.00

I. SUBJECT: COMPLAINT AND GRIEVANCE

J. PURPOSE

The purpose of the North Sound Mental Health Administration (NSMHA) Complaint and Grievance Policy is to outline the NSMHA, provider, provider network, and formal designee complaint, grievance, and expedited grievance processes and requirements. (See 1001- NSMHA Complaint, Grievance, Appeal, and Fair Hearing Policy General Policy Requirements, 1003-NSMHA Appeal Policy and 1004-NSMHA Fair Hearing Policy for information about additional policy requirements).

K. COMPLAINT POLICY

A **complaint** is a verbal statement of dissatisfaction with any aspect of mental health services. If a complaint is initiated in writing, assistance will be provided by the person who receives the complaint to clarify whether the intension is to initiate a complaint or grievance.

Complaints may involve but are not limited to services provided by providers or networks, services provided directly by formal designees, or services provided directly by the NSMHA.

Ombuds services are available to provide advocacy, assistance, and investigation to consumers, family members and other interested parties throughout the complaint process. Ombuds services work to assist in resolving the complaint at the lowest possible level. Ombuds services may assist callers with complaints through the provider/network/formal designee complaint process or with NSMHA customer services.

For complaints about services by providers, consumers or their representatives may contact Ombuds services for assistance with the complaint process or may initiate complaints with their Mental Health Care Provider or other provider staff, their identified provider complaint and grievance contact, or through NSMHA customer services staff.

For complaints about services provided directly by the provider network or formal designee, consumers may contact Ombuds services for assistance with the complaint process or may initiate complaints with the provider network or formal designee complaint and grievance contact or NSMHA customer services staff.

For complaints that involve services provided by the NSMHA, consumers or their representatives may contact Ombuds services for assistance with the complaint process or may initiate complaints directly with NSMHA customer services.

1. **For Complaints Initiated with Providers/Networks/Designees**

    a. The provider/network/formal designee will provide assistance
    b. If the caller, consumer, or consumer representative is not receiving assistance from Ombuds services, Ombuds services will also be offered for assistance
    c. Staff will attempt to resolve complaints informally, quickly, and to the consumer's satisfaction.
    d. Staff will resolve the complaint to the consumers' satisfaction as expeditiously as the consumer's mental health condition requires, not to exceed 30 days of receipt of the complaint by the provider/network/formal designee or mail the consumer and the NSMHA a written response within 30 days of receipt of the complaint, in the event the consumer is not satisfied with the resolution.
    e. The written response will include the reason for the decision, the right to pursue a grievance with the provider/network/formal designee or the NSMHA, the right for previously authorized services to continue or be reinstated during the grievance process at the consumer or consumer representative's request, and the process and available supports if the consumer has any concerns about retaliation.
    f. The provider, provider network, or formal designee will document all complaints, including the date of receipt, actions taken, resolution, and date of resolution to the consumer or representative.
    g. Complaints will be documented and tracked for continuous quality improvement regardless of the resolution. Complaints by allied systems, advocates, family members or other parties on behalf of consumers, where consumers choose not to pursue the complaint, will be documented.
    h. The provider, provider network, or formal designee will arrange for staff with the authority to assure implementation of agreements to provide follow-up.
    i. For all complaints, consumers may have representatives of their choice involved throughout the complaint process. Staff will notify the consumer or representatives that previously authorized services will continue or be reinstated during the complaint process at the consumer or representative's request. Staff with the authority to resolve the complaint or require corrective action will participate in the process and offer a face-to-face meeting as needed to resolve the complaint. Consumers and their representatives may examine their case file, including medical records, and any other documents and records considered during the complaint process (before and during the complaint process). Qualified mental health care professionals who have the appropriate clinical expertise will make the decision.

2. **For Complaints Initiated through NSMHA Customer Services**

    a. NSMHA customer services staff will provide assistance to the caller
    b. If the caller is not receiving assistance from Ombuds services, Ombuds services will be offered for assistance.
    c. NSMHA customer services staff will typically arrange for follow up and resolution on the complaint with provider/network/designee complaint and grievance contacts depending on the nature of the complaint and needed resolution. NSMHA customer services staff may also provide for follow up and resolution internally by the NSMHA. All complaints about the NSMHA will be followed up on internally.

1) For complaints triaged to provider/network/designee complaint and grievance contacts the process outlined above will be followed.

In addition, providers/networks/designees will forward information to the NSMHA about all complaints triaged through NSMHA customer services. The information will include the nature of the resolution and the date the consumer was notified of the resolution. All complaints triaged to providers/networks/designees by NSMHA customer services will be resolved to the consumer's satisfaction within 30 days of receipt of the complaint by NSMHA customer services staff, or the provider/network/formal designee will mail the consumer and the NSMHA a written response, in the event the consumer is not satisfied with the resolution. The NSMHA may request a follow up report from providers/networks/designees.

2) For complaints triaged internally, NSMHA staff will attempt to resolve complaints informally, quickly, and to the consumer's satisfaction.

NSMHA staff will resolve the complaint to the consumers' satisfaction as expeditiously as the consumer's mental health condition requires, not to exceed 30 days of receipt of the complaint by the NSMHA or mail the consumer a written response within 30 days of receipt of the complaint, in the event the consumer is not satisfied with the resolution.

The written response will include the reason for the decision, the right to pursue a grievance with the provider/network/formal designee or the NSMHA, the right for previously authorized services to continue or be reinstated during the grievance process at the consumer or consumer representative's request, and the process and available supports if the consumer has any concerns about retaliation.

d. The NSMHA will arrange for staff with the authority to assure implementation of agreements to provide follow-up.
e. For all complaints, consumers may have representatives of their choice involved throughout the complaint process, NSMHA staff will notify the consumer or representatives that previously authorized services will continue or be reinstated during the complaint process at the consumer or representative's request, staff with the authority to resolve the complaint will participate in the process and offer a face-to-face meeting as needed to resolve the complaint, consumers and their representatives may examine their case file, including medical records, and any other documents and records considered during the complaint process (before and during the complaint process), NSMHA qualified mental health care professionals who have the appropriate clinical expertise will make the decision, and the NSMHA Privacy Officer will be informed of any complaint that relates to the NSMHA Privacy practices. The Privacy Officer will document all Privacy complaints received and their disposition.

f. NSMHA staff will document all complaints received through customer services, including the date of receipt, actions taken, resolution, and date of resolution to the consumer or representative. Complaints will be documented and tracked for continuous quality improvement regardless of the resolution. Complaints by allied systems, advocates, family members or other parties on behalf of consumers, where consumers choose not to pursue the complaint, will be documented.

If the consumer or representative is dissatisfied with the results of the complaint process, they may pursue a grievance with the provider or NSMHA.

L. GRIEVANCE POLICY

For Medicaid enrollees **grievances** are an expression of dissatisfaction about any matter other than an "action" as defined in the NSMHA Policy. For state funded consumers **grievances** are an expression of dissatisfaction about any matter. (Possible subjects for grievances include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness.)

A **Grievance** is a more formal way to express dissatisfaction than a complaint and may be pursued at the provider/network/designee level or the NSMHA level. **Grievances** may be initiated orally but are followed up with a signed written request.

Grievances regarding authorization decisions by the NSMHA or designee for state funded consumers will be pursued directly with the NSMHA. State funded consumers will receive written notification about adverse authorization decisions by the NSMHA or formal designee and their right to grieve these decisions. (See 1003-NSMHA Appeal Policy for information about appeals for Medicaid enrollees.)

An **Expedited grievance** is a request for a more immediate response to a grievance. **Expedited grievances** may be pursued at the provider/network/formal designee or NSMHA level.

For provider/network/designee level grievances consumers or their representatives may contact Ombuds services for assistance with the grievance process or may initiate grievances with their Mental Health Care Provider or other provider staff, the identified provider/network/designee complaint and grievance contact or through NSMHA customer services.

For NSMHA level grievances consumers or their representatives may contact Ombuds services for assistance with the grievance process or may initiate grievances directly with NSMHA customer services.

1. Provider/Network/Formal Designee Level Grievances

A. For provider/provider network/formal designee level grievances or expedited grievances initiated with the provider/network/designee:

Non Expedited Grievances

a. The provider, network, or formal designee will provide assistance.

b. If the consumer or their representative is not receiving assistance from Ombuds services, Ombuds services will be offered for assistance.
c. The provider/network/designee will notify the NSMHA that they have received a grievance within two business days of the receipt of the grievance and indicate the date they received the grievance.
d. If the grievance is done verbally, the consumer or representative will follow up within ten (10) days of the oral request with a written signed request. The start date of the grievance will be the original date of request whether oral or written.
e. Written requests for grievances should include the consumer name, how the provider/network/designee can best contact the consumer, the nature of the grievance, the requested resolution, and any information consumers or others wish to submit.
f. The provider, network, or formal designee will acknowledge (maybe by telephone) receipt of the grievance within one business day from the oral or written grievance (whichever is first). If the acknowledgement is made orally, they will mail a written acknowledgement within five (5) business days of receipt of the oral or written grievance (whichever is first).
g. The written acknowledgement will include notice to the consumer or representative that previously authorized services will continue or be reinstated during the grievance process at the consumer or representative's request and notice for any circumstances in which the consumer may be asked to pay for the cost of those benefits if the grievance upholds the original decision.
h. Staff not involved in any previous level of service provision, review or decision-making will make decisions on grievances.
i. Qualified mental health care professionals who have the appropriate clinical expertise will hear grievances and make decisions.
j. Staff with the authority to resolve the grievance or require corrective action will participate in the process and offer a face-to-face meeting with the consumer to discuss the grievance. Consumers may invite representatives of their choice to the meeting and have representatives of their choice involved throughout the grievance process.
k. Consumers or their representatives may examine their case file, including medical records, and any other documents and records considered during the grievance process (before and during the grievance process).
l. The provider, provider network, or formal designee will mail a written notice of resolution to the consumer or representative (with a copy to the NSMHA) as expeditiously as the enrollee's mental health condition requires, not to exceed 30 days of receipt of the grievance (either oral or written, whichever is first).
m. The written response will include the reason for the decision, the results of the resolution process, the date it was completed, the process and available supports if the consumer has any concerns about retaliation.
n. For grievances not resolved wholly in favor of the consumer, the written response will also include the right and process to pursue a grievance with the NSMHA, and the right for previously authorized services to continue or be reinstated during the NSMHA grievance process at the consumer or consumer representative's request, and notice for any circumstances in which the consumer may be asked to pay for the cost of those benefits if the grievance upholds the original decision.

o. Providers, provider networks, or formal designees will issue a report to the NSMHA within 30 days of the decision for grievances resolved partially or completely in favor of the consumer.
p. Staff with the authority to assure implementation of agreements or decisions will provide follow up.
q. Staff will document all grievances, including the date of receipt, actions taken, resolution, and date of resolution to the consumer or representative and forward a copy of this information the NSMHA.
r. The NSMHA will send a notice of action to the consumer about their right to request a fair hearing if the provider fails to meet the 30 day timeline for the disposition of the grievance.

Expedited Grievances-Additional Requirements

The provider/network/designee will expedite grievances when a consumer's condition requires a more immediate response to a grievance. When consumer's or representatives request expedited resolution of a grievance, the provider/network/designee must respond to the request within 3 working days or sooner based on the medical necessity of the consumer.

a. Requests for expedited resolution may be initiated orally and are not required to be followed by a written signed request by the consumer or representative.
b. The provider, network, or formal designee will make a decision on the consumer's request for expedited grievance and provide written notice of resolution, as expeditiously as the consumer's mental health condition requires, within three (3) working days or sooner based upon the medical necessity of the consumer. They will also make reasonable efforts to provide oral notice.
c. The provider, network, or formal designee will provide the consumer a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing and inform the consumer of the limited time available for expedited resolutions.
d. The provider, network, or formal designee and NSMHA will ensure that retaliation or punitive action is not taken against a consumer who requests an expedited resolution.

B. For provider/provider network/formal designee level grievances or expedited grievances initiated through NSMHA customer services:

a. NSMHA customer services staff will assist callers with triage to the provider/provider network/formal designee complaint and grievance contact to initiate the grievance or expedited grievance process outlined above.

b. NSMHA customer services staff will also offer Ombuds services for assistance.
c. NSMHA customer services staff will provide assistance to the caller as needed.
d. Providers/networks/designees will forward information to the NSMHA about all grievances triaged through NSMHA customer services. The information will include the nature of the resolution and the date the consumer was notified of the resolution. Provider/network/formal designees will mail the consumer and the NSMHA a written response to all grievances triaged through customer services within 30 days of the date the grievance was received by NSMHA customer services staff. The NSMHA may request a follow up report from providers/networks/designees.
e. NSMHA staff will document all provider/network/designee level grievances received through customer services, including the date of receipt, actions taken, resolution, and date of resolution to the consumer or representative.
f. If the consumer is dissatisfied with the results of the provider/network/formal designee grievance process, they may pursue the grievance with the NSMHA.

