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MISSION STATEMENT

All Washington County Health Share of Oregon OHP and other low-income residents will have ready access to necessary, high quality behavioral health services appropriate to their level of need. Services are cost-effective, integrated, coordinated, flexible, evidence-based, and culturally competent and involve consumers and families. System-wide planning, advocacy and coordination will be accomplished through a collaborative partnership of stakeholders. Limited resources are managed to be both clinically effective and cost-effective; meeting identified priority needs.
WASHINGTON COUNTY HEALTH & HUMAN SERVICES OVERVIEW

WHAT IS WCHHS?

Washington County Health & Human Services (WCHHS) Behavioral Health Program holds a contract with Health Share of Oregon to manage mental health benefits for Oregon Health Plan (OHP) members residing in Washington County. WCHHS receives capitated OHP mental health funds to provide medically appropriate mental health services to members assigned to the program. WCHHS also receives limited funding from the State of Oregon to provide outpatient mental health services to indigent, uninsured or underinsured adults and children with a mental health diagnosis.

WCHHS sub-contracts the provision of direct mental health treatment services to a panel of mental health provider agencies located throughout Washington County. These agencies offer a continuum of services for all age groups.

WCHHS endeavors to develop and participate in a regional mental health delivery system in partnership with Multnomah and Clackamas counties.

VALUES:

WCHHS's approach to the provision of mental health services is to work in partnership with our sub-contracted providers and allied agencies (e.g. Child Welfare, Corrections).

WCHHS contracted providers agree to provide mental health services that are:

- Individualized, matching services to member needs, not matching members with standardized programs,
- Strengths based and recovery oriented,
- Consumer and family driven,
- Flexible, comprehensive, integrated and culturally competent,
- Community based, provided in the least restrictive, most natural setting possible,
- Based in best practices and incorporates Evidence-Based Practices.
Who WCHHS serves:

WCHHS is responsible for providing medically appropriate mental health services for Washington County residents enrolled in the Health Share of Oregon OHP medical plan.

Within available resources, WCHHS also provides medically appropriate mental health services to low-income adults and children with a mental health diagnosis who have no insurance coverage or whose benefits do not meet the needs of the individual. Services are prioritized to those most in need, defined by utilization of high levels of care, poor functioning, dangerousness, community impact, and/or multi-systemic involvement.

BECOMING A WCHHS PROVIDER

Membership on the WCHHS provider network is primarily done through a public procurement process. Approximately every five years, WCHHS issues Requests for Proposals (RFP) for adult, child and adolescent, intensive community services, and crisis services. Contracts are issued based on the RFP selection process.

Contracting

Public procurement procedures require that provider selection result from a competitive Request for Proposals process. This competitive procurement process must occur, minimally, every five (5) years, unless a waiver is requested from the Board of County Commissioners. In addition to the standards generally used in selection of qualified providers, selection criteria in any procurement process should include the considerations listed below.

- The anticipated plan enrollment.
- The expected utilization of services, taking into consideration the characteristics and mental health needs of specific member sub-populations.
- The numbers and types of providers required to provide the contracted services.
- The number of network providers who are not accepting new patients.
- The geographic location of providers and clients, considering distance, travel time, the means of transportation ordinarily used by members, and whether the location provides physical access for members with disabilities.
Provider Contracting Requirements

WCHHS and its participating providers must comply with:

- All provisions and conditions outlined in the current Agreement between WCHHS and the community mental health care provider.
- All provisions and conditions outlined in the current Oregon Health Plan Mental Health Organization Agreement between the State of Oregon and Health Share of Oregon.
- All provisions and conditions outlined in the current County Financial Assistance Agreement with the State of Oregon.
- All State Administrative rules pertaining to the provision of applicable mental health services.
- All applicable federal, state and local laws, rules and regulations.
- All policies and procedures adopted by WCHHS.

Providers contracted with WCHHS are responsible for all appropriate coordination of services for their clients including: comprehensive strength based assessments, individualized treatment planning, intensive community-based outreach and treatment; interagency collaboration, transition planning and aftercare.

Providers may not refuse to provide services to any consumer meeting criteria established by Washington County Policy. If there are reasonable clinical reasons why the provider is unable to provide services that are a good fit for the consumer, arrangements for service to be received at an alternative agency is the mutual responsibility of the consumer, providers and County staff.

