Salish Behavioral Health Organization

Levels of Care

Revised November 2018

Effective December 17, 2018

Age Definitions

Child: A *child* is defined as a person birth to 12 (twelve) years of age.

Youth: A *youth* is defined as a person 13-17 years of age, requires youth consent.

For persons eligible for the Medicaid program, the term *youth* extends to individuals that have not reached their 21st (twenty-first) birthday. NOTE: The new ACS defines youth as below age 21, and either the Adult or Child & Youth ACS criteria may be applied to individuals age 18-20.

Adult: An *adult* is generally defined as a person over the age of 18 (eighteen) years.

For the purposes of residential services, an adult is always defined as a person 18 (eighteen) years or older.

SBHO Levels of Care

Level 1 Service Description

To include all covered services under the Medicaid State Plan with the exception of services identified as Level 2 (Mental Health Residential) and Level 3 (Inpatient Mental Health; Freestanding Evaluation and Treatment Services (E&T); Residential Substance Use Disorder Services)

Services to be provided include:

- Brief Intervention Treatment;
- Crisis services;
- Day Support;
- Family treatment;
- Group treatment services;
- High Intensity Treatment;
- Individual Treatment Services;
- Intake evaluation;
- Medication Management;
- Medication Monitoring;
- Peer Support;
- Psychological Assessment;
- Rehabilitation Case Management;
- Special population evaluation;
- Stabilization Services;
- Therapeutic psychoeducation
- Care Coordination Services;
- Child and Family Team Meeting
- ASAM Level 1.0 Outpatient
- ASAM Level 2.0 Intensive Outpatient

Level 2 Services

- Mental Health Residential, Short term and Long term

Level 3 Services

- Substance Use Residential (ASAM 3.1; 3.3; 3.5)
- Mental Health Inpatient (including Freestanding Evaluation and Treatment Services)

Salish BHO Levels of care			
Category	Description	Prior Auth Process	Types of Service/Modalities
c			
Crisis	Crisis Services	None	Crisis services, Stabilization (Triage, Crisis Respite), Withdrawal management (Level 3.2 or 3.7)
Level 1	Routine Outpatient	None	All outpatient mental health services including CLIP, WISe and PACT; SUD ASAM Levels 1 and 2.1
Level 2	Specialty Outpatient	BHO authorization	MH Residential (both long and short term)
Level 3	Inpatient Mental Health and Substance Use Disorder Residential	CommCare	Inpatient hospitalization in community hospitals or E&Ts. Substance Use Residential Treatment (ASAM Levels 3.1, 3.3, or 3.5)
Denial	Does not meet criteria	BHO Review	Decline from all services

American Society of Addiction Medicine (ASAM) Levels of Care		
Treatment		
Level of Care	**Title**	**Description**
1.0	Outpatient Services	Outpatient treatment services provided in regularly scheduled sessions, less than 9 hours of treatment services per week.
2.1	Intensive Outpatient Services	Provides 9-19 hours of structured services per week including individual and group counseling, medication management, educational groups, occupational and recreational therapy.
3.1	Clinically Managed Low-Intensity Residential Services (Recovery House)	24-hour structure with available trained personnel, receiving at least 5 hours of clinical services per week. Treatment can include individual, group, and family therapy, medication management, and psychoeducation.
3.3	Clinically Managed Population-Specific High-Intensity Residential Services	24-hour care with trained counselors including clinical and didactic motivational interventions appropriate to the individual's stage of readiness to change, designed to enhance the individual's understanding of the relationship between their substance use disorder and connected life issues.
3.5	Clinically Managed High-Intensity Residential Services	24-hour care with trained counselors that includes goals of promoting abstinence from substance use, preventing other addictive and antisocial behaviors, and encouraging change in lifestyle, attitude and behavior. Prepares individuals for Outpatient treatment.
Levels of Withdrawal Management		
3.2	Clinically Managed Residential Withdrawal Management	For individuals experiencing moderate withdrawal but needing 24-hour support to complete withdrawal management and increase likelihood of continuing treatment or recovery.
3.7	Medically Monitored Inpatient Withdrawal Management	For individuals in severe withdrawal and needing 24-hour nursing care and physician visits as necessary. Individuals are unlikely to complete withdrawal management without medical/nursing monitoring.