2. NSMHA level grievances or expedited grievances

Non-expedited Grievances

a. NSMHA customer services staff will provide assistance to the caller.
b. If the consumer or their representative is not receiving assistance from Ombuds services, Ombuds services will be offered for assistance.
c. NSMHA customer service staff will document the grievance, including the date of receipt, actions taken, resolution by the NSMHA, and date of notification to the consumer.
d. If the grievance is done verbally, the consumer or representative will follow up within ten (10) days of the oral request with a written signed request. The start date of the grievance will be the original date of request whether oral or written.
e. Written requests for grievances should include the consumer name, how the provider/network/designee can best contact the consumer, the nature of the grievance, the requested resolution, and any information the consumers or others wish to submit.
f. The NSMHA will acknowledge (maybe by telephone) receipt of the grievance within one business day from the oral or written grievance (whichever is first). If the NSMHA acknowledgement is made orally, the NSMHA will mail a written acknowledgement within five (5) business days of receipt of the oral or written grievance (whichever is first).
g. The written acknowledgement will include notice to the consumer or representative that previously authorized services will continue or be reinstated during the grievance process at the consumer or representative's request and notice for any circumstances in which the consumer may be asked to pay for the cost of those benefits if the grievance upholds the original decision.
h. The NSMHA will notify the involved provider/network/designee within 2 days of receipt of a grievance.

i. Staff not involved in any previous level of service provision, review or decision-making will make decisions on grievances.
j. The NSMHA will provide a grievance committee to make decisions on consumer grievances. The grievance committee will be comprised of:

    1) NSMHA staff not involved in any previous level of service provision, review or decision-making.
    2) Qualified mental health care professionals who have the appropriate clinical expertise.
    3) The NSMHA Medical Director, a licensed, Board – certified psychiatrist.

k. Consumers may invite representatives of their choice to the grievance meeting and have representatives of their choice involved throughout the grievance process.
l. Consumers and their representatives may examine their case file, including medical records, and any other documents and records considered during the grievance process (before and during the grievance process).
m. Consumers, providers, provider networks, and other involved parties will provide all documentation five (5) days in advance to allow for review prior to the grievance meeting. In situations where there is little advanced notice this timeline may be shortened.
n. The NSMHA will mail a written notice of resolution as expeditiously as the consumer's mental health condition requires, not to exceed 30 calendar days from the request for grievance (either oral or written, whichever is first).
o. The NSMHA may extend the timeframes for resolution of grievances by up to 14 calendar days if:

The consumer or community mental health agency acting on behalf of the consumer requests the extension and there is written agreement.

p. Notices of resolution will include the reason for the decision, the results of the resolution process, the date it was completed, the process and available supports if the enrollee has any concerns about retaliation, and the right to request a fair hearing at any time if they believe there has been a violation of the Washington Administrative Code.
q. For grievances regarding denial of service, that are resolved in favor of the consumer, the notice of resolution will include information about how the consumer may obtain services, supports available to assist in obtaining service, and information that consumers must initiate services within sixty days.
r. For grievances not resolved wholly in favor of the consumer,

The notice of resolution will also include the process to request additional consideration of the formal grievance from the state MHD.

and

The right to request a State Fair Hearing, the process for requesting a Fair Hearing, the right to request to continue to receive benefits while the hearing is pending, how to make the request, and notice for any circumstances in which the consumer may be asked to pay for the cost of those benefits if the hearing decision upholds the original decision.

s. Providers, networks, or formal designees will issue a report to the NSMHA within 30 days of the decision for grievances resolved partially or completely in favor of the consumer. Providers, provider networks, or designees will issue additional follow up reports upon request.
t. Provider/network/designee staff with the authority to assure implementation of agreements or decisions will provide follow up.
u. The NSMHA may offer the consumer a follow up interview with the grievance committee to discuss any concerns about retaliation.
v. The NSMHA will send a notice of action to the consumer about their right to request a fair hearing if the NSMHA fails to meet the timeline for normal disposition or extension of the grievance.

Expedited Grievances-Additional Requirements

a. The NSMHA will expedite grievances when a consumer's condition requires a more immediate response to a grievance. When consumers or representatives request expedited resolution of a grievance, the NSMHA must respond to the request within 3 working days or sooner based on the medical necessity of the consumer.

1) Requests for expedited resolution may be initiated orally and are not required to be followed by a written signed request by the consumer or representative.
2) The NSMHA will make a decision on the consumer's request for expedited grievance and provide written notice of resolution, as expeditiously as the consumer's mental health condition requires, within three (3) working days or sooner based upon the medical necessity of the consumer. They will also make reasonable efforts to provide oral notice.
3) The NSMHA will provide the consumer a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing and inform the consumer of the limited time available for expedited resolutions.
4) The NSMHA will ensure that retaliation or punitive action is not taken against a consumer who requests an expedited resolution.

b. If the consumer is dissatisfied with the results of the grievance process, they may under certain circumstances request additional consideration of the formal grievance from the state MHD. The consumer must request consideration within five (5) days of receipt of the NSMHA decision. The consumer may also request a fair hearing, with the Office of Administrative Hearings. Requests for fair hearing must be made within 20 days of notice of disposition of a grievance. The consumer may also request a fair hearing at any time if they believe there has been a violation of the Washington Administrative Code. (See 1004-NSMHA Fair Hearing Policy for additional information.)

Effective Date: 6/29/20004, BOD Approved, Motion #04-027
Revised Date: November 17, 2005
Review Date:

North Sound Mental Health Administration

Section 1000 – Administrative: Appeal

Authorizing Source: 42 CFR 438.214
Cancels:
See Also: Approved by: Board of Directors Date:
Responsible Staff: Quality Manager Motion #:

M. POLICY #1003.00

SUBJECT: APPEAL

PURPOSE

The purpose of the North Sound Mental Health Administration (NSMHA) Appeal Policy is to outline the NSMHA appeal and expedited appeal process and requirements. (See 1001- NSMHA Complaint, Grievance, Appeal, and Fair Hearing Policy General Policy Requirements, 1002 NSMHA Complaint and Grievance Policy, and 1004 NSMHA Fair Hearing for information about additional policy requirements).

NSMHA APPEAL POLICY

Medicaid enrollees or providers or representatives on behalf of the enrollee and with the enrollee's written permission may request an appeal of actions to the NSMHA. They may also request an expedited appeal. For appeals of the denial of inpatient authorization or extension an inpatient provider may also request an appeal or expedited appeal with written permission of the consumer.

A. Appeals Process

Medicaid enrollees will receive a written notice of action that explains the action the NSMHA or formal designee intends to take or has taken, the reasons for the action, and the right to request an appeal or expedited appeal of these actions. The notice of action will also outline the process to appeal an action. Community mental health agency's requesting services on behalf of an enrollee will also receive oral notice. For denials of inpatient authorization or extension the inpatient provider will also receive a written notice of action.

Appeals are requests by a Medicaid enrollee, provider, or representative on behalf of the enrollee and with the enrollee's written permission to the NSMHA for review and reconsideration of an action as outlined in the notice of action. For appeals that involve inpatient services, inpatient providers may also request an appeal on behalf of the consumer, with the enrollee's written permission.

Expedited appeals are requests by a Medicaid enrolled consumer, provider, or representative on behalf of the enrollee and with the enrollee's written permission to the NSMHA for expedited review and reconsideration of an action. For appeals that involve inpatient services, inpatient providers may also request an expedited appeal on behalf of the consumer, with the enrollee's written permission.

Enrollees or representatives on behalf of the enrollee with the enrollee's written permission may initiate an appeal or expedited appeal verbally or in writing. Requests for appeal that are initially orally must be followed up with a signed written request by the enrollee or representative within seven days. Requests for expedited appeal are not expected to be followed with a written request.

Expedited appeals may be requested when the enrollee, provider or other representatives believe that taking the time for a standard resolution could seriously jeopardize the enrollee's life, mental health, or ability to attain, maintain, or regain maximum function.

The NSMHA will follow the expedited appeal process outlined below when: 1). An expedited appeal is requested by an enrollee or representative and the NSMHA determines that taking the time for a standard resolution could seriously jeopardize the enrollee's life, mental health, or ability to attain, maintain, or regain maximum function or 2). A provider or inpatient provider indicates that the consumer's condition requires a more immediate response and that taking the time for a standard resolution could seriously jeopardize the consumer's life, mental health, or ability to attain, maintain, or regain maximum function.

Appeals must be initiated within 20 calendar days of the receipt of the NSMHA notice of action (Appeals must be initiated within 10 calendar days of the receipt of the NSMHA notice of action, for enrollees to request that their previously authorized services continue or be reinstated during the appeals process).

Enrollee's, providers, or other representatives may contact Ombuds services for assistance or may initiate an appeal or expedited appeal verbally or in writing with NSMHA customer services. Ombuds services are available to provide advocacy, assistance, and investigation throughout the NSMHA appeals process Ombuds services work to assist the consumer or representative with appeals through the NSMHA appeals and expedited appeals processes outlined below.

1. ***Non expedited appeals***

    a. NSMHA customer services staff will assist callers and provide follow up with the appeals process.
    b. If the Medicaid enrollee or their representative is not receiving assistance from Ombuds services, Ombuds services will be offered for assistance.
    c. The Medicaid enrollee may also have assistance from their provider or anyone of their choice, throughout the process.
    d. NSMHA customer service staff will document the appeal, including the date of receipt, actions taken, resolution by the NSMHA, and date of notification to the consumer.
    e. If the appeal is done verbally, the Medicaid enrollee or representative will follow up within ten (7) days of the oral request with a written signed request (written requests are not required for expedited appeals). Oral inquiries related to appeal are treated as appeals and therefore establish the earliest possible filing date for appeals.
    f. Written requests for appeal should include the enrollees name, address, how the NSMHA can best contact the enrollee, reasons for appealing, and any evidence the enrollee or representatives wish to attach. The enrollee may send in supporting records, letters from their mental health provider, a list identifying qualified witnesses, or other information that explains services should be provided. Enrollees may request information from their mental health provider.

g. The NSMHA will acknowledge (maybe by telephone) receipt of the appeal within one working day from the oral or written appeal (whichever is first). If the NSMHA acknowledgement is made orally, the NSMHA will mail a written acknowledgement within five (5) working days of receipt of the oral or written appeal (whichever is first).
h. The written acknowledgement will include notice to the Medicaid enrollee or representative that previously authorized services will continue or be reinstated during the appeals process at the consumer or representative's request if:

1) The enrollee or the community mental health agency files the appeal timely.
2) The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment.
3) Services were requested by an authorized community mental health agency,
4) The enrollee requests an continuation of services/benefits, and
5) The original period covered by the original authorization has not expired at the time of the request for continuation of benefits. (See section C below for additional information regarding continuation of services/benefits during the appeals process.)

The written acknowledgement will also include notice for any circumstances in which the enrollee may be asked to pay for the services received during the appeals process if the decision is not in their favor.

i. Qualified mental health care professionals who have appropriate clinical expertise will conduct appeals and make decisions. The NSMHA Medical Director, a licensed, Board – certified psychiatrist will also review all appeals prior to upholding the original action and all appeals that involve inpatient services.
j. NSMHA staff not involved in any previous level of service provision, review or decision-making will decide all appeals.
k. The NSMHA will provide the enrollee a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. Enrollees may also invite representatives of their choice to the meeting. All parties will provide documentation five (5) days in advance to allow for review prior to the meeting and all parties may present their information at the meeting.
l. The parties to the appeal may include the enrollee, and his or her representative, or the legal representative of a deceased enrollee's estate.
m. Consumers and their representatives may examine their case file, including medical records, and any other documents and records considered during the appeals process (before and during the appeals process).
n. The NSMHA will mail a written notice of resolution as expeditiously as the enrollee's mental health condition requires, not exceeding, 45 days of receipt of the oral or written notice of appeal. The NSMHA may extend the prescribed timeframes for resolution of appeals by up to days if:

1) The consumer or provider acting on behalf of the consumer requests the extension and there is written agreement.

