CROSS REFERENCES

- Plan: Utilization Management Plan
- Policy: Access to Services Prior To Intake Assessment - Medicaid Only
- Policy: Authorization for Outpatient Services based on Medical Necessity
- Policy: Corrective Action Plan

PURPOSE

The Salish Behavioral Health Organization (SBHO) shall ensure individuals seeking, or requesting services, have timely access to services. The SBHO network providers will consistently assess an individual for initial authorization into services.

- For non-Medicaid individuals, an intake and authorization into services will only be provided within available resources.

The SBHO contracts with an administrative service organization (ASO) to conduct the SBHO authorization reviews for services. The contracted ASO will consistently apply the SBHO Access Standards as outlined in the SBHO Levels of Care (LOC) standards.

DEFINITIONS

Enrollee means a person who has applied for, is eligible for or who has received publicly funded behavioral health services.

- For a child under the age of thirteen (13), the definition of enrollee includes the parents or legal guardians.
• For a child thirteen (13) years or older who provides consent for their parents or legal guardians to be involved in the treatment planning, the definition of enrollee includes the parents or legal guardians.

Enrollee is defined as an individual currently enrolled in a Medicaid plan that provides a behavioral health benefit, or an individual not yet enrolled but eligible for a Medicaid plan that provides a behavioral health benefit.

Family means:
For child clients: Family means a child’s biological parents, adoptive parents, foster parents, guardian, legal custodian authorized pursuant to Title 26 RCW, a relative with whom a child has been placed by the Department, or a Tribe.

For adult clients: Family means those the person defines as family or those appointed/assigned to the client (such as guardians, siblings, caregivers, and significant others)

Request for services is defined as the point in time when a request for behavioral health services are sought or applied for through a telephone call, in person, or receipt of a written request from an enrollee or the person authorized to consent to treatment for that individual through any of the following access points:
• Contacting SBHO
• Contacting CommCare
• Contacting the network provider
• Crisis services

PROCEDURE

1. Medicaid enrollees shall have timely access to care and services. Services for non-Medicaid individuals will be provided within available resources.

2. Providers shall comply with state access to care guidelines for timeliness:
   a. The determination of eligibility for authorization to service shall be based on the Access to Care standards. Authorization shall not take more than fourteen (14) calendar days, unless the enrollee or the community behavioral health agency requests an extension.
      • Urgent and emergent medically necessary behavioral health services may be accessed without full completion of intake evaluations and/or other screening and assessment processes.
      • Expedited Reviews can be utilized to authorize emergent an urgent service requests.
   b. An intake assessment is initiated within ten (10) working days of the request for behavioral health services.
• If the intake does not occur due to cancellation or no show by the consumer, another intake appointment will be initiated to occur within ten (10) days of the original request or as soon as possible if ten (10) days from the original request has already lapsed.

• If the enrollee has any of the following risk factors, active outreach and engagement should occur until the enrollee has received an intake assessment:
  ➢ Indication of current or recent past danger to self or others, or grave disability, or
  ➢ Indication that symptoms of mental illness or substance use disorder may be a barrier to attending an appointment, or
  ➢ Any other indication of factors that indicate a barrier to accessing services or a need for a more assertive approach, such as an outreach.

• If after the guidelines in 2.b of this policy have been applied, and the enrollee has still not received an intake assessment within 30 days of the request, the request may be closed and a new request may be made and recorded as appropriate to the enrollee’s needs or desires.

c. Routine behavioral health services are offered to occur within fourteen (14) calendar days of a determination of eligibility. An extension is possible upon request by the enrollee. A total of twenty-eight (28) calendar days from request for services to first routine appointment will be the normal time period expected.

d. Emergent behavioral health care occurs within two (2) hours of the request for behavioral health services from any source.

e. Urgent care occurs within twenty-four (24) hours of the request for behavioral health services from any source.

3. The SBHO network providers will use the SBHO standardized form to request services from the delegated ASO.

4. The contracted ASO will follow the authorization procedures as outlined in the SBHO Utilization Management Plan, LOC standards, and Service Denial Determinations policies.

MONITORING

1. This policy is a mandate by contract and statute. This policy will be monitored through use of SBHO:
   • Annual SBHO Provider and Subcontractor Administrative Review
   • Annual Provider Chart Reviews
   • SBHO Grievance Tracking Reports
   • Quarterly Provider Performance Reports
• Quality Management Plan activities, such as review targeted issues for trends and recommendations
• Review of previous Provider Corrective Action Plans related to Age and Cultural Competence policy, including provider profiles related to performance on targeted indicators

2. If a provider performs below expected standards during any of the reviews listed above a Corrective Action will be required for SBHO approval.
CROSS REFERENCES

- Plan: Utilization Management Plan
- Policy: Access to Timely Services
- Policy: Corrective Action Plan

PURPOSE

The Salish Behavioral Health Organization (SBHO) ensures Medicaid recipients/enrollees and individuals eligible for Medicaid are made aware of their right to access crisis and stabilization services, evaluation and treatment services, rehabilitation case management services, and psychiatric inpatient services, prior to having an intake assessment.

DEFINITIONS

Enrollee means a person who has applied for, is eligible for or who has received publicly funded behavioral health services.

- For a child under the age of thirteen (13), the definition of enrollee includes the parents or legal guardians.
- For a child thirteen (13) years or older who provides consent for their parents or legal guardians to be involved in the treatment planning, the definition of enrollee includes the parents or legal guardians.

Enrollee is defined as an individual currently enrolled in a Medicaid plan that provides a behavioral health benefit, or an individual not yet enrolled but eligible for a Medicaid plan that provides a behavioral health benefit.
Family means:
For child clients: Family means a child’s biological parents, adoptive parents, foster parents, guardian, legal custodian authorized pursuant to Title 26 RCW, a relative with whom a child has been placed by the Department, or a Tribe.

For adult clients: Family means those the person defines as family or those appointed/assigned to the client (such as guardians, siblings, caregivers, and significant others)

Request for services is defined as the point in time when a request for behavioral health services are sought or applied for through a telephone call, in person, or receipt of a written request from an enrollee or the person authorized to consent to treatment for that individual through any of the following access points:

- Contacting SBHO
- Contacting CommCare
- Contacting the network provider
- Crisis services

Crisis Services are defined as crisis evaluation and treatment services to Medicaid individuals experiencing a behavioral health crisis.

A Mental Health Crisis is defined by an individual 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 negative consequences will follow.

Stabilization Services are defined as services provided to Medicaid individuals who are experiencing a mental health crisis. These services are to be provided in the person's own home, or another home-like setting, or a setting which provides safety for the individual and the mental health professional. Stabilization services shall include short-term (less than two weeks per episode) face-to-face assistance with life skills training, and understanding of medication effects.

Rehabilitation Case Management Services are defined as a range of activities by the outpatient community behavioral health agency's liaison conducted in, or with, a facility for the direct benefit of a Medicaid individual in the public behavioral health system. To be eligible, the individual must be in need of case management in order to ensure timely and appropriate treatment and transitional care coordination from the facility. Activities include assessment for discharge or admission to community based behavioral health care, integrated behavioral health treatment planning, community-based resource identification and linkage to behavioral health rehabilitative services, and collaborative development of individualized services that promote continuity of behavioral health care as a person transitions from facility to community-based care.

Psychiatric Inpatient Services are defined as 24-hour psychiatric services provided to individuals admitted to a hospital.
Freestanding Evaluation and Treatment Services are defined as services provided in freestanding inpatient residential (non-hospital/non-IMD) facilities licensed by the Department of Health (DOH) and certified by the mental health Department to provide medically necessary evaluation and treatment to Medicaid individuals who would otherwise meet hospital admission criteria. At a minimum, services include evaluation, stabilization and treatment provided by or under the direction of licensed psychiatrists, nurses and other mental health professionals, and discharge planning involves the individual, family, significant others, and the identified outpatient provider to ensure continuity of mental health care.

**PROCEDURE**

1. Prior to receiving an intake assessment and/or evaluation, an individual with Medicaid is made aware of his or her right to access the following services:
   - Crisis services
   - Evaluation and treatment services
   - Stabilization services
   - Rehabilitation case management services
   - Psychiatric inpatient services
   - SUD Assessment
   - SUD Brief Intervention
   - SUD Withdrawal Management Services
   - ADIS (Alcohol and Drug Information School)
   - SUD Involuntary Commitment

2. Individuals with Medicaid are referred and/or assisted to the appropriate service(s) listed above, as medically necessary, prior to requiring an intake assessment to ensure access to all services are available to individuals in need.

3. Individuals with Medicaid receive the following written information regarding the Medicaid and non-Medicaid services that are available and they are eligible for. The written information includes their right to receive certain services prior to an intake evaluation. Reference the SBHO Policy: General Information Requirements
   a. Department of Social and Health Services (DSHS) benefits booklet is provided when an individual enrolls into a Medicaid plan.
   b. DSHS benefits booklet is posted in the lobby of all the SBHO network community behavioral health agencies. Information is available in English, Cambodian, Chinese, Korean, Laotian, Russian, Spanish, Vietnamese and any other prevalent language(s) within the SBHO geographical area.
   c. SBHO member handbook and informational brochure with general information.
   d. SBHO notice of determination (NOD) letters notifying individuals of the level of authorized outpatient services or justification for not authorizing services (reason of ineligibility).
e. The SBHO requires network providers, subcontractors, and Ombuds to give each individual written material available in English or other alternate languages which include:
   - A statement of services provided by the agency or organization, and how to access
   - Enrollee Rights and Responsibilities
   - Agency/SBHO Grievance Procedures, including how to file a concern at various levels
   - Ombuds Services
   - HIPAA Privacy Statements
   - Signs of mental illness or substance use disorder
   - How to request information in another format/language

e. The SBHO requires network providers to offer every Medicaid enrollee a Behavioral Health Benefit Booklet at Intake and inform enrollee that the booklet is kept on the DBHR website.

4. Individuals covered by Medicaid are asked to acknowledge that they received, read, or been explained this information, prior to an intake assessment.
   a. Individuals with any questions regarding the information are asked to discuss these questions with a SBHO network community behavioral health agency staff member, contact the Ombuds office, or call the SBHO office directly.

5. The SBHO requires network providers to provide special accommodations for individuals, regardless of funding status, who request and/or need assistance understanding their rights. Reference SBHO policy: Enrollee Information, Enrollee Rights, and Interpreter Service & Assistance
   a. Individuals who speak a language other than English will be provided translation interpreter services.
   b. Individuals who are blind or hearing impaired are provided with special assistance needed to ensure that their right to care is understood.

6. The SBHO ensures all required Medicaid state plan services are available and accessible to individuals residing within the SBHO through the Utilization Management Plan and resource monitoring activities. Reference SBHO Plan: Utilization Management Plan and monitoring activities table.
   a. The SBHO maintains the provision of crisis services, including crisis stabilization services. Reference SBHO policy: Service Modalities- Crisis and Crisis Prevention Plan Standards
   b. The SBHO provides oversight to the rehabilitation case management services provided via a network community behavioral health agency. The SBHO monitors bed allocation, daily usage, and transitional care coordination for children and youth transitioning in and out of the state administered Children’s Long Term...
Inpatient (CLIP) facilities, Western State Hospital (WSH), and other facility based care.

c. The SBHO ensures access to Psychiatric Inpatient, Withdrawal Management, and Residential Substance Use Disorder Services, when needed.

MONITORING

This policy is mandated by contract and statute.

1. The SBHO monitors this policy through the use of the SBHO:
   - Annual SBHO Provider and Subcontractor Administrative Review
   - Annual Provider Chart Reviews
   - SBHO Grievance Tracking Reports
   - Quality Management Plan activities, such as review targeted issues for trends and recommendations
   - The Department conducts the Mental Health Statistical Improvement Project (MHSIP) every year, one year for adults, alternating the next year for children/youth. The MHSIP measures general enrollee satisfaction with the existing service delivery system, appropriateness and quality of services, participation in treatment goals, access to services, and perceived outcomes of services they received. The SBHO requests over-sampling of the region to gather specific catchment area data and analyze for trends.
   - Utilization Management Committee, utilization data reports to monitor the rates and trends of Medicaid individuals authorized for the services not requiring an intake and not concurrently authorized for outpatient services, provide in depth analysis of concerning trends, and make policy and auditing recommendations to the SBHO and the network providers.

2. If a provider performs below expected standards during any of the reviews listed above a Corrective Action will be required for SBHO approval.
The Salish Behavioral Health Organization (SBHO) shall ensure the full range of outpatient behavioral health services and modalities, as described in the Medicaid State Plan or Waiver are available within the SBHO to Medicaid covered individuals. These services are available and provided based on the individual’s needs and medical necessity. Additional criteria for non-Medicaid individuals include referrals made from the criminal justice system, withdrawal management, or residential treatment facility.

PROCEDURE

1. Outpatient behavioral health treatment services are a provision of services designed to help an individual attain goals as prescribed in their Individual Service Plan. These services shall be congruent with the age, strengths, and cultural framework of the individual. The services shall include participation with the individual, his or her family, or others at the individual’s request that play a direct role in assisting the individual to establish and/or maintain stability in his/her daily life. Services shall be offered at the location preferred by the individual.
2. The following outpatient mental health modalities must be provided if determined medically necessary (see contract exhibit for service definitions):
   - Brief Intervention Treatment
   - Day Support
   - Family Treatment
   - Group Treatment
   - High Intensity Treatment
   - Individual Treatment Services
   - Intake Assessment/Intake Evaluation
   - Medication Management
   - Medication Monitoring
   - MH Services within Residential Settings
   - Peer Support
   - Psychological Assessment
   - Special Population Evaluation
   - Rehabilitation Case Management
   - Therapeutic Psychoeducation
   - Mental Health Clubhouse
   - Respite Care
   - Residential Services
   - Supported Employment
   - Wrap Around with Intensive Services (WISe)

3. The following outpatient substance use disorder modalities must be provided if determined medically necessary (see contract exhibit for service definitions):
   - Level I.0, Outpatient Treatment
   - Level 2.1, Intensive Outpatient Treatment

4. All mental health services must be provided by or under the supervision of a mental health professional. All substance use disorder services must be provided by or under the supervision of a chemical dependency professional.

5. For Medicaid eligible: If it is determined a service/modality is required but not available, the network provider shall purchase the medically necessary service/modality for the duration that is medically necessary.

6. For all clients: In addition to the required services/modalities, the network provider may provide or purchase:
   - Assistance with application for entitlement programs
   - Assistance with meeting the requirements of the Medically Needy spend down program; and
• Services provided to Medicaid eligible that are not included in the Medicaid State Plan or Waiver

7. The SBHO network providers may share resources within the region to meet SBHO sufficiency standards.

MONITORING

1. This policy is a mandate by contract and statute. This policy will be monitored through use of SBHO:
   • Annual SBHO Provider and Subcontractor Administrative Review
   • Annual Provider Chart Reviews
   • Over and Under Utilization Projects
   • SBHO Grievance Tracking Reports

2. If a provider performs below expected standards during any of the reviews listed above a Corrective Action will be required for SBHO approval.
Wraparound with Intensive Services (WISe)

Program, Policy, and Procedure Manual

The Washington State Wraparound with Intensive Services (WISe) program model is designed to provide comprehensive services and supports to eligible clients. The purpose of this manual is to direct the development of a sustainable service delivery system for providing intensive mental health in home and community settings to Medicaid eligible children and youth.
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Section 1: Purpose and Goals

Washington State’s Wraparound with Intensive Services (WISe) is designed to provide comprehensive behavioral health services and supports to Medicaid eligible individuals, up to 21 years of age, (herein referred to as “youth”) with complex behavioral health needs and their families. The goal of WISe is for eligible youth to live and thrive in their homes and communities, as well as to avoid or reduce costly and disruptive out-of-home placements.

The implementation of WISe will be statewide by June 30, 2018. The purpose of this manual is to create consistency across Washington State’s service-delivery system for providing intensive mental health services in home and community settings to Medicaid eligible youth who screen in for these services.

The manual will assist the community mental health system and allied agencies, as well as other formal, informal, and natural supports with the identification of eligible youth and the implementation and provision of WISe. It is intended to provide an understanding of:

- The required infrastructure and expectations of WISe
- The Practice Model for the core elements of WISe, in each of the following phases:
  - Engagement
  - Assessing
  - Teaming
  - Service Planning and Implementation
  - Monitoring and Adapting
  - Transition

This manual is a living document. It will continue to be refined and revised as we learn from communities through the WISe roll out. The most current version of the manual will be posted on our Children’s Behavioral Health website at: [http://www.dshs.wa.gov/dbhr/cbh-wise.shtml](http://www.dshs.wa.gov/dbhr/cbh-wise.shtml).

This version of the manual was updated at a time of multiple transitions. Referenced links, documents, and Washington Administrative Codes (WACs) are still in the process of being updated. Until future versions of the manual are released, any reference to the delivery system within this manual or within referenced material is intended to include any successor.

OBJECTIVE:

The specific objective of this manual is to develop and successfully implement Wraparound with Intensive Services (WISe) statewide by June 30, 2018. This manual will provide guidelines to ensure consistency in the goals, principles, and the delivery of the program, as WISe becomes available over the next five years in communities across the state.
We believe implementing this program, utilizing the Washington State Children’s Behavioral Health Principles (previously named the Mental Health Principles) outlined below, will:

- Reduce the impact of mental health symptoms on youth and families, increase resiliency, and promote recovery.
- Keep youth safe, at home, and making progress in school.
- Help youth to avoid delinquency.
- Promote youth development, maximizing their potential to grow into healthy and independent adults.

The Washington State Children’s Behavioral Health Principles are outlined below. These principles guide the implementation of WISE and provide the foundation for the practice model and clinical delivery of intensive services.

**Washington State Children’s Behavioral Health Principles**

Washington State’s Department of Social and Health Services (DSHS) and Health Care Authority (HCA) believe that youth and families should have access to necessary services and supports in the least restrictive, most appropriate, and most effective environment possible. Washington State is committed to operating its Medicaid funded mental health system that delivers services to youth, in a manner consistent with these principles:

- **Family and Youth Voice and Choice**: Family and youth voice, choice and preferences are intentionally elicited and prioritized during all phases of the process, including planning, delivery, transition, and evaluation of services. Services and interventions are family-focused and youth-centered from the first contact with or about the family or youth.

- **Team based**: Services and supports are planned and delivered through a multi-agency, collaborative teaming approach. Team members are chosen by the family and the youth and are connected to them through natural, community, and formal support and service relationships. The team works together to develop and implement a plan to address unmet needs and work toward the youth’s and family’s vision.

- **Natural Supports**: The team actively seeks out and encourages the full participation of team members drawn from the youth’s and family members’ networks of interpersonal and community relationships (e.g. friends, neighbors, community and faith-based organizations). The care plan reflects activities and interventions that draw on sources of natural support to promote recovery and resiliency.

- **Collaboration**: The system responds effectively to the behavioral health needs of multi-system involved youth and their caregivers, including youth in the child welfare, juvenile justice, developmental disabilities, substance abuse, primary care, and education systems.

- **Home and Community-based**: Youth are first and foremost safely maintained in, or returned to, their own homes. Services and supports strategies take place in the most inclusive, most responsive, most accessible, most normative, and least restrictive setting possible.
• **Culturally Relevant**: Services are culturally relevant and provided with respect for the values, preferences, beliefs, culture, and identity of the participant/youth and family and their community.

• **Individualized**: Services, strategies, and supports are individualized and tailored to the unique strengths and needs of each youth and family. They are altered when necessary to meet changing needs and goals or in response to poor outcomes.

• **Strengths Based**: Services and supports are planned and delivered in a manner that identifies, builds on, and enhances the capabilities, knowledge, skills, and assets of the youth and family, their community, and other team members.

• **Outcome-based**: Based on the youth and family’s needs and vision, the team develops goals and strategies, ties them to observable indicators of success, monitors progress in terms of these indicators, and revises the plan accordingly. Services and supports are persistent and flexible so as to overcome setbacks and achieve their intended goals and outcomes. Safety, stability and permanency are priorities.

• **Unconditional**: A youth and family team’s commitment to achieving its goals persists regardless of the youth’s behavior, placement setting, family’s circumstances, or availability of services in the community. The team continues to work with the family toward their goals until the family indicates that a formal process is no longer required.
Section 2: Agency Infrastructure

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 team members demonstrate a high level of flexibility and accessibility by working at times and locations that ensure meaningful participation of family members, youth and natural supports, including evenings and weekends. WISe also provides access to crisis response 24 hours a day, seven days a week, by individuals who know the youth and family’s needs and circumstances, as well as their current crisis plan. The service array includes intensive care coordination, intensive treatment and support services, and mobile crisis outreach services, provided in home and community settings, based on the individual’s needs and a plan developed using a wraparound process with a Child and Family Team (CFT). Mental health services and supports will be available that are sufficient in intensity and scope, including those based on available evidence of effectiveness, and individualized to each youth and their family’s unique needs. Care is integrated in a way that ensures youth are served in the most natural, least restrictive environment. The intended outcomes are individualized to the goals identified and prioritized by each youth and family. They often include: increased safety, stabilization, school success, and community integration; and support to ensure that youth and families can live successfully in their homes and communities and make positive and informed decisions regarding their care and lives, with an avoidance of hospitalizations and out-of-home placements.

This section will outline the infrastructure requirements an agency must have in place to be eligible for consideration as a WISe provider.

Federal and State Requirements

The services provided under WISe are Medicaid services, and therefore require agencies to meet all applicable federal standards related to the provision of mental health services covered under Medicaid. Agencies interested in becoming a WISe provider must hold a current Behavioral Health Agency License, issued by the Division of Behavioral Health and Recovery (DBHR), under Chapter 388-877 WAC. Agencies must also have a contract with a Behavioral Health Organization (BHO) or a Fully Integrated Managed Care Organization, (herein collectively referred to as the “Managed Care Entity(s)”, or “MCEs” throughout this manual, unless otherwise specified). Additionally, agencies must be certified, or have sub-contracts or Memorandums of Understanding (MOUs) in place, to provide all of the following services under WAC 388-877A:

- Individual treatment services
- Family therapy services
- Case management services
- Psychiatric medication services
- Crisis mental health services—Outreach services
Recovery support—Wraparound facilitation services
Recovery support—Peer support services

The list above is intended to direct the minimum certification requirements. If an agency provides other services, additional certification standards may apply. The monitoring of these requirements will continue to be completed by DBHR’s Licensing and Certification staff. Adherence to WISE, outlined below, will be reviewed by the WISE agency, the associated Managed Care Entity (MCE), and DBHR.

**WISE-Specific Requirements**

Adherence to WISE, outlined below, will be reviewed by the WISE agency, the associated MCE, and DBHR according to the Quality Management Plan (see Appendix J for link).

Agencies interested in becoming a WISE provider must meet standards related to:

1. Access
2. Practice model
3. Service array
4. Staffing
5. Community oversight and cross-system collaboration
6. Documentation

Access and Practice Model (items one and two) will be discussed in detail in subsequent chapters, beginning on pages nine and 13. The requirements for items three through six in the list above are as follows.

**Service Array**

Agencies providing WISE must have capacity to provide a wide array of services within the agency, or through sub-contracts or an MOU. WISE agencies will provide each participating youth and his or her family with a Child and Family Team (CFT), and at a minimum, access to these services (provided in home and community settings):

1. Intake Evaluation
2. Intensive Care Coordination
3. Intensive Services
4. 24/7 Crisis Intervention and Stabilization Services

The above listed services are to be as described in this document, the Service Encounter Reporting Instructions (SERI) for Behavioral Health Organizations, and as described in the larger Encounter Data Reporting Guide, for Fully Integrated Managed Care Organizations.

Mental health services offered to youth and families that are participating in WISE should typically be provided by staff employed at a WISE-qualified agency. The CFT has the responsibility to identify needs and develop the most appropriate and normalized strategies to meet these needs, including
referral and coordination with other services and systems. Other needed services and supports are to be outlined in the **single Cross System Care Plan (CSCP)** that is developed by the CFT and will be monitored by the members of the CFT.

*Note: See the WISE Service Requirements Section for further information on services.*

**Staffing**

WISE provider agencies must have sufficient WISE qualified staff to:

- Manage the capacity-level delegated by the MCE and DBHR.
- Deliver or coordinate all medically necessary mental health services (including intensive services, Psychiatric/Medical).
- Provide each youth/family served with:
  - Mental health therapies (i.e., family, individual treatment, etc.).
  - Care coordination.
  - Peer counseling through Family Partner and/or Youth Partner who are certified peer counselors, or qualify for certification. *Note: Descriptions and responsibilities for staff that provide each of these services are outlined in Appendix B.*
- Provide clinical supervision and ongoing trainings to WISE-qualified staff (see Appendix K for the framework).
- Have psychiatric consultation available to each team.
- Maintain an **average** caseload size of 10 or fewer participants, with a maximum of 15 at any given time, for each Care Coordinator.
- Provide 24/7 mobile crisis intervention (see Section 4 for details) to youth and families, preferably through staff that are known to the youth and family.
- Meet timelines for completing WISE screens and CANS Assessments, as well as entering the information into the Behavioral Health Assessment System (BHAS).

**Cross-System Collaboration**

WISE provider agencies are required to collaborate and include other child serving system partners on CFTs, as applicable to each youth and family, as identified in the Point of Identification section of the Access Model (hereafter system partners). The agency is to work with the youth and family and system partners to develop a single Cross System Care Plan (CSCP) for the youth and family. The CSCP can encompass the individual service plan requirements found in **WAC 388-877-0620** and **WAC 388-877A-0135**, but will likely include a variety of other activities. Medicaid services must be prescribed clearly, according to Medicaid documentation standards, regardless of whether the individual service plan is incorporated into the CSCP or a separate document.

The MCEs will work within their local communities to invite diverse representation and establish appropriate communication channels for engaging family, youth, and local community representative in the Children’s Behavioral Health Governance structure to inform policy-making
and program planning. Section 6 describes the requirements to identify regional process(es) on how MCEs coordinate and participate in the governance structure.

A link to WISE informational materials that have been developed for specific system partners, and other identified child-serving formal and informal supports, is located on Appendix I.

**Documentation**

WISE provider agencies must maintain the following administrative documentation, in addition to that required for Behavioral Health Agency licensing:

- Quality Management Plan
- WISE infrastructure monitoring
- Calculation used for caseload management and capacity
- Child and Family Team requirements (Cross System Care Plan {CSCP}, plan reviews, progress, revisions, CFT meeting sign-in sheets, and CFT minutes)

WISE provider agencies must maintain the following documentation for each WISE-qualified provider’s personnel:

- Skill development and implementation support
- Training, recertification and competency demonstration
- Coaching
- Supervision

In addition to documentation requirements for behavioral health agencies, and compliance with Medicaid regulation, WISE provider agencies must ensure the following WISE-specific documentation can be found in each client’s record:

- Completed CANS Screen, CANS Full within 30 days of the WISE screen, updated CANS Full at least every 90 days, and CANS Full again upon discharge or transition to a lower level of care.
- Cross System Care Plan (note: see Appendix H for core elements and a sample format), including revisions and updates.
  - The CSCP must address the needs found within the ISP, or could include all required elements of the Individual Service Plan (ISP) within the CSCP.
  - Expected outcomes/transition activities and transition/discharge criteria will be clearly defined in the CSCP.
- All necessary Releases of Information
- Safety/crisis plan.
- CFT meeting notes:
  - From the meetings that occur at least monthly
  - Notes should include a list of attendees (the youth and/or family are required to be present for a meeting to occur). Participation of young children will be decided upon by the CFT, as appropriate.
  - A record that notes were shared with all members of the CFT within a week of each meeting that reflects the voice of family and youth.
Section 3: WISE Access Protocol

This section provides uniform standards on the administrative practices and procedures for providing access to WISE and its services. WISE providers and MCEs will utilize the protocols of this section to meet the requirements related to:

- The identification of youth who may qualify/benefit from WISE.
- The WISE referral process.
- The components of the WISE Screening and Intake Process.

**Identification**

Child-serving systems, such as agencies that fall under the auspice of the Department of Social and Health Services (DSHS) (i.e., Children's Administration, Rehabilitation Administration, Development Disabilities Administration), Health Care Authority (HCA), school personnel, county and community providers, and Tribal service providers will be informed to assist in the identification and referral of youth who might benefit from WISE. 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.

Information sheets with more detailed factors to consider, specific to identified affinity groups, have been developed. A link to these materials is included in Appendix I.

**Referrals**

Anyone can make a referral for a WISE screen, including the youth and family. All Medicaid-eligible youth, under the age of 21, who might benefit from WISE should be referred for a WISE Screen.
A referral for a WISe screen **must** be made for Medicaid-eligible youth in the following circumstances:

1. When a youth is referred to Children's Long-Term Inpatient Program (CLIP) or Behavioral Rehabilitation Services (BRS).
2. While a youth is enrolled in BRS or receiving CLIP services: no less frequently than every six months, and during discharge planning.
3. Prior to a youth discharging from a psychiatric hospital.
4. When a step-down request has been made from institutional or group care.
5. When a youth receives crisis intervention or stabilization services, and there are past and/or current functional indicators of need for intensive mental health services.

If a youth **is currently** receiving Medicaid mental health services from a MCE’s provider, a referral for a WISe Screen can be completed in the following ways:

- The current provider can complete the CANS screen, if they are certified in the CANS, or
- The current provider can make a referral to a WISe-contracted provider agency that will complete the CANS Screening. If a youth does not meet the CANs algorithm, clinical judgment may be used to continue with a referral to WISe.

If a youth **is not currently** receiving Medicaid mental health services from a MCE’s provider, a referral to WISe can be most easily completed by contacting the WISe referral contacts for each county, found in the following link: [http://www.dshs.wa.gov/dbhr/cbh-wise.shtml](http://www.dshs.wa.gov/dbhr/cbh-wise.shtml). In addition, requests for assistance with referrals for a WISe screen may be made directly to a MCE or any MCE provider.

**WISe Screening and Intake**

All referrals for a WISe screen to the MCE, any MCE provider or other WISe referral contact, should result in a WISe screening, regardless of referral source. A WISe screen must be offered within 10 business days of receiving a referral.

All WISe screens will include:

1. Information gathering that utilizes the information provided by the referent (i.e. the youth, a family member, a system partner, and/or an informal or natural support). Additional information may be gathered from the youth and family directly and others who have been involved with the family (including extended family and natural supports) and/or its service delivery.
2. Completion of the Child Adolescent Needs and Strengths (CANS) Screen, which consists of a subset of 26 questions, pulled out the full CANS assessment. The CANS screen must be completed by a CANS-certified screener ([https://canstraining.com](https://canstraining.com)).
   *Note: Training materials, related to how to enter CANS into BHAS can be found at: [https://www.wa-bhas.org](https://www.wa-bhas.org).
**Note:** For children age 4 and younger, WISe providers will use the CANS 0-4.

3. Entering the CANS Screen into the Behavioral Health Assessment System (BHAS) which will apply the CANS algorithm to determine whether the youth would benefit from WISe.