PROVIDER SERVICES

Provider Workshops

WCHHS sponsors provider continuing education trainings from time to time. Workshop topics focus on training needs identified by providers, WCHHS staff, and the WCHHS Quality Assurance Committee. WCHHS strives to obtain continuing education credit from a professional organization for all workshops.
Provider Meetings

WCHHS conducts the following provider meetings to keep agencies informed and facilitate communication and coordination between WCHHS and participating providers:

- Quality Improvement Committee
- Adult Rehabilitation Services Meeting (Consortium)

In addition, Washington County co-facilitates several meetings in collaboration with Health Share of Oregon, Multnomah County and Clackamas County. These include:

- Clinical Directors Meeting
- Admin and Billing Meeting
- Behavioral Health Steering Committee

WCHHS Staff

Providers are encouraged to contact WCHHS staff with any questions, concerns, or recommendations. WCHHS staff is committed to working closely with its providers and being readily available for consultation and problem solving.
OBJECTIVE:

To ensure that clients are informed of their right to participate in decisions regarding treatment services and are informed of their right to initiate Advanced Directives, including the right to designate others to represent their interests in the event they become incapacitated.

To ensure that client Advanced Directives are appropriately communicated to providers.

POLICY:

It is the policy of the Washington County Mental Health Program that adults and emancipated youth clients have the right to initiate Advanced Directives and Declarations for Mental Health Treatment. Advanced Directives and Declarations for Mental Health Treatment may be implemented in the event that the individual becomes incapacitated or is otherwise not able to exercise his/her right to participate in treatment planning decisions. It is the policy of WCHHS that clients are informed of their rights to initiate advanced directives. Contracted providers will have policies and procedures relating to advanced directives for clients of their programs.

PROCEDURE:

Individuals are informed of their rights to develop and implement Advanced Directives and Declarations for Mental Health Treatment consistent with State of Oregon statutes and administrative rules pertaining to Advanced Directives of Mental Health Treatment and Declarations for Mental Health Treatment. Individuals will be informed of their right to develop and implement Advanced Directives and Declaration for Mental Health Treatment through written information included in the Health Share of Oregon member handbook that is provided to all members and contracted providers. The information in the
A copy of the State of Oregon Declaration for Mental Health Treatment is available online at the following website:


Contracted providers of community mental health services for adults are expected to inform WCHHS clients at the time of enrollment in services of their rights pertaining to advanced directives in accordance with Oregon Administrative Rules and Oregon statutes pertaining to Declarations for Mental Health Treatment. It is the expectation of Washington County that clients will receive this information as part of the standard notification of rights when entering into services with contracted providers. Providers are expected to provide support to members through the provision of information about advanced directives and how to obtain necessary forms to complete necessary documentation. Additionally, in response to federal directives, providers will be required to assess whether individual clients have completed advanced directives for medical care in addition to advance directives for mental health treatment. Copies of medical and mental health advanced directives will be retained in the client’s treatment file.

Documentation of Advanced Directives in clinical records shall include protections against discrimination and will include written authorization or denial of access to information in the client’s record by persons authorized to act on the client’s behalf, including the copy of advanced directive, during situations in which the client is incapacitated. The documentation shall indicate whether Washington County and/or its contracted provider can provide information to family members or surrogates.

Contracted providers will be monitored for compliance with requirements stated in applicable Oregon Administrative Rules (OARs) and the Mental Health Agreement between Washington County and the state Addictions and Mental Health Division pertaining to Advanced Directives and Declarations for Mental Health Treatment. Provider policies and procedures will be examined and clinical records will be inspected during periodic credentialing reviews to verify implementation of these requirements.

Members and authorized health care representatives may file a complaint if a health care provider has not followed an Advance Directive or Declaration for Mental Health Treatment. Information on how to file Advance Directive complaints Washington County may be obtained by contacting the Washington
Health Share members, their families, surrogates, and/or assigned Health Care Representative who have any questions in understanding their Advance Directive or Declaration for Mental Health Treatment rights may contact the Washington County QI Coordinator at (503) 846-4554 for assistance.
OBJECTIVE:

To provide alternatives to involuntary inpatient psychiatric care for WCHHS clients for whom community based services are deemed safe and appropriate.

To establish a network of community mental health service providers to provide community based services as an alternative to involuntary inpatient psychiatric care for clients for whom such alternatives are deemed appropriate and safe.

To provide a mental health system that includes the capacity for emergency psychiatric care. Emergency psychiatric care, including involuntary hospitalization, shall be available when a less restrictive voluntary service will not meet the medically appropriate needs of the WCHHS client consistent with State of Oregon Statutes and Administrative Rules.

To coordinate alternatives to involuntary care with Involuntary Commitment Program (ICP) staff, providers and client support services.

To coordinate with providers of involuntary inpatient services and ICP staff as necessary for clients who cannot be safely treated in alternative settings.

POLICY:

It is the policy of WCHHS that, within available resources, an array of community based services will be made available to WCHHS clients that provide alternatives to involuntary inpatient psychiatric care. Alternatives to involuntary psychiatric services will be provided based on the client’s assessed level of need and safety concerns.