Outpatient Level 1 Services

Routine Admission Criteria

Individuals must meet the Washington State Access to Care Standards (ACS), and the requested service is determined medically necessary by an MHP or CDP as appropriate.

Non-Medicaid individuals: May be served within available resources.

Individuals without Medicaid who meet the state definition of low income (including those with Medicare only coverage), who have no other SUD insurance benefit, and were referred to treatment from:

i. The criminal justice system

ii. A withdrawal management facility
iii. A residential treatment facility

These services may be funded by CJTA, SABG, or the agency's state funded contract. If an agency does not have any of these funding sources available at the time the individual applies for services, the individual should be referred to an alternative agency.

Type of Services/ Modalities/ Intensity of Service

- Includes all allowable outpatient mental health services under the state plan/full scope of outpatient treatment modalities.
- Includes substance use.

Service Description
May include:

Long Term Rehabilitation and Children's Intensive Services (CIS) are necessary to improve or maintain stability in the community. Intense level of acute outpatient treatment may include active outreach and home-based services necessary to prevent hospitalization, out of home placement, reinforce personal and community safety and/or decrease the use of other costly services.

Wraparound with Intensive Services (WISe) is a range of Medicaid-funded service components that are individualized, intensive, coordinated, comprehensive, culturally relevant, and home and community based. WISe is for youth who are experiencing mental health symptoms that disrupt or interfere with their functioning in family, school or with peers. WISe services may be requested prior to intake by either the youth, family, or family representative. Youth eligible for WISe based services, if not enrolled in SBHO agency, will be referred for intake and to determine further medical necessity and Access to Care Standards.
WISe services are determined by a CANS screen documenting eligibility for WISe services. The screening is performed by someone certified in CANS screening and assessment, either prior to authorization for services or in conjunction with the intake assessment. Consideration for referral begins with youth who are Medicaid eligible, under age 21, and who have complex behavioral health needs. Other indicators to consider for a WISe referral may include, but are not limited to:

1. Youth with involvement in multiple child-serving systems (e.g., child welfare, mental health, juvenile justice, developmental disabilities, special education, substance use disorder treatment).
2. Youth for whom more restrictive services have been requested, such as psychiatric hospitalizations, residential placement, or foster care placement, due to mental/behavioral health challenges.
3. Youth at risk of school failure and/or who have experienced significant and repeated disciplinary issues at school due to mental/behavioral health challenges.
4. Youth who have been significantly impacted by childhood or adolescent trauma.
5. Youth prescribed multiple or high dosages of psychotropic medications for mental/behavioral health challenges.
6. Youth with a history of detentions, arrests, or other referrals to law enforcement due to behaviors that result from mental/behavioral health challenges.
7. Youth exhibiting risk factors such as suicidal ideation, danger to self or others, behaviors due to mental/behavioral health challenges.

8. Youth whose family requests support in meeting the youth's mental/behavioral health challenges.

Continuing Care Criteria for WISe

- Continue to meet Access to Care Standards (ACS)
- Continue to have Medicaid eligibility
- Continue to meet eligibility based on Child and Adolescent Needs and Strengths Assessment (CANS) screening within 30 days of request

EPSDT

Any Medicaid recipient under the age of 21 who meets ANY of the following criteria in addition to the ACS may be offered EPSDT services:

1. Involved in one or more of the following systems, in addition to mental health:
   - Children's Administration
   - Developmental Disabilities Administration
   - Juvenile Rehabilitation or Department of Corrections
2. Diagnosed with Substance Abuse or Addiction
3. Receiving Special Education Services
4. Has a chronic and disabling medical condition
5. As a Medicaid recipient, has previously been enrolled for Level 1 services twice.