For any youth who is **not currently enrolled in a MCE**, for behavioral health services, in addition to the WISe screen, the following intake eligibility determinations must be made:

1. Establish Medicaid eligibility. WISe is a Medicaid program and can only serve youth who are under 21 and covered by Medicaid.

2. Establish that the youth meets qualifying medical necessity criteria, based on a covered mental health diagnosis, under the MCE’s contracted standards, such as Access to Care Standards for Behavioral Health Organizations. All youth who meet the CANS algorithm and the MCE’s qualifying criteria will be determined to meet WISe level of care. If a youth does not meet the CANS algorithm, clinical judgment may be used to continue with a referral to WISe.

All youth, ages 5-20, who meet the CANS algorithm and are eligible for mental health services through an MCE’s qualifying criteria will be offered entry to WISe (or WISe-like services until full implementation in June 2018). For those children under 5 years of age, this decision shall be made based on clinical judgment and in accordance with authorization standards and protocols established in each MCE.

At this point, initial engagement to begin planning, facilitating, and coordinating services will occur. Initial engagement is typically done by a Care Coordinator and Youth Partner and/or Family Partner (depending on the youth and family’s preference). WISe may be declined or accepted by any youth (over the age of consent - 13 years and older) and/or a legal decision-maker for each youth.

Youth who are not enrolled in a MCE and do not meet intake eligibility requirements will be referred to other community resources, including their health care plan for mental health services. All youth receiving or eligible for MCE services, but who do not meet the CANS algorithm, will be referred to and offered other services.

**Note:** Per existing requirements, MCEs and/or WISe providers are responsible for providing information and access to crisis services to the youth and/or family, while they await the WISe screen and intake.
Access Model to Wraparound with Intensive Services (WISe)

WA State Children’s Behavioral Health Principles

POINT OF IDENTIFICATION

Self and Families
- Self Referral

Department of Social and Health Services
- Children already receiving services through a DSHS administration
  - Economic Services
  - Child Welfare
  - Juvenile Rehabilitation
  - Developmental Disabilities
  - Substance Use Disorder Treatment Providers
  - Mental Health
  - Crisis

Health Care Authority
- Primary Care & Mental Health Providers

County
- Juvenile Justice
- Other county agency

Community
- Schools
- Public Health
- Social Service Organizations

Tribes
- Tribal Mental Health Centers

PREVENTION AND PROMOTION

REFERRAL PROCESS

WISe Requested
Medicaid verified?
- YES
  - MCE Enrolled?
    - YES
      - WISe Screen Completed
      - DATA
    - NO
      - Intake Completed with WISe Screen
      - Crisis & Stabilization services provided as needed during intake process
      - DATA

- NO
  - WISe Indicated?
    - YES
      - Begin Care Planning for WISe
      - DATA
    - NO
      - Referral & Linkage Made
      - Mental Health &/or Other Community Services

NOTE: May go to Other Social Service Entity (Referral & Linkage)
Crisis services available if needed regardless of eligibility

INTAKE AND ENGAGEMENT

DATA = Data Points Utilizing Child and Adolescent Needs and Strengths (CANS) Tools and Process
Section 4: WISE Service Requirements

What is Different about WISE?

Focus on Youth and Family Voice Utilizing a Strength-based Approach

Family and youth voice, choice and preferences are intentionally elicited and prioritized during all phases of the process, including planning, delivery, transition, and evaluation of services. Supports and services are delivered in a way that honors the value of family-driven and youth-guided care. Services and supports are planned and delivered in a manner that identifies, builds on, and enhances the capabilities, knowledge, skills, and assets of the youth and family, their community, and other team members.

Primary setting

WISE services are not intended to be facility-based. Instead, WISE services are provided in the home and in community locations, and at times and locations that ensure meaningful participation of family members, youth and natural supports. WISE is targeted to youth with intensive and complex mental health needs. Assessment, treatment and support services are provided in the youth and family's natural setting, where needs, strengths, and challenges present themselves (such as the home, school and community).

Flexible and Creative Services

WISE is intended to be provided in creative and flexible ways. Those served through WISE tend to come into services with complex needs and involved histories. This approach must provide support differently, as many of the youth and families served have found traditional behavioral health care unable to meet their behavioral health needs. Others remain at risk of more restrictive care, in spite of having received effective traditional mental health services. This circumstance requires the WISE team to deliver purposeful support without delay, with a “take action” mentality, moving from a ‘compliance practice model’ to a needs-driven, strength-based, intensive and flexible service-provision approach.

Involvement of Family Partners and Youth Partners (Certified Peer Counselors) is Essential

Family Partners and Youth Partners who have lived experience must be meaningfully involved in the provision of WISE. The Family Partner and/or Youth Partner must be an equal team member with the Care Coordinator and Mental Health Clinician. The Youth Partner and/or Family Partner meet with the youth and/or family on a regular basis to provide support in addressing the needs of the youth and family, as defined in the Cross System Care Plan (CSCP). Youth Partners and Family Partners should be educated in how to utilize the CANS results to support and educate the youth and family, and are encouraged to be certified in CANS. See Appendix B for more detailed information related to the role of Family Partner and Youth Partner.
WISe assists youth and families in moving toward:

1. Increased optimism and hope that a better life is possible
2. An enhanced sense of the power gained by family members to influence the direction, quality and outcomes of their lives
3. Increased clarity regarding realistic possibilities for a better life
4. The development of a realistic family vision as evidenced by the family’s ability to create statements which accurately reflect the better life they prefer and believe is possible

Providing Intensive Care Coordination and Services Using a Wraparound Model

WISe is intended to operationalize the system of care (SOC) values in service delivery to a specific class of children, youth, and their families with complex behavioral health needs. WISe will be implemented through the support of a statewide system of care to the fullest extent feasible. It is delivered using a wraparound approach, to improve collaboration among child-serving agencies. It focuses on the individual strengths and needs of each participating youth and family.

Once authorized by the MCE for WISe, youth and families participating will have access to a wide array of services and supports to address their specifically identified needs. Although the intensive care coordination and services available under WISe are funded by Medicaid (see appendix F for links to Reporting Instructions), the program’s model is intended to draw in other resources through teaming with both formal (e.g., service providers and representatives of schools and child-serving agencies) and informal (e.g., family, friends, and community members) supports and programs that are offered in a variety of settings (home, community, school, etc.).

Intensive Care Coordination

*Intensive Care Coordination is a service that facilitates assessment of, care planning for, and coordination and monitoring of services and supports, through the phases below.*

While WISe is a team-based approach, it is typically the role of a Care Coordinator to facilitate and coordinate services and supports. Through each of the following phases (adapted from the nationally recognized Wraparound phases) other WISe Practitioners* should be partnering to most effectively meet the needs of the youth and family.

* WISe Practitioners— a term used to describe the collection of WISe-certified staff roles, required for each team (the Care Coordinator, the Family Partner and/or Youth Partner, and the Mental Health Clinician)

The key to successful Intensive Care Coordination is also holding central to a key wraparound principle that “Needs are not Services.”
**Engagement**

**Overview:** During this phase, the groundwork for trust and shared vision among the youth, family, and WISE team members is established, so people are prepared to come to meetings and collaborate. The tone is set for teamwork and team interactions that are consistent with the Washington State Children's Behavioral Health Principles, particularly through the initial conversations about strengths, needs, and culture. In addition, this phase begins to shift the youth and family's orientation to one in which they understand they are an integral part of the process and their preferences are prioritized. Initial engagement should be completed relatively quickly (within 1-2 weeks if possible), so that the team can begin meeting and establish ownership of the process as soon as possible. However, elements of the engagement phase will be implemented in conjunction with other phases.

When a youth is coming into WISE from another program or placement (i.e., CLIP, BRS, an inpatient hospitalization, or a juvenile justice facility), this phase is especially important, to begin prior to discharge, to assist in successfully transitioning youth back into the community.

**Goals/Purpose:**

- To address pressing needs and concerns, prior to forming a Child and Family Team when necessary, so the youth, family and team can give their attention to the WISE process
- To explore the results of the CANS and the individual’s and family’s strengths, needs, culture, and vision, and develop a youth and family narrative that will serve as the starting point for planning
- To orient the family and youth to the WISE process
- To gain the participation of team members who care about and can aid the youth and family, and to set the stage for their active and collaborative participation on the team
- To ensure that the necessary procedures are undertaken so the team is prepared to begin an effective WISE process

**Essential Steps**

- To lay the groundwork for trust and shared vision among the youth, family and WISE team
- To establish rapport and build commitment to WISE process through warmth, optimism, humor, and identification of strengths
- The WISE Practitioner(s) meet with the youth and family to explain the WISE process, and how it differs from traditional care.
- The WISE Practitioner(s) obtains consent for services.
- The WISE Practitioner(s) discuss with the youth and family the events, circumstances, and moments that brought the youth and family to WISE.
- The WISE Practitioner(s) obtain the youth and family perspective on where they are presently (including listening for both their expressed needs and strengths), and where they would like to go in the future.
- The WISe Practitioner(s) discuss the youth’s and family’s view of crises, and develops a written plan to stabilize dangerous or harmful situations immediately.
- The WISe Practitioner(s) ensure the youth and family understand any system mandates (if applicable) and ethical issues.

**Note:** For services under this phase of the intervention to be Medicaid compliant, an initial Individual Service Plan, under the direction of a Mental Health Professional, must be in place that directs the ongoing assessment and team development of services.

### Assessing

**Overview:** In this continuation of the engagement phase, the WISe Practitioners expand the discussion with the youth and family to add context to their involvement in WISe. The WISe Practitioners helps the youth and family to understand that their input is central to the WISe process, and that their preferences at all phases of care planning and implementation will be prioritized. This includes helping the youth and family understand and incorporate any legal mandates into their plan. The WISe Practitioners also listen to the youth and family perspective for information about the youth’s and family’s strengths, needs, culture, and natural supports. A WISe Practitioner reviews the CANS results with the youth and family and determines how to present this information to the team.

**Goals/Purpose:**

- To continue meeting and engaging to further understand the youth and family’s story and context
- To begin initial documentation of strengths, needs, and natural supports (including CANS scores and other information obtained)
- To complete a youth- and family-approved narrative

**Essential Steps**

- The WISe Practitioner(s) complete a strengths discovery and a list of strengths for all family members.
- The WISe Practitioner(s) discuss and lists existing and potential natural supports.
- The WISe Practitioner(s) complete a list of potential team members.
- The WISe Practitioner(s) summarize the youth and family context, strengths, needs, vision for the future, and supports.
- The WISe Practitioner(s) determine with the youth and family how the CANS information will be provided to the team.

### Teaming

**Overview:** In this continuation of engagement, the WISe Practitioners help the youth and family identify, and reach out to persons who should be part of the WISe Child and Family Team (CFT). The team is essential to successful planning and intervention.
Goals/Purpose:

- To identify and engage other who are involved in the youth and family's life in order to align the interests and ensure all involved individuals have a shared mission for the youth and family
- To explain the team process to potential team members and elicit commitment to the process from team members
- To make necessary meeting arrangements

Essential Steps:

- The WISE Practitioner(s) explain WISE to potential team members, eliciting their perspectives, and working to get their commitment to participate in the team process.
- The WISE Practitioner(s) invite potential team members to join the team process.
- The WISE Practitioner(s) partner and orient team members to the WISE process and team meeting structure.
- The CFT members help to create the team meeting agenda, provide input about the meeting logistics and provide comfort for youth and family.
- The CFT will include the youth, parents/caregivers (see definitions in Appendix B), relevant family members, and natural and community supports.
- The CFT will be expected to meet with sufficient regularity (every 30 calendar days, at a minimum), as indicated in the CSCP, to monitor and promote progress on goals and maintain clear and coordinated communication.
- The CFT reviews the interventions and action items and adjusts these accordingly, using the outcomes/indicators associated with each priority need, included in the CSCP. A WISE Practitioner guides the team in evaluating whether selected strategies are promoting improved health and wellness for the youth and successfully assisting in meeting the youth and family's identified needs.
- The CFT works together to resolve differences regarding service recommendations, with particular attention to the preferences of the youth and family
- The CFT has a process to resolve disputes and arrive at a mutually agreed upon approach for moving forward with services.
- The WISE Practitioner(s) are expected to check in with team members on progress made on assigned tasks between meetings.
- The WISE Practitioner(s) set a time, date and location for the team meeting that is convenient to the youth and family.

Service Planning and Implementation

Overview: During this phase, team trust and mutual respect are built while the team creates an initial Cross System Care Plan using a high-quality planning process that reflects the Washington State Children’s Behavioral Health Principles. In particular, youth and family should feel that they are heard, that the needs chosen are ones they want to work on, and that the options, strategies, and interventions chosen capitalize on the strengths of the youth and family and have a reasonable chance of success. The team
also reviews and expands the crisis plan to reflect proactive and graduated strategies to prevent crises, or to respond to them in the most effective and least restrictive manner. The initial CSCP should be completed during one or two meetings that take place within 1-2 weeks. The rapid time frame is intended to promote team cohesion and shared responsibility toward achieving the team’s mission or overarching goal, as identified on the CSCP.

Goals/Purpose:

- To create a CSCP using a facilitated process that elicits multiple perspectives and builds trust and shared vision among team members, with an ever present focus that the youth and family drive the plan
- To base care planning in relationship to high needs and identified strengths, as indicated on the CANS
- To establish a Team Mission that guides the planning direction and builds cohesion in the work of the team members and empowers the youth and their family
- To establish a set of prioritized needs, including the strategies to meet them, and to determine expected outcomes
- To identify team tasks and roles, and document commitments and timelines
- To establish ground rules to guide team meetings
- To identify potential problems and crises, prioritize according to seriousness and likelihood of occurrence, and create an effective and well-specified crisis prevention and response plan

Essential Steps:

- The WISe Practitioner(s) meet with the youth and family and develops a list of possible needs of the family prior to the team meeting, based on the results of the CANS assessment.
- The WISe Practitioner(s) convene one or more team meetings to discuss and obtain agreement on the elements of the CSCP.
- In the CFT meeting, the youth and family’s vision for their future is presented.
- The CFT discusses and sets ground rules to guide the meetings.
- The CFT reviews and expands the list of strengths for the youth and family.
- The CFT creates a mission that details a collaborative goal describing what needs to happen prior to transition from WISe.
- The CFT reviews the list of needs and agrees which to prioritize in the CSCP, respecting and including the preferences and priorities of the youth and family.
- The CFT determines the intended outcomes that will transpire when the needs are met.
- The CFT brainstorms an array of strategies to meet these needs, and then prioritizes strategies for each need, including the use of natural supports and intensive services.
- CFT members agree upon assignments, or action steps, around implementing the strategies.
- The CFT evaluates the crisis plan and adapts as necessary.
- The work of the team is documented, and distributed among team members.

Note: See the Cross System Care Plan example in Appendix G.
Monitoring and Adapting

Overview: During this phase, the CSCP is implemented, progress and successes are continually reviewed, and changes are made to the plan and then implemented; all the while maintaining or building team cohesiveness and mutual respect. The activities of this phase are repeated until the team’s mission is achieved and WISE is no longer needed.

Goals/Purpose:

• To implement the CSCP, monitor completion of action steps, strategies, success in meeting needs, and achieving outcomes
• To use a facilitated team process to ensure that the plan is continually revisited and updated to respond to the successes of initial strategies and the need for new strategies
• To maintain awareness of team members' satisfaction and "buy-in" to the process, and take steps to maintain or build team cohesiveness and trust

Essential Steps:

• The CFT continues to meet at a minimum of every 30 calendar days to evaluate progress towards meeting needs and the effectiveness of indicated strategies.
• The CFT adjusts strategies to meet changes in the needs and outcomes. The team adds, subtracts and modifies strategies to create the most effective mix of services and supports.
• The CFT evaluates whether there is progress towards the designated outcomes. The team adjusts the strategies to guide next steps.
• The CFT adds members, as necessary and appropriate, and strives to create a mix of formal, informal, and natural supports.
• The CFT celebrates successes and adds to strengths as they are identified.
• Full CANS assessments are administered and entered into BHAS every 90 days to help track progress, and to catch emerging needs and make changes to the plan as necessary.
• The WISE Practitioner(s) maintain ongoing communication outside of the team meetings to best monitor "buy-in", and to ensure that all members' perspectives are heard.

Intensive Services Provided in Home and Community Settings:

Intensive services ("direct services") provided in home and community-based settings are individualized, strength-based interventions designed to correct or ameliorate mental health conditions that interfere with a youth's functioning, or provided in order to maintain or restore functioning. Interventions are aimed at promoting health and wellness and helping the youth build skills necessary for successful functioning in the home and community and improving the family's ability to help the youth successfully function in the home and community.

Direct services are delivered according to an Individualized Service Plan, coordinated with the Cross System Care Plan to deliver integrated Wraparound with Intensive Services. The CFT develops goals and objectives for all life domains in which the youth's mental health condition produces impaired functioning (including family life, community life, education, vocation, and
independent living) and identifies the specific interventions that will be implemented to meet those goals and objectives. The goals and objectives seek to maximize the youth's ability to live and participate in the community and to function independently by building social, communication, behavioral, and basic living skills. WISe Practitioners should engage the youth in home and community activities where the youth has an opportunity to work towards identified goals and objectives in a natural setting. Phone contact and consultation may be provided as part of the service.

Direct services include, but are not limited to:

- Educating the youth's family about the mental health challenges the youth is experiencing, and how to effectively support the youth.
- In-home functional behavioral assessment.
- Behavior management, including developing and implementing a behavioral plan with positive behavioral supports, modeling for the youth's family and others how to implement behavioral strategies, and in-home behavioral aides who assist in implementing the behavior plan, monitor its effectiveness, and report on the plan’s effectiveness to clinical professionals.
- Therapeutic services delivered in the youth's home or community including, but not limited to, therapeutic interventions such as individual and/or family therapy and evidence-/research-based practices (e.g., Trauma-Focused Cognitive Behavioral Therapy, Multi-Systemic Therapy, Family Functional Therapy, etc.). These services are designed to:
  - Improve self-care, by addressing behaviors and social skills deficits that interfere with daily living tasks and to avoid exploitation by others.
  - Improve self-management of symptoms including self-administration of medications.
  - Improve social functioning by addressing social skills deficits and anger management.
  - Reduce negative effects of past trauma, using evidence-/research-based approaches.
  - Reduce negative impact of mental health disorders, such as depression and anxiety, through use of evidence-/research-based approaches.
  - Support the development and maintenance of social support networks and the use of community resources.
  - Support employment objectives by identifying and addressing behaviors that interfere with seeking and maintaining a job.
  - Support educational objectives through identifying and addressing behaviors that interfere with succeeding in an academic program in the community.
  - Support independent living objectives, by identifying and addressing behaviors that interfere with seeking and maintaining housing and living independently.

**Settings:** Direct services will be provided in any setting where the youth is naturally located, including the home, schools, recreational settings, childcare centers, and other community settings wherever and whenever needed, including in evenings and on weekends.
**Availability:** Direct services will be available in the amount, duration, and scope necessary to address the medically necessary identified needs.

**Providers:** Non-clinical direct services are typically provided by paraprofessionals under clinical supervision. Peers, including Family Partner and/or Youth Partners, may provide direct services. Clinical treatment services are provided by a qualified clinician, rather than a paraprofessional. Paraprofessionals and Family Partner and/or Youth Partners may provide a follow-on “care extension” role for clinical services (e.g., to provide support to caregivers’ efforts to manage behavior, support to youths’ skill building to develop emotional regulation skills, etc.).

**Authorization:** The full array of WISe services may be provided, as medically necessary, once WISe is authorized by the MCE.

**Crisis Planning and Delivery**

**Crisis Planning**

Effective crisis planning is a critical component of an effective care plan. A Crisis Plan includes the following elements:

- Crisis identification and prevention steps, including CFT members’ roles related to proactive interventions to minimize the occurrence and severity of crises.
- Crisis response actions using a tiered approach to address the severity level of the crisis situation.
- Clear behavioral benchmarks that change over time to reflect progress, changing capacities and changes in the youth/family's expectations.
- A post-crisis plan for evaluating the management of the crisis and overall effectiveness of the plan.

Services include:

- Crisis planning that, based on youth’s history and needs:
  - Anticipates the types of crises that may occur.
  - Identifies potential precipitating events and methods to reduce or eliminate.
  - Establishes individualized responsive strategies by caregivers and members of the youth’s team to minimize crisis and ensure safety.
- Stabilization of functioning by reducing or eliminating immediate stressors and providing counseling to assist in de-escalating behaviors and interactions.
- Referral and coordination with:
  - Services and supports necessary to continue stabilization or prevent future crises from occurring.
  - Any current providers and team members including a care coordinator, clinicians, youth partner, family partner, family members, primary care practitioners, or school personnel.
• Post-crisis follow-up services (stabilization services) provided periodically to:
  o Ensure continued safety and delivery of services necessary to prevent future crises.
  o Coordinate services between the out-of-home provider (if the youth is placed out of home) and the youth’s treatment team to facilitate a plan for rapid return home.
• Tools and resources available to manage potential risks.

**Crisis Delivery**

Crisis services include crisis planning and prevention services, telephone support, as well as face-to-face interventions that support the youth in the community.

**Settings:** WISe crisis services are typically provided at the location where the crisis occurs, including the home or any other setting where the youth is naturally located, including schools, recreational settings, childcare centers, and other community settings.

**Availability:** WISe mobile crisis and stabilization services are available 24 hours a day, 7 days a week, 365 days a year.

**Providers:** Each WISe provider agency must have capacity to respond to destabilizing events whenever the need arises. Individuals who know the youth and family’s needs and circumstances, as well as their current crisis plan, will respond to the crisis episode and are preferably drawn from the team. Crisis responders may partner with others outside the team if necessary, and when it is written into the crisis plan.

**Transition**

**Overview**

*During this phase, plans are made by the team for a purposeful transition out of WISe services, to a mix of formal and natural supports in the community. The focus on transition is continual during the WISe process, and the preparation for transition is apparent even during the initial engagement activities.*

**Goals/Purpose:**

• To plan a purposeful transition out of WISe in a way that is consistent with the Principles, and that supports the youth and family in maintaining the positive outcomes achieved in the WISe process
• To ensure that the cessation of WISe is conducted in a way that celebrates successes and frames transition proactively and positively
• To ensure that the family is continuing to experience success after WISe and to provide support if necessary

**Essential Steps:**

• The CFT creates strategies within the CSCP for a purposeful exit out of WISe to a mix of possible formal and natural supports in the community (and, if appropriate, to services and supports in the adult system). At the same time, it is important to note that focus on
transition is continual during the WISe process, and the preparation for transition is apparent even during the initial engagement activities.

- The CFT creates a post-WISe crisis plan that includes action steps, specific responsibilities, and communication protocols. Planning may include rehearsing responses to crises and creating linkage to post-WISe crisis resources.
- New members may be added to the team to reflect identified post-transition strategies, services, and supports. The team discusses responses to potential future situations, including crises, and negotiates the nature of each team member’s post-WISe participation with the team/youth and family. CFT meetings reduce in frequency and ultimately cease.
- The WISe Practitioner(s) guide the CFT in creating a document that describes the strengths of the youth, family, and team members, and lessons learned about strategies that worked well and those that did not work so well. The CFT prepares/reviews necessary final reports (e.g., to court or participating providers).
- The CFT is encouraged to create and/or participate in a culturally appropriate “commencement” celebration that is meaningful, to the youth, family, and team, and that recognizes their accomplishments.

CFT’s use the CANS to monitor for an increase of strengths and a reduction of needs. The CFT, using clinical judgment and supervision, will determine the beginning of the transition window, and make preparations for the youth and family to transition out of WISe. The timing of transition is determined by the CFT and outlined in the CSCP. Up to six months are allowed under the WISe model. Upon discharge from WISe, a full CANS (coded as discharge) must be completed and entered into BHAS.

**Note:** When there is sufficient CANS data within BHAS, as well as data from DBHR-sponsored surveys on youth in WISe and their caregivers, the Department, in consultation with the Health Care Authority, will examine the development and use of a Reliability Change Index to inform the CFT as to when it may be appropriate for a youth to begin transitioning out of WISe.
Section 5: Client Rights

Decisions and Dispute Resolution

This section is intended to explain the decision-making and appeal procedures for individuals seeking or receiving WISe services. This section of this manual does not alter any Medicaid or due process rights contained in state or federal law.

Reaching Consensus on a CFT

Youth participating in WISe are entitled to any services on the Medicaid mental health service array that are necessary to correct or ameliorate a mental health condition. These include services needed to build on strengths that reduce, eliminate, or improve a mental health condition, as well as services needed to maintain functioning or prevent the condition from worsening.

CFT members should use the WISe planning model described in Section 4 and the Principles when developing the Cross System Care Plan to reach consensus on the services and supports necessary to reach the youth's best possible functional level. The team should also adhere to the needs and strengths identified with the CANS and utilize the preferred strategies expressed by the youth and family. Although the CANS assessment is not the sole measure of individual functioning, the CANS assessment will be utilized to evaluate the progress of the youth in reaching his or her best possible functional level.

The CFT should attempt to reach consensus about what services and supports should be provided, when to increase or reduce services and supports in frequency or amount, and when to terminate services. If there is disagreement among CFT members during the care planning process, the WISe Practitioners should help build agreement among the team to develop a plan, for a specified period of time. The impact of the plan can be assessed and monitored by the CFT and adjusted as necessary.

If the CFT can reach agreement on a plan:

- The CFT should meet again after a specified timeframe has passed.
- The CFT should look at the outcomes in relation to the services that were provided.
- Using the decision-making guidelines described above, paying particular attention to the needs and preferences of the youth and parent(s)/guardian(s), the care coordinator should help the CFT determine whether they are able to reach a consensus on continuing with the services or whether to make changes.

If the CFT cannot reach agreement on services to be provided on an interim basis, or whether interim services should continue, the:

- Care Coordinator should ensure the youth and family is aware of how to use the grievance process to notify the MCE of any disagreements they have with specific mental health treatment recommendations made during the care planning process.
- The team will invite agency administrative or supervisory staff to the next CFT meeting to assist in finding resolution to the dispute. This process may escalate up the chain of
authority until consensus is reached on the matter. All attempts at finding a solution to a grievance should be made at the lowest level possible.

Right to Appeal a Denial, Termination, Reduction, or Suspension of Services.

The MCE and/or provider agency must provide the youth and/or family with a written Notice of Action advising them of their right to request an appeal and to obtain an administrative fair hearing when:

- An individual is screened for WISE and not found to need that level of care, or assessed and found no longer eligible for WISE.
- An individual participating in WISE indicates to the MCE that there is disagreement with treatment plan recommendations found in the Individual Service Plan, made during the care planning process.
- The MCE and/or agency denies, terminates, reduces or suspends the authorization of services to the youth and family that are included in the Medicaid mental health service array and recommended by the CFT in the Cross System Care Plan.

These rights are further explained in the Washington Medicaid Behavioral Health Benefits Booklet, WAC 388-877A-0400 to 0460 for BHOs, and in WAC 182-538 for Fully Integrated Managed Care Organizations.

Types of Appeals.

Appeals are sent to the MCE. There are two types of appeals a youth or family member/caregiver can file to challenge a denial, termination, reduction or suspension of services: a standard or expedited appeal. An appeal must be filed within 90 calendar days from the date on the notice of action. A youth, family member/caregiver or their mental health care provider or other authorized representative acting on the individual’s behalf can ask for either type of appeal.

- **Standard (decision within 45 calendar days):** For a standard appeal, a decision must be issued by the MCE no later than 45 days after the appeal is filed. The MCE may extend this time by up to 14 days based on a request for an extension.

- **Expedited (decision within 3 working days):** An expedited appeal is available to a youth or family member, or their mental health care provider who believes that the youth’s life,

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1. A “denial” is the decision not to offer an intake or a decision by the Managed Care Entity (MCE), or their formal designee, or not to authorize covered medically necessary Medicaid mental health services.
2. A “termination” is a decision by a MCE, or their formal designee, to stop the previously authorized covered Medicaid mental health services. A decision by a provider to stop or change a covered service (in the Individualized Service Plan) solely based on clinical judgment is not a termination.
3. A “reduction” of services is the decision by a MCE to decrease the amount duration or scope of previously authorized covered Medicaid mental health services. The decision by a provider to decrease or change a covered service (in the Individualized Service Plan) solely based on his/her clinical judgment is not a reduction.
4. A “suspension” of services is the decision by a RSN, or their formal designee, to temporarily stop previously authorized covered Medicaid mental health services. The decision by a provider to temporarily stop or change a covered service (in the Individualized Service Plan) solely based on his/her clinical judgment is not a suspension.
health or major ability to function could be seriously harmed by waiting for a standard appeal. An expedited appeal must be decided no later than 3 working days after the appeal request.

- If the mental health care provider asks for an expedited appeal, or supports the youth or family in asking for one, and indicates that waiting 45 days could seriously harm the youth’s health, the MCE will automatically grant an expedited appeal.
- If a youth or family member asks for an expedited appeal without support from their mental health care provider, the MCE will decide if the youth’s health requires one. If the MCE does not agree with the request, the state will decide the appeal within 45 days.

**Process for Filing an Appeal and Requesting a State Medicaid Fair Hearing**

At this stage, there are two levels:

- **Level 1**: An appeal is filed with the MCE, and
- **Level 2**: The State Medicaid Fair Hearing.

**Level 1:**
When an appeal is filed, someone from the MCE who was not involved in the initial decision will review the appeal and provide a written decision within 45 days, unless an extension has been requested. After the MCE makes a decision about the appeal, if the decision is unfavorable to the youth or family, he/she/they may ask for a fair hearing through the State Office of Administrative Hearings (1-800-583-8271).

**Level 2:**
In order to request a State Medicaid Fair Hearing, a youth or family member must first use either the grievance process (described below) or the Level 1 appeal process and receive a decision from the MCE. If the decision is unfavorable, a fair hearing must be requested within 90 calendar days after the MCE issues its decision. A youth or family member may also obtain a state fair hearing if:

- The MCE did not provide a written response within the allowed time frames; or
- There has been a violation of WA State Department of Social and Health Services rules.

**How to Request a State Medicaid Fair Hearing:**

For a **standard hearing**, the youth, a family member, their mental health provider, authorized representative, or an Ombuds, should mail a written appeal to the address below. A verbal request can be made but it must be followed by a request in writing.

Office of Administrative Hearings  
P.O. Box 42489  
Olympia, WA 98504  
1-800-583-8271

For an **expedited hearing**, the youth, a family member, their mental health provider, authorized representative, or an Ombuds should contact the Office of Administrative Hearings by telephone at the numbers (listed above).
Continuing Services During the Appeal

If a youth is currently receiving services, his or her services will be continued during the appeal process and state fair hearing when:

1. The appeal or state fair hearing request is filed within 10 calendar days from the date the notice of action is mailed;
2. The appeal involves the reduction, suspension or termination of previously authorized covered Medicaid mental health services; and
3. The youth or family asks for continuing services.