Clients who are assessed as being at substantial risk of harm to self or others or are unable to care for their basic needs due to a covered mental health diagnosis and who cannot be safely treated in community settings will be referred for inpatient psychiatric services.
PROCEDURE:

All clients will be authorized for services at the least-restrictive level of care necessary to maintain the safety of the client and community. Each crisis situation will be evaluated by a qualified mental health professional to explore the least restrictive level of care available to maintain safety of the client and the community.

When a Washington County resident is identified as being at significant risk of harm to self or others the person should be referred to a local emergency department or mental health mobile crisis team for assessment. When the individual is also enrolled in services with a contracted provider, reasonable efforts should be made to include the provider in the decision making process for their clients identified as being at risk.

All involuntary psychiatric treatment is coordinated through Washington County’s Involuntary Commitment Program following all applicable Oregon Administered Rules and Statutes. Washington County mental health care coordination staff will work in collaboration with the ICP team for clients on a hold or committed to involuntary treatment to create individualized plans of care that will provide clinically appropriate services at the least restrictive level.

When WCHHS clients are placed on an emergency psychiatric hold, contracted providers are expected to cooperate with Washington County investigators to complete all necessary investigations relating to court hearings and civil commitment proceedings.

WCHHS contracts with service providers to provide an array of less-restrictive alternatives to involuntary psychiatric treatment. Contracted community based mental health services include, but are not limited to:

- 24-hours per day 7-days per week crisis services
- Community based crisis response
- Outpatient counseling and therapy
- Case management services
- Out of facility respite services
- Voluntary inpatient care
- Intensive Transition Team services
- Independent housing supports
- Other services as clinically indicated

Contracted providers will provide care planning and service delivery for WCHHS clients enrolled in services. This includes the provision of medically appropriate community based alternatives to involuntary inpatient care and coordination with Washington County and local hospitals for individuals on emergency psychiatric holds.
Within available resources, WCHHS will use exceptional needs providers to provide clinically appropriate treatment when the client’s service needs are unable to be met within the contracted provider network. Authorizations for exceptional needs providers will be made in accordance with Washington County’s policy on exceptional needs.
OBJECTIVE:

To coordinate implementation and ongoing management of the Adult Mental Health Initiative (AMHI) in Washington County.

To coordinate closely with local mental health treatment and residential providers, consumers, and family advocates.

To ensure the use of compassionate managed care principles to assure resources are closely matched to client need and that services are high-quality, evidence-based, coordinated, culturally competent, consumer-centered, and provided in the least restrictive setting possible.

To enlist the AMHI Exceptional Needs Care Coordinator (ENCC) in ensuring that all parties involved in the provision of services for the client are working collaboratively and in support of the client’s goals.

To employ the use of personal recovery plans in guiding the development of services and supports to individuals served in the AMHI program.

To ensure data collection and outcomes monitoring in order to inform continued program development.

POLICY:

The principles of Recovery, Person-Centered Planning, and consumer choice will guide program implementation and service delivery for consumers being served through the AMHI program. The AMHI ENCC will be responsible for facilitating the coordination of care being provided across systems for consumers in the program.

The ENCC will continue to work with a consumer as long as the consumer continues to be served by Washington County Mental Health, regardless of the
consumers’ current level of care, place of residence, or service providers in the community. The goal is to maintain continuity of the consumer’s care coordination throughout their involvement with the mental health system in Washington County, with the goal being that close, consistent, well-informed coordination of care by one coordinator will maximize the effectiveness of all aspects of the consumer’s care.

Washington County will participate in all AMHI-related planning and coordination meetings with the State, as well as community partners in Washington County, as well as Multnomah and Clackamas, when appropriate.

Washington County will routinely collect data in order to monitor outcomes and participate in statewide sharing of information and lessons learned.

**PROCEDURE:**

Washington County will provide a masters level ENCC (meeting QMHP criteria) for each individual accepted into the AMHI program. Eligibility for AMHI will be prioritized to the following groups:

- Currently in the State Hospital on commitment and a resident of Washington County (FamilyCare OHP individuals excluded)
- Currently committed and in an acute care setting and a resident of Washington County (FamilyCare OHP individuals excluded)
- In licensed residential settings but determined able to step down into independent community living with adequate supports

Other criteria used in determining whether a consumer is appropriate for AMHI include such factors as:

- Multiple crisis episodes
- Multiple hospitalizations and ED visits
- Significantly complicated co-occurring disorders that require extensive multi-system coordination

Assessment for AMHI supports and services will include an evaluation of whether the client’s identified service needs are outside the range of the contractual responsibilities of the community providers. All other options available in the array of services provided through all the community providers should be ruled out (i.e., EASA, TAY, ACT, ICM), prior to determining that a consumer is appropriate for AMHI.