CIS

Any Medicaid recipient from 5-17 years of age who meets <u>any one</u> of the following criteria may be offered CIS services:

1. Involved in two or more of the following systems, in addition to mental health
   - Children's Administration
   - Developmental Disabilities Administration
   - Juvenile Rehabilitation or Department of Corrections
   - Receiving Special Education services
   - Involved with substance use disorder services
2. Has been hospitalized for psychiatric care within the previous 12 months
3. Three or more crisis contacts in the previous 6 months (to be counted by day)
4. Has received inpatient treatment for a substance use disorder within the previous 12 months

** In addition to the ACS, Non-Medicaid individuals will only be offered services if there are sufficient resources and meet ONE of the following criteria:

1. Present with psychotic symptoms
2. Present with a risk of Danger to Self or Danger to Others, or have been hospitalized for psychiatric care within the last 6 months
3. Recently released from JRA or Juvenile Detention facility.
4. MHP determines that current symptoms and history demonstrate treatment is necessary to avoid hospitalization.
5. Under age of 6 years, with inadequate caregiver
6. Applied for Medicaid and enrollment decision is pending

Safety/ Risk Assessment. In addition to the above criteria, one of the following qualifying risk factors must apply for an individual:

1. Current severity of symptoms makes the individual at risk for hospitalization, if services are not provided at this level
2. Child/ youth's placement is at significant risk
3. More than 3 contacts with the provider crisis team in the previous month
4. Psychiatric hospitalization in the previous three months
5. Current suicidal or homicidal ideation, or history of an attempt
6. Is EPSDT program eligible

Discharge Consideration
Individuals are ready for discharge when they no longer meet medical necessity requirements determined by an MHP or CDP, as appropriate.

Authorization Process
No authorization required

Child and Youth Services

Children's Long-Term Inpatient (CLIP) Services

Service Description
CLIP services are a blended residential program that includes therapeutic, medical, and educational modalities for severely emotional disturbed children and youth. CLIP is considered the most restrictive setting. The average length of stay is 6 months. The criteria are for *voluntary* CLIP services.

Program Criteria

- Applicants must have a severe psychiatric impairment which warrants the intensity and restrictions of the treatment provided in a CLIP Program with verified failure (unable to stabilize) of treatment at a lesser level of care determined medically necessary.
- Per CLIP Administration policy, an individual will be considered to have an impairment if a severe emotional disturbance, corroborated by a clear psychiatric diagnosis, is demonstrated, with one or more of the following behaviors exhibited:

    1. Symptoms explicitly associated with marked, severe and/or chronic thought disorders, as defined in the DSM-5, such as bizarreness, delusions, hallucinations, disturbed thought processes (e.g., loosened associations, illogical thinking, poverty of content of speech), blunt, flat or inappropriate affect, or grossly disorganized behavior
    2. Symptoms explicitly associated with a marked, severe or chronic affective disorder, as defined in the DSM-5, including mania, depression, vegetative signs, suicide attempts or self-destructive behaviors.
    3. Chronic or grossly maladaptive behaviors due to a diagnosed severe psychiatric impairment. The presence of such symptoms should be clearly identified as resulting from a mental disorder and not be solely attributable to other factors.

- Medical evaluation determines that the child's/youth's current medical needs do not exceed the level of care available in the CLIP setting.
- Clear treatment goals and discharge planning recommendations including placement are provided to the CLIP program, prior to admission.
- Youth (13 years and older) are willing to agree to voluntary admission and to comply with treatment.
- Youth (13 years and older) whose mental state incapacity or developmental stage does not rule out a "good faith voluntary" admission by virtue of significant cognitive impairment that precludes making a reasoned decision. Determination of "Good Faith Voluntary" may include a review of previous voluntary hospitalizations and the recent pattern of outpatient treatment compliance.
- The local CLIP gatekeeping committee reviews all the material in accordance with these admission criteria, discusses alternative options to CLIP, and provides a determination for CLIP admission.

    1. If the application is approved, it is forwarded to the CLIP Admission for review and approval.
    2. If the application is denied by the community gatekeeping committee, a letter is provided with alternative treatment recommendations outlined.

Continuing Stay Criteria

- Per the CLIP policy, once a child/youth has been approved for voluntary admission by the CLIP Certification Team and placed on the CLIP Waiting List, the designated child psychiatrist shall

review the youth's continued need for admission every 30 days up until the time when they are admitted.

Discharge Considerations

- When the individual meets their treatment goals, no longer meets CLIP criteria for continued stay treatment, and a discharge date is identified:

1. The CLIP treatment team members, including the community treatment team, shall plan for a smooth transition back to community services.
2. The CLIP case manager is responsible for coordinating outpatient mental health services and will invite ancillary community-based formal systems to participate in the discharge planning, per established designated working agreements (e.g. DCFS and DDA).
3. All youth discharging from CLIP treatment will be screened for WISe services prior to discharge, by a certified CANS screening and assessment staff member.
4. If the child/youth is planning to move to another BHO, the SBHO CLIP Case Coordinator coordinates with the local community mental health agency to liaison and transition care.