Grievances on Other Issues

A youth or family member can file a complaint on any matter with which they are dissatisfied. This is called a “grievance.” Such a grievance is used by an individual or their representative to express dissatisfaction in person, orally, or in writing about any matter other than an action to deny, terminate, reduce or suspend services. If the grievance is filed first with the provider agency and the agency’s written decision is not favorable to the individual, the individual may then choose to file the grievance with the MCE. If the MCE’s written decision is not favorable to the individual, the individual can request an appeal or go straight to an administrative hearing.

Help for Youth, Families, and Caregivers

If youth, families, or caregivers request help with filing an appeal or grievance, they should be referred to the Regional behavioral health Ombuds.

Below is a list of additional legal or mental health advocates where the youth and family may be referred:

TeamChild
(206) 322-2444 (Headquarters)
http://www.teamchild.org

Northwest Justice Project
1-888-201-1014

Disability Rights Washington
1-800-562-2702 (ask for a “Technical Assistance” appointment)
Section 6: Governance and Coordination

The Settlement Agreement for *T.R. vs. Quigley and Teeter* states that Washington State will “maintain a collaborative governance structure that includes child-serving agencies, youth and families, and other stakeholders,” as a central mechanism for ensuring success of settlement agreement implementation, as well as overseeing implementation of Wraparound with Intensive Services (WISe).

This governance and cross-system collaboration is essential in system change efforts to ensure:

- Collaboration and coordination of care for WISe participants
- Participation by local and regional representatives in Child and Family Teams (CFTs) for youth who are enrolled in WISe and served by multiple child-serving systems.
- Coordination of funding sources, to the extent permissible by the state legislature and federal law, to strengthen inter- and intra-agency collaboration, support improved long-term outcomes, and establish systems to achieve sustainability of WISe.
- The development and provision of cross-system training and technical assistance.
- The development of data-informed quality improvement processes.
- Increased participation of family and youth in all aspects of policy development and decision-making for WISe.

The figure below provides a visual of the various components of the governance structure.
The following table provides a brief description of the role and function for each component.

### Children’s Behavioral Health Governance Structure

#### Component Descriptions

<table>
<thead>
<tr>
<th>Regional and Local Family, Youth, System Partner Round Table (FYSPRT)</th>
<th>Required Members</th>
<th>Of Note:</th>
</tr>
</thead>
</table>
| **Role** | Behavioral Health Organization (BHO) staff, local/regional-level system partners, youth, family members, past/present WISE youth and past/present WISE family members, youth leaders, family leaders, and other community system partners | • Tri-Led by a Youth Leader, Family Leader, and System Partner Leader  
• Open Meetings – No confidential information shared  
• Minimum of 51% youth and family membership  
• Based on how a region defines their community(ies), they may select to have more localized groups (Local FYSPRTs) that feed into their regional structure, to better meet the needs of that region, and address challenges and barriers as close to the community as possible. |
| Looks at the full continuum of care, including WISE implementation, at the local/regional level, and addresses challenges and barriers identified at the local/regional level, and reviews local/regional data, related to meeting the systemic needs and improving the outcomes for youth with behavioral health challenges | Engagement with tribal governments, to participate in the Regional FYSPRT |
| Identifies local needs and problem-solves at the lowest level possible | |

#### Statewide FYSPRT

<table>
<thead>
<tr>
<th><strong>Role</strong></th>
<th>Regional FYSPRT Tri-leads, state-level child-serving system partners, tribal government representatives, representatives of the Division of Behavioral Health and Recovery, and community partner representatives</th>
<th>Of Note:</th>
</tr>
</thead>
</table>
| Looks at the full continuum of care, including WISE implementation, at the statewide level | • Tri-Led by a Youth Leader, Family Leader, and System Partner Leader  
• Open Meetings – No confidential information shared  
• Workgroups are utilized as a means for completing specific work products, or as a strategy for making systemic changes. Representatives from the Statewide and Regional level will participate, as needed, on groups such as: Finance, Workforce Development, and Data & Quality.  
• Receives and considers input from the T.R. Implementation Advisory Group (TRIAGe) to improve the coordination and delivery of Title XIX services and WISE |
| Brings forward potential solutions and addresses challenges and barriers identified by Regional FYSPRTs that require policy level decisions/direction, as well as reviews statewide data, related to meeting the systemic needs and improving the outcomes of youth with behavioral health challenges | |
| Problem-solves at the lowest level possible | }

#### Executive Leadership Team (ELT)
### Executive Leadership Team (ELT)

<table>
<thead>
<tr>
<th><strong>Role</strong></th>
<th><strong>Members</strong></th>
<th><strong>Of Note:</strong></th>
</tr>
</thead>
</table>
| Receives recommendations, requests input, and makes policy-level decisions related to WISe implementation and meeting the systemic needs of youth with behavioral health challenges and improving outcomes of youth. | DSHS Assistant Secretaries, Health Care Authority, and representatives from Office of Financial Management | • ELT Representative(s) attend Statewide FYSPRT meetings  
• ELT Meeting notes posted to website |


### Developing Regional Linkages to the Governance Structure

Managed Care Entities, or MCEs, (Behavioral Health Organizations and Fully Integrated Managed Care Organizations) will work within their local communities to define processes in which local implementation and oversight of WISe will be achieved and coordinated with the Regional and Local FYSPRT efforts, and the governance structure. These processes will differ from the work of Regional and Local FYSPRTs in that they could include confidential information. The identified processes would describe efforts to:

- Provide collaboration and coordination of care for youth that are eligible for WISe or are participating in WISe
- Address concerns and barriers expressed by a CFT or CFTs. Barriers unresolved through the identified regional processes should be advanced to the local and/or regional FYSPRT within the Governance Structure.
- Reviewing WISe data at a more local level for continuous quality improvement to problem solve or identify systemic barriers. This includes areas such as local referents’ understanding of referral procedures and enrollment criteria, gaining access to WISe in a timely fashion, the array of services and supports is adequately accessible and of high quality, WISe service utilization (e.g., patterns, attention to outliers, use of home and community versus restrictive services, patterns by child-serving system and locality, and local data on outcomes, including: youth, family, and system outcomes.
  - **Note:** Although the above types of data and a process for review is largely a state and MCE function, those groups identified in the regional processes should also have access to information and use it to solve problems and help improve the local WISe implementation, as is appropriate per their respective group’s responsibilities.

Each Managed Care Entity will submit information once to DBHR (or the Health Care Authority in the Fully Integrated Managed Care regions) for approval, outlining the processes and mechanisms in which local implementation and oversight of WISe will be achieved and coordinated with the Governance Structure. Any updates or changes in the future to an MCE’s processes will also need to be resubmitted for approval.
Appendices
A. Background: T.R. Settlement Agreement

Background

_T.R. vs. Quigley and Teeter_, a Medicaid lawsuit regarding intensive children’s mental health services for youth, was filed in November 2009. The lawsuit was based on federal EPSDT (Early and Periodic Screening, Diagnosis and Treatment) statutes, requiring states to provide any medically necessary services and treatment to youth, even if the services have not been provided in the past. After several years of negotiations, a full settlement agreement was reached with the plaintiffs. With this settlement agreement, Washington has committed to build a mental health system that will bring this law to life for all young Medicaid beneficiaries who need intensive mental health services in order to grow up healthy in their own homes, schools, and communities.

Who is in the Class (and thus eligible for Wraparound with Intensive Services)?

All persons under the age of 21 who now or in the future:

1. Meet or would meet the State of Washington’s Title XIX Medicaid financial eligibility criteria;
2. Have a mental illness or condition;
3. Have a functional impairment, which substantially interferes with or substantially limits the ability to function in the family, school or community setting; and
4. For whom intensive mental health services provided in the home and community based would address or ameliorate a mental illness or condition.

Goals

To have a mental health system that will:

a) Identify and screen putative Class members and link eligible youth to the WISe program.
b) Communicate to families, youth and stakeholders about the nature and purposes of the WISe program and services, who is eligible for the program, and how to gain access to the WISe program and services regardless of the point of entry or referral source.
c) Provide timely statewide mental health services and supports that are sufficient in intensity and scope, based on available evidence of effectiveness, and are individualized to each Class member’s needs consistent with the WISe program model and state and federal Medicaid laws and regulations.
d) Deliver high quality WISe services and supports facilitated by a system of continuous quality improvement that includes tools and measures to provide and improve quality care, transparency, and accountability to families, youths, and stakeholders.
e) Afford due process to Class members denied services.
f) Coordinate delivery of services and supports among child-serving agencies and providers to Class members in order to improve the effectiveness of services and improve outcomes for families and youth. Reduce fragmentation of services for Class members, avoid duplication and waste, and lower costs by improving collaboration among child-serving agencies.
g) Support workforce development and infrastructure necessary for adequate education, training, coaching and mentoring of providers, youth and families.

h) Maintain a collaborative governance structure that includes child-serving agencies, youth and families, and other stakeholders.

i) Minimize hospitalizations and out-of-home placements.

j) Correct or ameliorate mental illness.

k) Reduce mental disability and restore functioning.

l) Keep children safe, at home, and in school making progress; avoid delinquency; promote youth development; and maximize Class members’ potential to grow into health and independent adults.

m) Use available approaches that have been effective at achieving these outcomes.
B. WISe Terminology, Definitions, and Roles

Phases

- **Engagement**: Engagement is the process that lays the groundwork for building trusting relationships and a shared vision among members of the Child and Family Team that includes the family, natural supports and individuals representing formal support systems in which the youth is involved. Team members, including the family, are oriented to the WISe process. Discussions about the youth’s and the youth and family’s strengths and needs set the stage for collaborative teamwork within the Washington State Children’s Behavioral Health principles.

- **Assessing**: Information gathering and assessing needs is the practice of gathering and evaluating information about the youth and family, which includes gathering and assessing strengths as well as assessing the underlying needs. Assessing also includes determining the capability, willingness, and availability of resources for achieving safety, permanence, and well-being of youth.

- **Teaming**: Teaming is a process that brings together individuals agreed upon by the youth and family who are committed to them through informal, formal and community support and service relationships. Where medically necessary and/or with cross system involvement, a formal Child and Family Team will be used.

- **Service Planning and Implementation**: Service planning is the practice of tailoring supports and services unique to each youth and family to address unmet needs. The plan specifies the goals, roles, strategies, resources, and timeframes for coordinated implementation of supports and services for the youth, family, and caregivers.

- **Monitoring and Adapting**: Monitoring and adapting is the practice of evaluating the effectiveness of the plan, assessing circumstances and resources, and reworking the plan as needed. The team is responsible for reassessing the needs, applying knowledge gained through ongoing assessments, and adapting the plan in a timely manner.

- **Transition**: The successful transition away from formal supports can occur as informal supports are in place and providing needed support. Transition to the most normalizing activities and environments is consistent with the principle of treatment at the least restrictive level and the system values of recovery and resilience.

Roles

**Family** - people who are committed, “forever” individuals in the identified youth’s life with whom the youth also recognizes as family; a family is defined by its members, and each family defines itself.

**Parent** – biological, step or adoptive. If this is not applicable or unclear, the youth should identify who they consider their parent.

**Caregiver** – a family member or paid helper who provides direct care for the identified youth.

**Youth** - the statewide-accepted term to describe children, adolescents, teenagers, and young adults.
**Care Coordinator** - a formal member of the WISe team who is specially trained to coordinate and facilitate the WISe process for an individual youth and family and provide advanced care coordination activities within the phases and activities of WISe. The Care Coordinator is typically the facilitator of the CFT, and ultimately responsible for leading the team through the phases and activities of WISe both during and outside of the meetings. The Care Coordinator contributes knowledge and skills related to making sure that the team process honors each member’s role, responsibility and perspective. The Care Coordinator is qualified by completing the WISe training, participating in technical assistance, and is involved in ongoing WISe training and coaching activities. Generally, the Care Coordinator will:

- Facilitate CFT meetings.
- Guide the team process.
- Be the central point of communication.
- Encourage each CFT member to identify their priority concerns, work proactively to minimize areas of potential conflict, and acknowledge the mandates of others involved in child-serving systems.
- Utilize consensus-building techniques to meet the needs of the youth and family.
- Establish and sustain an effective team culture by inviting CFT members to propose, discuss, and accept ground rules for working together.
- Engage all CFT members and identify their needs for meeting agency mandates. The Care Coordinator identifies the strengths and needs of the youth and family, provides CFT members with an overview of CFT practice, and clarifies their role and responsibilities as a team member in this process.
- Increase the “natural supports” in CFT membership and the youth/family’s integration into their community. This is accomplished by getting to know the family history, culture, and resources, and by helping the youth and family to identify and engage potential supports. Examples of natural supports include friends, extended family, neighbors, members of the family's faith community, co-workers. The goal is to have more natural and informal supports on the team than formal supports.
- Work with the Youth Partner and/or Family Partner to identify family support, peer support or other “system” and community resources that can assist the youth and family with exercising their voice in the CFT process, if needed.
- Prepare for meetings:
  - Develop a meeting agenda with the youth, family, and other CFT members.
  - Schedule meetings at a place/time that is accommodating (comfortable and convenient) to the youth and family and available to all CFT members.
  - Prepare visual aids or tools to facilitate the meeting process.
  - Inform all CFT members of the date, time and location of each meeting.
- Contact CFT members who are unable to attend a meeting, in advance, to elicit their input.
- Ensure all CFT members receive an updated copy of the care plan, documentation of progress, CFT meeting activities, discussions and task assignments within 7 days after the CFT meeting.
- Maintain team focus on scope of work for the WISe team and progress/movement toward transition.
• Be sensitive to the needs of team members when working in rural areas where getting members together physically may be challenging. The Care Coordinator is creative in establishing a team that may meet via phone or through teleconferencing.
• Ensure respect for the input and needs of the youth when forming the team.
• Inform the youth and family of their rights (including Due Process) and obtaining all necessary consents and releases of information.
• Acknowledge and celebrate successes and transitions.

It is important to note that the team facilitation may change during the transition phase in order to allow for family members and/or youth to become facilitators of their own meetings - depending on what the family and team thinks works best.

The Mental Health Clinician- is a provider and resource for the WISE team. The majority of WISE-enrolled youth will have clinical needs that may be met at least in part through the efforts of a skilled clinician. A clinician is a person providing outpatient mental health services (as described in WAC 388-877A; section one) to a WISE enrolled youth. While confidentiality of the details of the clinician-client (i.e., family and/or youth) relationship should be protected, the clinical professionals on the team also must have clearly defined roles in terms of meeting needs in the plan of care. WISE practitioners should be trained and supported to use effective treatment elements that connect to the youth and family’s strengths and preferences, when therapy or some other mental health service is included in a Cross System Care plan. The role of the clinician in WISE is expanded upon in “The Role of the Clinician Employed in a Wraparound Program” available at: http://www.nwi.pdx.edu/NWI-book/Chapters/Manners-4d.2-(clinician-role).pdf

The Family Partner - a formal member of the WISE team whose role is to serve the family and help them engage and actively participate on the team and make informed decisions that drive the WISE process. They are qualified through their lived, personal experience as the parent of a youth with complex emotional/behavioral needs, hold a peer certification, and have participated in the full WISE training and technical assistance and is involved in ongoing WISE training activities.

Family Partners have a strong connection to the community and are very knowledgeable about resources, services, and supports for families. The Family Partner’s personal experience raising a youth with emotional, behavioral, or mental health needs is critical to earning the respect of families and establishing a trusting relationship that is valued by the family. The Family Partner can be a mediator, facilitator, or bridge between families and agencies. Family Partners ensure each family is heard and their individual needs are being addressed and met. The Family Partner should communicate and educate agency staff on the importance of family voice and choice and other key aspects of family driven care.

The Family Partner has a collaborative relationship with the Care Coordinator, Clinician, and Youth Partner. Together they establish mechanisms to keep each other informed, make sure the family partner knows when new families are enrolled, as well as when and where team meetings will occur, and insure all newly enrolled families have the opportunity to have support from a Family Partner, if they choose. In the absence of a Youth Partner, the Family Partner will not fulfill that role. The Family Partner collaborates with the Care Coordinator to establish the trust and mutual respect necessary for the team (including the family) to function well.
The Family Partner will be:

- A biological/adoptive/step parent, kin or other “forever” person in the parent role – who has been the primary caregiver of a youth with emotional or behavioral challenges.
- Willing to use their own lived experiences to provide hope and peer support to other families experiencing similar challenges.
- Committed to ensuring that other parents have a voice in the youth’s care and are active participants in the WISe process.
- Able to share resources and information in an individualized manner so that families understand the WISe process and have access to information regarding their child’s care.
- Able to engage and collaborate with people from diverse backgrounds.
- Able to maintain a non-judgmental attitude towards youth, families and professionals.
- Ability to maintain a stance of appreciation and acceptance of parents, including their choices.
- Certified as a Peer Counselor and have training in WISe when serving as WISe Provider Agency staff.

The role of the Family Partner in WISe care coordination is fully spelled out in “How family partners contribute to the phases and activities of the wraparound process,” available at http://www.nwi.pdx.edu/pdf/FamPartnerPhasesActivitiesStandalone.pdf.

The WISe Practitioner – a term used interchangeably to describe the collection of WISe-certified staff roles, required for each team (the Care Coordinator, the Family Partner and/or Youth Partner, and the Mental Health Clinician).

The Youth Partner – an equitable member of the WISe team whose role is to partner with the youth to help support their engagement and active participation in making informed decisions to drive the WISe process. They are qualified through their lived experience and knowledge of community resources and the wraparound or WISe process. The Youth Partner is a mediator, facilitator, and cultural broker between youth and agencies.

Youth Partners utilize their lived experience and connection to communities and the peer movement to bring resources and informal supports to the CFT. Youth Partners work in collaboration with the other WISe Practitioners. Youth Partners ensure each youth is heard and their individual needs are being addressed and met. The Youth Partner communicates with and educates agency staff on the importance of youth voice and choice, and the power and benefits of peer involvement- particularly in transition age youth. Youth Partners serve as a peer advocate to help empower youth in gaining the knowledge and skills necessary to be able to guide and eventually drive their own treatment. Youth Partners also conduct CANS assessments, if CANS certified.

Youth Partners will:

- Be a person with **lived experience** as a participant in Children’s Mental Health Services
- Be willing to use their own lived experiences to provide hope and peer support to other youth experiencing similar challenges.
• Demonstrate leadership experience and diplomacy in resolving conflicts and integrating divergent perspectives.
• Have knowledge of community resources and supports
• Build relationships with community members and organizations to connect the youth with resources.
• Be able to share resources and information in a developmentally appropriate way to ensure that youth understand the WISE process and have access to information regarding their care.
• Be committed to ensuring that youth have voice and choice in their own care and are active participants in the WISE process.
• Be certified as a Peer Counselor and have training in WISE when serving as WISE Provider Agency staff.

Practice Considerations and Potential Conflict
The National Wraparound Initiative views the Family Partner, Youth Partner, Care Coordinator and Clinician as four different, full-time roles. Placing these roles together may result in none of them being done well. There is also a distinct difference in the role of coordination/facilitation, support and a specific therapeutic treatment modality. A duality of roles of those in the provider relationship with youth and families (clinicians) acting as coordinators, is not always optimal and has been known to cause confusion, conflicts and frustration for families, youth and team members.

WISE Supervisor – an individual responsible for supervising a Care Coordinator, Family Partner and/or Youth Partner and who fully understands WISE policies, procedures and mandates. Equally important, a WISE supervisor should have experience in the role in which he/she is supervising, have received specific training in being a high-quality supervisor, and use a structured, directed model for supervision including observation of practice and review of records.

WISE Agency Administrator – a champion for WISE, providing the appropriate level of support and flexibility for this work aligning it with other agency books of business and the system of care.

Child and Family Team (CFT) - A group of people – chosen with the family and connected to them through natural, community, and formal support relationships – who develop and implement the family’s plan, address unmet needs, and work toward the family’s vision and team mission, monitoring progress regularly and using this information to revise and refine the plan of care.

Family Organization - a family run and family led grass roots, non-profit community organization providing connection, empowerment and education to families and their communities to assure improved outcomes for youth experiencing significant behavioral health challenges and to fulfill a significant role in facilitating family/youth voice in local, state and national policy making.

Managed Care Entity(s) or “MCEs”- A term used to collectively refer to Behavioral Health Organizations (BHO) and Fully Integrated Managed Care Organizations.

Youth Organization - a youth-led non-profit organization dedicated to improving the services and systems that foster and promote positive growth of youth and young adults by using peer support and uniting the voices of individuals who have lived through and experienced obstacles in child-
serving systems. Typically focus on activities such as increasing youth participation in service planning, delivery, coordination and evaluation; awareness of challenges young people with cross-systems needs face as adolescents and young adults; and youth involvement in community councils/organizations.

**Documents**

**Child and Adolescent Needs and Strengths Assessment (CANS)** - a multi-purpose tool developed for children’s services to support decision making, including level of care and service planning, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services. CANS was developed from a communication perspective so as to facilitate the linkage between the assessment process and the design of individualized service plans including the application of evidence-based practices. All CANS (screen and full) must be entered and maintained in the Behavioral Health Assessment System (BHAS).

**Child and Family Team Meeting Minutes (CFT Minutes)** - A document that captures the details of a Child and Family Team meeting including a list of team members present, ground rules, family vision, team mission, strengths, needs, outcomes, action items and next team meeting date and time.

**Crisis and Safety Plan** - A family friendly, one to two page document that the CFT creates to address potential crises that could occur for the youth and their family and to ensure everyone’s safety. It should include 24/7 response, formal and natural supports, respite/back-up care, details of what leads to crises, successful strategies that have worked in the past, as well as strengths-based strategies that prevent and avoid escalation toward a crises.

**Cross System Care Plan** - An individualized comprehensive plan created by a Child/Family Team that reflects treatment services and supports relating to all systems or agents with whom the child is involved and who are participating on the CFT. This plan does not supplant, but may supplement the official individual service plan that each system maintains in the client record.

**Individual Service Plan** – A document that outlines the progression and planning of an individual’s treatment. This plan must include the requirements found in WAC 388-877-0620 and WAC 388-877A-0135.

**WISe Planning Elements**

**Youth and Family Vision** - A statement constructed with only the youth and family’s voice and describes how they wish things to be in the future (including long-term goals, hopes and dreams), individually and as a family.

**Team Mission** - A statement crafted by the CFT that provides a one to two sentence description of what the team needs to accomplish while they are together and to know when the WISe program has been completed. Mission statements are written in the present tense as if they are true today.

**Strengths** - Strengths are the assets, skills, capacities, actions, talents, potential and gifts in each family member, each team member, the family as a whole, and the community. In WISe, strengths
help family members and others to successfully navigate life situations; thus, a goal for the WISE process is to promote these strengths and to use them to accomplish the goals in the team’s plan of care.

**Needs** - Anything that is necessary, but lacking. A need is a condition requiring relief and something required or wanted. Needs are not considered services.

**Outcomes** - Youth, family and/or team goals stated in a way that can be observed and measured as indicators of progress related to addressing an identified need.

**Strategies** - Ideas, plans and/or methods for achieving the desired outcome. When coming up with strategies in the WISE process, a brainstorming process is applied.

**Action Steps** - Statements in a Cross System Care plan that describe specific activities that will be undertaken, including who will do them and within what time frame.

**Services and Supports**

**Formal supports** - Services and supports provided by individuals who are “paid to care” under a structure of requirements for which there is oversight by state or federal agencies or national professional associations, or.

**Informal supports** - Supports provided by individuals or organizations through citizenship and work on a volunteer basis under a structure of certain qualifications, training and oversight.

**Natural Supports** - Individuals or organizations in the family's own community, kinship, social, or spiritual networks, such as friends, extended family members, ministers and neighbors who are not “paid to help.”

**Peer Support** – State certified peer counselors who work with their peers, mental health consumers and the parents of children with serious emotional disturbances. They assist consumers and families with identifying goals and taking specific steps to achieve them such as building up social support networks, managing internal and external stress, and navigating service delivery systems. As defined by Washington DSHS - [https://www.dshs.wa.gov/bha/division-behavioral-health-and-recovery/peer-support](https://www.dshs.wa.gov/bha/division-behavioral-health-and-recovery/peer-support)
C. Guidance on Team Functioning and Facilitation of WISE

The Approach

The WISE approach in the state of Washington will strive toward quality and consistency of practice within the Washington States Children’s Behavioral Health Principles.

WISE Team Meeting Facilitation Components and Team Structure

Each team meeting must include the following facilitation components:

- The youth and/or a family must be present for a meeting to occur.
- Team meetings are held at times and locations to ensure meaningful participation of family members, youth and natural supports. Participation of young children will be decided upon by the CFT, as appropriate.
- A Family Partner and/or Youth Partner will be available to all family and youth.

WISE Process

Facilitate Introductions and Review Agenda:

- Allow the youth and family to introduce themselves first. Consider having other team members include their role (formal supports) or how they know the youth and family (informal/natural supports).
- Bring a copy of a written agenda for everyone or write it on easel paper for everyone to see. The agenda should be an outline of the facilitation components listed here so that everyone can begin to learn the process.

Set Ground Rules or Review Ground Rules:

- A discussion about ground rules to refer to during difficult times should take place at the first meeting.
- “Ground Rules” is not a common term and may need to be explained.
  - Examples include: cell phone ringer off, one person talks at a time, use respectful language when talking about concerns and needs, be on time, etc.

Review the Youth and Family Vision Statement(s):

- The WISE Practitioners should talk with the youth and family about their vision(s) before the first team meeting and help them express this vision(s) to the rest of the team.
  - Generally, there should be one collective vision for the youth and family. However, there are times that the youth may have a separate vision than the family.
- The language used by the youth and family should be preserved in the final vision statement.
- Avoid letting team members add to the youth and family vision. Team members may, however, need clarification as to the implications.
- All team members should be given a written copy of the final vision statement and should be reviewed by the team regularly.
**Construct a Team Mission Statement and Review Team Mission:**

- The team should formulate a mission statement that is focused on what they need to accomplish during their time together and how they will know when they are done.
- All team members should add to the mission statement.
- Consider recording major themes and edit final statement at a later time.
- All team members should be given a written copy of the final mission statement and it shall be reviewed by the team regularly.

**Develop a List of Strengths and Review Strengths:**

- The WISe Practitioners should talk with the youth and family about their strengths prior to the first team meeting and help them list their strengths for the team.
- The WISe Practitioners should prompt all CFT members prior to the first CFT to come prepared with a list of strengths about the youth and family.
- The initial list of strengths should come from the youth and family and the CANS, and then all team members should add to these strengths.
- Maintain a written list of strengths and add to these at each team meeting. After the first team meeting, the list should also include successes.
- At the first team meeting, members may be focused on descriptive and contextual strengths. As the team gets to know each other, WISe Practitioners can assist the team in formulating functional strengths to use in the plan of care.
- Avoid going back-and-forth between strengths and needs. Finish the strengths list before moving on.

**Develop a List of Needs and Review Current Needs:**

- The WISe practitioners should talk with the youth and family about their needs, as indicated on the CANS, and help them list these at the first team meeting.
- Team members should state all concerns or identified problems in needs language: “I need... we need... they need... etc.”
- Needs are not services. Team members should be redirected to state the real need(s).
- Avoid going back-and-forth between strengths and needs. Complete strengths before identifying needs.
- During the brainstorming of needs, avoid organizing the list of needs by person.

**Prioritize Needs:**

- Facilitate a discussion with the team about which needs should be prioritized (including those domains with 2's or 3's on the CANS) to work on over the next 30/60/90 days.
- Typically, teams work better with less than 5 needs prioritized at one time.
- Avoid a numeric ranking of each need by importance.

**Develop Outcome Statements for Prioritized Needs:**

- Teams may need a lot of guidance with this at first.
• Use the SMART test.
• Avoid wasting time with specific wording at the team meeting. You can rewrite the statements after the team meeting and revisit the final statement for group approval.

**Brainstorm Strategies:**

• Brainstorm multiple strategies for one outcome statement at a time.
• Devise strategies to help achieve each desired outcome and meet the identified need.
• Encourage the youth and family to select which strategies they think would work best for them and fit with the culture of their family.
• Include strategies that draw from the strengths of the youth and family.

**Assign Action Steps:**

• Each selected strategy includes specific action steps and should be assigned to a specific team member(s).
• When appropriate, all team members are given action steps for the strategy that will help achieve the outcome statement and meet the need.

**Summarize and Agree on the Plan:**

• The meeting facilitator summarizes the entire plan for the team and solicits feedback about missing components or needs.
• Following the team meeting, the Cross System Care Plan is documented and given to each member of the team.

**Schedule the next Team Meeting:**

• The next team meeting is scheduled while all team members are present.
• Meetings will be scheduled *at least* every 30 calendar days.

**Transition**

• Transitioning out of WISe should be discussed with the team from the beginning.
• Crisis drills should be practiced, and the youth and family should be confident they know what to do if things...
go poorly.

- The youth and families should be able to articulate how to access services in the future.
- The youth and family should have a way to connect with other youth and families who have been through the WISE process.
- The youth and family’s concerns should be considered in the transition planning.
- The youth and family should have a list of team members’ contact information, to include phone numbers and email addresses, who they can contact if needed.
- The youth and family should have written documents that describe their strengths and accomplishments.
- The youth and family should be offered a formal opportunity to celebrate their successful transition from the WISE program.

**Principles Evidenced in Practice**

The ten Washington State Children’s Behavioral Health Principles are the guide to practice-level decision-making.
### D. WISE Capacity Attestation

<table>
<thead>
<tr>
<th>Start Up</th>
<th>Expansion</th>
</tr>
</thead>
</table>

**Agency Name:**  
**Agency RUID #:**  
**Agency Address(es):**  
**County/Counties Serving:**  
**Key WISE contact person:**  
**Phone number and email:**

### Background

The WISE Capacity Attestation must be completed by the Managed Care Entity (MCE) upon the initiation and any expansion of WISE within their area.

### WISE Key Elements

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has the MCE met with DBHR to address local issues?</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Agency holds current Behavioral Health Agency License, issued by the Division of Behavioral Health and Recovery (DBHR).</td>
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<tr>
<td>Agency has a contract with a MCE.</td>
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<tr>
<td>Agency is certified to provide all of the following services</td>
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<tr>
<td>- Individual treatment services</td>
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<tr>
<td>- Family therapy services</td>
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<td></td>
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<tr>
<td>- Case management services</td>
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<tr>
<td>- Psychiatric medication services</td>
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<tr>
<td>- Crisis mental health services—Outreach services</td>
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<tr>
<td>- Recovery support—Wraparound facilitation services.</td>
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<tr>
<td>- Recovery support—Peer support services</td>
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<tr>
<td>WISE program staff have attended the WISE training?</td>
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<tr>
<td>- If yes, please list staff, role and training date</td>
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<tr>
<td>- If no, please indicate training plan</td>
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<tr>
<td>Family partners are peer certified (or qualify for certification)?</td>
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<tr>
<td>- If yes, please note on staff list</td>
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<tr>
<td>- If no, please indicate plan to certify on staff list</td>
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<tr>
<td>Youth partners are peer certified (or qualify for certification)?</td>
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<td>- If yes, please note on staff list</td>
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<td></td>
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<tr>
<td>- If no, please indicate plan to certify on staff list</td>
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<tr>
<td>WISE staff certified in CANS on each team?</td>
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<tr>
<td>- If yes, please note on staff list</td>
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<tr>
<td>Established protocols for responding to crisis, in line with Section 4?</td>
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<tr>
<td>Established process(es) in which local implementation and oversight of WISE will be achieved and coordinated?</td>
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<tr>
<td>- If yes, please submit process(es)</td>
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</tbody>
</table>
- If no, please attach a written plan to establish this structure with a completion date.