The AMHI ENCC will be responsible for the coordination of care across all service providers and community partners working with the consumer. The ENCC will provide support and coordination, as well as additional specialized
Adopted 2-6-14

services as required for each client. All providers working with the client will maintain responsibility for all tasks within their respective areas of expertise (e.g., case managers will continue to maintain responsibility for all case management-related tasks).
Washington County Health and Human Services (WCHHS)
Mental Health Program
Policy and Procedure

Policy Title: Appeals and Administrative Hearings
Approved: __________________________     ______________
Division Manager   Date

OBJECTIVE:

To ensure that Washington County Mental Health program acting as a Risk Accepting Entity (RAE) under contract with Health Share of Oregon implements Appeals and Hearing procedures in keeping with requirements and standards delegated by HSO to Washington County.

To provide Washington County Mental Health clients and providers with an opportunity to express their disagreement with an action taken by WCCHS and/or its contractors including referral and authorization decisions and claims payment determinations.

To ensure that Washington County Mental Health clients and providers have a process for reconsideration of any termination, suspension, or limitation of services or benefits; denial or limitation of requests for authorization; or denial of claims payment in whole or in part.

To ensure that clients have a process to seek formal reconsideration and redress for actions or inactions by Washington County Mental Health and its contracted provider system.

To ensure that clients and providers are educated in the Appeals process and feel free to use it without fear of negative consequences.

POLICY:

Washington County will receive Administrative Hearing requests and will process them according to the procedures described in this policy. As a contracted Risk Accepting Entity of Health Share of Oregon, Washington County recognizes that Health Share of Oregon may retain final decision making authority within the Health Share of Oregon system. Contracted providers will be educated in the appeals and administrative hearing process and will be monitored for compliance with these procedures. Contracted providers will be educated about enrollee’s rights to a Hearing process through discussions with the Washington County
Revised 1-8-2014

Mental Health Quality Improvement Committee, Provider Business Meetings, and other such forums as well written expectations defined in contract.

Information will be provided to clients and/or client representatives regarding their rights to appeal the outcome of grievance decisions, Notices of Action, and other related concerns and their rights to seek a formal Hearing in accordance with the terms of the contract between Washington County and Health Share of Oregon and in keeping with standards established by the State of Oregon relating to the Hearing process.

Any Health Share of Oregon member eligible for services through the Washington County Mental Health Program, their authorized representative, or provider may request an appeal or state Hearing to contest a denial, reduction, or termination of a covered service. For the purposes of this document, “member” includes a client representative including family members. Clients and their authorized representatives have the right to examine the client’s case file as authorized by the member. The client may include his/her representative or the client’s estate representative if the client is deceased, in the appeals process consistent with state and federal law.

Washington County Mental Health and Health Share of Oregon members will be informed through written material, or alternative formats as required by the client’s special need, about the appeal and administrative hearings procedures and educated in using these processes within the appropriate time frames. Written notification will include documentation in the Health Share of Oregon Member Handbook of the client’s right to submit an appeal or to request a Hearing.

Clients will be assured that all clinical information related to grievances, appeals and OHA Administrative Hearings processes will be kept confidential except as it is necessary for Washington County, Health Share of Oregon, OHA, and other persons authorized by the client to resolve the issue.

No retaliatory action will be taken by Washington County, Health Share of Oregon or participating providers against the client for filing an appeal, or requesting an Administrative Hearing. All appeal decisions will be made by a qualified mental health professional with sufficient experience and expertise to address the client’s concerns. The client also has the right to obtain a second opinion from a qualified healthcare professional at no cost.

All handling of appeals and resolutions will comply with the requirements set forth in the current Agreement with the Health Share of Oregon.

**PROCEDURE:**
A. **Filing an Appeal**

1. A Health Share of Oregon member receiving services through Washington County may ask for reconsideration of an action taken by Washington County and/or its contractors relating to decisions described in a Notice of Action by filing an appeal. An appeal may be made either verbally or in writing. A verbal request must be followed by a written appeal unless an expedited appeal is requested or the client is not capable of completing a written appeal. If the client is not able to complete a written appeal, WCHHS will provide assistance as appropriate.

2. Appeals must be submitted directly to Washington County. A provider who is informed that a client or client representative disagrees with a Notice of Action will direct that client to contact the WCHHS Quality Improvement Program Coordinator and will provide any needed assistance to file an appeal.

3. Appeals may be filed at any time but must be filed within 45 calendar days from the date of the Notice of Action. The designated Washington County representative will contact the client and confirm receipt of the client’s appeal.