2) If the NSMHA extends the timeframes, when the enrollee does not request an extension, the NSMHA will give the enrollee written notice of the reason for the delay.

o. Notices of resolution will include the reason for the decision, the results of the resolution process, the date it was completed, the process and available supports if the enrollee, provider or inpatient provider has any concerns about retaliation, and the right to request a fair hearing at any time if the enrollee believes there has been a violation of the Washington Administrative Code. For appeals regarding denial of service, that are resolved in favor of the enrollee, the notice of resolution will include information about how the enrollee may obtain services, supports available to assist in obtaining service, and information that enrollees must initiate services within sixty days.

p. For appeals not resolved wholly in favor of the enrollees, the notice will also include the right to request a State Fair Hearing, the process for requesting a Fair Hearing, the right to request to continue to receive benefits while the hearing is pending, how to make the request, and notice for any circumstances in which the enrollee may be asked to pay for the cost of those benefits if the hearing decision upholds the original action.

q. When enrollees, providers, or inpatient providers have concerns about retaliation they will be offered assistance by the NSMHA.

r. The NSMHA will send a notice of action to the consumer about their right to request a fair hearing if the NSMHA fails to meet the timeline for disposition or extension of the appeal.

Enrollees or their representative may request a fair hearing, with the Office of Administrative Hearings within 20 days of the date of the NSMHA's notice of disposition of the appeal, if the disposition is not favorable to the enrollee. The enrollee or representative may also request a fair hearing at any time if they believe there has been a violation of the Washington Administrative Code. Enrollees or their representatives may file a request for expedited fair hearing if the enrollee and/or representative believe that the standard time for resolution would jeopardize the enrollee's ability to maintain or regain maximum function.

2. Expedited Appeals Process-Additional Requirements

Enrollees or their representatives may file a request for expedited appeal if the enrollee and/or representative believe that the standard time for resolution would jeopardize the enrollee's ability to maintain or regain maximum function.

If an expedited appeal is requested and the NSMHA determines, or a provider or inpatient provider indicates, that that taking the time for a standard resolution could seriously jeopardize the enrollee's life, mental health, or ability to attain, maintain, or regain maximum function, the NSMHA will meet the additional requirements below:

a. Requests for expedited resolution may be initiated orally and are not required to be followed by a written signed request by the enrollee or representative.

b. The NSMHA will make a decision on the enrollee's request for expedited appeal and provide notice, as expeditiously as the enrollee's mental health condition requires, within three (3) working days or sooner based on the medical necessity of the enrollee. The NSMHA will also make reasonable efforts to provide oral notice.
c. The NSMHA may extend the three (3) working days timeframe by up to 14 calendar days if:

1) The consumer or provider acting on behalf of the consumer requests the extension and there is written agreement
2) If the NSMHA extends the timeframes, when the consumer does not request an extension, the NSMHA will give the consumer written notice of the reason for the delay.
3) The NSMHA will provide the enrollee a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing and inform the enrollee of the limited time available for expedited resolutions.
4) The NSMHA will ensure that retaliation or punitive action is not taken against an enrollee or provider who requests an expedited resolution or supports an enrollee's appeal.
5) If the NSMHA denies a request for expedited resolution of an appeal, it will transfer the appeal to the timeframe for standard resolution; and make reasonable efforts to give the enrollee prompt oral notice of the denial, follow up within two (2) calendar days with a written notice, and inform the consumer of their right to file a grievance regarding the denial of expediency.

B. Continuation of Services/Benefits during the Appeals Process

The NSMHA will continue the enrollee's Services/Benefits if all of the following apply:

1. The enrollee or the provider files the appeal on or before the later of the following:

    a) Within 10 calendar days of receipt of the NSMHA notice of action, which for actions involving services previously authorized, must be delivered by a method which certifies receipt and assures delivery within three (3) calendar days of the intended effective date of the NSMHA or formal designee's proposed action or
    b) The intended effective date of the NSMHA's proposed action.

2. The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment.
3. Services were requested by an authorized community mental health agency.
4. The enrollee requests a continuation of services/benefits, and
5. The original period covered by the original authorization has not expired at the time of the request for continuation of benefits.

If, at the enrollee's request, the NSMHA continues or reinstates the enrollee's services while the appeal is pending, the services must be continued until one of the following occurs:

1. The enrollee withdraws the appeal.
2. Ten days pass after the NSMHA mails notice of disposition of an appeal and the resolution is not in favor of the enrollee, unless the enrollee requests a State Fair Hearing (with continuation of services until the Department of Social and Health Services fair hearing decision is reached), or
3. The State Office of Administrative Hearings (OAH) issues a fair hearing decision adverse to the enrollee.

Enrollees who request continuation of benefits will be notified that if the final resolution of the appeal is adverse to the enrollee (upholds the NSMHA or formal designee's action), the NSMHA may request the enrollee to reimburse the cost of the services furnished to the enrollee while the appeal was pending.

If the NSMHA fails to meet the timelines concerning any appeal, they will provide the services that are the subject of the appeal. The NSMHA will pay the community mental health agency to provide these services.

C. Effect of Reversed Resolutions of Appeals

1. If the NSMHA or the State Administrative Hearing Officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the NSMHA (or formal designee) must authorize and the community mental health agency must provide the disputed services promptly, and as expeditiously as the enrollee's mental health condition requires.
2. If the NSMHA or the State Administrative Hearing Officer reverses a decision to deny authorization of services, and the enrollee received the disputed services while the appeal was pending, the NSMHA and/or community mental health agency must pay for those services.
3. If the final resolution of the appeal upholds the NSMHA action, the regional support network may recover the amount paid for the services provided to the enrollee while the appeal was pending, to the extent that they were provided solely because of the requirement for continuation of services and in accordance with 42 CFR 431.230(b).

D. Notice of Action

The NSMHA must issue written notices of actions for Medicaid enrollees that explain the action the NSMHA intends to take, the reasons for the actions, and the right to file an appeal or expedited appeal of these actions. The notice of action will also outline the process to appeal an action.

1. General Requirements

Notices of Actions will explain the action the NSMHA intends to take, the reasons for the action, the enrollee's or the community mental health agency's (acting on behalf of the enrollee) right to file a NSMHA level appeal of the action, or request a fair hearing, the procedures for exercising the enrollee's rights, the circumstances under which expedited resolution is available and how to request it and the enrollee's right to have services continue pending resolution of an appeal, how to request that services be continued, and the circumstances under which the enrollee may be required to pay the costs of these services. The notice of action will also include the definitions of reduction, termination, suspension and denial.

2. Languages and Formatting

Notices of action will be in the enrollee's primary language and be easily understood as required in 42 CFR 438.10(c) and (d). Notices of actions will be available in the seven (7) prevalent DSHS non-English languages spoken by enrollees and potential enrollees in the North Sound Region. These languages are Cambodian, Chinese, Korean, Laotian, Russian, Spanish and Vietnamese. Oral interpretation services will be available free of charge to potential and current enrollees in all non-English languages.

Potential enrollees and enrollees will be notified that oral interpretation is available for any language; written information is available in the seven (7) prevalent non-English languages, and how to access those services.

Written notices of action will use easily understood language and format and be available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency. All enrollees and potential enrollees will be informed that information is available in alternative formats and how to access those.

3. Timeframes

Notices of action will be mailed as expeditiously as the enrollee's mental health condition requires and as follows:

a) For denial of payment, at the time of any action affecting the payment.
b) For standard service authorization decisions that deny or limit services, not exceeding 14 days following receipt of the request for service. Under certain circumstances 14 additional days are possible.
c) For termination, suspension, or reduction of previously authorized Medicaid-covered services, at least ten (10) days before effective date of the action except if the criteria noted in 42 CFR 431.213 or 431.214 are met:

    1) The NSMHA has factual information confirming the death of a recipient.
    2) The NSMHA receives a clear written statement signed by a recipient that they no longer wish services or gives information that requires termination or reduction of services and indicates that they understand that this must be the result of supplying that information.
    3) The recipient has been admitted to an institution where he or she is ineligible under the plan for further services.
    4) The recipient's whereabouts' are unknown and the post office returns NSMHA mail directed to the recipient indicating no forwarding address.
    5) The NSMHA establishes the fact that the recipient has been accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth.
    6) The recipient's physician prescribes a change in the level of medical care.
    7) The notice involves an adverse determination made with regard to the pre-admission screening requirements of section 1919(e) (7) of the Act.

8) The date of action will occur in less than ten (10) days, in accordance with Sec. 483.12 (a) (5) (ii), which provides exceptions to the 30-day notice requirements of Sec. 483.12 (a) (5) (i), (Long Term Care Requirements), or
9) The NSMHA has facts indicating that the recipient should take action because of probable fraud and the facts have been verified, if possible, through secondary services.

For exceptions (1) through (8) above the NSMHA may mail the notice of action not later than the date of action. In the case of fraud, the NSMHA may mail the notice of action five (5) days in advance of the action.

Notices of actions involving services previously authorized must be delivered by a method, which certifies receipt and assures delivery within three (3) calendar days or the intended effective date of the NSMHA's proposed action.

d) For service authorization decisions not reached in accordance with the established timeframes in a through c above (which constitute a denial and an adverse action and are subject to appeal) on the date the timeframe expires.

Effective Date: 6/29/2004, BOD Approved, Motion #04-027
Revised Date: November 17, 2005
Review Date:

North Sound Mental Health Administration

Section 1000 – Administrative: Fair Hearing

Authorizing Source: 42 CFR 438.214

Cancels:
See Also:
Responsible Staff: Quality Manager

Approved by Board of Directors Date:
Motion #:

N. POLICY #1004.00

O. SUBJECT: FAIR HEARING

P. PURPOSE

The purpose of the North Sound Mental Health Administration (NSMHA) Fair Hearing Policy is to outline the State Fair Hearing process and requirements. (See 1001- NSMHA Complaint, Grievance, Appeal, and Fair Hearing Policy General Policy Requirements, 1002-NSMHA Complaint and Grievance Policy, and 1003 NSMHA Appeal Policy for information about additional policy requirements.)

Q. FAIR HEARING POLICY

A. Rights to Request a Fair Hearing

Consumers and their representatives have the right to request the Department of Social and Health Services (DSHS) pre-hearing and administrative hearing processes as described in Chapter 388-02 WAC when:

1. A consumer believes there has been a violation of the Washington Administrative Code.
2. A Medicaid enrollee does not receive a favorable disposition of an appeal by the NSMHA.
3. A consumer does not receive a favorable disposition of a grievance from the NSMHA.

Medicaid enrollees or their representative may also request an expedited fair hearing when the enrollee or representative believes that taking the time for standard resolution would jeopardize the enrollee ability to maintain or regain maximum functioning.

B. Assistance with Fair Hearings

The NSMHA will provide assistance to consumers in pursuing fair hearings. Ombuds Services are also available to investigate, advocate, and assist consumers throughout the fair hearing process at no cost.

Consumers may have a representative who acts on their behalf in requesting a fair hearing. Consumers may also have representatives of their choice involved in the process. There will be no retaliation against a consumer who requests a fair hearing. Consumers may contact the NSMHA if they have concerns about retaliation.

C. Timelines to File a Fair Hearing

If consumers do not receive favorable disposition of a grievance or appeal (enrollees) by the NSMHA, they may request a fair hearing. The request for fair hearing must be filed within 20 days from the date of adverse ruling for appeals or 20 days of notice of disposition of grievances.

If consumers believe there has been a violation of the Washington Administrative Code or the NSMHA or providers have violated certain timelines, they may request a fair hearing at any time. Consumers may call the OAH at 1-800-583-8271 or Ombuds Services to inquire about qualifying for a state fair hearing prior to utilizing the NSMHA grievance or appeals process.

If consumers are unhappy with the NSMHA's decision about a grievance, they may under certain circumstances request additional consideration of the grievance by the mental health division. Consumers must request consideration within five (5) days of receipt of the NSMHA decision.

D. Where to Request a Fair Hearing

Consumers may request a fair hearing with the Office of Administrative Hearings (OAH) at 1-800-583-8271. The OAH is part of state government. Consumers may also contact the NSMHA Ombuds Services toll free at 1-888-336-6164 or the NSMHA for assistance in requesting a fair hearing.

E. Continuation of Benefits/Services during the Fair Hearing Process

Consumers may request that their previously authorized services or benefits continue or are reinstated during the fair hearing process, following a grievance. However, in some circumstances, if a grievance is not resolved in the consumer's favor, they may be asked to pay for these services.

Medicaid enrollees may, under certain circumstances request that their previously authorized services or benefits continue or are reinstated during the fair hearing process, following an appeal. (See 1002- NSMHA Complaint and Grievance Policy and 1003- NSMHA Appeal Policy for additional information and requirements.)