Type of Services/Modalities

- Blended residential program that includes therapeutic, medical, and educational modalities for SED children and youth.

Intensity of Service

- 24/7 long-term statewide residential program

Duration of Episode

- Upon admission to a CLIP facility, as determined by CLIP attending psychiatrist. Average LOS is 6 months.

Authorization Protocol

- Voluntary admission authorization occurs through a local gatekeeping panel review, and statewide CLIP Review. No additional authorization is required, upon admission.

Psychiatric Inpatient Services - Voluntary & Involuntary

Service Description

- Inpatient psychiatric services at community hospitals include evaluation, stabilization, and treatment and can be authorized prior to an intake.
- The SBHO network crisis team (which includes Designated Crisis Responders, DCR) designated to an individual's geographical area may provide a face to face assessment for inpatient service requests.
- All voluntary hospitalization requests must be made by a MHP. For child and youth: an MHP in consultation with, or by a child mental health specialist as appropriate.

Voluntary Admission Criteria

Voluntary inpatient admissions must meet all of the following baseline criteria (includes Parent-Initiated Voluntary hospitalizations):

1. The existence of a DSM-5 disorder.
2. Evidence that admission is medically necessary.
3. The individual poses an actual or imminent danger to self, others or property due to a mental disorder, **or**
   - The individual requires brief stabilization and assessment to rule out danger to self and/or others, **or**
   - The individual is experiencing significant deterioration in age appropriate behavior including family, school, and social functioning **and** an alternative care setting would be unable to provide sufficiently intensive services to diagnose and treat the mental disorder.
4. There is a verified failure of treatment at a lesser level of care, **or**
   - A crisis team/DCR determines that due to the severity of symptoms, intensity of treatment, or lack of supports, services cannot be provided at a lesser level of care.
5. Medical evaluation determines that the current medical needs do not exceed the level of care available in the inpatient setting.

Voluntary Continuing Stay Criteria & Extension Requests

When an individual *may exceed* the initial authorization expiration date, a request for continuing stay is required prior to the expiration date. The inpatient facility is responsible for requesting an extension at least 24 hours prior to the expiration date. The inpatient facility must contact the designated network CMHA to request the extension. Only the network CMHA can make a request for a continuing stay voluntary hospitalization to CommCare. The continuing stay/extension request is case specific and there is no range for authorization.

- **At least one of the following criteria must be present for inpatient extension authorization (includes Parent-Initiated Voluntary hospitalizations):**

1. The full assessment has not been completed and cannot be completed at a lesser level of care
2. The individual continues to pose actual or imminent danger to self, others, or property that cannot be contained at a lesser level of care
3. The individual demonstrates an inability to function or is gravely disabled and continues to require on-going inpatient care
4. The individual's level of functioning has regressed since admit

5. The individual continues to need stabilization to reach baseline functioning and further improvement in condition is expected

Discharge Considerations
Discharge planning starts upon admission. The CMHA will coordinate discharge.

Once an individual is admitted to the inpatient unit, the CMHA must contact the inpatient unit to begin coordinating care within one business day of receiving notification.

- Discharge happens as soon as a less-restrictive plan for treatment can be safely implemented.
- Reasonable efforts must be made to meet all of the following:

1. Inpatient treatment plan objectives have been substantially met **or** unmet objectives can be resolved at a lesser level of care.
2. Unresolved treatment plan objectives are addressed in a discharge plan and an appropriate outpatient program is identified.
3. Discharge to a less intensive level of care does not pose a threat **and** the treating physician authorizes the discharge.
4. For AMA discharges, contact information for local crisis line and community mental health agency is provided.

Inpatient Facility Transfers and Legal Status Changes
- With changes within an authorized episode, an individual can be transferred from one inpatient facility to another without meeting new admission criteria. With transfers occurring with expiring authorization within 3 days, an individual must meet continued stay criteria to be authorized.
- ***A new certification number must be requested*** and is automatically issued to differentiate between inpatient facilities and legal status changes.