4. The Washington County Quality Improvement (QI) Coordinator will receive and review all appeals submitted to Washington County for consideration. The QI Coordinator will determine the person’s eligibility for OHP services under the Washington County contract with Health Share of Oregon and will determine whether the appeal was submitted within the acceptable time frame.

5. The client, provider, and/or the client’s representative or provider will be offered the opportunity discuss the appeal in person and to present additional information and evidence for the appeal.

6. The client will be notified of his/her right to continue services pending the appeal resolution. Clients must file an appeal either verbally or in writing. The OHA Appeal Form will be made available to any client requesting an appeal. Clients must use the OHA Administrative Hearing Request Form 443 to request a Hearing. Any request continuation of services must be received by WCHHS before the effective date of the Notice of Action or within 45 days of the date the Notice of Action was mailed.

7. Following receipt of an appeal, Washington County will continue to provide funding for services for clients if:
   
   a) The appeal was filed in a timely manner;
b) The appeal involves termination, suspension, or reduction of a previously authorized service or treatment;

c) Services were authorized by Washington County or a participating provider; and/or

d) The original authorization has not yet expired but will expire during the time frame under which the appeal is being reviewed.

8. Services will continue or will be reinstated while an appeal is pending unless the client or client’s representative withdraws the appeal. If, at the client’s request, Washington County continues or reinstates payment for services while an appeal or hearing is pending, the benefits will continue until the appeal or hearing is completed. If the final resolution of the appeal or hearing is adverse to the client and upholds the actions of Washington County and/or Health Share of Oregon, then Washington County may seek to recover the cost of providing these services from the client for the time period when the appeal or hearing was pending.

9. Expedited Appeals. If an expedited appeal is requested and the appeal meets the criteria for an expedited appeal, the Washington County QI Coordinator will contact the client to review the appeal to inform the client that the expedited appeal request has been received. Expedited appeals must be based upon the client’s belief that taking time for a standard resolution of a request for a standard resolution could seriously jeopardize the client’s life, health or ability to attain, maintain, or regain maximum function. If Washington County determines that an expedited appeal is not warranted, the client will be notified of the determination within 2 working days and that the appeal will be addressed within the time frame for standard resolution of appeals.

Expedited appeals must meet the following criteria:

a. The client or client representative must request that resolution of an appeal be expedited.

b. To qualify for the expedited appeal process, the mental status of the client meets the urgent or emergent criteria in accordance with Washington County Utilization Guidelines and/or a determination by WCHHS that taking time for a standard resolution of a request for a standard resolution could seriously jeopardize the client’s life, health or ability to attain, maintain, or regain maximum function.
c. Washington County will reach a decision on an expedited appeal within three (3) working days of receipt of the request for an expedited appeal.

10. Resolution of Appeals. The Washington County appeal resolution process will include the following in determining the resolution of an appeal:

a. The QI Coordinator and/or a Mental Health Program Supervisor will review the Notice of Action, clinical information, and other documentation or evidence presented in support of the appeal. The Washington County Psychiatric Consultant may also review the appeal as appropriate.

b. No clinical staff involved in previous levels of review or decision making will make decisions on an appeal. The Human Services Division Manager, Mental Health Program Supervisor, and/or Washington County Psychiatric Consultant will review the appeal if the Washington County QI Coordinator was involved in the original determination.

c. A decision will be made to uphold the initial action or determination by Washington County, including a Notice of Action, or to overturn the decision therein.

d. All appeals will be resolved and the client or client representative notified of the resolution as expeditiously as the client’s mental health condition requires and within 16 calendar days of receipt of the appeal.

e. An extension of 14 days may be made at the request of the client or client representative. Washington County may also extend the resolution process by 14 days if additional information is necessary and the client can be shown that the delay is in the client’s best interest. If Washington County extends the timeframes, the client or client representative will be informed in writing of the reason for the delay and the date that a decision will be made.

11. Notification of Appeal Determination. The client or client representative will be informed in writing of the decision about an appeal within 16 days of the receipt of the appeal. If the decision in the initial Notice of Action is upheld and is not in the client’s favor, the notification will include:

a) Information on the client’s right to request an Administrative Hearing, including the right to request an Expedited Hearing, and an Administrative Hearing Request form (AFS #443);
b) The Oregon Administrative Rule on which the decision was based.

c) Explanation of how to request an OHA Administrative Hearing.

d) The requirement to make this request within 45 days of the Notice of Action or letter of resolution.

e) The right to request that services or benefits be continued while the hearing issue is resolved.

f) Notice that repayment of services provided pending hearing resolution may be required.

g) Assurance that no retaliatory action will be taken against the client for requesting a OHA Administrative Hearing.