F. Reversed Resolutions of Appeals

If the state fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while an appeal was pending, the NSMHA or formal designee and providers must authorize or provide the disputed services promptly, and as expeditiously as the enrollee's mental health condition requires.

If the state fair hearing officer reverses a decision to deny authorization of services and the enrollee received the disputed services while the appeal was pending, the NSMHA or providers must pay for those services.

If the final resolution of the appeal upholds the NSMHA action, the NSMHA may recover the amount paid for the services provided to the enrollee while the appeal was pending, to the extent that they were provided solely because of the requirement for continuation of services and in accordance with CFR42.431.230 (b).

G. Additional Requirements for Fair Hearings

For fair hearings that involve appeals, parties to the fair hearing include, the NSMHA, the consumer, and the consumer's representative or the representative of a deceased consumer's estate.

The NSMHA, community mental health agencies, designees, networks, and other contracted individuals and providers will cooperate with and abide by promptly all administrative hearing procedures and decisions. The NSMHA will require this in contracts and will monitor this requirement.

North Sound Mental Health Administration

Clinical Eligibility and Care Standards

For

Publicly-Funded Mental Health Services

Effective 1-1-06

DRAFT Four

Table of Contents

Introduction

This document, the NSMHA Clinical Eligibility and Care Standards for Publicly Funded Mental Health Services 2006-2007, defines NSMHA service standards and level of care guidelines. It is to be read and utilized in conjunction with the contract, NSMHA Core Values and Principles, and all pertinent State and Federal Requirements, and Washington State Administrative Codes, particularly WAC 388-865 or its successor.

The Mental Health Division's State-wide Access to Care Standards, which are the minimum eligibility requirements are also a core component of this document.

Eligibility

All consumers are eligible for crisis, ITA, and Inpatient care.

Medicaid enrollees are also eligible for all Outpatient and Residential levels of care and clinical services based on medical necessity and the Access to Care Standards.

Consumers without Medicaid are also eligible for Outpatient and Residential services based on medical necessity and the Access to Care Standards and ***within available resources*** to the following priority populations (listed in priority order):

1. Low-income individuals released from state and community hospitals and jails
2. Low-income persons in crisis who are at risk of hospitalization
3. Low-income frequent high utilizers of mental health and other public services (such as emergency services and criminal justice services)
4. All other low-income individuals

Low income is defined as individuals and families at no more than 200% of federal poverty level.

Intake

All Medicaid enrollees requesting routine covered mental health outpatient services are authorized for an intake evaluation as defined in the Medicaid State Plan. A request for mental health services is defined as a point in time when mental health services are sought or applied for through a telephone call, EPSDT referral, walk-in, or written request for mental health services. There is no limit on the number of intakes.

All consumers without Medicaid requesting state-funded routine covered mental health outpatient services within available resources will be screened to determine if they meet the above priority population criteria. If so, they will be authorized for a face to face intake to determine medical necessity per the Access to Care Standards.

NSMHA PHILOSOPHICAL FOUNDATIONS and VALUES
Recovery Model

NSMHA promotes the use of recovery and resilience oriented services. We provide ongoing training and information to our staff and subcontracted providers on these strategies and services that promote wellness, recovery, and resilience.

- Mental health will be understood as an essential element of overall health.
- Mental illness shall be understood as a condition from which people can and do recover.
- Recovery from mental illness involves regaining a sense of purpose and control over one's life that overcomes, to the extent possible, limitations imposed by the illness.
- Recovery-oriented approaches provide opportunities for consumers to manage their mental illness; rebound from adversity, trauma, tragedy, threats, or other stresses; maintain their independence; and live productive lives.
- Wellness/recovery models are integrated into culturally competent individualized service plans. The individualized service plan shall include information on quality of life outcomes, as desired by the consumer.

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 many 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.

Outreach

Engagement (Outreach) services – The NSMHA is committed to locating and engaging those needing services such as providing outreach to consumers, including homeless persons and families as defined in Public Law 100-77, and home-bound individuals.
Outreach is a required activity for all NSMHA providers.

We are committed to providing mental health services that are community-based and taking services to the person in their natural environment whenever possible.

Continuity of Care

NSMHA requires that children and their parents/caregivers/families are served at the same agency whenever possible.

NSMHA requires that adolescent consumers reaching the age of majority are provided continuity of care without service disruptions or mandatory changes in service providers.

We encourage our providers to assign enrollees to clinicians who are anticipated to provide services to the consumer throughout the authorization period.

Quality Care

Although specific interventions are not generally prescribed, the NSMHA does expect continuous movement toward treatment methodologies and evidence-based and promising practices that demonstrate the highest (research-based) likelihood of positive outcomes and movement toward recovery and resilience.

This document, the contract, and pertinent Federal and State requirements, establish a base of NSMHA's standards against which service provision will be measured.

CRISIS SERVICES

ELIGIBILITY

Any individual currently located in NSMHA geographical area who is in crisis (defined in the crisis services modality as a turning point in the course of anything decisive or critical, a time, a stage or an event or a time of great danger or trouble whose outcome decides whether possible bad consequences will follow), who meets the criteria of WAC 388-865, is referred for evaluation for ITA services, or is willing to accept voluntary crisis intervention services regardless of age, county of residence, enrollment status with another RSN, funding source, and/or ability to pay.

SERVICES

Crisis services are available on a 24/7 basis. Crisis services are intended to stabilize the person in crisis, prevent further deterioration and provide immediate treatment and intervention in a location best suited to meet the needs of the individual and in the least restrictive environment available. Crisis services may be provided prior to the completion of an intake evaluation. Services are provided by or under the supervision of a mental health professional. Crisis services are provided in an emergent response within two hours or an urgent response (within 24 hours) based on clinical need. Consumers in crisis will be screened over the telephone by the Crisis Line to determine clinical need and the Crisis Line will dispatch crisis staff or ITA personnel as required. The intensity of crisis services will be individualized to the individual's immediate needs.

COORDINATION OF SERVICES AND CLINICAL OVERSIGHT

Each CMHA is responsible for the management, quality assurance and improvement, and clinical oversight of crisis services provided. Such services are subject to protocols and policies and procedures as developed and maintained by NSMHA in consultation with the Regional ICRS committee, which are consistent with the Crisis Response System Values and Principles as outlined in NSMHA contracts. CMHA policies and procedures shall not conflict with any such requirements established currently or in the future by the NSMHA.

ICRS Service Components are defined in NSMHA policies and procedures, including designated crisis responder responsibilities.

OUTPATIENT SERVICES

R. Access

Individuals/families seeking mental health services within the NSMHA will be assisted by mental health clinicians who are skilled at triage and screening functions and responsive to the caller's identified needs. The first level of screening will be for safety concerns. If emergent (two hour response) or urgent (24 hour response) is needed, the caller will be immediately connected to crisis services where Mental Health Professionals are available for consultation. The next level of screening will be for Medicaid coverage. Individuals who have a current medical coupon (meet financial eligibility) will be offered an assessment appointment with a NSMHA provider agency (to determine clinical eligibility) within 10 working days. Individuals without Medicaid will be offered state-funded mental health services according to established NSMHA priorities, as resources are available. Response to access calls will meet all standards and requirements and be friendly and helpful.

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

Assessment for Determination of Clinical Eligibility

Washington State's Mental Health Division has adopted State-wide Access to Non-Emergency Care Standards. Decisions regarding Clinical Eligibility are made using the Access to Care (ACS) standards. The Statewide standards have been incorporated into all NSMHA provider contracts.

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 within 30 seconds 90% of the time with a 3% abandonment rate	NSMHA
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
Consumers will be informed to bring all pertinent information and available medical records to assist in determining clinical eligibility	NSMHA
Access staff will inform individuals that they are encouraged to bring family and/or natural supports to initial assessment, if desired	MHD
An appointment is offered to occur for a face-to-face contact within seven days of discharge from community inpatient care and state hospitals	MHD
An initial face-to-face full multi-axial assessment will be authorized and offered to occur within ten working days of completed request for services for all eligible consumers	MHD Contract
Access staff will seek information from the consumer requesting services regarding age, culture, language, gender, and physical condition, and/or special requests	NSMHA
Information and assistance, referral and/or service appointment.	NSMHA

Outpatient Intake and Ongoing 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.

Statewide Standard: Assessment is provided face to face by a mental health professional and determines the presence of a covered mental health diagnosis. Assessment by 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 at a minimum of 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 including the provision of certified interpreters.

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

At the conclusion of the assessment the consumer will be notified in writing of the services they are eligible for, their determined level of care, how medical necessity was determined and the services available within their determined level of care and their choice of services and providers. If the consumer does not meet the Access to Care and medical necessity criteria they will be informed, if Medicaid, by a Notice of Action form generated by the NSMHA. If unfunded and seeking state-funded services and denied because they do not meet the Access to Care and medical necessity criteria, they will be notified by the North Sound Mental Health Administration through oral or written means of the decision and how to file a grievance if they so choose.

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
Assessments will be offered within 10 working days of completed request for services	MHD
Assessments will be conducted by MHPs	MHD
Assessment of children/youth will be performed by a Children's Specialist	MHD
Assessments must be completed according to the NSMHA Assessment for Ongoing Services policy.	NSMHA Contract
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 Contract 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
Assessments shall be conducted at locations in the community, as needed	WACs 388-865-0415
The MHD Medicaid Benefit Booklet will be provided at assessment	MHD
The NSMHA Brochure will be provided at assessment	MHD
The NSMHA and provider Notice of Privacy Practices will be given at assessment	MHD
Washington State information regarding Advance Directives will be given at Assessment	MHD
Consumer rights will be given at assessment	MHD
Telesage outcome assessment will be initiated at assessment	MHD

Regional Requirement	**Source of Requirement**
Routine mental health services are offered to occur within 14 calendar days of the determination of eligibility	MHD
Consumers will be informed of their determined level of care, how medical necessity was determined and the services available within that level of care.	MHD
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)	

Access to Care Standards – 11/25/03
Eligibility Requirements for Authorization of Services for Medicaid Adults & Medicaid Older Adults

Please note: <u>The guidelines are not intended to be applied as continuing stay criteria.</u>

An individual must meet all of the following before being considered for a level of care assignment:

* The individual is determined to have a mental illness. The diagnosis must be included as a covered diagnosis in the list of Covered Adult & Older Adult 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 can not be more appropriately met by any other formal or informal system or support.

**** = Descriptive Only***

	Level One - Brief Intervention	**Level Two - Community Support**
Goal & 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 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 **OR** may be up to twelve months of care when an individual is receiving long term, low intensity treatment.	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).
Functional Impairment **<u>Must be the result of a mental illness.</u>**	* **Must demonstrate moderate functional impairment in at least <u>one</u> life domain requiring assistance in order to meet the identified need AND-** * **<u>Impairment is evidenced by a Global Assessment of Functioning (GAF) Score of 60 or below.</u>** **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 & Stability * Work, school, daycare, pre-school or other daily activities * Ability to use community resources to fulfill needs	* **Must demonstrate serious functional impairment in at least <u>one</u> life domain requiring assistance in order to meet the identified need AND-** * **<u>Impairment is evidenced by a Global Assessment of Functioning (GAF) Score of 50 or below.</u>** **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 & Stability * Work, school, daycare, pre-school or other daily activities * Ability to use community resources to fulfill needs

Access to Care Standards – 11/25/03
Eligibility Requirements for Authorization of Services for Medicaid Adults & Medicaid Older Adults

Please note: <u>The guidelines are not intended to be applied as continuing stay criteria.</u>

An individual must meet all of the following before being considered for a level of care assignment:

* The individual is determined to have a mental illness. The diagnosis must be included as a covered diagnosis in the list of Covered Adult & Older Adult 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 can not be more appropriately met by any other formal or informal system or support.

**** = Descriptive Only***

	Level One - Brief Intervention	Level Two - Community Support
Covered Diagnosis	Assessment is provided by or under the supervision of a mental health professional and determines the presence of a covered mental health diagnosis. Special population consultation should be considered. Diagnosis A = Covered Diagnosis B = Covered + One Additional Criteria (See Covered Adult & Older Adult Disorders)	Assessment is provided by or under the supervision of a mental health professional and determines the presence of a covered mental health diagnosis. Special population consultation should be considered. Diagnosis A = Covered Diagnosis B = Covered + One Additional Criteria (See Covered Adult & Older Adult Disorders)
Supports & 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 requiring coordination. Requires treatment to develop supports, address needs and remain in the community.	May have lack of or severely limited natural supports in the community due to mental illness. May be involvement 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.
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 and individual need.	Access to the following modalities is based on clinical assessment, medical necessity and individual need. <u>In addition to the modalities listed in Level of Care One</u>, individuals may be referred for the following treatment: * Individual Treatment * Medication Monitoring * Peer Support The full scope of available treatment modalities may be provided based on clinical assessment, medical necessity and individual need.
Dual Diagnosis	Individuals who have both a covered and a non-covered diagnosis are eligible for service based on the covered diagnosis.	Individuals who have both a covered and a non-covered diagnosis are eligible for service based on the covered diagnosis.