Tribal relationship established?
- If yes, please list tribe(s)
- If no, please indicate plan to engage

Discussion with DBHR to determine approved number of WISe participants?
- If yes, please indicate the approved number of participant in comments.

<table>
<thead>
<tr>
<th>Requested capacity number:</th>
<th>DBHR Approved number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>(MCE will complete another attestation prior to expanding capacity beyond this agreed upon number)</td>
<td></td>
</tr>
</tbody>
</table>

**Additional Comments**

**Signatures**
Managed Care Entity:
Print Name ________________ Signature ____________ Date: ___/___/____

**Approval**

DBHR:
Print Name ________________ Signature ____________ Date: ___/___/____

**Agency capacity and qualifications forwarded to Provider One**
Date__________ Initials__________
E. MEMORANDUM OF UNDERSTANDING

MEMORANDUM OF UNDERSTANDING

in connection with T.R. vs Quigley & Teeter Litigation

AMONG

WASHINGTON’S DEPARTMENT OF SOCIAL AND HEALTH SERVICES (DSHS):

Behavioral Health Administration (BHA),

Children’s Administration (CA),

Developmental Disabilities Administration (DDA),

Rehabilitation Administration (RA),

Aging and Long-Term Support Administration (ALTSA)

AND

WASHINGTON HEALTH CARE AUTHORITY (HCA)

A. Background

In 2009, a class of children and youth in Washington State with serious emotional disturbances sued the State in federal court in the T.R. vs Dreyfus & Porter case, now known as T.R. vs Quigley & Teeter. The class of plaintiffs argued that they had insufficient access to intensive services provided in home and community settings in violation of federal Medicaid requirements. On December 19, 2013, U.S. District Court Judge Thomas Zilly approved a Settlement Agreement to that lawsuit. The Settlement Agreement committed DSHS to infrastructure development for a system of care which provides culturally responsive services and supports that are individualized, flexible, and coordinated to meet the needs of the child and family, in the family home or community. The Settlement Agreement also contemplated that the State would develop an interagency Memorandum of Understanding (MOU) to coordinate certain services performed by the agencies pursuant to the Settlement Agreement.

B. Purpose

This MOU describes the mutually supportive working partnerships between BHA, CA, DDA, RA, ESA, and HCA as they relate to the community-based mental health needs and service delivery systems for children and youth with significant emotional and behavioral health needs, and their families, who are typically served by more than one state agency. Consistent with the Settlement Agreement, this MOU will support the agencies developing cross-system protocols to coordinate services for these youth and their families.
C. Agreements:

The above-named agencies hereby agree to promote the **WA Children’s Behavioral Health Principles**:

- **Family and Youth Voice and Choice**: Family and youth voice, choice and preferences are intentionally elicited and prioritized during all phases of the process, including planning, delivery, transition, and evaluation of services. Services and interventions are family-focused and youth-centered from the first contact with or about the family or youth.
- **Team based**: Services and supports are planned and delivered through a multi-agency, collaborative teaming approach. Team members are chosen by the family and the youth and are connected to them through natural, community, and formal support and service relationships. The team works together to develop and implement a plan to address unmet needs and work toward the youth’s and family’s vision.
- **Natural Supports**: The team actively seeks out and encourages the full participation of team members drawn from the youth’s and family members’ networks of interpersonal and community relationships (e.g. friends, neighbors, community and faith-based organizations). The care plan reflects activities and interventions that draw on sources of natural support to promote recovery and resiliency.
- **Collaboration**: The system responds effectively to the behavioral health needs of multi-system involved youth and their caregivers, including youth in the child welfare, juvenile justice, developmental disabilities, substance abuse, primary care, and education systems.
- **Home and Community-based**: Youth are first and foremost safely maintained in, or returned to, their own homes. Services and supports strategies take place in the most inclusive, most responsive, most accessible, most normative, and least restrictive setting possible.
- **Culturally Relevant**: Services are culturally relevant and provided with respect for the values, preferences, beliefs, culture, and identity of the participant/youth and family and their community.
- **Individualized**: Services, strategies, and supports are individualized and tailored to the unique strengths and needs of each youth and family. They are altered when necessary to meet changing needs and goals or in response to poor outcomes.
- **Strength Based**: Services and supports are planned and delivered in a manner that identifies, builds on, and enhances the capabilities, knowledge, skills, and assets of the youth and family, their community, and other team members.
- **Outcome Based**: Based on the youth and family’s needs and vision, the team develops goals and strategies, ties them to observable indicators of success, monitors progress in terms of these indicators, and revises the plan accordingly. Services and supports are persistent and flexible so as to overcome setbacks and achieve their intended goals and outcomes. Safety, stability and permanency are priorities.
- **Unconditional**: A youth and family team’s commitment to achieving its goals persists regardless of the youth’s behavior, placement setting, family’s circumstances, or availability of services in the community. The team continues to work with the family toward their goals until the family indicates that a formal process is no longer required.
These principles provide a framework for the success of cross-system work on behalf of children, youth and families served through the Medicaid funded behavioral health system and in compliance with the T.R. vs Quigley & Teeter Settlement Agreement.

D. The parties mutually agree that:

1. Working together cooperatively and collaboratively develops the best possible foundation to achieve shared, successful outcomes.

2. Planning will strive to balance mandates, interests and resources of participating agencies.

3. An integrated system of effective services and supports for treating children and youth with significant emotional or behavioral health needs must:
   
   a. Be based in organizations that are accountable for costs and outcomes.
   b. Be delivered by teams that coordinate medical, behavioral, and long-term services.
   c. Be provided by networks capable of addressing the full range of needs.
   d. Emphasize primary care and home and community-based service approaches while reducing the need for institutional levels of care.
   e. Provide information regarding available services, supports and client rights.
   f. Provide access to qualified providers.
   g. Respect and prioritize consumer preferences in the services and supports they receive.
   h. Align financial incentives to support integration of care.

4. Specific activities for collaboration are:
   
   a. To set up practices and procedures consistent with the WA Children’s Mental Health Principles and Wraparound with Intensive Services (WISe) Program Model established under this MOU to guide inter- and intra-agency efforts to collaborate and coordinate delivery of care in order to improve the effectiveness of services and outcomes for children, youth and their families that are served by or may need services from more than one agency.
   b. To require relevant state, local and regional representatives of the above-named collaborating child-serving agencies to be invited and to participate and engage in Child and Family Teams (or care planning teams) for children and youth enrolled in WISe as well as governance structure meetings.
   c. To align and support efforts to secure funding sources, within funding restrictions, to strengthen inter- and intra-agency collaboration, support improved long-term outcomes, and sustain funding for WISe.
   d. To develop cross system training and technical assistance for the parties’ respective staff and relevant stakeholders and government partners, including Washington Tribes, to address information sharing, the coordination of programs and services, enhancement of working relationships and increase the use of evidence and research-based practices across disciplines. Specifically, this may include training and assistance on the implementation of Evidence and Research Based Practices, the Child Adolescent Needs and Strengths (CANS) tool, and the WISe access protocol, practice model, and service array.
e. To develop and implement data-informed quality improvement processes (utilizing the Measures of Statewide Performance) in order to strengthen and sustain the System of Care\(^5\) over time.

f. To increase youth and family participation in all aspects of policy development and decision-making that will lead to increased system transparency.

E. Governance Structure

The interagency governance structure that is part of the Settlement Agreement is intended to improve the coordination of access to intensive community-based mental health services and thereby improve both effectiveness of services and outcomes for youths and their families. Governance informs decision-making at a policy level that has legitimacy, authority, and accountability.

The structure of the Children’s Mental Health Governance will consist of chief operating bodies with clear roles and reporting guidelines:

1. Executive Team - The role of the Executive Team is to provide leadership, problem solving and decision making regarding progress in implementing system-wide practice improvements, fiscal accountability and quality oversight. Each agency will identify an executive leader to participate in the Executive Team meetings.

2. Regional Family, Youth, System Partner Round Tables (FYSPRTs) identify local needs and develop a plan to bring those needs forward to the Statewide FYSPRT, with recommendations about how to meet those needs. Representatives from the agencies that are parties to this MOU will attend the Statewide FYSPRT.

3. Work Groups comprised of but not limited to representatives from DSHS, HCA, Office of the Superintendent of Public Instruction (OSPI), Department of Health (DOH), Washington Tribes, youth and families, Behavioral Health Organizations (BHO’s), Managed Care Organizations (MCO’s), Administrative Service Organizations (ASO’s) and service providers will be developed as needed.

    a. Cross Systems Initiatives Team - Policy and Practice - Works on behalf of the Governance structure to addresses cross system issues and initiatives through the facilitation and development of policies and procedures based on WA Children’s Mental Health Principles.

    b. Children’s Behavioral Health Data and Quality (DQ) Team - The mission of the Team is to provide a forum for developing and refining data collection and management strategies related to screening, assessment, performance measurement and quality improvement relevant to children’s behavioral health in Washington State. Reporting, outcomes evaluation, and other types of accountability activities are another aspect of the Team purpose. Working in an inclusive and transparent fashion

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\(^5\) A “system of care” (SOC) is an organizational philosophy and framework that is designed to create a network of effective community-based services and supports to improve the lives of children and youth with, or at risk of, serious mental health conditions and their families.
the Team will assure integration of data activities across systems involving children, youth and families.

c. Children’s Mental Health Cross-Administration Finance Team - A cross-system team to address the need of aligning funding sources, costs of expanding service capacity and improving cost effectiveness.

d. Workforce Development - Develops and strengthens a workforce that operationalizes the WA Children’s Mental Health Principles and WISc Program Model.

F. **Period of Performance**

This MOU will be reviewed every three years.

Effective Date: July 30, 2016

Signatories,

All signatures are affixed on behalf of all program and sub-division within each respective department. Each signatory agency is committed to the implementing the systemic changes necessary to support an integrated system of care for children, youth and families in Washington,

Carla Reyes, Assistant Secretary
Behavioral Health Administration

Bill Moss, Assistant Secretary
Aging and Long-Term Support Administration

John Clayton, Assistant Secretary
Juvenile Justice and Rehabilitation Administration

Jennifer Strus, Assistant Secretary
Children’s Administration

Evelyn Perez, Assistant Secretary
Developmental Disabilities Services Administration

Maryjane Lindeblad
Medicaid Director

Dorothy Teeter, Director
Health Care Authority
F. Service Array and Coding

For service array and coding, follow the Service Encounter Reporting Instructions (SERI) for Behavioral Health Organizations. The Service Encounter Reporting Instructions can be found online at:

https://www.dshs.wa.gov/bha/division-behavioral-health-and-recovery/seri-cpt-information

For Fully Integrated Managed Care Organizations follow the instructions in the Encounter Data Reporting Guide. This document can be found online at:

### G. Washington’s Provisional CANS Algorithm

**7/24/14**

A child will be recommended for Wraparound with Intensive Services (WISe) if:
Criterion 1 AND (Criterion 2 OR Criterion 3)

<table>
<thead>
<tr>
<th><strong>Criterion 1. Behavioral/Emotional Needs</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>1a. Rating of 3 on “Psychosis” OR</td>
</tr>
<tr>
<td>1b. Rating of 2 on “Psychosis” and 2 or 3 on any other Behavioral/Emotional Needs item OR</td>
</tr>
<tr>
<td>1c. 2 or more ratings of 3 on any Behavioral/Emotional Needs items OR</td>
</tr>
<tr>
<td>1d. 3 or more ratings of 2 or 3 on any Behavioral/Emotional Needs items</td>
</tr>
<tr>
<td><em>Note: Behavioral/emotional needs items we plan to include in our screener: Psychosis; Attention/Impulse; Mood; Disturbance; Anxiety; Disruptive Behavior; Adjustment to Trauma; Emotional Control</em></td>
</tr>
</tbody>
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<table>
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<tr>
<th><strong>Criterion 2. Risk Factors</strong></th>
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</thead>
<tbody>
<tr>
<td>2a. Rating of 3 on “Danger to Others” or “Suicide Risk” OR</td>
</tr>
<tr>
<td>2b. One rating of 3 on any Risk Factor item OR 2 or more ratings of 2 or 3 on any Risk Factor item</td>
</tr>
<tr>
<td><em>Note: Risk factors included: Suicide Risk; Non-Suicidal Self-Injury; Danger to Others; Runaway</em></td>
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<table>
<thead>
<tr>
<th><strong>Criterion 3. Serious Functional Impairment</strong></th>
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<tbody>
<tr>
<td>3a. 2 or more ratings of 3 on “Family”, “School”, “Interpersonal” or “Living Situation” OR</td>
</tr>
<tr>
<td>3b. 3 or more ratings of 2 or 3 on “Family”, “School”, “Interpersonal” and “Living Situation”</td>
</tr>
</tbody>
</table>
## H. Cross System Care Plan

### WISe and CANS: Cross System Care Plan - Elements for Teams

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Family Vision Statement (Family)</td>
</tr>
<tr>
<td></td>
<td>What does better look like for the family (long term)?</td>
</tr>
<tr>
<td>2</td>
<td>Team Mission Statement (Team)</td>
</tr>
<tr>
<td></td>
<td>What does the team have to accomplish while they are together (short term)?</td>
</tr>
<tr>
<td>3</td>
<td>Useful Strengths (CANS)</td>
</tr>
<tr>
<td></td>
<td>Strengths items with a 0 or 1 on the CANS and should be used in planning</td>
</tr>
<tr>
<td>4</td>
<td>Additional Strengths (Team)</td>
</tr>
<tr>
<td></td>
<td>Other strengths identified by the family and team.</td>
</tr>
<tr>
<td>5</td>
<td>Background Needs (CANS)</td>
</tr>
<tr>
<td></td>
<td>Needs that are most likely not addressable but shift the pathway which interventions are provided</td>
</tr>
<tr>
<td>6</td>
<td>Targeted Needs (CANS)</td>
</tr>
<tr>
<td></td>
<td>Needs that are the focus of interventions.</td>
</tr>
<tr>
<td>7</td>
<td>Needs Statements (Team)</td>
</tr>
<tr>
<td></td>
<td>Statements that describe the individualized needs of the youth and/or family members.</td>
</tr>
<tr>
<td>8</td>
<td>Anticipated Outcomes (CANS)</td>
</tr>
<tr>
<td></td>
<td>Needs that would be expected to respond as a result of effectively addressing the targeted needs.</td>
</tr>
<tr>
<td>9</td>
<td>Target Outcomes Statements (Team)</td>
</tr>
<tr>
<td></td>
<td>Measureable indicator of progress. What the end result looks like when the need is met. SMART (Specific,</td>
</tr>
<tr>
<td></td>
<td>Measurable, Achievable, Realistic, Timeline).</td>
</tr>
<tr>
<td>10</td>
<td>Strategies and Interventions (Team)</td>
</tr>
<tr>
<td></td>
<td>Selected interventions, services, EBP, formal, informal or natural support, and processes that the family and team selects to meet the targeted needs and achieve the desired outcome.</td>
</tr>
<tr>
<td>11</td>
<td>Useful Strengths Activities (Team)</td>
</tr>
<tr>
<td></td>
<td>Planned activities that utilize the useful strengths in the planning process.</td>
</tr>
<tr>
<td>12</td>
<td>Action Steps for Team Members (Team)</td>
</tr>
<tr>
<td></td>
<td>Specific list of action items that each team member will do in order to initiate and support the strategy / intervention and achieve the desired outcome.</td>
</tr>
<tr>
<td>13</td>
<td>Strengths to Build (CANS)</td>
</tr>
<tr>
<td></td>
<td>Strengths Items with a 2 or 3 on the CANS.</td>
</tr>
<tr>
<td>14</td>
<td>Strengths Building Activities (Team)</td>
</tr>
<tr>
<td></td>
<td>Planned activities to identify or build strengths.</td>
</tr>
</tbody>
</table>
Cross System Care Plan of Example

Name:

Demographic Information:

Record Information:
Family Members:
Parent Partner:
Youth Partner:
Team Members:

Other Information:

Family Vision Statement (family and youth):

Team Mission (all team members):

Strengths (all team members):

Background Needs (CANS):

<table>
<thead>
<tr>
<th>Targeted Need (CANS)</th>
<th>Score</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>#1</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
</tr>
</tbody>
</table>

Individualized Needs Statement:

Outcome Statement (SMART):

Interventions:
1. 
2. 
3. 

<table>
<thead>
<tr>
<th>Targeted Need (CANS)</th>
<th>Score</th>
<th>Change</th>
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<tbody>
<tr>
<td>#2</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
</tr>
</tbody>
</table>

Individualized Needs Statement:

Outcome Statement (SMART):

Interventions: 

Steps:
1. 
2. 
3. 

<table>
<thead>
<tr>
<th>Targeted Need (CANS)</th>
<th>Score</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>#3</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Individualized Needs Statement:

Outcome Statement (SMART):

Interventions: Team Member Action
Steps:
1.
2.
3.

Targeted Need (CANS) #4:

Individualized Needs Statement:

Outcome Statement (SMART):

Interventions: Team Member Action
Steps:
1.
2.
3.

Targeted Need (CANS) #5:

Individualized Needs Statement:

Outcome Statement (SMART):

Interventions: Team Member Action
Steps:
1.
2.
3.

Other Anticipated Outcomes:
(Other CANS domains expected to improve as a result of addressing the targeted needs)

Useful Strengths (CANS):

Useful Strengths Activities (all team members):

Strengths to Build (CANS):

Strengths to Build Activities (all team members):
I. Affinity Groups

Materials have been developed to support each of the following affinity groups:

- Child Psychiatrists and ARNPs
- Children's Administration Social Service Specialists
- Children's Long Term Inpatient Program Staff
- Developmental Disabilities Administration
- DMHPs and Crisis Teams
- Families/Family Organizations
- Heath Care Authority and Contracted Providers
- Individuals Providing Mental Health Services
- Juvenile Court, Detention, and Probation Personnel
- Juvenile Rehabilitation Personnel
- K-12 Educators and Professionals
- Pediatricians, Family Practitioners, Physicians Assistants and ARNPs
- Substance Use Disorders (SUD) Providers
- Youth/Youth Organizations

These materials can be found at the following website: [www.dshs.wa.gov/dbhr/cbh-wise.shtml](http://www.dshs.wa.gov/dbhr/cbh-wise.shtml)

**Specific elements to be included are:**

- Identifying youth that may benefit from WISe, and when a referral is mandatory.
- How to refer; who to contact/what information is needed.
- Individual roles and responsibilities of cross-system partners.
- What to expect in the WISe model and how to participate including how to utilize and contribute to a single Cross System Care Plan.
J. Quality Management Plan

The Quality Management Plan (QMP) for WISe prescribes the quality management goals, objectives, tools, resources, and processes needed to measure the implementation and success of the Commitments set forth in the *T.R. v. Quigley and Teeter* Settlement Agreement dated December 19, 2013 (DKT 119-1, paragraphs 18 – 64). The QMP is based on the requirements set forth in the Settlement Agreement at paragraphs 45 – 54 (Quality Management Commitments) and is informed by the terms of the WISe Implementation Plan dated August 1, 2014. Complete implementation of the QMP will occur on or before December 19, 2016. This Plan is intended to be a working document.

A copy of the Quality Management Plan can be found online at:

K. WISe Practitioner Training and Coaching Framework

The WISe Practitioner Training and Coaching Framework is in the process of being reviewed and finalized by key stakeholder workgroups. The anticipated completion date for this framework is August 2016. Once completed, it will be posted on the WISe website (www.dshs.wa.gov/dbhr/cbh-wise.shtml) under Trainings.
CROSS REFERENCES

- Form: Crisis Prevention Plan
- Policy: Additional State Funded Services
- Policy: Corrective Action Plan
- Policy: Culturally Competent Services
- Policy: Provisions of Priority State Funded Services

PURPOSE

The Salish Behavioral Health Organization (SBHO) shall ensure the full range of required crisis behavioral health services and modalities are available to individuals within the SBHO. These services are available and provided based on the individual’s needs, medical necessity, SBHO Level of Care criteria, and possible authorization for voluntary inpatient services.

DEFINITIONS

A behavioral health crisis is defined 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.

PROCEDURE

1. Crisis services provide evaluation and treatment of mental health crisis to all individuals experiencing a crisis.
2. Crisis services must be available on a 24-hour basis and may be provided without an intake evaluation/assessment.

3. 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.

4. Services must be provided by or under the supervision of a mental health professional. The SBHO network providers will ensure there is an adequate number of designated mental health professionals (DMHPs) to respond to requests for crisis services. The SBHO network provider DMHPs must incorporate the statewide DMHP protocols or its successors into the practice of the DMHPs.

5. Crisis services must be provided regardless of the individual's ability to pay for the medically necessary service.

6. The following crisis services and modalities must be provided if determined medically necessary, prior to an intake assessment (see Contract Exhibit for service definitions):
   - Stabilization Services
   - Involuntary Treatment Act Services
   - Ancillary Crisis Services
   - Freestanding Evaluation and Treatment Services

7. Crisis services must be provided within the following timeframes:
   - Emergent care within two (2) hours of the request received from any source for crisis behavioral health services
   - Urgent care within twenty-four (24) hours of the request received from any source for crisis behavioral health services

8. The SBHO network providers may share resources within the region to meet SBHO sufficiency standards.

9. If a network provider provides or purchases 24-hour supervised crisis respite or hospital diversion beds, they must report these on the report form provided by the state within the required timeframes.

OUTREACH SAFETY PROTOCOLS

1. No DMHP or crisis intervention worker shall be required to respond to a private home or other private location to stabilize or treat a person in crisis, or to evaluate a person for potential detention under the state's involuntary treatment act, unless a second trained individual accompanies them.
2. The clinical team supervisor, on-call supervisor, or the individual professional acting alone based on a risk assessment for potential violence, shall determine the need for a second individual to accompany them.

3. The second individual may be a law enforcement officer, a Mental Health Professional, a mental health paraprofessional who has received training required in RCW 49.19.030, or other first responder, such as fire or ambulance personnel.

4. No retaliation may be taken against an individual who, following consultation with the clinical team or supervisor, refuses to go to a private home or other private location alone.

5. SBHO providers of crisis services must have a plan to provide training, mental health staff back-up, information sharing, and communication for crisis outreach staff who respond to private homes or other private locations.

6. Every Mental Health Professional dispatched on a crisis visit, as shall have prompt access to information about any history of dangerousness or potential dangerousness on the client they are being sent to evaluate that is documented in crisis plans or commitment records and is available without unduly delaying a crisis response.

7. Every Mental Health Professional who engages in home visits to enrollees or potential enrollees for the provision of crisis services shall be provided a wireless telephone or comparable device for the purpose of emergency communication.

**MONITORING**

This policy is mandated by contract and statue.

1. This policy is monitored through the use of the SBHO:
   - Annual SBHO Provider and Subcontractor Administrative Review
   - Annual Provider Chart Reviews
   - Over and Under Utilization Projects
   - SBHO Grievance Tracking Reports
   - Utilization Management Committee activities

2. If a provider performs below expected standards during any of the reviews listed above a Corrective Action will be required for SBHO approval.
CROSS REFERENCES

- Policy: Corrective Action Plan
- Policy: Notice of Action Requirements

PURPOSE

The Salish Behavioral Health Organization (SBHO) shall ensure that network providers establish an individualized and culturally competent treatment service plan for clients requesting and/or receiving outpatient services.

STANDARDS

Standards for the Individual Service Plan (ISP)

The ISP must be an individual-driven, strength-based individualized service plan that meets the individual's unique behavioral health needs. The ISP must be developed in collaboration with the individual, or the individual's parent or other legal representative if applicable. The service plan must:

1. Be completed or approved by a professional appropriately credentialed or qualified to provide behavioral health services.
2. Address age, gender, cultural, strengths and/or disability issues identified by the individual or, if applicable, the individual's parent(s) or legal representative.
3. Be in a terminology that is understandable to the individual and the individual's family.
4. Document that the plan was mutually agreed upon and a copy was provided to the individual.
5. Demonstrate the individual’s participation in the development of the plan.
6. Document participation of family or significant others, if participation is requested by the individual and is clinically appropriate.
7. Be strength-based.
8. Contain measurable goals or objectives, or both.
9. Be updated to address applicable changes in identified needs and achievement of goals and objectives.
10. When required by law, the agency must notify the required authority of a violation of a court order or nonparticipation in treatment, or both.
11. Be completed within thirty days from the date of the first session following the initial assessment.
12. Be individual-driven, strength-based, and meet the individual’s unique behavioral health needs.
13. Be initiated with at least one goal identified by the individual or if applicable, the individual’s parent or legal representative, during the initial assessment or the first service session following the assessment.
14. Document that the plan was updated to reflect any changes in the individual’s treatment needs, or as requested by the individual or, if applicable, the individual’s parent or legal representative.
15. Document coordination with any systems or organizations the individual identifies as being relevant to treatment, with the individual’s consent or if applicable, the consent of the individual’s parent or legal representation. This includes coordination with any individualized family service plan (IFSP) when serving an individual three years of age or younger.
16. Identify services mutually agreed upon by the individual and provider for this treatment episode.

**Treatment Plan Requirements Specific to Substance Use Disorder Treatment**

1. The Individual Service Plan (ISP) must:
   (a) Be personalized to the individual's unique treatment needs
   (b) Include individual needs identified in the diagnostic and periodic reviews, addressing:
       (i) All substance use needing treatment, including tobacco, if necessary
       (ii) The individual's bio-psychosocial problems
       (iii) Treatment goals
       (iv) Estimated dates or conditions for completion of each treatment goal
       (v) Approaches to resolve the problem
   (c) Document approval by a chemical dependency professional (CDP) if the staff member developing the plan is not a CDP.
(d) Document that the plan has been reviewed with the individual.

2. Individual Service Plans must be developed prior to the individual’s participation in treatment.

3. ISP’s for individuals in level 2.1, Intensive Outpatient treatment must be reviewed at least once per month to assess adequacy and attainment of goals.

4. ISP’s for individuals in level I.0, Outpatient treatment must be reviewed at least once per month for the first three months and quarterly thereafter.

### 180 Day Assessment Update (Mental Health)

The plan must include documentation that the individual service plan was reviewed at least every 180 days. The 180 day review must include an updated assessment of the individual’s treatment needs. The assessment must include, at a minimum:

1. A narrative description of any changes in the individual’s functioning or life circumstances during the review period. Areas of functioning that are addressed in the assessment could include:
   - Health & Self-Care
   - Home & Family Life Safety & Stability
   - Work, school, daycare, pre-school or other daily activities
   - Cultural Factors
   - Ability to use community resources to fulfill needs
2. A narrative justification of the need for continued treatment at the current level of care
3. The clinician’s assessment of the individual’s progress toward the goals on the treatment plan during the review period
4. The individual’s view of their progress during the review period (in their own words)

### Additional Requirements

If an individual disagrees with specific treatment recommendations or is denied a requested treatment service, they may file a grievance under WAC 388-877-0660.

Consumer disagreement with the treatment plan is considered an action under the PIHP contract. A network agency is responsible for notifying the SBHO when there is a disagreement regarding a Treatment Plan. The SBHO mails a Notice of Action to an enrollee when there is a disagreement.

### PROCEDURE

1. SBHO providers will comply with Washington Administrative Code (WAC), contract and policy requirements concerning the provision of individualized treatment/service plans.
2. The SBHO provider will initiate a minority specialist consultation when required by WAC or applicable laws, and incorporate treatment recommendations into the treatment plan.
3. The network providers will ensure agency staff receive adequate training in developing treatment plans, in accordance with these standards.

4. Profiler provides a uniform and consistent way of documenting treatment goals and progress.
   - Profiler allows for a customized text to be entered.

**MONITORING**

1. This policy is monitored through the use of the SBHO:
   - Annual SBHO Provider and Subcontractor Administrative Review
   - Annual Provider Chart Reviews
   - Over and Under Utilization Projects
   - SBHO Grievance Tracking Reports
   - Utilization Committee activities, such as the CommCare case review
   - Quality Management Plan activities, such as review targeted issues for trends and recommendations
   - The Department conducts the Mental Health Statistical Improvement Project (MHSIP) every year, one year for adults and the alternating the next year for children/ youth. The MHSIP measures general enrollee satisfaction with the existing service delivery system, appropriateness and quality of services, participation in treatment goals, access to services, and perceived outcomes of services they received. The SBHO requests over-sampling of the region to gather specific catchment area data and analyze for trends.
   - In addition, the Department monitors WAC compliance during licensing and certification reviews.

2. If a provider performs below expected standards during any of the reviews listed above a Corrective Action will be required for SBHO approval.
CROSS REFERENCES

- Policy: Advance Directives
- Policy: Corrective Action Plan

PURPOSE

The Salish Behavioral Health Organization (SBHO) shall ensure that mental health network providers complete a Crisis Prevention Plan (Crisis Plan) for any client who meets the established criteria.

PROCEDURE

Standards for the Individual Crisis Prevention Plan (applies to Mental Health providers):

1. The need for a Crisis Prevention Plan will be determined at the Intake evaluation and at each 180-day Treatment Plan Review. The client and the primary clinician will work collaboratively on developing the Crisis Plan. Family members and other natural supports will be included in the development of the Crisis Plan as requested by the client.
   - The current Crisis Plan will be reviewed and updated, as necessary, at each Treatment Plan Review.

2. A Crisis Prevention Plan will be written for individuals who meet any one of the following criteria:
Adult clients who:

- Have had a psychiatric hospitalization in the previous two (2) years.
- Have current suicidal ideation or a suicide attempt within the previous two (2) years.
- Are currently a danger to others or have committed a violent act in the previous two (2) years.
- Have had an ITA evaluation in previous six (6) months.
- The Intake assessor or clinician indicates a Crisis Plan/Prevention Plan is clinically appropriate.

Child clients who:

- Meet any one of the above criteria, or
- The child’s behaviors or living situation is at risk.

3. A Crisis Prevention Plan must address the following:

   a. Early warning signs of decompensation or increasing psychiatric symptoms that are particular to the individual client.
   b. Proactive and progressive measures to divert or prevent a crisis or psychiatric hospitalization.
   c. Client’s family and other supports’ roles, directives, and responsibilities, (with the consent of the client.) and contact information.
   d. A clearly defined progressive process that includes:
      - Specific steps the client will take when his or her symptoms begin to increase.
      - Specific steps or actions a client’s family or significant others will take to assist the client (with client’s consent).
      - Intervention strategies the primary clinician and other care providers can employ to assist the client in averting a crisis.

4. The network providers will ensure agency staff receive adequate training in developing Crisis Plans, per these standards.