Retro-authorizations
An inpatient unit may request retro-authorization reviews.

1. The retro-authorization determination can take up to an additional 30 days.
2. For an individual currently admitted to an inpatient facility, CommCare may provide a verbal review and retro-authorization.
3. For an individual discharged from inpatient facility, CommCare requires hospital documentation for comprehensive review and determination.
4. For out of state retro-authorization requests for involuntary treatment, the request must be made within three months of discharge.
5. **No** retro authorization will be approved for out of state **voluntary** inpatient stays.

Type of Services/Modalities
May include individual and family therapy, milieu therapy, psycho-educational groups and pharmacology.

Intensity of Service
24/7 acute psychiatric inpatient care

Duration of Episode
- For ITA, or if LRA is revoked, the authorization is automatically approved on admission and for 20 days. Continuing stay as clinically indicated.

- For voluntary hospitalizations, the standard benefit period for admission and extension requests is determined and requested by the crisis team (no more than 10 days).
- Continuing stay and extension requests range of days authorized are on a case by case basis (no more than 10 days).

Authorization Protocol

For Community Hospitals and E&T's:

- CommCare collects the necessary information for ProviderOne Prior Authorization from Profiler or verbally, identifying the requested inpatient authorization, funding source, and supporting clinical documentation. .
- CommCare verifies voluntary criteria sufficiently met through supporting documentation and provides the authorization determination within 12 hours of request. If criteria and medical necessity for voluntary admission is not sufficiently met, CommCare may authorize administrative days.
- With an inpatient service denial, CommCare provides a Peer Review and Notice of Adverse Benefit Determination (NOABD) within 1 business day. SBHO conducts 100% review of all NOABDs and tracks appeals.

Adult Services

Mental Health Residential Services:

Brief & Long Term

Service Description
Residential services are services provided to assist individuals living in community-based settings, like Keller House and Arlene Engel House. Residential services differ from other services in terms of location and duration. Residential services can be brief or long-term:

Brief Residential Service is defined as residing less than 30 days but more than 14 days.

Long Term Service is defined as residing 30 days or more at a residential facility.

Routine Admission Criteria

- Individuals with Medicaid and Non-Medicaid coverage. *Non-Medicaid individuals will only be authorized within available resources.*
- Must meet Access to Care Standards (ACS) and medical necessity criteria, functional impairment, and diagnosis.
- Must be a requested service by MHP and deemed medically necessary. An individual must demonstrate one of the following to be admitted:

    1. The presenting signs of a psychiatric illness clearly demonstrate a need for residential level structure, supervision and treatment that cannot be stabilized at a lesser level of care.
    2. The individual has a history or recent episode of failing to live independently in the community due to his/her psychiatric illness.

- In addition to the above criteria, all the following must apply:

    1. The individual is an adult age 18 year or older.
    2. The individual is ambulatory and does not require physical or chemical restraints.
    3. The individual has adequate cognitive functioning to enable him/her to respond to fire alarms and evacuate the premises without emergency assistance.
    4. The individual is currently enrolled in outpatient services and has a current Crisis Plan or is in the process of being authorized and assigned to outpatient services.

Exclusion Criteria
If an individual demonstrates any of the following, they are excluded from residential services: However, the exclusion can be waived based on the individual's level of functioning.

1. The individual has a psychiatric condition that qualifies for a higher level of care.
2. The individual is actively suicidal and/or homicidal, per MHP assessment.
3. The individual has a recent history of a pattern of assault/violent behaviors toward self or others.

4. The individual has a physical condition requiring medical or nursing care available only in a hospital or other more intensive nursing environment. Cases requiring limited medical or nursing care will be evaluated on an individual basis by CMHA Registered Nursing (RN) staff.
5. The individual is in need of detoxification.
6. The individual has a history of being a sexual predator or of committing arson.

Continuing Stay Criteria
At least one of the following criteria must be met (reviewed every 180 days):

1. Admission criteria for residential services continues to be met.
2. The individual must have a treatment plan that identifies need and measurable goals for residential services. The individual must be making progress toward treatment goals.