Access to Care Standards – 11/25/03
Eligibility Requirements for Authorization of Services for Medicaid Children & Youth

Please note: <u>The guidelines are not intended to be applied as continuing stay criteria.</u>

An individual must meet all of the following before being considered for a level of care assignment:

* The individual is determined to have a mental illness. The diagnosis must be included as a covered diagnosis in the list of Covered Childhood 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.

**** = Descriptive Only***

	Level One - Brief Intervention	**Level Two - Community Support**
Goal & 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 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 **OR** may be up to twelve months of care when an individual is receiving long term, low intensity treatment.	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).
Functional Impairment **Must be the result of an emotional disorder or a mental illness.**	* **Must demonstrate moderate functional impairment in at least <u>one</u> life domain requiring assistance in order to meet the identified need AND-** * **<u>Impairment is evidenced by a Children's Global Assessment Scale (CGAS) Score of 60 or below.</u>** (Children under 6 are exempted from CGAS.) **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 & Stability * Work, school, daycare, pre-school or other daily activities * Ability to use community resources to fulfill needs	* **Must demonstrate severe and persistent functional impairment in at least <u>one</u> life domain requiring assistance in order to meet identified need AND-** * **<u>Impairment is evidenced by a Children's Global Assessment Scale (CGAS) Score of 50 or below.</u>** (Children under 6 are exempted from CGAS.) **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 & Stability * Work, school, daycare, pre-school or other daily activities * Ability to use community resources to fulfill need

Access to Care Standards – 11/25/03
Eligibility Requirements for Authorization of Services for Medicaid Children & Youth

Please note: <u>The guidelines are not intended to be applied as continuing stay criteria.</u>

An individual must meet all of the following before being considered for a level of care assignment:

* The individual is determined to have a mental illness. The diagnosis must be included as a covered diagnosis in the list of Covered Childhood 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.

**** = Descriptive Only***

	Level One - Brief Intervention	Level Two - Community Support
Covered Diagnosis	Assessment is provided by or under the supervision of 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 = Covered Diagnosis B = Covered + One Additional Criteria (See Covered Childhood Disorders)	Assessment is provided by or under the supervision of 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 = Covered Diagnosis B = Covered + One Additional Criteria (See Covered Childhood Disorders)
Supports & 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.	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 child serving system requiring coordination.
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. Children eligible for Level One EPSDT services in the 1992 EPSDT plan are included here.	Children eligible for Level Two EPSDT services in the 1992 EPSDT plan are defined as needing 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.

Access to Care Standards – 11/25/03
Eligibility Requirements for Authorization of Services for Medicaid Children & Youth

Please note: <u>The guidelines are not intended to be applied as continuing stay criteria.</u>

An individual must meet all of the following before being considered for a level of care assignment:

* The individual is determined to have a mental illness. The diagnosis must be included as a covered diagnosis in the list of Covered Childhood 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.

**** = Descriptive Only***

	Level One - Brief Intervention	Level Two - Community Support
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.	**Access to the following modalities is based on clinical assessment, medical necessity and individual need. <u>In addition to the modalities listed in Level of Care One,</u> individuals may be referred for 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.
Dual Diagnosis	Individuals who have both a covered and a non-covered diagnosis may be eligible for service based on the covered diagnosis.	Individuals who have both a covered and a non-covered diagnosis may be eligible for service based on the covered diagnosis.

Washington State Medicaid Program
Minimum Covered Diagnoses for Medicaid Adults & Medicaid Older Adults
11-25-03

Washington State defines acutely mentally ill, chronically mental ill adult, seriously disturbed person, and severely emotionally disturbed child in RCW 71.24 and RCW 71.05. The following diagnoses are considered to further interpret the statute criteria in establishing eligibility under the Washington State Medicaid Program. Additional eligibility requirements must be met to qualify for outpatient mental health services. Minimum eligibility requirements for authorization of services for Medicaid Adults and Older Adults are further defined in the Access to Care Standards.

Please note: *The following covered diagnoses must be considered for eligibility. RSN's may choose to expand this list based on savings generated from Medicaid capitation payments.*

DSM-IV-TR CODE	DSM-IV-TR DEFINITION	A = Covered B = Covered with Additional Criteria
	ATTENTION-DEFICIT AND DISRUPTIVE BEHAVIOR DISORDERS	
314.01	Attention-Deficit/Hyperactivity Disorder, Combined type	B
314.00	Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type	B
314.01	Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulsive Type	B
314.9	Attention-Deficit/Hyperactivity Disorder DOS	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
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	

DSM-IV-TR CODE	DSM-IV-TR DEFINITION	A = Covered B = Covered with Additional Criteria
294.9	Cognitive Disorder NOS	B
	SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS	
295.30	Schizophrenia Paranoid Type	A
295.10	Schizophrenia Disorganized Type	A
295.20	Schizophrenia Catatonic Type	A
295.90	Schizophrenia Undifferentiated Type	A
295.60	Schizophrenia Residual Type	A
295.40	Schizophreniform Disorder	A
295.70	Schizoaffective Disorder	A
297.1	Delusional Disorder	A
298.8	Brief Psychotic Disorder	A
297.3	Shared Psychotic Disorder	A
293.81	Psychotic Disorder Due to *(Indicate the General Medical Condition)* With Delusions	A
293.82	Psychotic Disorder Due to *(Indicate the General Medical Condition)* With Hallucinations	A
298.9	Psychotic Disorder NOS	A
	MOOD DISORDERS **DEPRESSIVE DISORDERS**	
296.21	Major Depressive Disorder Single Episode, Mild	A
296.22	Major Depressive Disorder Single Episode, Moderate	A
296.23	Major Depressive Disorder Single Episode, Severe Without Psychotic Features	A
296.24	Major Depressive Disorder Single Episode, Severe With Psychotic Features	A
296.25	Major Depressive Disorder Single Episode, In Partial Remission	A
296.26	Major Depressive Disorder Single Episode, In Full Remission	A
296.20	Major Depressive Disorder Single Episode, Unspecified	A
296.31	Major Depressive Disorder Recurrent, Mild	A
296.32	Major Depressive Disorder Recurrent, Moderate	A
296.33	Major Depressive Disorder Recurrent, Severe Without Psychotic Features	A
296.34	Major Depressive Disorder Recurrent, Severe With Psychotic Features	A
296.35	Major Depressive Disorder Recurrent, In Partial Remission	A
296.36	Major Depressive Disorder Recurrent, In Full Remission	A
296.30	Major Depressive Disorder Recurrent, Unspecified	A
300.4	Dysthymic Disorder	B
311	Depressive Disorder NOS	B
	BIPOLAR DISORDERS	
296.01	Bipolar I Disorder Single Manic Episode, Mild	A
296.02	Bipolar I Disorder Single Manic Episode, Moderate	A
296.03	Bipolar I Disorder Single Manic Episode, Severe Without Psychotic Features	A
296.04	Bipolar I Disorder Single Manic Episode, Severe With Psychotic Features	A
296.05	Bipolar I Disorder Single Manic Episode, In Partial Remission	A
296.06	Bipolar I Disorder Single Manic Episode, In Full Remission	A
296.00	Bipolar I Disorder Single Manic Episode, Unspecified	A
296.40	Bipolar I Disorder Most Recent Episode Hypomanic	A
296.41	Bipolar I Disorder Most Recent Episode Manic, Mild	A
296.42	Bipolar I Disorder Most Recent Episode Manic, Moderate	A
296.43	Bipolar I Disorder Most Recent Episode Manic, Severe Without Psychotic Features	A
296.44	Bipolar I Disorder Most Recent Episode Manic, Severe With Psychotic Features	A
296.45	Bipolar I Disorder Most Recent Episode Manic, In Partial Remission	A
296.46	Bipolar I Disorder Most Recent Episode Manic, In Full Remission	A
296.40	Bipolar I Disorder Most Recent Episode Manic, Unspecified	A
296.61	Bipolar I Disorder Most Recent Episode Mixed, Mild	A

DSM-IV-TR CODE	DSM-IV-TR DEFINITION	A = Covered B = Covered with Additional Criteria
296.62	Bipolar I Disorder Most Recent Episode Mixed, Moderate	A
296.63	Bipolar I Disorder Most Recent Episode Mixed, Severe Without Psychotic Features	A
296.64	Bipolar I Disorder Most Recent Episode Mixed, Severe With Psychotic Features	A
296.65	Bipolar I Disorder Most Recent Episode Mixed, In Partial Remission	A
296.66	Bipolar I Disorder Most Recent Episode Mixed, In Full Remission	A
296.60	Bipolar I Disorder Most Recent Episode Mixed, Unspecified	A
296.51	Bipolar I Disorder Most Recent Episode Depressed, Mild	A
296.52	Bipolar I Disorder Most Recent Episode Depressed, Moderate	A
296.53	Bipolar I Disorder Most Recent Episode Depressed, Severe Without Psychotic Features	A
296.54	Bipolar I Disorder Most Recent Episode Depressed, Severe With Psychotic Features	A
296.55	Bipolar I Disorder Most Recent Episode Depressed, In Partial Remission	A
296.56	Bipolar I Disorder Most Recent Episode Depressed, In Full Remission	A
296.50	Bipolar I Disorder Most Recent Episode Depressed, Unspecified	A
296.7	Bipolar I Disorder Most Recent Episode Unspecified	A
296.89	Bipolar II Disorder	A
301.13	Cyclothymic Disorder	B
296.80	Bipolar Disorder NOS	A
296.90	Mood Disorder NOS	B
	ANXIETY DISORDERS	
300.01	Panic Disorder Without Agoraphobia	B
300.21	Panic Disorder With Agoraphobia	B
300.22	Agoraphobia Without History of Panic Disorder	B
300.29	Specific Phobia	B
300.23	Social Phobia	B
300.3	Obsessive-Compulsive Disorder	B
309.81	Posttraumatic Stress Disorder	A
308.3	Acute Stress Disorder	A
300.02	Generalized Anxiety Disorder	B
300.00	Anxiety Disorder NOS	B
	SOMATOFORM DISORDERS	
300.81	Somatization Disorder	B
300.82	Undifferentiated Somatoform Disorder	B
300.11	Conversion Disorder	B
307.80	Pain Disorder Associated With Psychological Factors	B
307.89	Pain Disorder Associated With Both Psychological Factors and a General Medical Condition	B
300.7	Hypochondriasis	B
300.7	Body Dysmorphic Disorder	B
300.82	Somatoform Disorder NOS	B
	FACTITIOUS DISORDERS	
300.16	Factitious Disorder With Predominantly Psychological Signs and Symptoms	B
300.19	Factitious Disorder With Predominantly Physical Signs and Symptoms	B
300.19	Factitious Disorder With Combined Psychological and Physical Signs and Symptoms	B
300.19	Factitious Disorder NOS	B
	DISSOCIATIVE DISORDERS	
300.12	Dissociative Amnesia	B
300.13	Dissociative Fugue	B
300.14	Dissociative Identity Disorder	B
300.6	Depersonalization Disorder	B
300.15	Dissociative Disorder NOS	B
	SEXUAL AND GENDER IDENTITY DISORDERS	

DSM-IV-TR CODE	DSM-IV-TR DEFINITION	A = Covered B = Covered with Additional Criteria
	EATING DISORDERS	
307.1	Anorexia Nervosa	B
307.51	Bulimia Nervosa	B
307.50	Eating Disorder NOS	B
	ADJUSTMENT DISORDERS	
309.0	Adjustment Disorder With Depressed Mood	B
309.24	Adjustment Disorder With Anxiety	B
309.28	Adjustment Disorder With Mixed Anxiety and Depressed Mood	B
309.3	Adjustment Disorder With Disturbance of Conduct	B
309.4	Adjustment Disorder With Mixed Disturbance of Emotions and Conduct	B
309.9	Adjustment Disorder Unspecified	B
	PERSONALITY DISORDERS	
301.0	Paranoid Personality Disorder	B
301.20	Schizoid Personality Disorder	B
301.22	Schizotypal Personality Disorder	B
301.7	Antisocial Personality Disorder	B
301.83	Borderline Personality Disorder	B
301.50	Histrionic Personality Disorder	B
301.81	Narcissistic Personality Disorder	B
301.82	Avoidant Personality Disorder	B
301.6	Dependent Personality Disorder	B
301.4	Obsessive-Compulsive Personality Disorder	B
301.9	Personality Disorder NOS	B

Additional Criteria for Diagnosis B

An individual 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.