5. Clients’ shall receive a copy of their current Crisis Plans, upon completion.

6. Through Profiler, a Crisis Plan shall be accessible to the agency crisis response teams and other staff responsible for responding to a crisis.

**MONITORING**

1. This policy is monitored through the use of the SBHO:
   - Annual SBHO Provider and Subcontractor Administrative Review
   - Annual Provider Chart Reviews
   - Annual Provider Crisis Chart Reviews
   - Biennial Quality Review Team On-Site Review
• Quality Management Plan activities, such as review targeted issues for trends and recommendations
• QUIC review of utilization management and sentinel incidents trends
• The Department conducts the Mental Health Statistical Improvement Project (MHSIP) every year, one year for adults and the alternating the next year for children/youth. The MHSIP measures general enrollee satisfaction with the existing service delivery system, appropriateness and quality of services, participation in treatment goals, access to services, and perceived outcomes of services they received. The SBHO requests over sampling of the region to gather specific catchment area data and analyze for trends.
• In addition, the Department monitors Washington Administrative Code (WAC) compliance during licensing and certification reviews

2. If a provider performs below expected standards during any of the reviews listed above a Corrective Action will be required for SBHO approval.
CROSS REFERENCES

- Policy: Corrective Action Plan
- Policy: Crisis Prevention Plan Standards

PURPOSE

The Salish Behavioral Health Organization (SBHO) shall ensure that when a designated mental health professional (DMHP), or designated peace officer, escorts an individual to an inpatient/ stabilization facility that reasonable precautions to safeguard the individual's property are taken.

PROCEDURE

The DMHP, or designated peace officer, must take reasonable precautions to safeguard the individual's property including:

1. Safeguarding the individual's property in the immediate vicinity of the point of apprehension; including coordinating care for children and pets.
2. Safeguarding belongings not in the immediate vicinity if there may be possible danger to those belongings.
3. Take reasonable precautions to lock and otherwise secure the individual's home or other property as soon as possible after the individual’s initial detention to an inpatient facility.
MONITORING

1. This policy is monitored through the use of the SBHO:
   - Annual SBHO Provider and Subcontractor Administrative Review
   - Annual Provider Chart Reviews
   - In addition, the Department monitors Washington Administrative Code (WAC) compliance during licensing and certification reviews

2. If a provider performs below expected standards during any of the reviews listed above a Corrective Action will be required for SBHO approval.
Policy Name: EPSDT COORDINATION PLAN AND REQUIREMENTS  
Reference: DSHS Contract and related exhibits  
Effective Date: 10/2005  
Revision Date(s): 2/2013  
Reviewed Date: 12/2014; 7/2017  
Approved by: SBHO Executive Board

CROSS REFERENCES

- Plan: Cross System Working Agreements
- Policy: Corrective Action Plan
- Policy: Crisis Prevention Plan Standards
- Policy: Cross System Working Agreements
- Policy: Individualized Service Plans Standards
- Schedule: Cross System Working Agreements

PURPOSE

The Salish Behavioral Health Organization (SBHO) ensures our network provides coordinated Early and Periodic Screening and Diagnostic Testing (EPSDT) assessment and early intervention for children and youth. Physicians refer children and youth for EPSDT behavioral health screenings and services.

The EPSDT guidelines are to be implemented for Medicaid individuals ranging in age from birth up to 21 years old.

Behavioral health services provided to EPSDT referrals must be age and culturally appropriate, and involve the family.

The SBHO will ensure accessible network behavioral health services, resource development, data collection, and maintenance of the required program records.
DEFINITIONS

Child is defined as an individual who has not reached their eighteenth (18) birthday. For persons eligible for the Medicaid program and EPSDT, the term child extends to individuals that have not reached their twenty-first birthday.

PROCEDURE

1. The SBHO mandates, per contract, that the network providers adhere to the EPSDT guidelines in the state contract and related exhibits, such as the EPSDT Plan.

2. The SBHO designates an EPSDT Care/Resource Manager who provides resource management services and is the gatekeeper for the SBHO EPSDT program implemented through the network. The SBHO EPSDT Care/Resource Manager will:
   - Be a child behavioral health specialist, or supervised by a child behavioral health specialist.
   - Coordinate initial evaluations; review services for medical necessity, develop and coordinate support services for the EPSDT referred individual; and coordinate, staff, and develops the Individual Service Team.
   - Facilitate local community communication between physicians and the behavioral health clinicians and maintain an open referral process.

3. The SBHO EPSDT Children’s Services Manager is responsible for placing EPSDT issues on the agenda of the SBHO Executive Board, the Advisory Board, and any relevant region wide committees (such as the Clinical Directors meeting), when appropriate.

4. The SBHO EPSDT Children’s Services Manager is responsible for oversight of coordination between the network providers and community interagency councils, state agencies and divisions, as appropriate.

EPSDT Physical Screening

1. EPSDT Physical Screening shall include:
   - A comprehensive health and development history, updated at each screening examination
   - A comprehensive physical examination performed at each screening examination
   - Vision and hearing testing
   - Appropriate laboratory tests, including blood lead level testing
   - Immunization according to age and health status
   - Maintaining records of the child’s developmental progress, significant physical findings, and any treatments or referrals

2. After a behavioral health need has been identified through an EPSDT screen, an initial behavioral health assessment will be completed.
EPSDT Behavioral Health Evaluation and Assessment

1. The behavioral health assessment is designed to provide a thorough picture of the child’s condition (strengths and weaknesses) and determine the need for further behavioral health intervention.

2. Upon receiving an EPSDT referral, the SBHO network providers will:
   - Offer an intake assessment with a Child Behavioral Health Specialist within ten (10) working days. If the assessment is not offered within the required ten (10) working days, the provider will describe in the clinical record the problems encountered, remedial action to be taken, and specific line for the completion of the comprehensive evaluation.
   - An EPDST referral takes priority for evaluation and services, over a self-referred Medicaid individual.

3. The intake assessment must include the following:
   - Developmental, psycho-social and medical history
   - Child’s current condition (physical and/or behavioral)
   - Child’s academic/learning problems
   - Family’s needs
   - Chemical dependency assessment, if appropriate

Service Authorization

1. The SBHO Children’s Services Manager, or the designated SBHO utilization management contractor, will make the authorization determination for outpatient services and the Level of Service.
   - The SBHO will inform the family of the services authorized.

2. For Level 1 admission authorization, the EPSDT Children’s Services Manager or designee will develop the Individual Service Plan (ISP) and make a referral for services. Level 1 services may be provided by other appropriate child-serving agencies (such as youth service centers) to meet the needs of the child and family. Services not reimbursed by medical coupons may be included in the overall service plan/treatment plan.

3. When admission authorization for Level 1 expires and there appears to be continued need for services, the EPSDT Children’s Services Manager or designee will review the clinical record. If appropriate, services may be re-authorized for Level 1-time specific services or authorized for Level 2 services.

4. Independent of the current level of functioning, Level 2 services may be authorized as described in the Access To Care Standards when indicated for children who are:
   - involved in one or more of the following in addition to behavioral health:
     - Children’s Administration
- Developmental Disabilities Administration
- Juvenile Rehabilitation Administration
- County Youth Court Services

b. diagnosed with a substance abuse or addiction;
c. receiving special education services: or,
d. a chronic and disabling medical condition

5. Level 2 services may include longer term intensive community-based options, integrated across all service systems involved with the child and family. These services are individually tailored for the specific needs of the child and family through an Individualized Service Team (IST). The IST is activated to further establish and develop a cross-system ISP.

6. Formalized IST/ISP development shall be considered for all Children also receiving services from Children’s Administration (DCFS).

Individualized Service Team (IST)

1. For Level 2 authorized children that are involved in two or more identified service systems development of IST/ISP will be provided.

2. The IST must include the child if age 13, or older. Younger children may participate, as appropriate and agreed upon by the Team.

3. The IST must include, as appropriate, cross-system professionals including, but not limited to, representatives from education, child welfare, behavioral health, drug and alcohol, developmental disabilities, and juvenile justice.

4. The IST may include the parent or guardian of the child, as appropriate and agreed upon by the Team.

5. The IST may be co-located within other plans, such as an Individualized Education Plan (IEP), other Special Education program IDEA, 504 Plan, or an Individual Family Service Plan (IFSP). The ISP may be incorporated into the regular behavioral health treatment plan.

Individualized Service Plan (ISP)

1. A Level 2 authorized EPSDT child and family shall establish an Individualized Service Plan and Crisis Prevention Plan, within the required time frames. See SBHO policy: Individualized Service Plan and Crisis Prevention Plan Standards.

2. The ISP must address the overall needs of the child and family, not just the Medicaid reimbursable services, in all life areas including residential, family, social, and medical needs.

3. The ISP must clearly identify which system is responsible for a specific need of care.

4. The SBHO Care/Resource Manager or designee will review and sign the ISP for behavioral health services. The ISP may be returned to the IST for revisions, if needed.
5. Other local agency team members are responsible for reviewing the ISP and identified agency’s role and responsibilities in the ISP.

6. The SBHO care manager, or designee, shall ensure an established IST reviews the ISP at least semi-annually, identifying progress and revised service needs.

**EPSDT Program Training**

1. The SBHO Children’s Services Manager will provide technical assistance/consultation and team-building training (IST) to the network providers, and upon request from other parties.

2. The SBHO provides training and policy updates regarding EPSDT requirements at least quarterly at the Clinical Directors meeting. Trainings may include:
   - EPSDT periodicity scale requirements
   - Child and family self-reporting issues.
   - Verify need for EPSDT (referral to physician for Wellness checks) during intake assessment; assessor makes voluntary referral to child/youth/ caregiver.
   - Requirements and updates to the Child and Family Team (CFT) service roll-out

3. The SBHO provides additional local community EPSDT trainings and education to local health providers, other out of network behavioral health providers, juvenile justice, education, and child welfare systems upon request.

4. The SBHO distributes EPDST state surveys and DSHS written policy updates, as requested, to the network providers.

**EPSDT Cross System Working Agreements**

1. To effectively promote and facilitate coordination of care for EPSDT referred children, the SBHO shall maintain updated working agreements with the following allied system providers:
   - Developmental Disabilities Administration (DDA) – Child
   - Division of Child and Family Services (DCFS)
   - Children’s Long-term Inpatient Program (CLIP)
   - Juvenile Rehabilitation Administration (JRA)
   - Chemical Dependency and Substance Abuse
   - Healthy Options Plans
   - Tribes

   Reference 14.01 SBHO Cross System Working Agreement policy

**EPSDT Reporting**

The SBHO shall provide a report to the Department, upon request, that contains the following:

- Number of EPSDT unduplicated children referred
• Level of service to which each child is assigned
• Types of services required/ noted on each ISP (for level 2 only)
• Behavioral health service utilization associated for each child
• Behavioral health expenditures associated for each child

MONITORING

1. This policy is mandated by state and contract. The SBHO monitors this policy through the use of:
   • Annual SBHO Provider and Subcontractor Administrative Review
   • Annual Provider Chart Reviews
   • SBHO participation and oversight of network Utilization Management Committee meetings
   • SBHO Grievance Tracking Reports
   • SBHO Care Manager tracking referrals between physicians and network providers
   • The Department conducts the Behavioral Health Statistical Improvement Project (MHSIP) every year, one year for adults and the alternating the next year for children/youth. The MHSIP measures general enrollee satisfaction with the existing service delivery system, appropriateness and quality of services, participation in treatment goals, access to services, and perceived outcomes of services they received. The SBHO requests over sampling of the region to gather specific catchment area data and analyze for trends.

2. If a provider performs below expected standards during any of the reviews listed above a Corrective Action will be required for SBHO approval.
POlICY NAME: PACT STAKEHOLDERS ADVISORY GROUP


Effective Date: 12/2012

Revision Date(s): 12/2012

Reviewed Date: 5/2016; 7/2017

Approved by: SBHO Executive Board

PURPOSE

The Salish Behavioral Health Organization (SBHO) shall ensure that the PRSN WA-PACT team subcontractor, Kitsap Mental Health Services, manages a PACT Stakeholders’ Advisory Group that adheres to all relevant Washington State PACT Program Standards.

PROCEDURE

1. The SBHO will ensure that the regional PACT program meets all WA-PACT program requirements through subcontract.

MONITORING

1. This policy is monitored through:
   - Review of SBHO Advisory Group meeting minutes
   - SBHO participation in annual state PACT fidelity review meetings.
   - Review and approval of subcontractor’s internal Policy and Procedure regarding the WA-PACT Stakeholder Advisory Group

2. If a provider performs below expected standards during any of the reviews listed above a Corrective Action will be required for SBHO approval.
CROSS REFERENCES

- Plan: Quality Management Plan
- Policy: Corrective Action Plan

PURPOSE

The Salish Behavioral Health Organization (SBHO) shall ensure coordination with rehabilitation and employment services to assure that all individuals wanting to work are provided with employment services, supports, and/or opportunities.

PROCEDURE

All individuals that have a current employment goal listed on Individual Treatment Plan (or Individual Service Plan) meet the criteria for rehabilitative employment services.

1. Identifying staff knowledgeable in and responsible for employment activities
2. In cooperation or partnership with interested parties and financial, promoting access to and use of community employment services available to individuals, which may include:
   a. Coordination and referral with the Department of Vocational Rehabilitation, WorkSource, and other community-based employment programs.
   b. Providing supported employment services as an agency
c. Agreements between employment service providers and the SBHO or its providers

3. Encouraging employment:
   a. Which provides for maximum integration of individuals into their own identified areas of interest
   b. Which provides support for individuals to secure and maintain employment with supportive services as necessary

MONITORING

1. The SBHO will review a random sample of individuals who have received supported employment services at each agency. These will be reviewed using the SBHO supported employment chart review tool. See SBHO QMP for chart review compliance thresholds.

2. If a provider performs below expected standards during any of the reviews listed above a Corrective Action will be required for SBHO approval.
Policy Name: HOUSING SERVICES

Policy Number: 11.11

Reference: WAC 388-865-0235;
WAC 388-877B -0700-0740
WAC 388-877A -0300-0335,-1700-1765

Effective Date: 7/2005

Revision Date(s): 6/2016

Reviewed Date: 6/2016; 6/2017

Approved by: SBHO Executive Board

CROSS REFERENCES

- Policy: Corrective Action Plan
- Policy: Cross System Working Agreement
- Policy: Homeless Individuals, Providing Services

PURPOSE

It is the policy of the Salish Behavioral Health Organization (SBHO) and its providers to actively promote individual access to, and choice in, safe, decent and affordable housing, which is integrated into the community and appropriate to the age, culture and residential needs of the person.

PROCEDURE

The SBHO requires its providers to evidence outcomes supporting this policy, which may be promoted by:

1. Identifying staff knowledgeable in and responsible for housing-development activities
2. Maintaining a listing of housing stock for individuals
3. In cooperation or partnership with interested parties and financial institutions, promoting access to and use of community housing available to individuals, which may include:
   a. Ownership or leases by the SBHO or its providers
   b. Agreements between landlords and the SBHO or its providers
c. Securing HUD Section 8 or other rental subsidies, including rental subsidies provided directly by the SBHO

d. Loans or grants for low-income or special need housing by federal, state or local funding sources

e. Working with local Coordinated Entry programs for access to services

f. Other means

4. Encouraging housing:
   a. Which provides for maximum integration of individuals into their own identified community
   b. Which provides support for individual to secure and maintain independent housing with supportive services as necessary

MONITORING

1. This policy is a contract requirement. This policy will be monitored through use of SBHO:
   a. Annual SBHO Provider and Subcontractor Administrative Review
   b. Monthly Provider Chart Reviews

2. If a provider performs below expected standards during any of the reviews listed above a Corrective Action will be required for SBHO approval.
Salish BHO Housing Plan
Update: June 2017

Purpose and Goals

Salish BHO is committed to helping consumers obtain safe and affordable housing in the most independent setting possible given each consumer’s individual skills and needs. With this goal in mind, the providers within SBHO have a wide range of residential and support services available for consumers.

SBHO and its providers will, as resources allow, continue to develop residential resources that meet our consumers’ needs while helping them obtain the skills necessary for more independent housing, with the following goals in mind:

- Consumers will have access to housing at the most independent level possible based on their individual needs.
- Housing will be both safe and affordable.
- There will be a focus on consumer choice regarding type and location of housing.
- When consumers are hospitalized or in residential treatment, providers will work toward helping consumers protect and maintain housing.
- Providers will provide advocacy for consumers in both obtaining and retaining housing.
- Providers will continue to assess each consumer’s life skills to best advocate for their needs.
- The BHO and providers will pursue subsidies and additional funds that increase access to community housing.

Current Resources

SBHO mental health providers are responsible for four distinct geographical areas across three counties. Provider agencies are between one and a half to four hours apart from each other. There are two substance use providers providing supported housing services in Kitsap County only. For this reason, the BHO asks each provider to describe the resources and development plans for their areas separately.

In addition to other community resources, the providers within SBHO currently have the following housing resources available:

- Boarding Home (1 operated by a CMHC)
- ARTF (1 operated by CMHC)
- Mental Health Supported Housing
- Substance Use supported housing and Co-Occurring Supported Housing
- Section 8 Apartments
- Master lease agreements
- Transitional housing from jail
• Transitional and permanent family housing including pregnant and parenting women
• Emergency Shelters for families, individuals, and couples
• Housing repair assistance
• Stabilization services
• PATH providing outreach and engagement to the chronically homeless to move toward permanent housing.
• HARPS providing transition case management for homeless clients leaving or at risk of entering inpatient settings. Also providing financial subsidy to this population as needed.

Analysis of Barriers to Housing

The BHO’s plan to develop housing options for consumers is contingent not only upon available resources and funding, but on the needs of consumers. The following continue to be themes around barriers to obtaining and maintaining consumer housing as in previous years:

• **Lack of Affordable Rental Options**: In many areas the rent is higher than most consumers can afford. Also, the closing of the Section 8 list is an ongoing problem.

• **Lack of Adequate Support Services**:
  - Some consumers have challenges in functioning due to symptoms that impact their ability to manage housing independently.
    - This can lead to challenges maintaining the property in a safe and hygienic manner.
    - There may be challenges following through with appointments and other responsibilities.
    - Behaviors related to mental health decompensation can put housing at risk.
    - Disruptive behavior related to substance use by consumers can also threaten housing stability and lead to loss of housing.
    - This includes allowing other non-renters stay in apartments, especially when they engage in illegal or disruptive activities.
    - Lack of adult family homes in coverage area moves consumers out of the area.

• **Lack of Financial Resources**: Limited or no income. Many clients in the Social Security application process cannot access housing. Challenges with accessing and maintaining employment.

• **Limited Access to Safe Neighborhoods**: Often the lowest rents are in unsafe neighborhoods. Another related problem is consumers having drug
users or others over to the property, which results in damage, complaints, victimization, etc.

- **Rental History**: Many consumers have a poor or no rental history including an inability to pay rent or maintain the property. Poor or no credit.

- **Access to rental property**: Challenges identifying landlords who are willing and able to rent to clients. Lack of flexibility in landlord market. This includes lack of vacancies in rental market.

- **Criminal History**: Consumers with a criminal history are difficult to place.

**Coordination with Other Organizations Around Housing Issues**

The BHO and its providers are extensively involved in coordinating with other housing organizations in each area of the region. These efforts include the 10-year plan to end homelessness, local housing committees, and statewide efforts. With integration of behavioral health, we are hoping for increased partnership between these mental health and substance use providers within the BHO.

BHO providers take part in ad hoc interventions with local governments and state agencies around appropriate housing for consumers.

The BHO has increased its presence in community housing arenas and is connecting to the housing consortiums in each area.

**Additional Funding**

The providers within SBHO have sought additional funding to help consumers maintain independent housing. A portion of this comes from Federal Block Grant monies dedicated by the BHO for housing projects. Each agency makes a proposal for the use of this funding to the BHO.

**Future Plans (updated June 2017)**

The BHO's plan to increase housing options available to consumers involves the use of Federal Block Grant funds as well as other local and state funding. Plans not involving Federal Block Grant funding include those pursued by providers when available.

The BHO is working to increase collaboration with other entities within each county and promote access to Housing First models and engaging permanent supported housing models.
CROSS REFERENCES

- Policy: Corrective Action Plan
- Policy: Housing Services

PURPOSE

This policy applies to all eligible persons in the Salish Behavioral Health Organization (SBHO) catchment area and SBHO contracted provider agencies.

PROCEDURE

Contracted providers shall:

1. Provide access to an emergency behavioral health response system for all age groups of homeless people and the availability to coordinate transportation for homeless individuals to emergency psychiatric inpatient services.
2. Provide outreach and assessment services to homeless individuals in their location.
3. Provide screening and diagnostic treatment to homeless individuals as soon as possible.
4. Provide emergency evaluations of homeless individuals referred for psychiatric inpatient hospitalizations.
5. Provide medication monitoring for homeless individuals behavioral health disorders when appropriate.
6. Ensure homeless persons with behavioral health disorders are informed of food and clothing banks, shelters, mental health centers and other needed services.

7. Assist homeless individuals with behavioral health disorders with safe havens, drop-in centers, clubhouse services and supports, crisis respite beds, residential services and emergency (temporary) housing, in absence of permanent housing.

8. Assist homeless individuals with Medicaid and other public entitlement applications and referrals.

9. Ensure representative payee services are available for homeless individuals with behavioral health disorders who need them.

MONITORING

1. This policy is a contract requirement. This policy will be monitored through use of SBHO:
   • Annual SBHO Provider and Subcontractor Administrative Review
   • Annual Provider Chart Reviews
   • Annual Provider Crisis Chart Reviews
   • Biennial Provider Quality Review Team On-site Review

2. If a provider performs below expected standards during any of the reviews listed above a Corrective Action will be required for SBHO approval.
Policy Name: CRIMINAL JUSTICE SYSTEM, PROVIDING SERVICES

Reference: WAC 388-865-0600 through 0640; Agreements; DSHS Contract

Effective Date: 7/2005

Revision Date(s): 6/2016

Reviewed Date: 6/2016; 6/2017

Approved by: SBHO Executive Board

CROSS REFERENCES

- Policy: Corrective Action Plan
- Policy: Cross System Working Agreement

PURPOSE

This policy applies to all eligible persons within the Salish Behavioral Health Organization (SBHO) catchment area and SBHO contracted network provider agencies.

PROCEDURE

Jail services are regulated by the Jail Services Agreement. The contract is based upon a pay point system requiring providers to report outcomes and services provided in order to receive payment for non-crisis services in the jail. Crisis services continue to be billed using non-Medicaid funds.

Contracted providers shall:

1. Devise and implement methodology to assure that person with behavioral health disorders diverted from jails, prisons or juvenile detention and rehabilitative facilities are identified and linked to community care.
2. Develop and implement methodologies to monitor criminal justice diversion for adults and youth, including pre-arrest diversion, court-ordered treatment, sentencing alternatives and post-incarceration treatment planning and implementation.

3. Provide access, availability and transportation to emergency behavioral health response system and/or psychiatric inpatient services for all age groups of offenders diverted from jails or prison and/or post prison or detention community transition in order to provide seamless service delivery for release/discharge planning made in conjunction with facility staff, medical personnel and the receiving community.

4. Assist local law enforcement in screening and diagnostic activities for all ages upon request for pre-sentence investigations or other diversion processes.

5. Assure offenders with behavioral health disorders of all ages who are diverted to and/or returning to the community are offered medication monitoring, and linkage with community supports.

6. Prominently display brochures and other materials provided by individual/family advocates regarding issues relating to offender’s behavioral health disorders in jails, juvenile detention, prison and juvenile rehabilitation facilities reception areas.

7. Maintain interagency collaboration related to people with behavioral health disorders who are in the criminal justice system, with the Developmental Disabilities Administration (DDA), the Children's Administration, Juvenile Rehabilitation Administration (JRA), Division of Behavioral Health and Recovery (DBHR) and other agencies and stakeholders that are integrally involved in providing services to enrollees.

**MONITORING**

This policy is a mandate by contract.

1. This Policy will be monitored through use of SBHO:
   - Annual Fiscal Review
   - Annual SBHO Provider and Subcontractor Administrative Review
   - Provider Chart Reviews
   - Charts of individuals who are on Conditional Release or Less Restrictive Alternative court orders will be examined to determine if care coordination is occurring.
   - QUIC annual review of Allied Systems Coordination Plans
   - SBHO Grievance Tracking Reports

2. If a provider performs below expected standards during any of the reviews listed above a Corrective Action will be required for SBHO approval.
Policy Name: MENTAL HEALTH PRACTICE GUIDELINES
Policy Number: 11.14
Reference: 42 CFR 438.236; DSHS Contract
Effective Date: 8/2004
Revision Date(s): 6/2016
Reviewed Date: 6/2016; 6/2017
Approved by: SBHO Executive Board

CROSS REFERENCES
- Guidelines: Bi-polar Disease Condensed Guidelines
- Guidelines: Schizophrenia Condensed Guidelines
- Plan: Quality Management Plan
- Policy: Corrective Action Plans

PURPOSE
The Salish Behavioral Health Organization (SBHO) adopts, disseminates and ensures compliance with designated research based American Psychiatric Association (APA) Practice Guidelines.

DEFINITIONS
Practice Guidelines are systematically developed statements designed to assist in decisions about appropriate mental health treatment. The guidelines are intended to assist practitioners in the prevention, diagnosis, treatment, and management of clinical conditions.

PROCEDURE
1. The SBHO adopted the APA Practice Guidelines because they are based on valid and reliable research-based clinical evidence demonstrating their utility in driving positive clinical outcomes or reflecting promising practices; and they reflect a consensus of national mental health professionals.
2. The SBHO adopted the two (2) APA Practice Guidelines for Schizophrenia and Bipolar Disorder after:
• The SBHO considered the service needs by targeting the most prevalent and covered psychiatric diagnosis in the SBHO

• The SBHO clinical directors, employed by the network providers, reviewed and recommended two practice guidelines for implementation

• The recommended guidelines were reviewed by the SBHO Quality Improvement Committee (QUIC)

3. The SBHO has disseminated the two (2) practice guidelines.

• The APA practice guidelines and condensed guides are sent electronically to all network providers’ clinical director(s) in the SBHO. The SBHO Practice Guidelines are also available through the SBHO website (in Manual).

• The APA practice guidelines are provided electronically to individuals, potential individuals, and interested parties upon request.

4. According to the PIHP contract, the network shall participate in the implementation of the Child and Family team (CFT) protocol under the timelines and guidance published by DSHS.

• The network providers will track all usage of CFT through routine encounter reporting

5. The SBHO shall ensure clinical assessments and treatment services incorporate the adopted practice guidelines.

• The SBHO, in consultation with the network clinical directors, will identify the elements within each adopted practice guideline to monitor. The SBHO will ensure those elements are included in the services provided to each client with a diagnosis of Schizophrenia or Bipolar Disorder.

6. The SBHO shall ensure the adopted practice guidelines are incorporated into the utilization management protocols, enrollee education, and the network provider training plan.

7. The SBHO adopted practice guidelines will be reviewed and updated biennially.

MONITORING

1. This policy is a mandate by contract. This policy will be monitored through use of SBHO:

• Monthly SBHO UMC & Clinical Directors Meetings

• Annual Provider Chart Reviews: Practice Guidelines Chart Reviews will be completed for all charts reviewed for adult clients who have a diagnosis of Schizophrenia or Bipolar Disorder in addition to the completion of the Standard Quality Chart Review.

  The Children’s CFT will be tracked through routine encounter reporting. Additional monitoring will be in accordance to guidance provided by the Department.

• Quality Management Plan activities, such as review targeted issues for trends and recommendations

2. If a provider performs below expected standards during any of the reviews listed above a Corrective Action will be required for SBHO approval.
American Psychiatric Association

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For Continuing Medical Education credit for APA Practice Guidelines, visit www.psych.org/cme.

To order individual Practice Guidelines or the 2004 Compendium of APA Practice Guidelines, visit www.appi.org or call 800-368-5777.

The American Board of Psychiatry and Neurology (ABPN) has reviewed the APA Practice Guidelines CME Program and has approved this product as part of a comprehensive lifelong learning program, which is mandated by the American Board of Medical Specialties as a necessary component of maintenance of certification.

ABPN approval is time limited to 3 years for each individual Practice Guideline CME course. Refer to APA’s CME web site for ABPN approval status of each course.
Introduction

"Treating Schizophrenia: A Quick Reference Guide" is a summary and synopsis of the American Psychiatric Association’s Practice Guideline for the Treatment of Patients With Schizophrenia, Second Edition, which was originally published in The American Journal of Psychiatry in February 2004 and is available through American Psychiatric Publishing, Inc. The Quick Reference Guide (QRG) is not designed to stand on its own and should be used in conjunction with the full text of the practice guideline. The psychiatrist using this QRG will find it helpful to return to the full-text practice guideline for clarification of a recommendation or for a review of the evidence supporting a particular strategy. Algorithms illustrating the treatment of patients with schizophrenia are included.

Statement of Intent

The Practice Guidelines and the Quick Reference Guides are not intended to be construed or to serve as a standard of medical care. Standards of medical care are determined on the basis of all clinical data available for an individual case and are subject to change as scientific knowledge and technology advance and practice patterns evolve. These parameters of practice should be considered guidelines only. Adherence to them will not ensure a successful outcome in every case, nor should they be construed as including all proper methods of care or excluding other acceptable methods of care aimed at the same results. The ultimate judgment regarding a particular clinical procedure or treatment plan must be made by the psychiatrist in light of the clinical data presented by the patient and the diagnostic and treatment options available.

The development of the APA Practice Guidelines and Quick Reference Guides has not been financially supported by any commercial organization.
A. Psychiatric Management

1. Assess symptoms and establish a diagnosis.

   Establish an accurate diagnosis, considering other psychotic disorders in the differential diagnosis because of the major implications for short- and long-term treatment planning. If a definitive diagnosis cannot be made but the patient appears prodromally symptomatic and at risk for psychosis, reevaluate the patient frequently.

   Reevaluate the patient’s diagnosis and update the treatment plan as new information about the patient and his or her symptoms becomes available.

   Identify the targets of each treatment, use outcome measures that gauge the effect of treatment, and have realistic expectations about the degrees of improvement that constitute successful treatment.

   Consider the use of objective, quantitative rating scales to monitor clinical status (e.g., Abnormal Involuntary Movement Scale [AIMS], Structured Clinical Interview for DSM-IV Axis I Disorders [SCID], Brief Psychiatric Rating Scale [BPRS], Positive and Negative Syndrome Scale [PANSS]).

2. Formulate and implement a treatment plan.

   Select specific type(s) of treatment and the treatment setting. (This process is iterative and should evolve over the course of the patient’s association with the clinician.)
### 3. Develop a therapeutic alliance and promote treatment adherence.