12. Documentation of Appeals. Washington County will maintain a log of all appeals received, the resolution, and DHS Administrative Hearings requested. This log may be incorporated into the grievance database. A file will also be maintained containing copies of all written appeals received records of the review or investigation, and the final resolution. Files will be maintained for a minimum of seven (7) calendar years.

13. As stated previously, Washington County recognizes that Health Share of Oregon may retain final decision making authority within the Health Share of Oregon system. As such, Health Share of Oregon may conduct a separate appeal review process as deemed appropriate.

B. OHA Hearings

1. Washington County clients enrolled with Health Share of Oregon are entitled to request an Administrative Hearing if Washington County has denied a requested service, payment of a claim, terminates, discontinues or reduces a course of treatment, or any other action that affects the client’s receipt of covered benefits.

2. A written hearing request must be received by the OHA Hearings Unit not later than 45 calendar days from the date of the Notice of Action, or if the hearing request was initiated after an appeal, not later than the 45th day following the Notice of Appeal Resolution.
3. Washington County will fully cooperate with and participate in the OHA Administrative Hearing process, including providing any documentation requested.

4. If the client wishes to have benefits or services covered while the hearing issue is resolved, services will continue to be provided pending the outcome of the hearing. Services will continue until:

   a) The client withdraws the hearing request;

   b) A final order is issued following a OHA Administrative Hearing that is adverse to the client;

   c) Ten days pass after the mailing of the Washington County Notice of Appeal Resolution unless the client has requested a OHA Administrative Hearing within the 10 day period; or

   2) The client is no longer eligible for Medicaid benefits.

5. Services will continue or will be reinstated while a hearing is pending unless the client or client representative withdraws the appeal. If, at the client’s request, Washington County continues or reinstates payment for services while a hearing is pending, the benefits will continue until the hearing is completed. If the final resolution of the hearing is adverse to the client and the actions of Washington County are upheld, Washington County may seek to recover the cost of providing these services from the client for the time period when the appeal and/or hearing was pending.
Solicitud de audiencia administrativa
(Administrative Hearing Request)

<table>
<thead>
<tr>
<th>El Departamento de Servicios Humanos (DHS) llena esta sección</th>
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<td>Date of Notice</td>
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<table>
<thead>
<tr>
<th>Claimant’s Name</th>
<th>Telephone Number</th>
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<tr>
<td>Address</td>
<td>City</td>
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Claimant is non-English speaking? [ ] Yes [ ] No
Alternate format: [ ] Yes [ ] No
If “yes,” specify: [ ] Braille [ ] Audio Tape [ ] Large Print [ ] Diskette [ ] Oral Presentation

Claimant understands: [ ] Braille [ ] Audio Tape [ ] Large Print [ ] Diskette [ ] Oral Presentation

El demandante o su representante completa esta sección

Si quiere una audiencia para beneficios médicos, de dinero en efectivo o de cuidado de niños, usted o su representante debe llenar este formulario. También puede usar este formulario para solicitar una audiencia para estampillas de comida. Un empleado de su oficina local puede ayudarle a llenar este formulario.

Solicito una audiencia porque no estoy de acuerdo con la decisión de [ ] denegar [ ] Que se me cobre un sobrepago [ ] reducir mis beneficios [ ] terminar

Recibí [ ] un aviso escrito para denegar mi solicitud o para reducir o terminar mis beneficios.

Fecha del aviso: __________

Programa(s) involucrados: [ ] SFPSS [ ] Medicaid/OHP [ ] TANF [ ] GA [ ] Post-TANF [ ] ERDC [ ] TA-DVS [ ] Otra:

Servicios de cuidado a largo plazo [ ] Estampillas de comida

Explique brevemente cuál fue la decisión y por qué no está de acuerdo con ella.

Antes de contestar esta pregunta, por favor lea la Parte 2 al reverso de este formulario.

¿Quiere seguir recibiendo los beneficios sin cambio (que no sean reducidos ni terminados) mientras espera la audiencia? [ ] Sí [ ] No (Nota: Sus beneficios pueden cambiar si sucede algo más que afecte la cantidad.)

Por favor lea la Parte 3 al reverso de este formulario para informarse sobre las audiencias rápidas.

Marque este casillero si usted reúne los requisitos para una audiencia rápida.

Nombre de mi abogado o representante: ________________________ Número de teléfono: ________________________

Dirección: ________________________ Ciudad: ________________________ Estado: ________________________ Código postal: ________________________

El Juez de Derecho Administrativo puede llevar a cabo la audiencia por teléfono.

En una audiencia telefónica, el Juez de Derecho Administrativo participa por teléfono. El cliente puede estar en la oficina o en otro lugar. Entiendo que me pedirán que tenga una conferencia informal con un representante de la agencia.