* 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 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 hospital admissions due to a mental health diagnosis during the previous two years
* 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
* 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)

Washington State Medicaid Program
Minimum Covered Diagnoses for Medicaid Children & Youth
11-25-03

Washington State defines acutely mentally ill, chronically mental ill adult, seriously disturbed person, and severely emotionally disturbed child in RCW 71.24 and RCW 71.05. The following diagnoses are considered to further interpret the statute criteria in establishing eligibility under the Washington State Medicaid Program. Additional eligibility requirements must be met to qualify for outpatient mental health services. Minimum eligibility requirements for authorization of services for Medicaid Children and Youth are further defined in the Access to Care Standards.

Please note: *The following covered diagnoses must be considered for coverage. RSNs may choose to expand this list based on savings generated from Medicaid capitation payments.*

DSM-IV-TR CODE	DSM-IV-TR DEFINITION	A = Covered B = Covered with Additional Criteria
	ATTENTION-DEFICIT AND DISRUPTIVE BEHAVIOR DISORDERS	
314.01	Attention-Deficit/Hyperactivity Disorder, Combined type	B
314.00	Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type	B
314.01	Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulsive Type	B
314.9	Attention-Deficit/Hyperactivity Disorder DOS	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
	SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS	
295.30	Schizophrenia Paranoid Type	A
295.10	Schizophrenia Disorganized Type	A
295.20	Schizophrenia Catatonic Type	A
295.90	Schizophrenia Undifferentiated Type	A
295.60	Schizophrenia Residual Type	A
295.40	Schizophreniform Disorder	A
295.70	Schizoaffective Disorder	A
297.1	Delusional Disorder	A
298.8	Brief Psychotic Disorder	A
297.3	Shared Psychotic Disorder	A
293.81	Psychotic Disorder Due to *(Indicate the General Medical Condition)* With Delusions	A
293.82	Psychotic Disorder Due to *(Indicate the General Medical Condition)* With Hallucinations	A
298.9	Psychotic Disorder NOS	A
	MOOD DISORDERS	
	DEPRESSIVE DISORDERS	
296.22	Major Depressive Disorder Single Episode, Moderate	A
296.23	Major Depressive Disorder Single Episode, Severe Without Psychotic Features	A

DSM-IV-TR CODE	DSM-IV-TR DEFINITION	A = Covered B = Covered with Additional Criteria
296.24	Major Depressive Disorder Single Episode, Severe With Psychotic Features	A
296.25	Major Depressive Disorder Single Episode, In Partial Remission	A
296.26	Major Depressive Disorder Single Episode, In Full Remission	A
296.20	Major Depressive Disorder Single Episode, Unspecified	A
296.31	Major Depressive Disorder Recurrent, Mild	A
296.32	Major Depressive Disorder Recurrent, Moderate	A
296.33	Major Depressive Disorder Recurrent, Severe Without Psychotic Features	A
296.34	Major Depressive Disorder Recurrent, Severe With Psychotic Features	A
296.35	Major Depressive Disorder Recurrent, In Partial Remission	A
296.36	Major Depressive Disorder Recurrent, In Full Remission	A
296.30	Major Depressive Disorder Recurrent, Unspecified	A
300.4	Dysthymic Disorder	A
311	Depressive Disorder NOS	A
	BIPOLAR DISORDERS	
296.01	Bipolar I Disorder Single Manic Episode, Mild	A
296.02	Bipolar I Disorder Single Manic Episode, Moderate	A
296.03	Bipolar I Disorder Single Manic Episode, Severe Without Psychotic Features	A
296.04	Bipolar I Disorder Single Manic Episode, Severe With Psychotic Features	A
296.05	Bipolar I Disorder Single Manic Episode, In Partial Remission	A
296.06	Bipolar I Disorder Single Manic Episode, In Full Remission	A
296.00	Bipolar I Disorder Single Manic Episode, Unspecified	A
296.40	Bipolar I Disorder Most Recent Episode Hypomanic	A
296.41	Bipolar I Disorder Most Recent Episode Manic, Mild	A
296.42	Bipolar I Disorder Most Recent Episode Manic, Moderate	A
296.43	Bipolar I Disorder Most Recent Episode Manic, Severe Without Psychotic Features	A
296.44	Bipolar I Disorder Most Recent Episode Manic, Severe With Psychotic Features	A
296.45	Bipolar I Disorder Most Recent Episode Manic, In Partial Remission	A
296.46	Bipolar I Disorder Most Recent Episode Manic, In Full Remission	A
296.40	Bipolar I Disorder Most Recent Episode Manic, Unspecified	A
296.61	Bipolar I Disorder Most Recent Episode Mixed, Mild	A
296.62	Bipolar I Disorder Most Recent Episode Mixed, Moderate	A
296.63	Bipolar I Disorder Most Recent Episode Mixed, Severe Without Psychotic Features	A
296.64	Bipolar I Disorder Most Recent Episode Mixed, Severe With Psychotic Features	A
296.65	Bipolar I Disorder Most Recent Episode Mixed, In Partial Remission	A
296.66	Bipolar I Disorder Most Recent Episode Mixed, In Full Remission	A
296.60	Bipolar I Disorder Most Recent Episode Mixed, Unspecified	A
296.51	Bipolar I Disorder Most Recent Episode Depressed, Mild	A
296.52	Bipolar I Disorder Most Recent Episode Depressed, Moderate	A
296.53	Bipolar I Disorder Most Recent Episode Depressed, Severe Without Psychotic Features	A
296.54	Bipolar I Disorder Most Recent Episode Depressed, Severe With Psychotic Features	A
296.55	Bipolar I Disorder Most Recent Episode Depressed, In Partial Remission	A
296.56	Bipolar I Disorder Most Recent Episode Depressed, In Full Remission	A
296.50	Bipolar I Disorder Most Recent Episode Depressed, Unspecified	A
296.7	Bipolar I Disorder Most Recent Episode Unspecified	A
296.89	Bipolar II Disorder	A
301.13	Cyclothymic Disorder	B
296.80	Bipolar Disorder NOS	A
296.90	Mood Disorder NOS	A
	ANXIETY DISORDERS	
300.01	Panic Disorder Without Agoraphobia	A
300.21	Panic Disorder With Agoraphobia	A

DSM-IV-TR CODE	DSM-IV-TR DEFINITION	A = Covered B = Covered with Additional Criteria
300.22	Agoraphobia Without History of Panic Disorder	A
300.29	Specific Phobia	B
300.23	Social Phobia	B
300.3	Obsessive-Compulsive Disorder	A
309.81	Posttraumatic Stress Disorder	A
308.3	Acute Stress Disorder	A
300.02	Generalized Anxiety Disorder	A
300.00	Anxiety Disorder NOS	A
	SOMATOFORM DISORDERS	
300.81	Somatization Disorder	B
300.82	Undifferentiated Somatoform Disorder	B
300.11	Conversion Disorder	B
307.80	Pain Disorder Associated With Psychological Factors	B
307.89	Pain Disorder Associated With Both Psychological Factors and a General Medical Condition	B
300.7	Hypochondriasis	B
300.7	Body Dysmorphic Disorder	B
300.82	Somatoform Disorder NOS	B
	FACTITIOUS DISORDERS	
300.16	Factitious Disorder With Predominantly Psychological Signs and Symptoms	B
300.19	Factitious Disorder With Predominantly Physical Signs and Symptoms	B
300.19	Factitious Disorder With Combined Psychological and Physical Signs and Symptoms	B
300.19	Factitious Disorder NOS	B
	DISSOCIATIVE DISORDERS	
300.12	Dissociative Amnesia	B
300.13	Dissociative Fugue	B
300.14	Dissociative Identity Disorder	B
300.6	Depersonalization Disorder	B
300.15	Dissociative Disorder NOS	B
	SEXUAL AND GENDER IDENTITY DISORDERS	
	EATING DISORDERS	
307.1	Anorexia Nervosa	B
307.51	Bulimia Nervosa	B
307.50	Eating Disorder NOS	B
	ADJUSTMENT DISORDERS	
309.0	Adjustment Disorder With Depressed Mood	B
309.24	Adjustment Disorder With Anxiety	B
309.28	Adjustment Disorder With Mixed Anxiety and Depressed Mood	B
309.3	Adjustment Disorder With Disturbance of Conduct	B
309.4	Adjustment Disorder With Mixed Disturbance of Emotions and Conduct	B
309.9	Adjustment Disorder Unspecified	B
	PERSONALITY DISORDERS	
301.0	Paranoid Personality Disorder	B
301.20	Schizoid Personality Disorder	B
301.22	Schizotypal Personality Disorder	B
301.7	Antisocial Personality Disorder	B
301.83	Borderline Personality Disorder	B
301.50	Histrionic Personality Disorder	B
301.81	Narcissistic Personality Disorder	B
301.82	Avoidant Personality Disorder	B

DSM-IV-TR CODE	DSM-IV-TR DEFINITION	A = Covered B = Covered with Additional Criteria
301.6	Dependent Personality Disorder	B
301.4	Obsessive-Compulsive Personality Disorder	B
301.9	Personality Disorder NOS	B

Additional Criteria for Diagnosis B

An individual 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.
[Please note: CGAS is generally not considered valid for children under the age of six. The DC03 may be substituted. Children under six are exempted from Axis V scoring. 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 in the last bullet.]

* 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
* 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.
* Two or more hospital admissions due to a mental health diagnosis during the previous two years
* 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
* 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)
* 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:
    1. 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).
    2. 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).

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.

Child/Youth Level One	State-wide Standard	Regional Service 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).
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;	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

Child/Youth Level One	State-wide Standard	Regional Service Requirement
	• Home and family life; • Safety and stability; • Work, school, daycare, pre-school or other daily activities; • Ability to use community resources to fulfill needs.	
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
Minimum Modality Set	See State Access to Care. 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

Child/Youth Level One	State-wide Standard	Regional Service Requirement
Exclusionary Criteria	Substance abuse, alcoholism, mental retardation, pervasive dev. disorders, autism, learning disabilities, 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

Children and Youth Outpatient Services

Child/Youth Level Two	State-wide Standard	Regional Service 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
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.

Child/Youth Level Two	State-wide Standard	Regional Service Requirement
***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: See State Access to Care. 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.
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.

Children and Youth Outpatient Services

Child/Youth Level Two Plus	State-wide Standard	Regional Service 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
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

Child/Youth Level Two Plus	State-wide Standard	Regional Service Requirement
		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

Adult Level One	State-wide Standard	Regional Service 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).

Adult Level One	State-wide Standard	Regional Service Requirement
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.
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** I. Health & Self-Care, including the ability to access medical, dental and mental health care to include access to psychiatric medications II. Cultural Factors	

Adult Level One	State-wide Standard	Regional Service Requirement
	III. Home & Family Life, Safety and Stability IV. Work, school, daycare or other activities V. Ability to use community resources to fulfill needs.	
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: See State Access to Care. The full scope of available treatment modalities may be provided based on clinical assessment, medical necessity and individual need.	
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 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.	

Adult Outpatient

Adult Level Two	State-wide Standard	Regional Service 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.
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,	In addition to modalities available to consumer at Level One and the State-wide Level Two

Adult Level Two	State-wide Standard	Regional Service Requirement
	individual may be referred for the following treatment; See State Access to Care. The full scope of available treatment modalities may be provided based on clinical assessment, medical necessity and individual need.	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.	Integrated co-occurring treatment or Facilitated referrals to community services and supports, as needed. Coordination of cross-system services 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

Adult Level Two Plus	State-wide Standard	Regional Service 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 High Risk Care Manager will be assigned from NSMHA
Dual Diagnosis	Same as Level Two	Integrated co-occurring treatment or Facilitated referrals to community services and supports, as needed. Coordination of cross-system services as needed.
Exclusionary Criteria	Same as Level Two	Same as State Requirement

Involuntary Outpatient Services (LRA/CR)
Post-Inpatient Services

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

Requirements following involuntary, for consumers on LRA's/CR's	**Source of Requirement**
All State and Federal Requirements	Waiver, BBA, RCW, WAC's.
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	NSMHA
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/CR, agency staff is expected to coordinate with the CDMHP's regarding issues related to the consumer's ability to remain in the community and successfully complete the LRA/CR.	NSMHA
During the course of the LRA/CR, 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/CR or document clinical status changes that have occurred since discharge that may warrant a change in treatment approach.	NSMHA

Requirements following <u>involuntary</u>, for consumers on LRA's/CR's	**Source of Requirement**
During the course of the LRA/CR, 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.	NSMHA
Consumers on court order to continue services (LRA/CR) cannot be closed.	NSMHA

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.