Discharge Considerations
- One of the following must be met for discharge from residential services:

1. The individual's residential treatment goals have been sufficiently met.
2. The individual no longer meets admission or continuing stay criteria for residential services**, or** meets criteria for a less/more intense LOC.
3. There is an appropriate discharge plan to a less restrictive level of care that identifies components for maintaining treatment gains.
4. Consent for treatment is withdrawn.

- If the individual is non-compliant in treatment or in following the residential program rules and regulations, despite treatment attempts to address non-compliance issues, they may be discharged to a more/less intensive level of care.

Type of Services/Modalities
- Residential program that includes therapeutic, medical, and assisted living for individuals.

Authorization Protocol
- The SBHO residential authorization requirements will not conflict with or overrule Boarding Home licensing requirements. Evictions will be in compliance with Boarding Home WAC 388-78A-2660 (Residents Rights) and applicable Landlord/Tenant laws.
- CMHA determines funding eligibility, establishes medical necessity, and identifies placement.
- CMHA submits Authorization Request for Residential to the SBHO for authorization. This is completed through the Cognito form link provided.
- With a service denial, the SBHO mails written Notice of Adverse Benefit Determination to Medicaid individuals or a Notice of Determination to non-Medicaid individuals.

Residential Substance Use Disorder Services

Service Description

A concentrated program of substance use disorder treatment, individual and group counseling, education, and related activities.

Routine Admission Criteria

The request for residential treatment admission follows an assessment by a CDP, or a CDPT under supervision of a CDP supervisor, and is based on ASAM criteria as follows:

- The existence of a DSM-5 disorder.
- The following ASAM Residential treatment levels of care are available to individuals based on medical necessity:
  - ASAM Level 3.1 Clinically Managed, Low Intensity Residential services (Recovery House)
  - ASAM Level 3.3 Clinically Managed, Population Specific, High Intensity, Residential services **(Adult services only)**
  - ASAM Level 3.5 Clinically Managed, High Intensity Residential Services

Continuing Care Criteria

If the residential provider determines that the individual needs services in excess of the initial authorization, an additional authorization request for continued residential care must be submitted to CommCare. Requests for extended residential treatment must be based on medical necessity determined by a CDP's review of ASAM criteria. Determination of medical necessity must include an evaluation of the effectiveness of services provided during the initial benefit period and justification for continuation of services.

Discharge Considerations

Individuals are ready for discharge from residential treatment services when they no longer meet medical necessity requirements determined by a review of ASAM by a CDP or a CDPT under supervision of a CDP supervisor.

Denials

If CommCare denies a request for authorization of Residential treatment services, CommCare will send a Notice of Adverse Benefit Determination (NOABD) for Medicaid individuals/services or a Notice of Determination for non-Medicaid individuals/services as well as provide a peer clinical review.

Authorization Protocol

- Requests for authorization of residential services should be made by an SBHO contracted outpatient, residential, or local Tribal SUD provider.
- Provider completes Residential Treatment Authorization Request and submits to CommCare.
- CommCare verifies criteria sufficiently met through supporting documentation and provides the authorization determination within 72 hours of request.

- Authorizations are issued for 60 days, pending activation of treatment upon admission. Upon admission, the admitting facility notifies CommCare of admission by submitting the Residential Treatment Authorization Request including the authorization number and date of admission. CommCare activates the authorization within 48 hours.
- If criteria and medical necessity not sufficiently met, CommCare provides a Peer Review and issues a Notice of Adverse Benefit Determination (NOABD) to the individual within 1 business day. SBHO conducts 100% review of all NOABDs and tracks appeals.

Admission Exclusion Criteria

- Medical needs exceed facility capability
- Presents physical risk to self or others
- Inability to perform basic self-care

Covered Individuals

The following individuals may be authorized for SUD Residential treatment services if the requirements of this section are met:

1. Medicaid enrollees
2. Individuals without Medicaid who meet the state definition of low income (including those with Medicare only coverage) who have no other SUD insurance benefit and were referred to treatment from:
   - The criminal justice system
   - A withdrawal management facility
   - Those entering residential treatment through the CD-ITA process

Crisis & Stabilization

Service Description

- A **crisis** is defined as an actual or perceived urgent or emergent situation that occurs when an individual's stability or functioning is disrupted and there is an immediate need to resolve the situation to prevent a serious deterioration in the individual's mental or physical health, or to prevent the need for referral to a significantly higher level of care. Services are intended to stabilize the person in crisis, prevent further deterioration and provide immediate intervention.
- **Stabilization services** are to be provided in the person's own home, or another home-like setting, or a setting that provides safety for the individual and the mental health professional. Stabilization services may include ancillary crisis services to cover costs for room and board.
- SBHO network CMHAs mental health crisis response teams are authorized to coordinate stabilization services. The CMHAs may coordinate crisis stabilization services outside their designated areas, and within the network, in order to ensure access and availability.