- **Identify the patient’s goals and aspirations and relate these to treatment outcomes to increase treatment adherence.**

- **Assess factors contributing to incomplete treatment adherence and implement clinical interventions (e.g., motivational interviewing) to address them. Factors contributing to incomplete treatment adherence include**
  - patient’s lack of insight about presence of illness or need to take medication,
  - patient’s perceptions about lack of treatment benefits (e.g., inadequate symptom relief) and risks (e.g., unpleasant side effects, discrimination associated with being in treatment),
  - cognitive impairment,
  - breakdown of the therapeutic alliance,
  - practical barriers such as financial concerns or lack of transportation,
  - cultural beliefs, and
  - lack of family or other social support.

- **Consider assertive outreach (including telephone calls and home visits) for patients who consistently do not appear for appointments or are nonadherent in other ways.**

### 4. Provide patient and family education and therapies.

- **Work with patients to recognize early symptoms of relapse in order to prevent full-blown illness exacerbations.**

- **Educate the family about the nature of the illness and coping strategies to diminish relapses and improve quality of life for patients.**
5. Treat comorbid conditions, especially major depression, substance use disorders, and posttraumatic stress disorder.

6. Attend to the patient’s social circumstances and functioning.

Work with team members, the patient, and the family to ensure that services are coordinated and that referrals for additional services are made when appropriate.

7. Integrate treatments from multiple clinicians.

8. Carefully document the treatment, since patients may have different practitioners over their course of illness.

B. Acute Phase

Goals of treatment
• Prevent harm.
• Control disturbed behavior.
• Reduce the severity of psychosis and associated symptoms (e.g., agitation, aggression, negative symptoms, affective symptoms).
• Determine and address the factors that led to the occurrence of the acute episode.
• Effect a rapid return to the best level of functioning.
• Develop an alliance with the patient and family.
• Formulate short- and long-term treatment plans.
• Connect the patient with appropriate aftercare in the community.
1. Assessment in the Acute Phase

**Goals of acute phase assessment**
- Evaluate the reason for the recurrence or exacerbation of symptoms (e.g., medication nonadherence).
- Determine or verify the patient’s diagnosis.
- Identify any comorbid psychiatric or medical conditions, including substance use disorders.
- Evaluate general medical health.
- Identify the patient’s strengths and limitations.
- Engage the patient in a therapeutic alliance.

Undertake a thorough initial workup, including complete psychiatric and general medical histories and physical and mental status examinations.

Routinely interview family members or other individuals knowledgeable about the patient, unless the patient refuses to grant permission.

In emergency circumstances (e.g., safety risk), it may be necessary and permissible to speak with others without the patient’s consent.

Conduct laboratory tests, including a complete blood count (CBC); measurements of blood electrolytes and glucose; tests of liver, renal, and thyroid function; a syphilis test; and, when indicated, a urine or serum toxicology screen, hepatitis C test, and determination of HIV status.
Consider use of a computed tomography (CT) or magnetic resonance imaging (MRI) scan (MRI is preferred) for patients with a new onset of psychosis or with an atypical clinical presentation, because findings (e.g., ventricular enlargement, diminished cortical volume) may enhance confidence in the diagnosis and provide information relevant to treatment planning and prognosis.

Assess risk factors for suicide (such as prior attempts, depressed mood, suicidal ideation, presence of command hallucinations, hopelessness, anxiety, extrapyramidal side effects, and alcohol or other substance use).

Assess likelihood of dangerous or aggressive behavior, including potential for harm to others.

2. Psychiatric Management in the Acute Phase

Reduce overstimulating or stressful relationships, environments, and life events.

Provide the patient with information (appropriate to his or her ability to assimilate) on the nature and management of the illness.

Initiate a relationship with family members. Refer family members to local chapters of the National Alliance for the Mentally Ill (NAMI) and to the NAMI web site (http://www.nami.org).
### 3. Use of Antipsychotic Medications in the Acute Phase

| Initiate antipsychotic medication as soon as it is feasible. It may be appropriate to delay pharmacologic treatment for patients who require more extensive diagnostic evaluation or who refuse medications or if psychosis is caused by substance use or acute stress reactions. |
| Discuss risks and benefits of the medication with the patient before initiating treatment, if feasible, and identify target symptoms (e.g., anxiety, poor sleep, hallucinations, and delusions) and acute side effects (e.g., orthostatic hypotension, dizziness, dystonic reactions, insomnia, and sedation). |
| Assess baseline levels of signs, symptoms, and laboratory values relevant to monitoring effects of antipsychotic therapy. |
| • Measure vital signs (pulse, blood pressure, temperature). |
| • Measure weight, height, and body mass index (BMI), which can be calculated with the formula weight in kilograms/(height in meters)\(^2\) or the formula \(703 \times \frac{\text{weight in pounds}}{\text{height in inches}}\)^2 or with a BMI table: [www.niddk.nih.gov/health/nutrit/pubs/statobes.htm#table](http://www.niddk.nih.gov/health/nutrit/pubs/statobes.htm#table) |
| • Assess for extrapyramidal signs and abnormal involuntary movements. |
| • Screen for diabetes risk factors and measure fasting blood glucose. |
| • Screen for symptoms of hyperprolactinemia. |
| • Obtain lipid panel. |
| • Obtain ECG and serum potassium measurement before treatment with thioridazine, mesoridazine, or pimozide; obtain ECG before treatment with ziprasidone in the presence of cardiac risk factors. |
| • Conduct ocular examination, including slit-lamp examination, when beginning antipsychotics associated with increased risk of cataracts. |
| • Screen for changes in vision. |
| • Consider a pregnancy test for women with childbearing potential. |
Minimize acute side effects (e.g., dystonia) that can influence willingness to accept and continue pharmacologic treatment.

Initiate rapid emergency treatments when an acutely psychotic patient is exhibiting aggressive behaviors toward self or others.
- Try talking to the patient in an attempt to calm him or her.
- Restraining the patient should be done only by a team trained in safe restraint procedures.
- Use short-acting parenteral formulations of first- or second-generation antipsychotic agents with or without parenteral benzodiazepine.
- Alternatively, use rapidly dissolving oral formulations of second-generation agents (e.g., olanzapine, risperidone) or oral concentrate formulations (e.g., risperidone, haloperidol).

See Tables 1 (p. 12) and 2 (p. 13) and Figure 1 (p. 14) for guidance in determining somatic treatment.

Select medication depending on the following factors:
- Prior degree of symptom response
- Past experience of side effects
- Side effect profile of prospective medications (see Table 3, p. 15)
- Patient’s preferences for a particular medication, including route of administration
- Available formulations of medications (e.g., tablet, rapidly dissolving tablet, oral concentrate, short- and long-acting injection)
## TABLE 1. Commonly Used Antipsychotic Medications

<table>
<thead>
<tr>
<th>Antipsychotic Medication</th>
<th>Recommended Dose Range (mg/day)(^a)</th>
<th>Chlorpromazine Equivalents (mg/day)(^b)</th>
<th>Half-Life (hours)(^c)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>First-generation agents</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Phenothiazines</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chlorpromazine</td>
<td>300–1000</td>
<td>100</td>
<td>6</td>
</tr>
<tr>
<td>Fluphenazine</td>
<td>5–20</td>
<td>2</td>
<td>33</td>
</tr>
<tr>
<td>Mesoridazine</td>
<td>150–400</td>
<td>50</td>
<td>36</td>
</tr>
<tr>
<td>Perphenazine</td>
<td>16–64</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Thioridazine</td>
<td>300–800</td>
<td>100</td>
<td>24</td>
</tr>
<tr>
<td>Trifluoperazine</td>
<td>15–50</td>
<td>5</td>
<td>24</td>
</tr>
<tr>
<td><strong>Butyrophenone</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Haloperidol</td>
<td>5–20</td>
<td>2</td>
<td>21</td>
</tr>
<tr>
<td><strong>Others</strong></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Loxapine</td>
<td>30–100</td>
<td>10</td>
<td>4</td>
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<tr>
<td>Molindone</td>
<td>30–100</td>
<td>10</td>
<td>24</td>
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<td>Thiothixene</td>
<td>15–50</td>
<td>5</td>
<td>34</td>
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<tr>
<td><strong>Second-generation agents</strong></td>
<td></td>
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</tr>
<tr>
<td>Aripiprazole</td>
<td>10–30</td>
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<td>Clozapine</td>
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</tr>
<tr>
<td>Olanzapine</td>
<td>10–30</td>
<td></td>
<td>33</td>
</tr>
<tr>
<td>Quetiapine</td>
<td>300–800</td>
<td></td>
<td>6</td>
</tr>
<tr>
<td>Risperidone</td>
<td>2–8</td>
<td></td>
<td>24</td>
</tr>
<tr>
<td>Ziprasidone</td>
<td>120–200</td>
<td></td>
<td>7</td>
</tr>
</tbody>
</table>

\(^a\)Dose range recommendations are adapted from the 2003 Schizophrenia Patient Outcome Research Team recommendations (Lehman AF, Kreyenbuhl J, Buchanan RW, et al.: “The Schizophrenia Patient Outcomes Research Team (PORT): Updated Treatment Recommendations 2003.” *Schizophr Bull* [in press]).

\(^b\)Chlorpromazine equivalents represent the approximate dose equivalent to 100 mg of chlorpromazine (relative potency). Chlorpromazine equivalents are not relevant to the second-generation antipsychotics; therefore, no chlorpromazine equivalents are indicated for these agents (Centorrino F, Eakin M, Bahk WM, et al.: “Inpatient Antipsychotic Drug Use in 1998, 1993, and 1989.” *Am J Psychiatry* 159:1932–1935, 2002).

\(^c\)The half-life of a drug is the amount of time required for the plasma drug concentration to decrease by one-half; half-life can be used to determine the appropriate dosing interval (Hardman JG, Limbird LE, Gilman AG (eds.): *Goodman and Gilman’s The Pharmacological Basis of Therapeutics*, 10th ed. New York, McGraw-Hill Professional, 2001). The half-life of a drug does not include the half-life of its active metabolites.
<table>
<thead>
<tr>
<th>Patient Profile</th>
<th>Group 1: First-Generation Agents</th>
<th>Group 2: Risperidone, Olanzapine, Quetiapine, Ziprasidone, or Aripiprazole</th>
<th>Group 3: Clozapine</th>
<th>Group 4: Long-Acting Injectable Antipsychotic Agents</th>
</tr>
</thead>
<tbody>
<tr>
<td>First episode</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Persistent suicidal ideation or behavior</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Persistent hostility and aggressive behavior</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tardive dyskinesia</td>
<td>Yes; all group 2 drugs may not be equal in their lower or no tardive dyskinesia liability</td>
<td></td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>History of sensitivity to extrapyramidal side effects</td>
<td>Yes, except higher doses of risperidone</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>History of sensitivity to prolactin elevation</td>
<td>Yes, except risperidone</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>History of sensitivity to weight gain, hyperglycemia, or hyperlipidemia</td>
<td>Ziprasidone or aripiprazole</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Repeated nonadherence to pharmacological treatment</td>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
</tr>
</tbody>
</table>
FIGURE 1. Somatic Treatment of Schizophrenia

**Acute Phase**

Choose medication based on clinical circumstances from following (refer to Tables 3 and 4):

- **Group 1**: First-generation agents
- **Group 2**: Risperidone, olanzapine, quetiapine, ziprasidone, aripiprazole
- **Group 3**: Clozapine
- **Group 4**: Long-acting injectable antipsychotic agents

- **Yes**: Good response without intolerable side effects?
  - Yes: Continue acute-phase medication treatment. Consider maintenance ECT for patients who have responded to an acute course of ECT and whose symptoms cannot be controlled with medication maintenance therapy alone.
  - No: For intolerable side effects: choose a different medication from Group 1 or 2 (refer to Tables 2 and 3).
  - For inadequate therapeutic response: choose a different medication from Group 1, 2, or 3 (refer to Table 3).

- **No**: For intolerable side effects: choose a different medication from Group 1 or 2 (refer to Tables 2 and 3).

**Stabilization or Maintenance Phase**

- **Yes**: Good response without intolerable side effects?
  - Yes: For residual or intercurrent positive, negative, cognitive, or mood symptoms: consider a different medication from Group 2 or 3 or appropriate adjunctive medication.
  - No: For intolerable side effects: choose a different medication from Group 1 or 2 (refer to Tables 2 and 3).

- **No**: For treatment nonadherence: consider a different medication from Group 4.
<table>
<thead>
<tr>
<th>Medication</th>
<th>Extra-pyramidal Side Effects/ Tardive Dyskinesia</th>
<th>Prolactin Elevation</th>
<th>Weight Gain</th>
<th>Glucose Abnormalities</th>
<th>Lipid Abnormalities</th>
<th>QTc Prolongation</th>
<th>Sedation</th>
<th>Hypotension</th>
<th>Anti-cholinergic Side Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thioridazine</td>
<td>+</td>
<td>++</td>
<td>+</td>
<td>+?</td>
<td>+?</td>
<td>+++</td>
<td>++</td>
<td>++</td>
<td>++</td>
</tr>
<tr>
<td>Perphenazine</td>
<td>++</td>
<td>++</td>
<td>+</td>
<td>+?</td>
<td>+?</td>
<td>0</td>
<td>+</td>
<td>+</td>
<td>0</td>
</tr>
<tr>
<td>Haloperidol</td>
<td>+++</td>
<td>+++</td>
<td>+</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>++</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Clozapine(a)</td>
<td>0(^b)</td>
<td>0</td>
<td>+++</td>
<td>+++</td>
<td>+++</td>
<td>0</td>
<td>+++</td>
<td>+++</td>
<td>+++</td>
</tr>
<tr>
<td>Risperidone</td>
<td>+</td>
<td>+++</td>
<td>++</td>
<td>++</td>
<td>++</td>
<td>0</td>
<td>++</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Olanzapine(b)</td>
<td>0(^b)</td>
<td>0</td>
<td>+++</td>
<td>+++</td>
<td>+++</td>
<td>0</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Quetiapine(c)</td>
<td>0(^b)</td>
<td>0</td>
<td>++</td>
<td>++</td>
<td>++</td>
<td>0</td>
<td>++</td>
<td>++</td>
<td>+</td>
</tr>
<tr>
<td>Ziprasidone</td>
<td>0(^b)</td>
<td>+</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>++</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Aripiprazole(d)</td>
<td>0(^b)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>+</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

\(0\) = No risk or rarely causes side effects at therapeutic dose. \(+\) = Mild or occasionally causes side effects at therapeutic dose. \(++\) = Sometimes causes side effects at therapeutic dose. \(+++\) = Frequently causes side effects at therapeutic dose. \(?\) = Data too limited to rate with confidence.

\(a\) Also causes agranulocytosis, seizures, and myocarditis.

\(b\) Possible exception of akathisia.

\(c\) Also carries warning about potential development of cataracts.

\(d\) Also causes nausea and headache.

Consider second-generation antipsychotics as first-line medications because of the decreased risk for extrapyramidal side effects and tardive dyskinesia.

- For patients who have had prior treatment success or who prefer first-generation agents, these medications are useful and for specific patients may be the first choice.
- With the possible exception of clozapine for patients with treatment-resistant symptoms, antipsychotics generally have similar efficacy in treating positive symptoms.
- Second-generation antipsychotics may have superior efficacy in treating global psychopathology and cognitive, negative, and mood symptoms.

Consider long-acting injectable antipsychotic medication for patients with recurrent relapses related to partial or full nonadherence. The oral form of the same medication (e.g., fluphenazine, haloperidol, and risperidone) is the logical choice for initial treatment.

Titrte as quickly as tolerated to the target therapeutic dose (sedation, orthostatic hypotension, and tachycardia are generally the side effects that limit the rate of increase), and monitor clinical status for at least 2–4 weeks.

- The optimal dose of first-generation antipsychotics is, for most patients, at the “extrapyramidal symptom (EPS) threshold,” or the dose at which minimal rigidity is detectable on physical examination.
- For second-generation antipsychotics, target dose usually falls within the therapeutic dose range specified by the manufacturer and in the package labeling approved by the U.S. Food and Drug Administration.
If the patient is not improving, consider whether the lack of response can be explained by medication nonadherence, rapid medication metabolism, or poor medication absorption.

Consider measuring plasma concentration for those medications for which plasma concentration relates to clinical response (e.g., haloperidol, clozapine).

If the patient is adhering to treatment and has an adequate plasma concentration but is not responding to treatment, consider raising the dose for a finite period (if tolerated) or switching medications.

4. Use of Adjunctive Medications in the Acute Phase

Use adjunctive medications to treat comorbid conditions (e.g., major depression, obsessive-compulsive disorder) or associated symptoms (e.g., agitation, aggression, affective symptoms), to address sleep disturbances, and to treat antipsychotic drug side effects.

Be aware that some antidepressants (those that inhibit catecholamine reuptake) can potentially sustain or exacerbate psychotic symptoms in some individuals.

Benzodiazepines may be helpful for managing both anxiety and agitation during the acute phase of treatment.

Mood stabilizers and beta-blockers may be effective in reducing the severity of recurrent hostility and aggression.
Consider the following factors when deciding on the prophylactic use of medications to treat extrapyramidal side effects:

- Propensity of the antipsychotic medication to cause extrapyramidal symptoms (Table 3, p. 15)
- Patient’s preferences
- Patient’s prior history of extrapyramidal symptoms
- Other risk factors for extrapyramidal symptoms (especially risk factors for dystonia)
- Risk factors for and potential consequences of anticholinergic side effects

Other potential strategies for treating extrapyramidal symptoms include lowering the dose of the antipsychotic medication or switching to a different antipsychotic medication.

Consider adding ECT to antipsychotic treatment for individuals with schizophrenia or schizoaffective disorder who have persistent severe psychosis and/or suicidal ideation or behaviors and for whom prior treatments, including clozapine, have failed.

Also consider ECT for individuals with prominent catatonic features that have not responded to an acute trial of lorazepam (e.g., 1–2 mg i.v. or i.m. or 2–4 mg p.o., repeated as needed over 48–72 hours).

For patients with schizophrenia and comorbid depression, ECT may also be beneficial if depressive symptoms are resistant to treatment or if features such as inanition or suicidal ideation or behavior, which necessitate a rapid response to treatment, are present.
Closely observe and document signs and symptoms over time, because a first episode of psychosis can be polymorphic and evolve into a variety of specific disorders (e.g., schizophreniform disorder, bipolar disorder, schizoaffective disorder).

More than 70% of first-episode patients achieve a full remission of psychotic signs and symptoms within 3–4 months, and more than 80% achieve stable remission at the end of 1 year. Predictors of poor treatment response include

- male gender,
- pre- or perinatal injury,
- more severe hallucinations and delusions,
- attentional impairments,
- poor premorbid function,
- longer duration of untreated psychosis,
- development of extrapyramidal side effects, and
- distressing emotional climate (e.g., hostile and critical attitudes and overprotection by others in one’s living situation or high levels of expressed emotion).

Strive to minimize risk of relapse in a remitted patient, because of its clinical, social, and vocational costs (i.e., recurrent episodes are associated with increasing risk of chronic residual symptoms and evidence of neuroanatomical changes).

Aim to eliminate exposure to cannabinoids and psychostimulants, enhance stress management, and employ maintenance antipsychotic treatment.
6. Special Issues in Treatment of First-Episode Patients (continued)

Discuss candidly the high risk of relapse and factors that may minimize relapse risk. Prudent treatment options include 1) indefinite antipsychotic maintenance medication and 2) medication discontinuation with close follow-up and a plan of antipsychotic reinstitution with symptom recurrence.

C. Stabilization Phase

Goals of treatment
- Minimize stress on the patient and provide support to minimize the likelihood of relapse.
- Enhance the patient’s adaptation to life in the community.
- Facilitate continued reduction in symptoms and consolidation of remission, and promote the process of recovery.

If the patient has achieved an adequate therapeutic response with minimal side effects, monitor response to the same medication and dose for the next 6 months.

Assess adverse side effects continuing from the acute phase, and adjust pharmacotherapy accordingly to minimize them.

Continue with supportive psychotherapeutic interventions.

Begin education for the patient (and continue education for family members) about the course and outcome of the illness and emphasize the importance of treatment adherence.
To avoid gaps in service delivery, arrange for linkage of services between hospital and community treatment before the patient is discharged from the hospital.

For hospitalized patients, it is frequently beneficial to arrange an appointment with an outpatient psychiatrist and, for patients who will reside in a community residence, to arrange a visit before discharge.

After discharge, help patients adjust to life in the community through realistic goal setting without undue pressure to perform at high levels vocationally and socially.

D. Stable Phase

Goals of treatment

- Ensure that symptom remission or control is sustained.
- Maintain or improve the patient’s level of functioning and quality of life.
- Effectively treat increases in symptoms or relapses.
- Continue to monitor for adverse treatment effects.

1. Assessment in the Stable Phase

Ongoing monitoring and assessment are necessary to determine whether the patient might benefit from alterations in the treatment program.

Perform a clinical assessment for extrapyramidal symptoms (for patients taking antipsychotic medications) at each clinical visit.
1. Assessment in the Stable Phase (continued)

Perform a clinical assessment for abnormal involuntary movements every 6 months for patients taking first-generation antipsychotics and every 12 months for patients taking second-generation antipsychotics. For patients at increased risk (e.g., elderly patients), assessments should be made every 3 months and 6 months with treatment using first-generation and second-generation antipsychotics, respectively.

Monitor the patient’s weight and BMI at each visit for 6 months and quarterly thereafter. For patients with BMI in the overweight (25 to 29.9 kg/m²) or obese (≥30 kg/m²) range, routinely monitor for obesity-related health problems (e.g., blood pressure, serum lipids, clinical symptoms of diabetes).

Monitor fasting blood glucose or hemoglobin A1c at 4 months and then annually, and monitor other blood chemistries (e.g., electrolytes; renal, liver, and thyroid function) annually or as clinically indicated; consider drug toxicology screen if clinically indicated.

Depending on the specific medication being prescribed, consider other assessments, including vital signs, CBC, ECG, screening for symptoms of hyperprolactinemia, and ocular examination.

If the patient agrees, maintain strong ties with individuals who are likely to notice any resurgence of symptoms and the occurrence of life stresses and events.
2. Psychosocial Treatments in the Stable Phase

Select appropriate psychosocial treatments based on the circumstances of the individual patient’s needs and social context.

Psychosocial treatments with demonstrated efficacy include
- family interventions,
- supported employment,
- assertive community treatment,
- social skills training, and
- cognitive behaviorally oriented psychotherapy.

3. Use of Antipsychotic Medications in the Stable Phase

Antipsychotics can reduce the risk of relapse in the stable phase of illness to less than 30% per year.

For most patients treated with first-generation antipsychotics, clinicians should prescribe a dose close to the “EPS threshold” (i.e., the dose that will induce extrapyramidal side effects with minimal rigidity detectable on physical examination).

Second-generation antipsychotics can generally be administered at doses that are therapeutic but that will not induce extrapyramidal side effects.

Weigh advantages of decreasing antipsychotics to the “minimal effective dose” against a somewhat greater risk of relapse and more frequent exacerbations of schizophrenia symptoms.

Evaluate whether residual negative symptoms are in fact secondary to a parkinsonian syndrome or an untreated major depressive syndrome, and treat accordingly.
4. Use of Adjunctive Medications in the Stable Phase

Add other psychoactive medication to antipsychotic medications in the stable phase to treat comorbid conditions, aggression, anxiety, or other mood symptoms; to augment the antipsychotic effects of the primary drug; and to treat side effects.

5. Use of ECT in the Stable Phase

Maintenance ECT may be helpful for some patients who have responded to acute treatment with ECT but for whom pharmacologic prophylaxis alone has been ineffective or cannot be tolerated.

6. Encourage the Patient and Family to Use Self-Help Treatment Organizations

E. Special Issues in Caring for Patients With Treatment-Resistant Illness

Carefully evaluate whether the patient has had an adequate trial of an antipsychotic, including whether the dose was adequate and whether the patient was taking the medication as prescribed.

Consider a trial of clozapine for a patient who has had what is considered a clinically inadequate response to two antipsychotics (at least one of which was a second-generation antipsychotic) and for a patient with persistent suicidal ideation or behavior that has not responded to other treatments.
Depending on the type of residual symptom (e.g., positive, negative, cognitive, or mood symptoms; aggressive behavior), augmentation strategies include adding another antipsychotic, anticonvulsants, or benzodiazepines.

ECT has demonstrated benefits in patients with treatment-resistant symptoms.

Cognitive behavior therapy techniques may have value in improving positive symptoms with low risk of side effects.

F. Treatment of Deficit Symptoms

Assess the patient for factors that may contribute to secondary negative symptoms.

If negative symptoms are secondary, treat their cause, e.g., antipsychotics for positive symptoms, antidepressants for depression, anxiolytics for anxiety disorders, or antiparkinsonian agents or antipsychotic dose reduction for extrapyramidal side effects.

If negative symptoms persist, they are presumed to be primary negative symptoms of the deficit state; although there are no treatments with proven efficacy, consider treatment with clozapine or other second-generation antipsychotics.
Indications for hospitalization usually include the patient’s being considered to pose a serious threat of harm to self or others or being unable to care for self and needing constant supervision or support.

Other possible indications for hospitalization include general medical or psychiatric problems that make outpatient treatment unsafe or ineffective.

Legal proceedings to achieve involuntary hospitalization are indicated when patients decline voluntary status and hospitalization is clearly warranted.

Alternative treatment settings such as day or partial hospitalization, home care, family crisis therapy, crisis residential care, and assertive community treatment should be considered for patients who do not need formal hospitalization for their acute episodes but require more intensive services than can be expected in a typical outpatient setting.

Patients may be moved from one level of care to another on the basis of the factors described in Table 4 (p. 27).
# TABLE 4. Factors Affecting Choice of Treatment Setting or Housing

## Availability of the setting or housing

**Patient’s clinical condition**
- Need for protection from harm to self or others
- Need for external structure and support
- Ability to cooperate with treatment

**Patient’s and family’s preference**

**Requirements of the treatment plan**
- Need for a particular treatment or a particular intensity of treatment that may be available only in certain settings
- Need for a specific treatment for a comorbid psychiatric or other general medical condition

**Characteristics of the setting**
- Degrees of support, structure, and restrictiveness
- Ability to protect patient from harm to self or others
- Availability of different treatment capacities, including general medical care and rehabilitation services
- Availability of psychosocial supports to facilitate the patient’s receipt of treatment and to provide critical information to the psychiatrist about the patient’s clinical status and response to treatments
- Capacity to care for severely agitated or psychotic patients
- Hours of operation
- Overall milieu and treatment philosophy

**Patient’s current environment or circumstances**
- Family functioning
- Available social supports
TREATING
BIPOLAR DISORDER
A Quick Reference Guide
American Psychiatric Association

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Introduction

"Treating Patients With Bipolar Disorder: A Quick Reference Guide" is a summary and synopsis of the American Psychiatric Association’s Practice Guideline for the Treatment of Patients With Bipolar Disorder, which was originally published in The American Journal of Psychiatry in April 2002 and is available through American Psychiatric Publishing, Inc. The Quick Reference Guide is not designed to stand on its own and should be used in conjunction with the full text of the Practice Guideline. Algorithms illustrating the treatment of bipolar disorder are included.

Statement of Intent

The Practice Guidelines and the Quick Reference Guides are not intended to be construed or to serve as a standard of medical care. Standards of medical care are determined on the basis of all clinical data available for an individual case and are subject to change as scientific knowledge and technology advance and practice patterns evolve. These parameters of practice should be considered guidelines only. Adherence to them will not ensure a successful outcome in every case, nor should they be construed as including all proper methods of care or excluding other acceptable methods of care aimed at the same results. The ultimate judgment regarding a particular clinical procedure or treatment plan must be made by the psychiatrist in light of the clinical data presented by the patient and the diagnostic and treatment options available.

The development of the APA Practice Guidelines and Quick Reference Guides has not been financially supported by any commercial organization.
### OUTLINE

#### B. Treatment Options
1. Acute Manic or Mixed Episodes
2. Acute Depression
3. Rapid Cycling
4. Maintenance

#### C. Additional Information About Pharmacotherapeutic Agents
1. Lithium
2. Divalproex/Valproate/Valproic Acid
3. Carbamazepine
4. Olanzapine
5. Lamotrigine

#### A. Psychiatric Management
1. Perform a diagnostic evaluation
2. Ensure the safety of the patient and others and determine a treatment setting
3. Establish and maintain a therapeutic alliance
4. Monitor the patient’s psychiatric status
5. Educate the patient and his or her family
6. Enhance treatment adherence
7. Promote awareness of stressors and regular patterns of activity and sleep
8. Work with the patient to anticipate and address early signs of relapse
9. Evaluate and manage functional impairments
A. Psychiatric Management

Goals of Psychiatric Management
• Establish and maintain a therapeutic alliance.
• Monitor the patient’s psychiatric status.
• Provide education regarding bipolar disorder.
• Enhance treatment adherence.
• Promote regular patterns of activity and sleep.
• Anticipate stressors.
• Identify new episodes early.
• Minimize functional impairments.

1. Perform a diagnostic evaluation.

Assess for the presence of an alcohol or substance use disorder or other factors that may contribute to the disease process or complicate its treatment.
• Neurological conditions commonly associated with secondary mania are multiple sclerosis and lesions involving right-sided subcortical structures or cortical areas closely linked to the limbic system.
• L-Dopa and corticosteroids are the most common medications associated with secondary mania.
• Substance use may precipitate mood episodes. Patients may also use substances to ameliorate the symptoms of such episodes.

Inquire about a history of time periods with mood dysregulation or lability accompanied by associated manic symptoms (e.g., decreased sleep).
• Bipolar disorder commonly presents with depressive symptoms.
• Patients rarely volunteer information about manic or hypomanic symptoms.
2. Ensure the safety of the patient and others and determine a treatment setting.

**Evaluate safety.**
- Careful assessment of the patient’s risk for suicide is critical; lifetime rates of completed suicide for people with bipolar disorder are as high as 10% to 15%.
- The overwhelming majority of suicide attempts are associated with depressive episodes or depressive features during mixed episodes.
- Ask every patient about suicidal ideation, intention to act on these ideas, and extent of plans or preparation for suicide.
- Collect collateral information from family members or others.
- Assess for access to means of committing suicide (e.g., medications, firearms) and the lethality of these means.
- Assess for factors associated with increased risk, such as agitation, pervasive insomnia, impulsiveness, or other psychiatric comorbidity such as substance abuse, psychosis (especially with command hallucinations), or personality disorder.
- Assess for family history of suicide and history of recent exposure to suicide.
- Consider the nature and potential lethality of any prior suicide attempts.
- Closely monitor patients who exhibit suicidal or violent ideas or intent.
- Carefully document your decision-making process.

**Consider hospitalization for patients who**
- pose a serious threat of harm to themselves or others,
- are severely ill and lack adequate social support outside a hospital setting or demonstrate significantly impaired judgment,
- have complicating psychiatric or general medical conditions, or
- have not responded adequately to outpatient treatment.
Reevaluate the treatment setting on an ongoing basis to determine whether it is optimal or whether the patient would benefit more from a different level of care.

Provide a calm and highly structured environment.

Consider limiting access to cars, credit cards, bank accounts, or telephones and cellular phones during the manic phase because of the risk of reckless behavior.