MENTAL HEALTH SERVICES

IN

A RESIDENTIAL SETTING

The North Sound Mental Health Administration will ensure that consumers, who are clinically eligible, receive mental health services in residential settings consistent with their individual service plan.

All persons calling the Access Center who have mental health coverage through Medicaid or who are determined through screening to be eligible for State-only funded services as a priority population are referred to a provider agency for a face-to-face assessment by a Mental Health Professional as defined by the state of Washington to determine clinical eligibility and medical necessity.

An individual must meet all of the following before referral to mental health services in a residential setting:

- Is 18 or older
- 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
- Meets WAC requirements for resident characteristics)

The process for requesting and authorizing residential placements will be done in a timely manner that recognizes the consumer's needs.

Residential placement for adults will be authorized by the NSMHA Quality Management Department according to NSMHA guidelines for this level of care using standardized forms and procedures. NSMHA will prioritize residential placement according to the following:

1. Clients at Western State Hospital/PALS
2. Clients being discharged from inpatient facilities or E & T's
3. Clients who are homeless
4. Clients who are incarcerated
5. Clients who are high utilizers of crisis, inpatient and/or jail services or who are otherwise assessed as being at risk.
6. Other clients who meet medical necessity for this intensive level of care.

This modality is a specialized form of rehabilitation service (non hospital/non IMD) that offers a sub-acute psychiatric management environment. Individuals receiving this service present with severe impairment in psychosocial functioning or have apparent mental illness symptoms with an unclear etiology due to their mental illness and treatment cannot be safely provided in a less restrictive environment and do not meet hospital admission criteria. Individuals in this service require a different level of service than High Intensity Treatment. The Mental Health Care Provider is sited at the residential location (e.g., boarding homes, supported housing, cluster housing, SRO apartments) for extended hours to provide direct mental health care to a Medicaid enrollee. Therapeutic interventions both in individual and group format may include medication management and monitoring, stabilization, and cognitive and behavioral interventions designed with the intent to stabilize the individual and return him/her to more independent and less restrictive treatment. The treatment is not for the purpose of providing custodial care or respite for the family, nor is it for the sole purpose of increasing social activity or used as a substitute for other community-based resources. This service is billable on a daily rate. In order to bill the daily rate for

associated costs for these services, a minimum of 8 hours of service must be provided. This service does not include the costs for room and board, custodial care, and medical services, and differs for other services in the terms of location and duration.

For New Medicaid Clients/Medicaid Hospital Discharges needing residential placement

All callers who have mental health coverage through their Medicaid benefits are offered a face-to-face assessment appointment with a clinician who is a Mental Health Professional as defined by the state of Washington within 10 working days (not to exceed 14 calendar days) to determine service eligibility and the appropriate level of care. Assessment documents are completed within two (2) days of first face-to-face assessment appointment. If seeking information presents a barrier to service, the item is left blank and the reason documented in the clinical chart.

The agency clinician who is a Mental Health Professional as defined by the state of Washington doing the face-to-face assessment will determine if the person being referred meets medical necessity for services per the NSMHA Residential Admission Criteria and Access to Care Standards. The Intake clinician will complete the Request for Residential Authorization form and submit to the NSHMA Quality Management Department to determine appropriateness for residential services. If so, the person is accepted into services and NSMHA staff will facilitate referral to the appropriate facility and appropriate appointments are made.

If not, the decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested will be made by a NSMHA staff who is a health care professional and who has appropriate clinical expertise in treating the enrollee's condition or disease. NSMHA will notify the referring clinician, and give the enrollee written notice of any NSMHA action to deny the service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice to the provider need not be in writing.

For New State-Funded Clients/State-funded Hospital Discharges needing residential placement

All callers who have mental health coverage through their Medicaid benefits are offered a face-to-face assessment appointment with a clinician who is a Mental Health Professional as defined by the state of Washington within 10 working days (not to exceed 14 calendar days) to determine service eligibility and the appropriate level of care.

Assessment documents are completed within two (2) days of first face-to-face assessment appointment. If seeking information presents a barrier to service, the item is left blank and the reason documented in the clinical chart.

The agency clinician who is a Mental Health Professional as defined by the state of Washington doing the face-to-face assessment will determine if the person being referred meets medical necessity for services per the NSMHA Residential Admission Criteria and Access to Care Standards. The Intake clinician will complete the Request for Residential Authorization form and submit to the NSHMA Quality Management Department to determine appropriateness for residential services. If so, the person is accepted into services and NSMHA staff will facilitate referral to the appropriate facility and appropriate appointments are made. If not, NSMHA will

notify the referring clinician, and give the enrollee written notice including their right to file a grievance.

Current NSMHA Medicaid clients

If Medicaid consumers are enrolled at a NSMHA provider in outpatient services already and either request residential services or are referred by their MHCP for this modality, the MHCP will complete the Request for Residential Authorization form and submit to the NSHMA Quality Management Department to determine appropriateness for residential services. If so, the person is accepted into services and NSMHA staff will facilitate referral to the appropriate facility and appropriate appointments are made. If not, the decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested will be made by a NSMHA staff who is a health care professional and who has appropriate clinical expertise in treating the enrollee's condition or disease. NSMHA will notify the referring clinician, and give the enrollee written notice of any NSMHA action to deny the service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice to the provider need not be in writing.

Current NSMHA State-Funded Clients

If State-funded consumers are enrolled at a NSMHA provider and either request residential services or are referred by their MHCP for this modality, the MHCP will complete the Request for Residential Authorization form and submit to the NSHMA Quality Management Department to determine appropriateness for residential services. If so, the person is accepted into services and NSMHA staff will facilitate referral to the appropriate facility and appropriate appointments are made.

If not, the NSMHA will notify the referring clinician, and give the consumer written notice including their right to file a grievance.

Re-authorizations

Reauthorizations are limited to those clients who are currently in residential placements.

The primary clinician (MHCP) sends a Request for Residential Reauthorization form, current treatment plan and all progress notes to the NSMHA Quality Management Department a minimum of 30 days prior to the end of the current authorization period.

Primary clinicians requesting a reauthorization for supervised living programs may ask for a one year authorization if the client has had four consecutive six month authorizations or has been in the current level of residential placement for more than two years.

The NSMHA Quality Management Department approves/denies the request and notifies the clinician within 5 working days of receiving the request. If the consumer is Medicaid-funded and the request is denied, the decision to deny a service authorization request or to authorize a

service in an amount, duration, or scope that is less than requested will be made by a NSMHA staff who is a health care professional and who has appropriate clinical expertise in treating the enrollee's condition or disease. NSMHA will notify the referring clinician, and give the enrollee written notice of any NSMHA action to deny the service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice to the provider need not be in writing. Following notification of denial NSMHA will request a transition plan to either transition the consumer to a less restrictive level of care or transition the consumer to discharge from services within a maximum of 90 days in order to ensure continuity of care. If consumer needs substantially change during that period the provider may resubmit their authorization request

If the consumer is state-funded, the NSMHA will notify the referring clinician, and give the consumer written notice including their right to file a grievance. Following notification of denial NSMHA will request a transition plan to either transition the consumer to a less restrictive level of care or transition the consumer to discharge from services within a maximum of 90 days to ensure continuity of care. If consumer needs change substantially during that period the provider may resubmit the authorization request.

Out of Region Referrals

Referrals from out of the region will be forwarded to the NSMHA Access Line who will request and review appropriate records for current and historical providers of service, consult with the client, family members and/or natural supports to gather information and authorize an intake assessment. The Intake MHP will complete the Request for Residential Authorization form and submit to the NSHMA Quality Management Department to determine appropriateness for residential services. If so, the person is accepted into services and NSMHA staff will facilitate referral to the appropriate facility and appropriate appointments are made. If not, the decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested will be made by a NSMHA staff who is a health care professional and who has appropriate clinical expertise in treating the enrollee's condition or disease. NSMHA will notify the referring clinician, and give the enrollee written notice of any NSMHA action to deny the service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice to the provider need not be in writing.

S. Mental Health Services in a Residential Setting Level of Care Guidelines

Housing Types and Authorization Period	**Description**

Residential Treatment Facility-authorization for 180 days.	Licensed per requirements of WAC 246-337 or its successor
Adult Family Home or Boarding Home initial authorization for 180 days. If the consumer has had four consecutive six month authorizations or has been in the current placement for more than two years, a one year authorization may be requested.	Licensed per requirements of WAC 388-76 or 388-78A or their successors
Other housing-Authorization of 180 days	Cluster housing, SRO, supported housing where provider is sited

T. 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 does not meet Access to Care criteria.
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. The consumer's medical and mental health needs cannot be met by the facility with reasonable accommodations.
7. Is under 18 years of age
8. Does not requires 24-hour supervision to live successfully in community settings
9. Is not medically stable and free of physical condition(s) requiring medical or nursing care beyond what the residential facility can provide
10. Does not meets WAC requirements for resident characteristics
11. Ineligible for placement due to the licensing requirements of the facility.
12. Ineligible for placement due to any other legal or funding source restriction

Admission Criteria:

Admission Criteria
Consumer has 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.
Residential Authorization Form has been completed and approved by NSMHA designee
Case Manager has been assigned
Preliminary Individual Service Plan has been developed. A completed Plan is signed/ approved by consumer within 30 days of admission. (WAC 388-865-0425)
Cross-system (fee) agreements have been approved when necessary

Functionality is within the (NSMHA-approved) range of Mental Health Residential Placement Guidelines Behavior Problems Self-Care Social Functioning Reasons for exceptions are well documented
Consumer meets WAC standards for admission per WAC 388-865-0235 and licensing WAC's:
Consumer receives/signs Client Rights, as per 388-865-0410
Consumer receives/signs facility's disclosure information before admission to facility

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

V. Care/Recovery Standards for Consumers in Residential Facilities:

A consumer receiving any level of NSMHA mental health services in a residential setting is eligible and entitled to the full range of medically necessary outpatient services . Treatment/recovery services and goals are established in the consumer's Individual Service Plan

W. Continuing Care Criteria:

Persons will remain eligible for residential treatment services until such time as they no longer meet medical necessity criteria and appropriate alternative housing and services can be arranged.

X.

Y. 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

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

CLIENT BEHAVIOR SCORE

_____

Behavior Management Assessment

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

High Intensity Treatment

(MATCH)

MATCH (MATCHED APPLICATION OF TREATMENT FOR CLIENTS WITH HIGH NEED)

Z. MATCH Level of Care Guidelines

Option and Authorization Period	**Description**
First authorization-1 year	Client must be Level Two Plus
If the consumer has had four consecutive six month authorizations or has been in the current placement for more than two years a one year authorization may be requested.	Client must be Level Two Plus

AA. Exclusionary Criteria:

1. Individuals who require 24 hour supervision for health and safety reasons
2. Individuals who require a more restrictive environment such as a hospital, nursing home or supervised residential placement

BB.

Admission Criteria:

Admission Criteria
Consumer has 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-Plus.
MATCH Authorization Form has been completed and approved by NSMHA designee
Case Manager has been assigned
Preliminary Individual Service Plan has been developed. A completed Plan is signed/ approved by consumer within 30 days of admission. (WAC 388-865-0425)
MATCH admission criteria are aimed at clients with severe and persistent mental illness (as listed in the diagnostic nomenclature (DSM-IV TR) which seriously impairs their functioning in community living. Priority is given to clients whose persistent mental illness would benefit from MATCH.
Consumer is assessed as having significant difficulty consistently performing the range of practical daily living tasks required for basic adult functioning in the community (e.g., taking medication, care for personal business affairs, obtaining medical, legal, and housing services; recognizing and avoiding common dangers or hazards to self and possessions; meeting nutritional needs; maintaining person hygiene) or persistent or recurrent difficulty performing daily living tasks except with significant support or assistance from others such as friends, family or relatives.
Consumer is assessed as having significant difficulty maintaining consistent employment as a self-sustaining level or significant difficulty consistently carrying out the homemaker role (e.g., household meal preparation, washing clothes, budgeting, or child-care tasks and responsibilities).
Consumer is assessed as having significant difficulty maintaining a safe living situation (e.g., repeated evictions or loss of housing, or unwillingness to maintain stable housing).
Consumer is assessed as needing a Multidisciplinary team in the community that is available on demand 24/7 if necessary to provide coordinated and integrated treatment

Care/Recovery Standards for Consumers in MATCH

1. A consumer receiving MATCH is eligible and entitled to the full range of medically necessary outpatient services. Treatment/recovery services and goals are established in the consumer's Individual Service Plan. Treatment is available upon demand based on the individual's need. Treatment intensity varies among individuals and for each individual across time.