Firma del demandante: ________________________ Número de Seguro Social: ________________________ Fecha: ________________________

DHS llena esta sección

DHS Representative for this Matter: ________________________ Issue Code: ________________________ Telephone Number: ________________________ Date: ________________________

El Departamento está autorizado a solicitar su Número de Seguro Social (SSN) de acuerdo con 42 USC 1320b-7(a) y (b), 7 USC 2011-2036, 42 CFR 435.910, 42 CFR 435.920, 42 CFR 457.340(b), y OAR 461-120-0210. Su SSN se usará para ubicar su expediente y registros. Los clientes que sólo estén en los programas CAWEM, ERDC, REF y REFM pueden proporcionar su SSN en forma voluntaria.
Qué hacer si usted no está de acuerdo con esta decisión

**Llame a su oficina local si necesita este formulario en otro idioma o en diferente formato.**

- Usted tiene derecho a objetar esta decisión. Para ello debe solicitar una audiencia. La Oficina de Audiencias Administrativas, independiente del Departamento de Servicios Humanos (DHS), lleva a cabo las audiencias. **Si desea una audiencia, debe solicitarla a tiempo.** Para más información, vea la Parte 1 abajo.
- También puede hablar con un gerente. Puede solicitar una reunión llamando a su oficina local. Llame al **1-800-442-5238** si no sabe a quién llamar. Su plazo para solicitar la audiencia (Parte 1 abajo) no cambia aunque usted esté en contacto con un gerente o tratando de comunicarse con un gerente.

**Parte 1 – Solicite una audiencia**

**¿Qué debo hacer para obtener una audiencia?** Para todos los beneficios excepto estampillas de comida, debe llenar una Solicitud de Audiencia Administrativa (DHS 0443) y presentarla en una oficina de DHS. Puede obtenerla en una oficina de DHS o en [http://dhsforms.hr.state.or.us/Forms/Served/DS0443.pdf](http://dhsforms.hr.state.or.us/Forms/Served/DS0443.pdf). Para beneficios de estampillas de comida, puede solicitar una audiencia en un formulario DHS 0443, por teléfono, por escrito o hablando con un empleado de DHS en persona. En su oficina local pueden ayudarle. En la mayoría de los casos, la audiencia se debe solicitar dentro de **45 días** de la fecha de envío del aviso de la decisión. Tiene **90 días** para beneficios de estampillas de comida y reducciones TANF por no cooperar con el plan de su caso. Puede solicitar audiencia en cualquier momento si no está de acuerdo con la cantidad de estampillas de comida que recibe.

**¿Quién puede ayudarme con la audiencia?** En los programas médicos y de estampillas de comida, puede representarlo cualquier adulto. En todos los demás programas usted debe representarse a sí mismo o tener un abogado o un asistente legal (supervisado por un abogado de una agencia de ayuda legal) que lo represente. Puede llamar a la Línea Directa de Beneficios Públicos (un programa de Servicios de Ayuda Legal de Oregón y del Centro de Leyes de Oregón) al **1-800-520-5292** para pedir consejos y posible representación.

**¿Cuáles son mis otros derechos de audiencia?** Durante la audiencia, puede explicar por qué no está de acuerdo con la decisión. Puede usar testigos. Las leyes sobre sus derechos y el proceso de audiencia están en OAR 137-003-0501 a 0700, 410-120-1860, 410-141-0264, 461-025-0300 a 0375, ORS 183.411 a 183.470 y ORS 411.095.

**¿Qué sucede si no hay audiencia?** Si no solicita una audiencia a tiempo, retira la solicitud o falta a la audiencia, puede perder el derecho a tenerla. Este aviso será la decisión final de DHS (llamado “falla final por defecto”). No se emitirá un fallo separado por defecto. El archivo del caso, junto con todo el material que usted haya presentado sobre el mismo, es el registro. El registro se usa para respaldar la decisión de DHS por defecto. Usted puede apelar el fallo final por defecto si presenta una petición en el Tribunal de Apelaciones de Oregón. (ORS 183.482) Si usted no solicita audiencia, esta apelación se debe presentar dentro de **60 días** de la fecha en que este aviso se convierte en fallo final por defecto. Si retira la solicitud o falta a la audiencia, el plazo de apelación se establece en la orden de desestimación.

**Parte 2 – ¿Cómo puedo seguir recibiendo beneficios hasta mi audiencia?**

- Puede pedir que sus beneficios sigan igual hasta la decisión de la audiencia (“beneficios continuos”). En todos los programas excepto estampillas de comida, debe llenar un formulario de Solicitud de Audiencia (DHS 0443). Para estampillas de comida, puede hacerlo en el DHS 0443, por teléfono, por escrito o en persona.
- Usted debe pedir en su oficina local que sus beneficios continúen antes de la “fecha efectiva” que figura en el aviso, o **10 días** después de la fecha identificada como fecha de envío del aviso. Para seguir recibiendo beneficios, usted debe solicitar la audiencia antes de la **más tardía** de esas dos fechas.
- Si sigue recibiendo beneficios y pierde la audiencia, tendrá que devolver lo que no debería haber recibido.
- Si deja de recibir beneficios y gana la audiencia, DHS le dará los beneficios que usted debería haber recibido.