3. Establish and maintain a therapeutic alliance.

- A therapeutic alliance is critical for understanding and managing the individual patient.
- Over time, knowledge gained about the patient and the illness course allows early identification of usual prodromal symptoms and early recognition of new episodes.

4. Monitor the patient’s psychiatric status.

- Monitoring is especially important during manic episodes, when patient insight is often limited or absent.
- Be aware that small changes in mood or behavior may herald the onset of an episode.
5. Educate the patient and his or her family.

- Be aware that, over time, patients will vary in their ability to understand and retain information and accept and adapt to the need for long-term treatment.
- Education should be an ongoing process in which the psychiatrist gradually but persistently introduces facts about the illness and its treatment.
- Printed and Internet material (e.g., from www.psych.org) can be helpful.
- Use similar educational approaches for family members and significant others.

6. Enhance treatment adherence.

- Ambivalence about treatment is often expressed as poor adherence to medication or other treatments.
- Causes of ambivalence include
  - lack of insight about having a serious illness and
  - reluctance to give up the experience of hypomania or mania.
- Medication side effects, cost, and other demands of long-term treatment may be burdensome and need to be discussed.
- Many side effects can be corrected with careful attention to dosing, scheduling, and medication formulation (e.g., sustained release, liquid).
7. Promote awareness of stressors and regular patterns of activity and sleep.

- Stressors commonly precede episodes in all phases of the illness.
- Social rhythm disruption with disrupted sleep-wake cycles may specifically trigger manic episodes.
- Patients and their families should be informed about the potential effects of sleep disruption in triggering manic episodes.
- Regular patterns for daily activities should be promoted, including sleeping, eating, physical activity, and social and emotional stimulation.

8. Work with the patient to anticipate and address early signs of relapse.

- The psychiatrist should help the patient, family members, and significant others recognize early signs and symptoms of manic or depressive episodes.
- Early markers of episode onset are often predictable across episodes for an individual patient.
- Early identification of a prodrome is facilitated by the psychiatrist’s consistent relationship with the patient as well as with the patient’s family.


Identify and address impairments in functioning.
- Assist the patient in scheduling absences from work or other responsibilities.
- Encourage the patient to avoid major life changes while in a depressive or manic state.
- Assess and address the needs of children of patients with bipolar disorder.
B. Treatment Options

1. Acute Manic or Mixed Episodes

Goals of Treatment

- Control symptoms to allow a return to usual levels of psychosocial functioning.
- Rapidly control agitation, aggression, and impulsivity.

Choose an initial treatment modality.

For patients not yet in treatment for bipolar disorder:

For severe mania or mixed episodes, initiate lithium in combination with an antipsychotic or valproate in combination with an antipsychotic.

For less ill patients, monotherapy with lithium, valproate, or an antipsychotic such as olanzapine may be sufficient.

- Short-term adjunctive treatment with a benzodiazepine may also be helpful.
- For mixed episodes, valproate may be preferred over lithium.
- Atypical antipsychotics are preferred over typical antipsychotics because of their generally more tolerable side effect profile (most current evidence supports the use of olanzapine and risperidone).
- Alternatives include 1) carbamazepine or oxcarbazepine in lieu of lithium or valproate and 2) ziprasidone or quetiapine in lieu of another antipsychotic.
- Treatment selection depends on illness severity, associated features such as rapid cycling or psychosis, and, where possible, patient preference.
- Antidepressants should be tapered and discontinued if possible.
- Psychosocial therapies and pharmacotherapies should be combined.
If symptoms are inadequately controlled within 10 to 14 days of treatment with optimized doses of the first-line medication regimen, add another first-line medication.

- Alternative treatment options include adding carbamazepine or oxcarbazepine in lieu of an additional first-line medication (lithium, valproate, antipsychotic), adding an antipsychotic if not already prescribed, or changing from one antipsychotic to another.
- Clozapine may be particularly effective in refractory illness.
- Electroconvulsive therapy (ECT) may also be considered for
  - manic patients who are severely ill or whose mania is treatment resistant;
  - patients who, after consultation with the psychiatrist, prefer ECT;
  - patients with mixed episodes; and
  - patients with severe mania during pregnancy.

For patients who suffer a “breakthrough” manic or mixed episode while on maintenance treatment, optimize the medication dose.

- Ensure that serum levels are within the therapeutic range; in some instances, achieve a higher serum level (but still within the therapeutic range).
- Introduction or resumption of an antipsychotic is often necessary.
- Severely ill or agitated patients may also require short-term adjunctive treatment with a benzodiazepine.

For psychosis during a manic or mixed episode, treat with an antipsychotic medication.

- Atypical antipsychotics are favored because of their generally more tolerable side effect profile.
- ECT may also be considered.
2. Acute Depression

Goals of Treatment
- Achieve remission of the symptoms of major depression and return the patient to usual levels of psychosocial functioning.
- Avoid precipitating a manic or hypomanic episode.

Choose an initial treatment modality.

For patients not yet in treatment for bipolar disorder, initiate either lithium or lamotrigine.
- As an alternative, especially for more severely ill patients, consider initiating treatment with both lithium and an antidepressant simultaneously (although supporting data are limited).
- Antidepressant monotherapy is not recommended.
- Consider ECT for
  - patients with life-threatening inanition, suicidality, or psychosis or
  - severe depression during pregnancy.
- Treatment selection should be guided by illness severity, associated features such as rapid cycling or psychosis, and, where possible, patient preference.
- Interpersonal therapy and cognitive behavior therapy may be useful when added to pharmacotherapy.
- Although psychodynamic psychotherapy for bipolar depression has not been empirically studied, it is widely used in combination with medication.

For patients who suffer a breakthrough depressive episode while on maintenance treatment, optimize the medication dosage.
Ensure that serum levels are within the therapeutic range; in some instances, achieve a higher serum level (but still within the therapeutic range).
If the patient fails to respond to optimized maintenance treatment, consider adding lamotrigine, bupropion, or paroxetine.

- Alternative next steps include adding another newer antidepressant (e.g., another selective serotonin reuptake inhibitor [SSRI] or venlafaxine) or a monoamine oxidase inhibitor (MAOI).
- Tricyclic antidepressants may carry a greater risk of precipitating a switch and are not recommended.
- MAOIs may be difficult to use because of the risk of severe drug and dietary interactions.
- Psychotic features during depression usually require adjunctive treatment with an antipsychotic medication.
- Consider ECT for:
  - severe or treatment-resistant depression,
  - psychotic features, or
  - catatonic features.
- Clinicians may elect to use antidepressants earlier for bipolar II depression than for bipolar I depression because patients with bipolar II disorder probably have lower rates of antidepressant-induced switching into hypomania or mania.

### 3. Rapid Cycling

- Identify and treat medical conditions such as hypothyroidism or drug or alcohol use that may contribute to cycling.
- If possible, taper medications (particularly antidepressants) that may contribute to cycling.
- For initial treatment, include lithium or valproate.
  - An alternative treatment is lamotrigine.
  - For many patients, combinations of medications are required (i.e., combining two of the agents above or one of them plus an antipsychotic).
4. Maintenance

Goals of Treatment
- Prevent relapse and recurrence.
- Reduce subthreshold symptoms.
- Reduce suicide risk.
- Reduce cycling frequency or milder degrees of mood instability.
- Improve overall function.

Determine whether maintenance treatment is indicated.
- Maintenance medication is recommended following a manic or a depressive episode.
- Although few maintenance studies of bipolar II disorder have been conducted, maintenance treatment warrants strong consideration for this form of the illness.

Choose an initial treatment modality.

Recommended options
- Treatment options with the best empirical support include lithium or valproate. Possible alternatives include lamotrigine, carbamazepine, or oxcarbazepine.
- If one of the above medications led to remission from the most recent depressive or manic episode, it generally should be continued.
- Maintenance ECT may also be considered for patients who respond to ECT during an acute episode.
- Treatment selection should be guided by illness severity, associated features such as rapid cycling or psychosis, and, where possible, patient preference.
Role of antipsychotics

- Antipsychotic medications should be discontinued unless they are needed for control of persistent psychosis or prevention of recurrence of mood episodes.
- Although maintenance therapy with atypical antipsychotics may be considered, there is as yet no definitive evidence that their efficacy in maintenance treatment is comparable to that of the other agents discussed above.

Role of psychosocial interventions

- Concomitant psychosocial interventions addressing illness management (i.e., adherence, lifestyle changes, and early detection of prodromal symptoms) and interpersonal difficulties are likely to be of benefit.
- Supportive and psychodynamic psychotherapies are widely used in combination with medication.
- Group psychotherapy and family therapy may also help patients address issues such as adherence to a treatment plan, adaptation to a chronic illness, regulation of self-esteem, and management of marital and other psychosocial issues.
- Support groups provide useful information about bipolar disorder and its treatment.

If the patient fails to respond (i.e., continues to experience subthreshold symptoms or breakthrough mood episodes), add another maintenance medication, an atypical antipsychotic, or an antidepressant.

- There are insufficient data to support one combination over another.
- Maintenance ECT may also be considered for patients who respond to ECT during an acute episode.
C. Additional Information About Pharmacotherapeutic Agents

1. Lithium

Side effects

- Up to 75% of patients experience some side effects, but most side effects either are minor or can be reduced or eliminated by lowering the lithium dose or changing the dosage schedule.
- Side effects related to peak serum levels (e.g., tremor within 1 to 2 hours of a dose) may be reduced or eliminated by using a slow-release preparation or changing to a single bedtime dose.
- Side effects include polyuria, polydypsia, weight gain, cognitive problems, tremor, sedation or lethargy, impaired coordination, gastrointestinal distress, hair loss, benign leukocytosis, acne, and edema.
- With long-term lithium treatment (>10 years), 10% to 20% of patients display morphological kidney changes. These changes are not generally associated with renal failure, although there are some case reports of renal insufficiency probably induced by lithium.
- Most patients experience some toxic effects with levels above 1.5 meq/L; levels above 2.0 meq/L are commonly associated with life-threatening side effects. At higher serum levels, hemodialysis may be needed to minimize toxicity.

Implementation

Initial workup

The following are generally recommended before beginning lithium therapy:

- General medical history and physical examination
- Blood urea nitrogen (BUN) and creatinine levels
- Tests of thyroid function
- Electrocardiogram (ECG) with rhythm strip for patients over age 40
- Pregnancy test (in women of childbearing age)
**Dosing**

- Start in low divided dosages to minimize side effects (e.g., 300 mg t.i.d. or less, depending on the patient’s weight and age).
- Titrate dosage upward (generally to serum concentrations of 0.5 to 1.2 meq/L) according to response and side effects.
- Check lithium level after each dosage increase (steady-state levels are likely to be reached approximately 5 days after a dosage adjustment).
- Check at shorter intervals after dosage increase as levels approach upper limits of the therapeutic range (i.e., greater than 1.0 meq/L).
- The “optimal” maintenance level may vary from patient to patient. Some patients require the level used to treat acute mania; others can be satisfactorily maintained at lower levels.

**Long-term monitoring of laboratory values**

- Serum lithium levels
  - At minimum, check every 6 months in stable patients and whenever the clinical status changes.
  - The optimal frequency of monitoring depends on the stability of lithium levels over time for that patient and the degree to which the patient can be relied on to notice and report symptoms.
- Renal function
  - In general, during the first 6 months of treatment, test every 2 to 3 months.
  - Subsequently, check every 6 to 12 months in stable patients as well as whenever the clinical status changes.
- Thyroid function
  - In general, during the first 6 months of treatment, test once or twice.
  - Subsequently, check every 6 to 12 months in stable patients and whenever the clinical status changes.
2. Divalproex/Valproate/Valproic Acid

Side effects
- Common dose-related side effects of valproate include gastrointestinal distress, benign hepatic transaminase elevations, osteoporosis, tremor, and sedation.
- Patients with past or current hepatic disease may be at increased risk for hepatotoxicity.
- Mild, asymptomatic leukopenia and thrombocytopenia occur less frequently and are reversible on drug discontinuation.
- Other side effects include hair loss, increased appetite, and weight gain.
- Although risks are unclear, female patients should be monitored for possible development of polycystic ovarian syndrome.
- Rare, idiosyncratic, but potentially fatal adverse events include irreversible hepatic failure, hemorrhagic pancreatitis, and agranulocytosis; patients should be educated about the signs and symptoms of hepatic and hematological dysfunction and warned to contact their physician immediately if symptoms develop.

Implementation

Initial workup
The following are generally recommended before beginning valproate therapy:
- Before treatment, take a general medical history with special attention to hepatic, hematological, and bleeding abnormalities.
- Obtain liver function tests and hematological measures.
Dosing

- For hospitalized patients with acute mania, valproate can be administered at an initial dosage of 20 to 30 mg/kg per day in inpatients. After obtaining a valproate level, adjust the dose to achieve a serum level between 50 and 125 µg/mL.
- For outpatients, elderly patients, or patients with hypomania or euthymia, start at 250 mg t.i.d. Titrate the dose upward by 250 to 500 mg/day every few days, depending on clinical response and side effects, generally to a serum concentration of 50 to 125 µg/mL, with a maximum adult daily dosage of 60 mg/kg per day. Once the patient is stable, simplify to once- or twice-daily dosing.
- Bioavailability of the extended-release preparation, divalproex ER, is about 15% less than that of the immediate-release preparation; doses of divalproex ER will need to be increased proportionately.

Drug interactions

- Valproate displaces highly protein-bound drugs from their protein binding sites. Dosage adjustments will be needed.
- Because valproate inhibits lamotrigine metabolism, lamotrigine must be initiated at less than half the usual dose.

Long-term monitoring of laboratory values

- Patients should be educated about the signs and symptoms of hepatic and hematological dysfunction and instructed to report these symptoms if they occur.
- Most psychiatrists perform clinical assessments, including tests of hematological and hepatic function, at a minimum of every 6 months for stable patients who are taking valproate.
- Serum levels of valproic acid should be checked when clinically indicated (e.g., when another medication may change the metabolism of valproic acid).
3. Carbamazepine

**Side effects**

- Up to 50% of patients receiving carbamazepine experience side effects.
- The most common side effects include fatigue, nausea, and neurological symptoms such as diplopia, blurred vision, and ataxia.
- Less frequent side effects include skin rashes, mild leukopenia, mild liver enzyme elevations, mild thrombocytopenia, hyponatremia, and (less commonly) hypo-osmolality.
- Rare, idiosyncratic, but serious and potentially fatal side effects include agranulocytosis, aplastic anemia, thrombocytopenia, hepatic failure, exfoliative dermatitis (e.g., Stevens-Johnson syndrome), and pancreatitis.
- In addition to careful monitoring of clinical status, it is essential to educate patients about the signs and symptoms of hepatic, hematological, or dermatological reactions and instruct them to report symptoms if they occur.
- Other rare side effects include systemic hypersensitivity reactions; cardiac conduction disturbances; psychiatric symptoms, including sporadic cases of psychosis; and, very rarely, renal effects, including renal failure, oliguria, hematuria, and proteinuria.
- The carbamazepine analogue oxcarbazepine may be a useful alternative to carbamazepine based on its superior side effect profile.
Implementation

Initial workup
The following are generally recommended before beginning carbamazepine therapy:

- Minimum baseline evaluation should include a complete blood count (CBC) with differential and platelet count, a liver profile (LDH, SGOT, SGPT, bilirubin, alkaline phosphatase), and renal function tests. Serum electrolytes may also be obtained, especially in the elderly, who may be at higher risk for hyponatremia.
- Before treatment, a general medical history and a physical examination should be done, with special emphasis on prior history of blood dyscrasias or liver disease.

Dosing
- Carbamazepine is usually begun at a total daily dose of 200 to 600 mg, in three to four divided doses.
- In hospitalized patients with acute mania, the dosage may be increased in increments of 200 mg/day up to 800 to 1000 mg/day (unless side effects develop), with slower increases thereafter as indicated.
- In less acutely ill outpatients, dose adjustments should be slower to minimize side effects.
- Maintenance dosages average about 1000 mg/day but may range from 200 to 1600 mg/day in routine clinical practice.
- Levels established for treatment of seizure disorders (serum concentration between 4 and 12 µg/mL) are generally applied to patients with bipolar disorder.
- Use trough levels (drawn prior to the first morning dose) 5 days after a dose change.
Long-term monitoring of laboratory values

- CBC, platelet, and liver function tests should be performed every 2 weeks during the first 2 months of carbamazepine treatment.
- Thereafter, if laboratory tests remain normal and no symptoms of bone marrow suppression or hepatitis appear, blood counts and liver function tests should be obtained at least every 3 months; more frequent monitoring is necessary if there are hematological or hepatic abnormalities.

Side effects

- Common side effects include somnolence, constipation, dry mouth, increased appetite, and weight gain.
- During initial dose titration, olanzapine may induce orthostatic hypotension associated with dizziness, tachycardia, and in some patients, syncope.

Implementation

- For inpatients with acute mania, a starting dosage of 15 mg/day is suggested.
- For outpatients, lower starting dosages of 5 to 10 mg/day may be indicated.
5. Lamotrigine

### Side effects
- The most common side effects are headache, nausea, infection, and xerostomia.
- In early clinical trials with patients with epilepsy, rapid titration of lamotrigine dosage was associated with a risk of serious rash, including Stevens-Johnson syndrome and toxic epidermal necrolysis. Risk was approximately 0.3% in adults and approximately 1% in children.
- Patients should be informed of the risk of rash and of the need to contact the psychiatrist or primary care physician immediately if any rash occurs.
- Rash can occur at any time during treatment but is more likely early in treatment.
- At rash onset, it is difficult to distinguish between a serious and a more benign rash.
- Particularly worrisome, however, are rashes accompanied by fever or sore throat, those that are diffuse and widespread, and those with prominent facial or mucosal involvement. In such circumstances, lamotrigine (and valproate, if administered concurrently) should be discontinued.
- In clinical trials, use of a slow dosage titration schedule (see below) reduced the risk of serious rash in adults to 0.01% (comparable to other anticonvulsants).
- Rash may be more likely if lamotrigine and valproate are administered concomitantly.

### Implementation
- Lamotrigine should be administered at 25 mg/day for the first 2 weeks, then at 50 mg for weeks 3 and 4.
- After that, 50 mg/week can be added as clinically indicated.
- To minimize the risk of potentially serious rash in patients who are receiving valproate, the dose or the dosage schedule should be halved (i.e., 12.5 mg/day or 25 mg every other day for 2 weeks, then 25 mg daily for weeks 3 and 4).
- Concurrent carbamazepine treatment will lead to increased metabolism of lamotrigine and will require that dosing be doubled.
Policy Name: USE OF EVIDENCE BASED PRACTICES  
Policy Number: 11.15

Reference: DSHS contract

Effective Date: 2/2013

Revision Date(s):

Reviewed Date: 12/2014; 6/2016; 7/2017

Approved by: SBHO Executive Board

CROSS REFERENCES

- Network Directory: Evidence Based Practices
- Policy: Corrective Action Plan
- Policy: Practice Guidelines
- Policy: Special Populations

PURPOSE

The Salish Behavioral Health Organization (SBHO) encourages network providers to use evidence based practices, attend trainings to increase staff expertise and knowledge, and maintain a list of specialty trained staff.

EBPs have strict and rigid protocol. It is understood that a network provider may use a blend of evidence based practices and utilize key points of a practice to provide high quality services.

DEFINITIONS

Evidence Based Practice (EBP) means a program or practice that has had a multiple site random controlled trials across heterogeneous populations demonstrating that the program or practice is effective for the population.

- The term "research based" is synonymous with evidence based.
PROCEDURE

The SBHO requires the provider network in subcontracts to participate with the Department to increase the use of evidence based practices (EBPs).

1. The SBHO recognizes the EBPs have rigid protocols that require specific training and associated high costs to implement to fidelity.

2. The Department has contractually focused to increase EBPs for children and youth as identified through legislative mandates. These EBPs include:
   - Trauma-Focused Cognitive Behavioral Therapy (TF-CBT/CBT) and CBT-Plus (TF-CBT/CBT+)
   - The network providers are expected to maintain a workforce trained in TF-CBT/CBT+.

3. The Department encourages the SBHO and network providers to expand the expertise in a multitude of recognized EBPs and research-based practices.
   - The SBHO will continue to provide the recognized list of EBPs and discuss possible implementation through the Clinical Directors meetings.

4. The network provider agencies are responsible for recording specific EBPs provided.
   - Prior to recording an EBP into the encounter system, the network agency is responsible for ensuring fidelity to a particular model.
   - An agency must sign an attestation to the fidelity of a recorded EBP.

5. The SBHO will maintain a directory of specialty trained EBP clinicians available in the network.
   - The SBHO Directory of EBP trained clinicians is updated annually and posted on the SBHO website. Reference SBHO Directory of Evidence Based Practices

MONITORING

This policy is mandated by statute and contract.

1. This policy will be monitored through use of SBHO:
   - Annual SBHO Provider and Subcontractor Administrative Review
   - Annual Provider Chart Review
   - Network Directory of Specialty trained network staff
   - Monthly SBHO UMC & Clinical Directors meetings

2. If a provider performs below expected standards during any of the reviews listed above a Corrective Action Plan will be required for SBHO approval. Reference SBHO Corrective Action Plan Policy.
CROSS REFERENCES

- Policy: Corrective Action Plan
- Policy: Individuals Service Plan Standards

PURPOSE

The Salish Behavioral Health Organization (SBHO) shall ensure individuals authorized for outpatient services are provided information about the options they have to choose a behavioral health care provider. The behavioral health care provider is responsible for the individual’s treatment plan.

PROCEDURE

1. Individuals (parents/guardians) must be allowed to choose a behavioral health care provider (BHCP) from the available network agency behavioral health care providers at the time of the intake assessment.
   - The network provider must have at least two (2) BHCP for each level of care and/or population (adult and child).

2. If an individual does not make a choice, the behavioral health agency must assign a BHCP no later than fourteen (14) working days following the request for behavioral health services.
   - The network provider must make a reasonable effort to assign a primary BHCP that most closely matches the individual’s preferences, such as gender, age, or clinical expertise.
3. The BHO managed care plan or its designee must allow an individual to change primary providers at any time for any reason. The individual must notify the BHO managed care plan or its designee of the request for a change, and inform the plan of the name of the new primary provider.

**MONITORING**

This SBHO policy is mandated by statute and contract.

1. This policy is monitored through the SBHO:
   - Annual SBHO Provider and Subcontractor Administrative Review
   - Annual Provider Chart Review
   - SBHO Grievance Tracking Reports
   - Biennial Provider Quality Review Team On-site Review
   - Quality Management Plan activities, such as target PIP improvements, issues for trends and recommendations

2. If a provider performs below expected standards during any of the reviews listed above a Corrective Action will be required for SBHO approval.
Policy Name: PROVIDER PURCHASING OUT OF NETWORK SERVICES- MEDICAID ONLY  Policy Number: 11.17

Reference: 42 CFR 438.207; DSHS Contract

Effective Date: 7/2005

Revision Date(s): 5/2016

Reviewed Date: 5/2016; 7/2017

Approved by: SBHO Executive Board

CROSS REFERENCES

• Policy: Corrective Action Plan
• Policy: Monitoring of Contractors
• Policy: Provider and Subcontractor Non-Compliance Penalties

PURPOSE

The Salish Behavioral Health Organization (SBHO) contracted community behavioral health agencies shall provide adequate and timely covered out of network services when unable to provide medically necessary services.

PROCEDURE

If a contracted network provider is unable to provide a medically necessary service to a Medicaid recipient, the provider shall arrange for such services to be delivered in a timely manner.

• Prior to procuring out of network services, the provider shall ensure that the out of network provider is fully credentialed by reviewing the agency or individuals licensing status with the Division of Behavioral Health or the Department of Health.

• Prior to procurement, the network provider's Compliance Officer shall complete, or have the out of network agency complete, a full Medicaid Exclusion review in compliance with SBHO policies and federal regulations.

• The behavioral health network provider is responsible to pay for such services until such time as they are able to provide them.

• The cost of services to the Medicaid enrollee shall be no greater than if the services were provided within the provider network.
MONITORING

This policy is mandated by federal statute and contract.

1. This policy will be monitored through use of SBHO:
   - Annual SBHO Provider Directory requests
   - Annual SBHO Provider and Subcontractor Administrative Review
   - Annual SBHO Provider Fiscal Review
   - SBHO Grievance Tracking Reports
   - Quality Management Plan and QUIC activities, such as review of Provider Directories updates and historical comparisons for staffing trends and recommendations.
   - Utilization Management Plan and Committee activities, such as review of monthly trends and service costs

2. If a provider performs below expected standards during any of the reviews listed above a Corrective Action will be required for SBHO approval.
The Salish Behavioral Health Organization (SBHO) will ensure medically necessary services and care coordination between the network providers and an individual’s primary medical care provider and/or hospital emergency room medical providers/staff will routinely occur in order to address the complex needs that could potentially impact the individual's behavioral health and physical health recovery.

PURPOSE

The SBHO understands that physical disorders and/or medical conditions can impede progress of an individual’s behavioral health recovery and overall well-being. Behavioral health disorders may complicate an individual’s ability to adhere to medical treatment plans.

2. The SBHO will promote communication and coordination of care with an individual’s Primary Medical Care Provider (MHCP) and the local hospital’s emergency room medical providers and staff through:
   • SBHO provided Early Periodic Screening and Diagnostic Testing (EPSDT) trainings to the network and, upon request, to the medical community
• Biennial SBHO Quality Review Team (QRT) on-site provider reviews, standardized ancillary interviews with local hospital emergency room administrators.

• Contractually requiring network service providers to assign a MHCP, for individuals authorized for outpatient care, responsible for outreach and coordination of care with a individual’s primary medical care provider. Network providers are encouraged to obtain a signed Release of Information prior to coordination efforts.

• The network provider will use best efforts to offer covered behavioral health services to an enrollee that they are aware has been recently treated in an emergency room for a psychiatric condition.

3. The SBHO will provide oversight and monitoring of the network providers primary MHCP and Crisis Response Teams who are responsible for coordinating the behavioral health care with the individual’s primary medical care provider and/or the local emergency room medical providers and staff.
   a. The SBHO conducts annual chart reviews that monitor the following;
      • specific indicators of quality care
      • specific clinical elements (such as treatment plan coordination of care)
   b. Trends identified from the data are used to target specific network trainings and community trainings (such as to local Emergency Rooms and the Early Periodic Screening and Diagnostic Testing “EPSDT” medical providers). The data is also presented before the SBHO Quality Improvement Committee (QUIC) and clinical directors.

4. The SBHO network provider primary MHCP is responsible for initiating the collaboration with the primary medical care provider.
   a. The primary focus is to develop or modify the individual’s behavioral health treatment plan in order to effectively identify and address behavioral health symptoms that may complicate the individual’s integrated behavioral health and physical health recovery.
   b. The primary MHCP will exchange information with the primary medical care provider, sharing past, present and current treatment interventions, and providing a comprehensive case overview of the individual.
   c. Mutually exchanged information includes:
      • current physical condition
      • medical history
      • demographic information
      • behavioral health and physical health assessments
      • treatment plan, with clearly stated measurable goals and objectives
      • significant progress notes
      • current diagnosis- behavioral health and physical health
      • pharmacology
- family and social assessments- behavioral health and physical health
- any other relevant information

d. The SBHO network provider primary MHCP will initiate exchanging updated information with the primary medical care provider when there is a change in the treatment plan or change in the general condition of the individual.

5. If the individual does not have a primary medical care provider, the SBHO network provider primary MHCP will assist them with a referral to the appropriate community clinic, Medicaid plan or private insurance plan for local medical provider information and services.

   • The primary MHCP will provide assistance in completing the Medicaid or private insurance application, if needed.

6. The SBHO Crisis Response Team will consult and assist the local hospital emergency room medical providers and staff with the development of an integrated medical and/or behavioral health treatment plan that will provide a coordinated and effective course of treatment for the individual.

7. The SBHO Crisis Response Team will collaborate with emergency room medical providers and staff to identify unique reasons for increased/decreased use of the local hospital emergency room.

   • The Crisis Response Team is responsible for initiating this communication with the local hospital emergency room.

8. The SBHO Crisis Response Team will consult and assist the emergency room medical providers and staff to identify appropriate community resources, remove barriers and problem solve difficult situations impacting the individual.

**MONITORING**

This policy is mandated by federal statute and contract.

1. This policy will be monitored through use of SBHO:
   - Annual SBHO Provider and Subcontractor Administrative Review
   - Annual Provider Chart Reviews
   - Biennial Provider Quality Review Team On-site Review
   - The Department conducts the Mental Health Statistical Improvement Project (MHSIP) every year, one year for adults and the alternating the next year for children/ youth. The MHSIP measures general individual satisfaction with the existing service delivery system, appropriateness and quality of services, participation in treatment goals, access to services, and perceived outcomes of services they received. The SBHO requests over sampling of the region to gather specific catchment area data and analyze for trends.

2. If a provider performs below expected standards during any of the reviews listed above a Corrective Action will be required for SBHO approval.
CROSS REFERENCES

- Policy: Corrective Action Plan

PURPOSE

The Salish Behavioral Health Organization (SBHO) shall ensure that services to individuals with special healthcare needs meet federal and state requirements.

DEFINITIONS

Individual with Special Healthcare Needs are defined as adult individuals who have a chronic and/or disabling condition, such as a biological, psychological, or a cognitive condition; have or certain to last for at least one year; and a condition caused from a disease (significant limitations in areas of physical, cognitive, or emotional functioning; dependency on medical or assistive devices).

- For child enrollees, identified as Individuals with Special Healthcare Needs, this can include any of the following: Significant limits in social growth or developmental function; need for related services over and above the usual for the child’s age; and special ongoing treatments, such as medications, interventions or accommodations at home or school.

- Individuals with Special Healthcare Needs are individuals who are eligible for public behavioral health services.
PROCEDURE

1. SBHO Network providers will develop and implement a process for identifying Individuals with Special Healthcare Needs.

2. Individuals with Special Healthcare Needs receiving treatment shall be delivered by or overseen by mental health professionals (MHP), chemical dependency professionals (CDP), and/or chemical dependency professionals in training (CDPT).
   - All initial intake and/or assessments shall be conducted by a mental health professional (MHP) or chemical dependency professional (CDP), as appropriate.
   - All treatment plans shall be developed or reviewed by a mental health professional (MHP) or chemical dependency professional (CDP) as appropriate, and follow the SBHO Individual Service Plan (IST)/Treatment Planning Standards.
   - All outpatient services, including crisis services, shall be delivered by or supervised by a mental health professional (MHP) or chemical dependency professional (CDP), as appropriate.
   - Individuals with special healthcare needs must have direct access to a mental health professional or chemical dependency professional if services are not being delivered by a clinician with MHP credentials.
   - A chemical dependency professional trainee (CDPT), with appropriate supervision by a chemical dependency professional (CDP), may provide treatment for Individuals with special healthcare needs.

3. An assessment will be conducted to identify the special healthcare needs, such as treatments and/or routine health care monitoring, of each individual with special health care needs.