2. Access to services is available twenty-four hours per day, seven days a week.

3. Ratio of client to staff not greater than 15 clients to one staff/clinician

4. Treatment team composed of the individual, Mental Health Care providers, under the supervision of a MHP, and other relevant persons as determined by the individual (e.g. family, guardian, friends, neighbor, etc), and or other community members including pastors, physician, probation or parole officers, CD counselors, etc.

5. Services delivered by the high intensity team are billed at a per diem rate and are not to be billed separately. Auxiliary services are those provided by staff that is not part of the team. Concurrent services in the following modalities will be allowed as auxiliary:

a. Medication Management
b. Day Support
c. Psychological Assessment
d. Special Population Evaluation
e. Therapeutic Psychoeducation
f. Crisis Services

6. Staff-to-Client Ratio – Each provider shall have the organizational capacity to provide a minimum staff-to-client ratio of at least one full-time equivalent (FTE) staff person for every 15 (1:15).

7. Availability of Services - Services shall be available 24 hours a day, seven days a week and be in the format of a team model. There must be availability for 24 hour a day face-to-face or telephone contact by a member of the individual's team as client need arises. This availability must include the ability to reach a medication prescriber or other specialty member of the client's treatment team as needed.

8. Frequency of Client Contact-The treatment team shall have the capacity to provide multiple contacts a week with clients experiencing severe symptoms, trying a new medication, experiencing a health problem or serious life event, trying to go back to school or starting a new job, making changes in living situation or employment, or having

significant ongoing problems of daily living. These multiple contacts may be multiple times a day, seven days per week and depend on client need and a mutually agreed upon plan between clients and program staff. Many, if not all, staff shall share responsibility for addressing the needs of all clients requiring frequent contact.

9. The team shall have the capacity to rapidly increase service intensity to a client when his or her status requires it or a client requests it.

10. The team shall have the capacity to match the individuals need for medication monitoring, to include multiple contacts per day as ordered by the prescriber.

11. Location of Services – Client services are primarily provided in the setting natural to the client including home, work, and residential or other community locations. The majority of client contacts shall not be made in the outpatient clinic or day support setting.

Continuing Care Criteria:

Persons will remain eligible for MATCH until such time as they no longer meet medical necessity criteria and appropriate alternative services can be arranged.

Discharge Criteria:

Discontinuation of the service modality occurs when clients no longer meet the definition of medical necessity. The following serve as examples for discontinuation of service but are not limited to:

1. Has successfully reached individually established goals for discharge, and no longer meets MATCH criteria described as demonstrated by a higher level of community integration and baseline functioning demonstrated over time.
2. Successfully demonstrated an ability to function in some role areas (i.e., work, social, self-care) without ongoing assistance from the program, without significant relapse when services are withdrawn, and/or when the client requests discharge, and the program staff mutually agree to the termination of services
3. Moves outside the service area, declines or refuse services and requests discharge, despite the team's best efforts to develop an acceptable treatment plan with the client.

Transition from MATCH services shall occur in a smooth and reasonable manner in coordination with the client and consistent with conditions and timelines outlined in Criteria for Closing An Episode of Care/Planned Discharge from Treatment (NSMHA Policy #1540).

MATCH CLIENT ASSESSMENT AND INDIVIDUAL TREATMENT PLANNING

Matched Application of Treatment of Clients with High Needs assessment and treatment planning should include the following elements:

Initial Evaluation– An initial evaluation and preliminary treatment plan shall be done in the first 24 hours after the client's admission by the team leader or psychiatrist, to assess for client needs and include an assessment for risk, medication monitoring, functional, and health and safety needs.
Comprehensive Evaluation – A comprehensive evaluation shall be initiated and completed within one month after a client's admission in collaboration with the client and selected collateral contacts, including family and community partners and include the following elements:

1. Psychiatric history, mental status and diagnosis
2. Physical health
3. Substance abuse history and/or current use
4. Education and employment
5. Social Development and functioning
6. Activities of Daily Living
7. Family Structure and Relationships
8. Risk Assessment
9. Employment support

Individualized Treatment Planning

The Individual Service Plan shall be developed in collaboration with the client and the family, natural supports or guardian as permitted by the client and shall identify individual issues/problems in collaboration with therapeutic standards, set specific measurable long and short term goals for each issue or problem, and establish specific approaches and interventions necessary for the client to meet his or her goals.

The treatment team shall meet at regularly scheduled times for treatment planning and as needed to match client's need for level of service to change or modify treatment plan. Minimally the (1) internal treatment team will meet at a minimum once a week, and (2) the combined internal and community team once a quarter.

The ISP and modality shall be readjusted, as there are changes in client condition, and reflect documentation of frequency and location of client contact. The written ISP will be reviewed and revised on an ongoing basis as needed at a minimum, every 6 months.

EMPLOYMENT and EDUCATION SUPPORT SERVICES

Supported Employment 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.
3. A service for consumers who are currently neither receiving nor who are on a waiting list to receive federally funded vocational services such as those provided through the Department of Vocational Rehabilitation. Services will include:

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)
An 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)
Involvement with consumers served in creating and revising individualized job and career development plans that include consumer strengths, consumer abilities, consumer preferences and the consumer's desired outcomes	WAC 388-865-0464(1)(c)

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 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)

ACUTE INPATIENT

Acute inpatient psychiatric units are hospital based structured treatment services that provide 24-hour nursing care and monitoring. Consumers who require this level of care should be served on inpatient psychiatric units primarily, but on occasion may be served on medical floors if admitted to a hospital without an inpatient psychiatric unit, or if the admitting hospital's psychiatric unit is at capacity. Hospitals may legitimately bill for these services.

Medical Necessity

A voluntary admission is determined to be medically necessary when all the following criteria apply:

1. Ambulatory care resources available in the community do not meet the treatment needs of the client.
2. Proper treatment of the client's psychiatric condition requires services on an inpatient basis under the direction of a physician.
3. The inpatient services can be reasonably expected to improve the client's condition or prevent further regression so that the services will no longer be needed; AND
4. The client has been diagnosed as having an emotional/behavioral disturbance as a result of a mental disorder as defined in the Diagnostic and Statistical Manual of the American Psychiatric Association, the edition current at the time of admission.

Authorization

It is the responsibility of the admitting hospital to communicate with the NSMHA Inpatient Certification Team to request authorization prior to admission. It is also the responsibility of the admitting hospital to provide the following subsequent to admission:

1. An active goal oriented treatment plan focused on symptom reduction, rapid stabilization, management of co-occurring medical and Substance-Use Conditions, and anticipated discharge disposition initiated within the first 24 hours of admission. The treatment plan is updated every 1-2 days to reflect the consumer's progress and any new information related to treatment or discharge ultimately ensuring that an appropriate and final discharge plan is in place prior to discharge. The treatment plan must include all of the following:

a) Must clearly address all risk issues and include close supervision for the monitoring of behavior, the effects/possible side effects of medication and any co-morbid medical problems.
b) Interventions for managing co-occurring Substance-Use Conditions.
c) The plan to contact the consumer's family and/or social support network, with the consumer's permission, within the first 48 hours of admission to participate in the consumer's treatment (ideally face-to-face) on a regular ongoing basis (at least 1 time per week) unless clinically contraindicated.
d) The plan to link the consumer with available community resources including the consumer's school and community-based sources of structure, therapy, and support with the goal of returning the consumer to his/her regular social environment as soon as possible, when appropriate.

2. An evaluation is conducted by a psychiatrist within the first 24 hours of the admission. There must be daily documented visits by the psychiatrist.
3. All relevant general medical services, including assessment and diagnostic, treatment, and specialty medical consultation services are available, as needed.
4. Discharge planning is initiated within 24 hours of admission with at least preliminary attention to the elements listed below, and is finalized during the course of the hospital stay. This plan should be provided to the NSMHA Care Manager 24 hours prior to the anticipated date of discharge or as soon as possible prior to discharge so as to leave the Care Manager ample time to ensure that the discharge plan is appropriate. The discharge plan must include ALL of the following elements:

a) Anticipated discharge date.
b) Next level of care recommended, the rationale for it, and whether the consumer has agreed to the follow-up care.
c) Name(s) of clinician(s) responsible for post-discharge care.
d) Date of first follow-up appointment within 7 days post-discharge. If there is more than one clinician, dates of appointments with each are indicated, one of which should be within 7 days. Details of the follow up appointment are to be provided in writing to the consumer/family.
e) Communication of all pertinent clinical information to the provider at the consumer's next level of care with the consumer's permission.
f) Modalities of post-discharge treatment to be employed, including:
i) Recommended frequency of each modality.
ii) Medications (including rationale, quantities and dosages) that will be given to consumer at discharge, and a schedule for appropriate lab tests when indicated.
g) With the consumer's permission discharge planning will include the active involvement of the consumer's family and/or primary support system.

5. Clinicians who were involved with the consumer's treatment prior to admission are contacted within 3 working days to obtain all relevant information and input. They should also be contacted prior to discharge for communication of the discharge plan, with the consumer's consent, when appropriate.

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 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 Volunteers of America 1-800-707-4656.

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.	Contract
Primary Care Clinician/Team and/or crisis services staff have seen consumer within the past twenty-four hours.	Contract
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.	Contract
Decision to use inpatient services has been reviewed and approved by MHP	Contract
Alternative community-based options have been attempted and did not meet the needs of the consumer, or were ruled out and rationale documented.	Contract
Support and assistance securing inpatient placement, as needed, i.e., there is a bed and hospital will accept this consumer at this time.	Contract
Assistance arranging transportation, as needed.	
Certification (from NSMHA contracted provider) for inpatient utilization has been obtained (800-707-4656)	Contract
	Contract
Pre-Hospitalization Requirement for Involuntary Services (in addition to above requirements):	Contract
If the primary care clinician/team has assessed the consumer as needing inpatient level of care to assure safety, but the consumer is refusing voluntary inpatient services, they shall request evaluation by a CDMHP for any consumer (13 and older).	Contract

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 The NSMHA Inpatient Certification Team will be responsible for ensuring immediate notification of clinicians when a hospitalization is certified.	MHD
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)	Contract
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.	Contract
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.	Contract
For eligible consumers who are not enrolled in services, there will be contact by the NSMHA Inpatient Certification Team within 3 working days to begin discharge planning to ensure that a community-based follow-up appointment for consumers is scheduled within seven days of discharge.	MHD
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 reviewed and updated as needed.	Contract

Post-Hospitalization

Service Requirements following voluntary hospitalization	Source of Requirement
Assess for needed intensity of services.	Contract
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)	Contract
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	MHD
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
Treatment intensity, frequency, modality and interventions that have the highest (research-based) likelihood of achieving positive outcomes	MHD
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)

Outpatient Criteria for Continuing or Discontinuing Services

Outpatient 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. Consumer is engaged in a transition to discharge plan. If the transition plan is successful, the consumer will be discharged from the Episode of Care within 90 days of initiation of the transition to discharge plan. If the consumer's condition changes in the course of the transition such that continued treatment is determined to be medically necessary a review of the treatment plan will occur and a revised treatment plan will reflect the purpose of ongoing care.

3. Although consumer's functioning has improved and exceeds the GAF/CGAS standard, continued treatment is deemed medically necessary to prevent deterioration as evidenced by previous documented unsuccessful efforts at discharge.

4. Although consumer's functioning has improved, they have needs, which cannot be met by any other system or resource other than publicly funded mental health, which if unmet, would result in deterioration of functioning and likely re-admission. (Example: Consumer has complex medication regime and no PCP can be found to manage medication needs.)

5. Consumer has a current Least Restrictive Alternative/Conditional Release (LRA/CR) order in place.

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.

Basis for Discharge

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 per NSMHA protocols.
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. Consumer is on a court order to continue services (LRA/CR).

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.

Changes in Service Provider or Services

Providers shall make a good faith attempt to give 15 day notice of change in MHCP 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.