Routine Admission Criteria

- Individuals with Medicaid and Non-Medicaid coverage.
- For stabilization services to be provided, all of the following baseline criteria must be met:

1. The individual is in crisis, as defined above.
2. The stabilization services will prevent further deterioration.
3. The stabilization services are located in the best-suited and least restrictive environment.
4. The stabilization services are medically necessary, as determined by a MHP.
5. The individual does not meet criteria for a more intensive level of care.
6. The individual agrees to participate in the voluntary stabilization services.
7. A description of the stabilization services that are to be provided with an estimate length of the services duration, up to 14 days per episode, is documented in the crisis/ clinical chart.

Admission Exclusion Criteria

- Stabilization services are not provided if any of the following apply:

1. The individual is in need of medical stabilization for physical/organic dysfunctions beyond the scope and resources of the stabilization services.
2. The individual is assessed to be in need of an inpatient facility.
3. The individual is in need of drug/alcohol detoxification.
4. When an individual exceeds the initial authorization amount and a request for continuing stay is made, the following criteria must be met.

Continuing Stay Criteria

- All of the following must apply:

1. Admission criteria for this level continues to be met.
2. A description explaining the continued need for the stabilization services with an estimated length of the services duration is documented in the crisis/clinical chart.

- When an individual exceeds the initial planned amount (up to 14 days), continuing stay is required to continue to provide the stabilization services.

Discharge Considerations

- Any of the following may lead to a discharge of stabilization services:

    1. The individual no longer meets admission criteria.
        - The individual requires a less/more restrictive level of care.
    2. There is a reasonable plan for follow-up services, in or outside the network, identified.

- The individual requests discharge/termination of stabilization services. If a child, the caregiver requests discharge/termination of stabilization services.

Type of Services/Modalities

- Stabilization services include short-term (up to 14 days, per episode) face-to-face assistance with life skills training and/or understanding of medication effects.

Authorization Protocol

- Stabilization services are considered a crisis service modality available to all residents of the SBHO.
- Crisis stabilization services do not require authorization from the SBHO **and** can be provided prior to an intake assessment.
- Provider must notify SBHO within 24 hours of all admissions to stabilization services.
- The CMHA MHP determines when stabilization services are medically necessary for initial and continuing stay.
- Stay cannot exceed14 days per episode.

Withdrawal Management

Service Description

Services provided to an individual to assist in the process of withdrawal from psychoactive substance in a safe and effective manner.

- Clinically Managed (Sub-Acute) Withdrawal Management is nonmedical withdrawal management or patient self-administration of withdrawal medications ordered by a physician.
- Medically Monitored (Acute) Withdrawal Management provides medical care and physician supervision for withdrawal from alcohol or other drugs.

Routine Admission Criteria

- The Withdrawal Management provider's qualified staff completes a screening per WAC requirements.
- The Withdrawal Management provider must obtain ROIs for SBHO.
- Based on the ACS, LOC Guidelines, and ASAM screening criteria, the Withdrawal Management provider determines if the individual meets medical necessity for Withdrawal Management services.

Admission Exclusion Criteria

- Medical needs exceed facility capability
- Presents physical risk to self or others
- Inability to perform basic self-care

Continuing Stay Criteria

- Admission criteria for this level continues to be met
- A description of explaining the continued need for the stabilization services with an estimated length of the services duration documented in the crisis/clinical chart

When an individual exceeds the initial planned timeframes, continuing stay must continue to meet medical necessity criteria on a case by case basis.

Type of Services/Modalities

Withdrawal Management services are determined by medical necessity to include coordination of follow up services.

Authorization Protocol

- No authorization is required.
- Withdrawal Management provider notifies the SBHO within 24 hours of admission.