4. An Individual Service Plan (ISP) shall include the individual enrollee, primary care provider, and also any specialists caring for the individual with special healthcare needs.
   a. The Individual Service Plan (ISP) must follow the standards for timeliness outlined in SBHO Policy 11.05, Individual Service Plan Standards.

5. Medicaid enrollees with special healthcare needs shall have direct access to specialists, for example by referral as appropriate for their assessed condition.
MONITORING

1. The SBHO will monitor compliance through:
   - Annual SBHO Provider and Subcontractor Administrative Review
   - Annual Provider Chart Reviews
   - Annual Data Encounter Validation (EDV) Reviews
     a. Quality Improvement Committee (QUIC), such as review targeted issues for trends and recommendations.

2. In addition, the Department will monitor compliance through licensing reviews.

3. If a provider performs below expected standards during any of the reviews listed above a Corrective Action will be required for SBHO approval.
Policy Name: SPECIAL HEALTHCARE NEEDS- DIRECT CARE, TREATMENT PLANNING AND ACCESS TO MENTAL HEALTH AND CHEMICAL DEPENDENCY PROFESSIONALS

Reference: 42 CFR 438.208, State Waiver

Effective Date: 8/2004

Revision Date(s): 5/2016; 6/2017

Reviewed Date: 5/2016; 6/2017

Approved by: SBHO Executive Board

CROSS REFERENCES

- Policy: Corrective Action Plan
- Policy: Special Healthcare Needs- Access, Quality and Appropriateness
- Policy: Special Healthcare Needs- Services and Coordination of Care

PURPOSE

The Salish Behavioral Health Organization (SBHO) shall ensure that services to individuals with special healthcare needs meet federal and state requirements.

PROCEDURE

1. All individuals eligible for services in the SBHO under state eligibility guidelines have special healthcare needs.

2. Care for all individuals receiving treatment shall be delivered by or overseen by mental health professionals or chemical dependency professionals.
   - All initial intake assessments shall be conducted by a mental health or chemical dependency professional, as appropriate.
   - All individual service plans (ISP) shall be developed or reviewed by a mental health professional or chemical dependency professional as appropriate, and follow the SBHO Individual Service Plan (ISP) Standards.
• All outpatient services, including crisis services, shall be delivered by or supervised by a mental health professional or chemical dependency professional, as appropriate.

3. Individuals with special healthcare needs must have direct access to a mental health professional or chemical dependency professional as appropriate.

4. Medicaid enrollees with special health care needs shall have direct access to specialists.

MONITORING

1. The SBHO will monitor compliance through:
   • Annual SBHO Provider and Subcontractor Administrative Review
   • Annual Provider Chart Reviews

2. In addition, the Department will monitor compliance through licensing reviews.

3. If a provider performs below expected standards during any of the reviews listed above a Corrective Action will be required for SBHO approval.
**CROSS REFERENCES**

- Plan: Quality Management Plan
- Policy: Corrective Action Plan
- Policy: Special Healthcare Needs- Direct Care, Treatment Planning and Access to Mental Health Professionals
- Policy: Special Health Care Needs- Services and Coordination of Care

**PURPOSE**

The Salish Behavioral Health Organization (SBHO) shall ensure that services to individuals with special healthcare needs meet federal and state requirements.

**DEFINITIONS**

Washington State defines individuals with special healthcare needs as individuals who are eligible for public behavioral health services.

**PROCEDURE**

1. The Quality Improvement Committee (QUIC) reviews each monitoring mechanism listed below on a quarterly basis and monitors for trends throughout the region. The QUIC makes recommendations for improvement to the SBHO.
MONITORING

This policy is mandated by contract and statute.

1. This policy is monitored through the use of the SBHO:
   - Annual SBHO Provider and Subcontractor Administrative Review
   - Annual Provider Chart Reviews
   - Annual Data Encounter Validation Reviews
   - Quality Management Plan activities, such as review targeted issues for trends and recommendations

2. If a provider performs below expected standards during any of the reviews listed above a Corrective Action will be required for SBHO approval.
Policy Name: USE OF SECLUSION AND RESTRAINT  
Policy Number: 11.22

Reference: WAC 388-865-0545; WAC 388-865-0546; DSHS contract

Effective Date: 7/2012

Revision Date(s): 5/2016

Reviewed Date: 5/2016; 6/2017

Approved by: SBHO Executive Board

CROSS REFERENCES

- Policy: Corrective Action Plans
- Policy: Monitoring of Contractors

PURPOSE

The Salish Behavioral Health Organization (SBHO) shall minimize the use of seclusion and restraint by its provider network.

All individuals have a right to be free from seclusion and restraint, including chemical restraint. The use of seclusion or restraint can only occur when there is imminent danger to self or others and less restrictive measures have been determined to be ineffective to protect an individual or others from harm. Seclusion and restraint should only occur in a licensed Evaluation and Treatment facility following guidelines set forth in 388-865 WAC.

DEFINITIONS

Seclusion and restraint are safety interventions of last resort and are not treatment interventions.

PROCEDURE

1. The SBHO provider network agencies shall maintain policies regarding seclusion and restraint to assure that procedures are utilized only to the extent necessary to ensure the safety to patients and others.
2. The use of seclusion and restraint should be the last resort in dealing with the psychiatric population. There must be imminent danger to self or others and all other least restrictive measures have been determined to be ineffective to protect the individual.

3. In the event that the use of seclusion or restraint becomes necessary, the following standards should apply to each episode:

- The dignity, privacy, and safety of individuals who are restrained or secluded should be preserved to the greatest extent possible, at all times, during the use of these interventions.

- Seclusion and restraint should be initiated only in those situations in which an emergency safety need is identified, and these interventions should be implemented only by staff trained in seclusion and restraint.

- Staff training in de-escalating, seclusion and restraint techniques should be provided annually.

- As part of the intake and ongoing assessment process, staff should assess whether or not an individual has a history of being sexually, physically or emotionally abused or has experienced other trauma, including trauma related to seclusion and restraint or other prior psychiatric treatment.

- Staff should discuss, with each individual case, strategies to reduce agitation which might lead to the use of seclusion and restraint. Discussion could include what kind of treatment or intervention would be most helpful and least traumatic for the individual.

- Only licensed practitioners, who are specially trained and qualified to assess and monitor the individual's safety, and the significant medical and behavioral risks inherent in the use of seclusion and restraint should order these interventions.

- All seclusion and restraint orders should be limited to a specific period of time. However, these interventions typically should end as soon as it becomes safe to do so, even if the time-limited order has not expired.

- Inpatient staff must notify, and receive authorization by, a physician within one (1) hour of initiating patient restraint or seclusion.

For children: No child/youth shall be restrained or secluded for a period in excess of two (2) hours without having been evaluated by a behavioral health professional.

- If the use of restraint or seclusion exceeds twenty-four (24) hours, a licensed physician must assess the individual and write a new order for the intervention will be continued. This procedure is repeated again for each 24-hour period that restraint or seclusion is used.
• All assessment and justification for the use of seclusion or restraint must be documented in the medical/mental health record. Direct observation every fifteen (15) minutes must be recorded in the medical/behavioral health record.

• Individuals placed in seclusion or restraints should be communicated with verbally and monitored at frequent, appropriate intervals (fifteen minutes or less) consistent with principles of quality care.

The individual must be informed of the reasons for the use of seclusion or restraint and the specific behaviors that must be exhibited in order to gain release from the restraint/seclusion procedures.

• Individuals who have been secluded or restrained and staff who have participated in these interventions are strongly encouraged to participate in debriefings, following each episode.

The purpose of a debrief is to review the experience and to plan for earlier, alternative interventions. The staff debriefing may be separate from the debriefing process with the consumer individual.

MONITORING

1. This policy is a mandate by Washington Administrative Code (WAC) statute. This policy is monitored through periodic reviews of the evaluation and treatment facilities, in addition to:

   • Annual SBHO Provider and Subcontractor Administrative Review
   • Annual Provider Chart Reviews
   • Annual Chart and Facility Review of Kitsap E&T
   • Biennial Quality Review Team On-site Review
   • Quarterly Provider Performance Reports

2. If a provider performs below expected standards during any of the reviews listed above a Corrective Action will be required for SBHO approval.
Policy Name: ENGAGEMENT AND OUTREACH SERVICES  
Policy Number: 11.23

Reference: DSHS Contract, Service Encounter Reporting Instructions (SERI)

Effective Date: 1/1/2014

Revision Date(s): 5/2016

Reviewed Date(s): 5/2016; 6/2017

Approved by: SBHO Executive Board

CROSS REFERENCES

- Policy: Authorization for Outpatient Services Based on Medical Necessity
- Policy: Corrective Action Plan
- Policy: Intake Assessment and Evaluation Services Standards

PURPOSE

The Salish Behavioral Health Organization (SBHO) shall ensure the consistent application of the engagement and outreach service code. These services are available and provided based on the individual’s needs, ability to engage in services, and funding.

Additional criteria for non-Medicaid individuals include within available resources.

DEFINITIONS

Engagement and outreach service code is defined (SERI) as a strategic set of activities that are implemented to develop an alliance with an individual for the purpose of bringing them into or keeping them in ongoing treatment.

The activities occur primarily in the field rather the worker’s office, or at another service agency such as food bank or public shelter, or via telephone if a potential client calls the worker’s office seeking assistance or by referral.
PROCEDURE

The purpose of engagement and outreach is to help individuals engage in ongoing outpatient treatment. This code is not meant to be a replacement for outpatient services when the individual is already willing to engage in treatment.

Use of the engagement and outreach code to provide ongoing services to individuals instead of enrolling them in services, simply because of their funding status, is considered a misuse of this code.

This code should not be used for individuals already enrolled in services.

If there are multiple Engagement and Outreach events – more than three in a 90-day period to the same person – and an intake has not been provided, a note must be included in the chart indicating why individual has not received an intake.

MONITORING

1. This policy is a mandate by contract and statute. This policy will be monitored through use of SBHO:
   - Annual SBHO Encounter Data Validation study
   - Annual Provider Chart Reviews
   - Quarterly Provider Performance Reports
   - Utilization Committee activities, such as the ASO case review
   - Quality Management Plan activities, such as review targeted issues for trends and recommendations

2. If a provider performs below expected standards during any of the reviews listed above a Corrective Action will be required for SBHO approval.
POLICY NAME: OUTPATIENT BEHAVIORAL HEALTH DISCHARGE PLANNING

Reference: WAC 388-877A-0120

Effective Date: 12/2013

Revision Date(s): 5/2016

Reviewed Date: 5/2016; 6/2017

Approved by: SBHO Executive Board

CROSS REFERENCES

- Policy: Corrective Action Plans
- Policy: Monitoring of Contractors

PURPOSE

The Salish Behavioral Health Organization (SBHO) authorizes care for individuals who meet access to care standards. When an individual’s treatment goals are met or they must leave SBHO services for some other reason, they are discharged from treatment.

The goal of the discharge process is an effective transition into a more independent level of care. This is more likely to occur when the individual and clinician work together to develop a specific discharge plan that includes appropriate referrals and specific instructions based on the individual’s ongoing treatment needs. When necessary, the clinician should assist individuals in accessing these referrals.

PROCEDURE

SBHO behavioral health providers must meet with individuals at the time of their discharge from outpatient treatment, unless the individual leaves without notice. The purpose of the meeting is to:

- Determine the appropriate recommendation for care after discharge
- Finalize the continuing care plan
- Assist the individual in making contact with necessary agencies and services
- Provide the individual with a copy of the written discharge plan
SBHO behavioral health providers must document that the individual was provided with a copy of the plan and that the discharge summary was completed within seven working days of the individual’s discharge.

The written plan must include, at a minimum:

- The date of discharge
- Continuing care plan
- Legal status
- Current prescribed medication (if applicable).

**MONITORING**

This policy is mandated by state statute.

1. This policy will be monitored through use of SBHO:
   - Annual Provider Chart Reviews
   - Grievance Tracking Reports

2. If a provider performs below expected standards during any of the reviews listed above a Corrective Action will be required for SBHO approval.
The Salish Behavioral Health Organization (SBHO) shall ensure all transfers between BHOs are conducted in a standardized manner across the state.

DEFINITIONS

“Multiple” means, for the purpose of defining risk factors, multiple three or more.

“Referring BHO” means the BHO in whose region the individual resided and/or from whom they received services prior to state hospital admission.

“Receiving BHO” means the BHO into whose region the Referring BHO is pursuing the transfer.

“Risk factors” include the following:

- Transfer is being requested due to availability of specialized non-Medicaid resource.
- High inpatient utilization – 2 or more inpatient admissions in the previous 12 months, an inpatient stay in a community hospital for 90 days or more in the previous 12 months, or discharge from a state hospital in the previous 12 months.
- History of felony assaults, ORCSP eligibility, or multiple assultive incidents during inpatient care (that may not have resulted in criminal charges but resulted in injuries).
- Significant placement barriers - behavioral issues resulting in multiple placement failures, level 3 sex offender, arson history, dementia (the BHO would need to be involved even though HCS might be arranging placement), and co-morbid serious medical issues.
“Specialized Non-Medicaid services” includes, for purposes of this protocol, IMD admissions, residential placement, and state hospital census.

PROCEDURE

BHOs in our state acknowledge and agree that:

1. Medicaid enrollees are entitled to Medicaid covered services in the community where they live.
2. Individuals who participate in mental health services have the right to freely move to the community of their choosing.
3. There are circumstances when an BHO (referring BHO) wishes to place an individual in another BHO’s region (receiving BHO) to better meet the needs of that individual, or moving to another BHO’s region would allow the individual to be closer to family and/or other important natural supports.
4. Some individuals require specialized, non-Medicaid services to meet their needs.
5. Due to the scarcity of specialized, non-Medicaid services, these may not be immediately available upon the request of the transferring individual.
6. The receiving BHO assumes immediate financial risk for crisis services and Medicaid covered services at the time of transfer.
7. The referring BHO will continue the financial responsibility for “specialized non-Medicaid services” provided to the individual for the duration of time as determined by the number of risk factors identified at the time of transfer.

<table>
<thead>
<tr>
<th>Number of Risk Factors</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>One risk factor</td>
<td>6 months</td>
</tr>
<tr>
<td>Two risk factors</td>
<td>9 months</td>
</tr>
<tr>
<td>Three or more risk factors</td>
<td>12 months</td>
</tr>
</tbody>
</table>

8. After completion of the risk factor time frame, the receiving BHO will assume all financial responsibility for the individual.
9. The referring BHO will retain the individual on their state hospital census until the individual is discharged. The referring BHO will accept on their census any individual placed in the receiving BHO who returns to the state hospital during the period of financial responsibility as defined above.
10. This protocol is intended to ensure a seamless transition for individuals with no more than minimal interruption of services.

Uniform Transfer Agreement-Community Inter-BHO Transfer Protocol: Outpatient Services Transfers

1. If a Medicaid enrollee re-locates to a region outside of their current BHO they are entitled to an intake assessment in the new region and are then provided all medically necessary mental health services required in the PIHP contract, based on the BHO’s level of care guidelines and clinical assessment.
2. When an enrollee is transferring to SBHO from another area, the receiving agency will contact the enrollee's current provider and request clinical records and other relevant information from that provider.

3. All Medicaid enrollees requesting a transfer will be offered an intake assessment and all medically necessary mental health services under the PIHP. The availability of Specialized Non-Medicaid Services cannot be the basis for determining if the enrollee is offered an intake for services in the desired community of their choice.

4. There are circumstances when moving between BHOs is necessary to better meet the needs of the individual, or moving to another BHO would allow the individual to be closer to family and/or other natural supports.

5. The receiving BHO will provide assistance to the enrollee to update the enrollee’s residence information for Medicaid Benefits.

When an enrollee is re-locating and may benefit from specialized non-Medicaid services beyond medically necessary services required in the PIHP, the BHOs agree to the following protocol:

   a. The placement is to be facilitated by the joint efforts of both BHOs.
   b. The referring BHO will provide all necessary clinical information along with the completed Inter-BHO transfer form.
   c. The receiving BHO will acknowledge the request within 3 working days.
   d. The receiving BHO will follow established procedures for prioritizing the referred enrollee and must offer an intake assessment to the enrollee for services Medicaid-covered services even if the specialized non-Medicaid services are not immediately available.
   e. The placement may not be completed without written approval on the inter-BHO transfer form from both BHO administrators, and their designees.
   f. The receiving BHO shall make a placement determination within 2 weeks of receiving all necessary information/documentation from the referring BHO. The enrollee and the referring BHO will receive information regarding the placement policy of the receiving BHO for the specialized non-Medicaid service.
   g. Placement will only occur when the specialized non-Medicaid service becomes available. If the specialized non-Medicaid service is not available at the time of the intended transfer, the receiving BHO will notify the referring BHO and continue to provide timely updates until such time the specialized non-Medicaid service is available. The referring BHO will keep the individual and others involved in the individual's care informed about the status of the transfer.
   h. Payment responsibility for individuals transferring between BHOs will be described in this protocol and specified on the inter-BHO transfer form.

Uniform Transfer Agreement: State Hospital Inter-BHO Transfer Protocol

1. This section describes the inter-BHO transfer process for individuals preparing for discharge from a state hospital, and who require specialized non-Medicaid resources.
2. Generally, individuals are discharged back to the BHO in whose region they resided prior to their hospitalization (designated by the state hospitals as the “BHO of responsibility”).

3. For **all individuals in a state hospital** (regardless of risk factors) who intend to discharge to another BHO, an Inter-BHO transfer request is required and will be initiated by the BHO of responsibility (hereinafter referred to as the referring BHO).

4. The financial benefits section at the state hospital will provide assistance to the enrollee to update the enrollee’s residence information for Medicaid Benefits.

5. The placement is to be facilitated through the joint efforts of the state hospital social work staff and the BHO liaisons of both the Referring BHO and Receiving BHO.

6. A *Request for Inter-BHO Transfer* form and relevant treatment and discharge information is to be supplied by the Referring BHO to the Receiving BHO via the liaisons.

7. The Referring BHO will remain the primary contact for the state hospital social worker and the individual until the placement is completed.

8. The Receiving BHO will supply the state hospital social worker with options for community placement at discharge.

9. Other responsible agencies must be involved and approve the transfer plan and placement in the Receiving BHO when that agency’s resources are obligated as part of the plan (e.g., DSHS Home and Community Services or Developmental Disabilities Administration).

10. Should there be disagreement about the discharge and outpatient treatment plan, a conference will occur. Participants will include the individual, state hospital social worker or representative of the state hospital treatment team, liaisons, the mental health care provider from the referring BHO, and other responsible agencies.

11. Once the discharge plan has been agreed upon, the *Request for Inter-BHO transfer* will be completed within two weeks. The Receiving BHO has two weeks to complete and return the form to the Referring BHO. This process binds both the Referring and Receiving BHOs to the payment obligations as detailed above.

**MONITORING**

This policy is mandated by state contract.

1. This policy will be monitored through use of SBHO:
   - Annual Provider Chart Reviews
   - Grievance Tracking Reports

2. If a provider performs below expected standards during any of the reviews listed above a Corrective Action will be required for SBHO approval.
INTER-BHO TRANSFER AGREEMENT

Individual Name:_________________________________________    DOB:___________________________

Responsibility for outpatient and crisis services is assumed by the receiving BHO upon transfer, regardless of risk factors. Responsibility for specialized non-Medicaid services remains with the referring BHO as below. Specialized non-Medicaid services include IMD admissions, residential placement, and state hospital census.

- One risk factor: 6 months
- Two risk factors: 9 months
- Three or more risk factors: 12 months

Indicate which risk factors are present:

☐ Transfer is being requested due to availability of specialized non-Medicaid resource.
☐ High inpatient utilization – 2 or more inpatient admissions in the previous 12 months, an inpatient stay in a community hospital for 90 days or more in the previous 12 months, or discharge from a state hospital in the previous 12 months.
☐ History of felony assaults, ORCSP eligibility, or multiple assaultive incidents during inpatient care (that may not have resulted in criminal charges but resulted in injuries).
☐ Significant placement barriers - behavioral issues resulting in multiple placement failures, level 3 sex offender, arson history, dementia, and co-morbid serious medical issues.

Indicate type of transfer

☐ State hospital discharge.
☐ Outpatient individual requiring specialized non-Medicaid resources moving to another BHO.

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Referring BHO Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient treatment and Crisis Services</td>
<td>N/A: Responsibility of accepting BHO immediately.</td>
</tr>
<tr>
<td>Specialized non-Medicaid services (IMD, Residential, State Hospital)</td>
<td>6mo</td>
</tr>
</tbody>
</table>

Signature of referring BHO administrator or designee ________________________________________________

Date:________________________________________

Signature of accepting BHO administrator or designee: ________________________________________________

Date:________________________________________
Request for Inter-BHO Transfer

Referring BHO/County: ___________________________________________ Date: ____________________

BHO Liaison Name: ___________________________________________________________________

Phone: __________________________  Fax: ____________________________

E-mail: _____________________________________________________________________________

Consumer Information:

Name: ______________________________________________________________________________

DOB: ________________________  SSN: _______________________________

Ward: ________________   WSH Social Worker: ____________________________________________

Phone: _________________________    E-mail: _______________________________________

Current Legal Status: ☐ Voluntary  ☐ Civil Commitment  ☐ LRA  ☐ Criminal Commitment

Date of Next Hearing: _______________ Income Source: _______________________________

Amount: $[Click here to enter text.]  Medicaid Eligible? ☐ Yes  ☐ No

Receives Medicare? ☐ Yes  ☐ No

Resources > $2000? ☐ Yes  ☐ No

Community Case Manager: ____________________________________________________________

Agency: __________________________________________________________________________

Case Manager Phone: ____________________ Fax: _______________________________

Reason for Referral: __________________________________________________________________

• Is individual specifically requesting the referral for placement to this BHO? ☐ Yes ☐ No
If yes, why?

• Has independent housing been arranged and secured for the individual? ☐ Yes ☐ No
If yes, please identify the type of housing:
  ☐ Apartment  ☐ SNF  ☐ Boarding Home  ☐ AFH  ☐ Other

• Is the request due to lack of residential resources in the referring BHO? ☐ Yes ☐ No

• Does the individual have natural supports available in the BHO requested? ☐ Yes ☐ No
If yes, please describe:
  __________________________

• Services needed by the consumer:
  __________________________

• Discharge address (if independent placement):
  __________________________

Packet is: ☐ Attached  ☐ In mail  ☐ In box  ☐ Faxed to __________________  ☐ E-mail (secure)
  ☐ Other __________________________

Signature of Referring BHO administrator or designee: _________________________________

Date: ____________________
PURPOSE

This policy applies to adults currently enrolled in services with a SBHO mental health provider.

SBHO understands that some individuals currently receiving BHO services need ongoing medication management in order to prevent worsening of symptoms and deterioration in their level of functioning. However, SBHO does not authorize a “medication only” level of care. The BHO also recognizes that WAC prohibits the BHO system from providing medication only services. Those who only need medication management should be transitioned to a community prescriber that accepts the individual’s Apple Health Medicaid outpatient coverage. SBHO realizes that there are some communities within the BHO where it is difficult to find a prescriber willing and able to treat individuals prescribed psychotropic medications. This policy is meant to address those concerns in light of current limitations on medication only services.

Note: Children should not be considered for medication only services. If a BHO provider has concerns about a specific case, they should contact the SBHO Children’s Services Manager.

PROCEDURE

The following factors relate to this policy:
• The WAC 388-877A-0180 prohibition on medication only services within the BHO system.
• The need to strike a balance between the BHO system (those who meet access to care) and the Apple Health system (those who are stable and no longer meet access to care and therefore should be using private providers).
• The lack of private psychiatric providers or PCPs willing to prescribe some psychotropic medications.
• The SBHO level of care guidelines, which suggest up to 24 hours of service per year for level one enrollees.
• The need for a consistent approach across the BHO.

The guidelines below should be applied when a mental health agency believes an individual’s primary treatment need is prescriber services:

• The BHO does not authorize medication management only services as a starting point for treatment (i.e. at intake).
• Medication management cannot be the only intervention/modality listed on the treatment plan.
• There needs to be at least one face to face contact between each 3-month medication appointment as well as another type of monthly contact.
• In addition to the minimal face to face contact requirement, there should be at least one other type of interaction with the client monthly. These other contacts could be by phone, if there is documented clinical content in the note.
• For these individuals (where medication management is the main treatment), there should be documentation that the enrollee’s needs cannot be met in the community via another available resource (e.g. doctor is not willing to prescribe).
• Enrollees who are currently receiving primarily medication management may at times need a higher level of treatment, and changes in the level of treatment provided should be adjusted based on the individual’s clinical needs.

**MONITORING**

1. This policy is a mandate by contract and statue. This policy will be monitored through use of SBHO:
   
   • Annual Provider Chart Reviews

2. If a provider performs below expected standards during any of the reviews listed above a Corrective Action will be required for SBHO approval.
The Salish Behavioral Health Organization (SBHO) shall ensure that tobacco use status is identified among individuals served and recorded so that outcomes can be measured consistent with industry standard practice guidelines.

DEFINITIONS

Chew: Includes anything smokeless or vaporless, meant to be absorbed nasally or in the oral cavity, such as chew, snuff, etc.

Smoking: includes anything that is burned and produces smoke such as cigarettes, bidis, cigars, pipes, and hookah.

E-cigarette: Includes e-cigarettes, Vape pens, etc.

Policy

SBHO providers shall maintain a written policy and procedure for asking and recording individuals’ tobacco use status. The policy and procedure shall contain the following features consistent with decisions resulting from SBHO Quality Improvement Activities:

1. A description of the target population for asking and recording current and past tobacco use status.

2. A description of each of the following categories, and requirement to ask about each category:
   a. Smoking
   b. Chew
   c. E-cigarettes
3. A description of the types of responses available for each category:
   a. Current/Everyday
   b. Current Somedays
   c. Former
   d. Never

4. Special population and cultural considerations.

5. Description of workflow to include at least the following:
   a. When the individual is asked about tobacco status
   b. Who asks the individuals about tobacco status
   c. How often tobacco status is gathered
   d. Who enters the status in the EMR
   e. A requirement that all three tobacco type statuses are recorded in the vitals section of the Electronic Medical Record (EMR) each time the information is gathered.

**MONITORING**

This policy is monitored through the SBHO Quality Improvement Program.
**Purpose**

Courts may order Assisted Outpatient Treatment (AOT) under Less Restrictive Alternatives (LRA) when an individual is released from an involuntary inpatient stay or through the “assisted outpatient” detention process described in RCW 71.05. BHOs serve the following individuals on Less Restrictive Alternatives (LRA) orders:

- Medicaid enrollees that meet BHO access to care standards.
- Individuals who are not Medicaid enrollees and have no other insurance to pay for treatment, if the BHO has adequate available resources to pay for services and the individual meets the BHO access to care standards.

When an individual is ordered to outpatient treatment with a non-BHO provider, the BHO agency is only responsible for monthly monitoring of the individual’s compliance with the LRA. When the individual is served by a non-BHO provider, the Caseload Guidelines and Services Provided sections below do not apply.

**Procedure**

In order to monitor individuals on less restrictive orders, an agency must be licensed by the Division of Behavioral Health and Recovery (DBHR) and have program specific certification in the area of LRA monitoring. The agency must meet the monitoring requirements of WAC 388-877A-0195. Individuals must be assessed at least monthly by an MHP to determine adherence to the LRA and need for continued treatment under the involuntary order.

**Caseload Guidelines for Care Coordinators Supervising LRA Orders**
Agencies determine clinician assignment for individuals on LRA orders based on the individual's clinical needs. Whenever possible, caseloads should be balanced so that high need individuals are not concentrated with one clinician, unless the clinician has a reduced caseload. Clinicians providing treatment to individuals on LRA orders must:

- Have capacity to provide multiple contacts per week based on individual needs
- Have capacity to rapidly increase service intensity as required
- Operate as continuous treatment service, LRA treatment must have the capacity to provide comprehensive treatment rehabilitation and support services.

**Response Time for Individuals During and Immediately Following Hospitalization or Incarceration**

Providers contact the inpatient facility within three days of admission when an individual from the agency’s catchment area is hospitalized. The agency must offer a face to face follow up appointment, to occur within seven days of discharge. Per BHO policy, the agency must attempt to contact the individual by phone within three days of discharge from an inpatient facility, even if the individual chooses to access services with a non-BHO provider.

When the agency learns that an individual under LRA order monitoring has been incarcerated, the agency should contact jail mental health staff for coordination and discharge planning, when possible, within three days of learning of the incarceration.

**Services Provided to Individuals on LRA Orders**

At a minimum, individuals that are on LRA Orders and enrolled in the BHO outpatient system must receive the following services:

- Utilize hospital liaison in discharge planning to minimize gaps in care
- Assignment of a Care Coordinator
- An intake evaluation with the provider of the less restrictive alternative treatment
- A psychiatric evaluation including providing verbal and written information about mental illness.
- Medication management
- A schedule of regular contacts with the provider of the less restrictive alternative treatment services for the duration of the order
- A transition plan addressing access to continued services at the expiration of the order;
- Access to crisis assessment and Intervention 24 hours per day, 7 days per week
- An individualized, strength-based crisis plan; and
- After the first month, evaluation to determine medical necessity for AOT.

The individual may, as clinically indicated, receive the following services as well:

- Psychotherapy
- Nursing
- Substance abuse counseling
• Residential treatment
• Peer Support Services
• Support for housing, benefits, education, and employment.
• Any other BHO covered state plan services deemed medically necessary by the provider and authorized by the BHO.

"Care Coordinator" means a clinical practitioner who coordinates the activities of less restrictive alternative treatment. The care coordinator coordinates activities with the designated mental health professional’s necessary for enforcement and continuation of less restrictive alternative orders and is responsible for coordinating service activities with other agencies and establishing and maintaining a therapeutic relationship with the individual on a continuing basis.

“In Need of Assisted Outpatient Treatment (AOT)” means that a person, as a result of a mental disorder:

1. Has been committed by a court to detention of involuntary mental health treatment at least twice during the preceding 36 months; or, if currently committed, has been committed at least once during the 36 months preceding the date of initial detention of the current commitment cycle.
2. Is unlikely to voluntarily participate in AOT without an order for LRA treatment in view of the person treatment history or current behavior
3. Is unlikely to survive safely in the community without supervision
4. Is likely to benefit from LRA treatment
5. Requires LRA treatment to prevent a relapse, decompensation, or deterioration that is like to result in the person presenting a likelihood of serious harm or the person becoming gravely disabled within reasonable short period of time (Time spent in a mental facility or in confinement as a result of a criminal conviction is excluded from the 36 months calculation)
6. When DMHP conducts investigations for likelihood of serious harm or grave disability, if DMHP determines individual is in need of AOT.

MONITORING

1. This policy is a mandate by contract and statute. This policy will be monitored through use of SBHO:
   • Annual SBHO Provider and Subcontractor Administrative Review
   • Annual Provider Chart Reviews

2. If a provider performs below expected standards during any of the reviews listed above a Corrective Action will be required for SBHO approval.