**Parte 3 – ¿Puedo tener una audiencia en cinco días hábiles?**

Usted puede tener derecho a una “audiencia rápida” para cualquiera de los siguientes tipos de beneficios o casos:

- Estampillas de comida rápidas o de emergencia
- Pagos de JOBS y pre-TANF
- Elegibilidad y pagos de Asistencia Temporal para Sobrevivientes de Violencia Doméstica (TA-DVS)
- Si está recibiendo beneficios médicos y se le niega un servicio médico para un peligro serio e inmediato para su vida o su salud.
- Si DHS deniega su solicitud de seguir recibiendo beneficios hasta su audiencia.

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**DHS no discrimina. Esto significa que DHS ayuda a todas las personas que tienen derecho a recibir sus servicios. DHS no negará ayuda a persona alguna por razones de edad, raza, color, nacionalidad de origen, sexo, orientación sexual, religión, creencias políticas o discapacidad. Puede presentar una queja si considera que DHS lo discriminó por alguna de estas razones.**

Spanish DHS 0447 (7/08), Can use prior version
NOTICE OF GRIEVANCE AND APPEAL PROCESS

Where to get a Grievance and Appeal form. Call the name and phone number of the mental health plan on your ID card for a Grievance and Appeal form. Also, you can call or ask your mental health provider for a form.

How to file the Grievance or Fill out the form. Explain why you disagree with the decision. Tell what you want to happen. Sign the form. Send it or take it to the address listed on the form.

If you have an urgent problem. If you need a decision quickly you may ask for an Expedited Appeal process. You need to indicate in the place provided on the form that you are requesting an expedited process and write why you need to have your Grievance or Appeal decided right away. The medical director will look at your records and the reason you gave and decide if your Grievance or Appeal needs to be decided right away.

Deadlines for filing the Appeal. If your Appeal is about a decision in a written notice you received, you must file your Appeal within 30 calendar days of the date of the notice you received. You may be able to get more time if you have good cause for being late.

If your Grievance or Appeal is about a change in services/benefits and you want the services/benefits to stay the same while you wait for the decision, you must file by the date your services/benefits will change or within 10 calendar days after the date the letter notifying you of the change was mailed or given to you, whichever is later.

When a decision will be made. You will get a decision about your Grievance or Appeal within 20 calendar days of when your Grievance or Appeal was received.

If you do not agree with the decision, you can ask for a hearing. Information about how to request a hearing is attached to this letter. If you ask for a hearing before you get a decision, you lose the right to use the Grievance and Appeal process.

Grievance and Appeal records. Any information in the file can be used in the hearing if you request a hearing.
NOTICE OF HEARING RIGHTS

Where to get a hearing request form. The form is called the Administrative Hearing Request (form AFS 443). You can get the form by calling the Oregon Health Authority (OHA) office and asking for it. Also, you can get the form from your mental health provider or by calling the name and phone number for Health Share of Oregon listed on your I.D. card, or by calling the Addictions and Mental Health Division (AMH) at (503) 947-5528.

How to file your request for a hearing. Fill out the hearing request form. Give the form to your provider or call the name and phone number on the attached letter for an address. You also may send the form directly to AMH Representative at Addictions and Mental Health Division at: 500 Summer Street E-86, Salem, OR 97301-1118.

If you need a decision quickly, you may ask for an Expedited Hearing. You need to write on your request that it is an expedited request and why you think you need to have a decision right away. An AMHD representative will look at your records and the reason you gave and decide if you need a decision right away.

Deadlines for filing your request for a hearing. If your hearing request is about a decision in a letter you received, you must file your hearing request within 45 calendar days of the date of the letter you received or within 45 calendar days of the date of the Complaint decision if you waited for a Complaint decision. You may be able to get more time if you have good cause for being late.

If your hearing request is about a change in services/benefits and you want the services/benefits to stay the same while you wait for the hearing decision, you must file a hearing request by the date your services/benefits will change or within 10 calendar days after the date the attached letter was mailed or given to you, whichever is later. If you waited for a Complaint decision and you want the services/benefits to stay the same while you wait for a hearing decision, you must file the hearing request within 10 calendar days of the date the Complaint decision was mailed or given to you, whichever is later.

What will happen. An AMH representative will ask you what you think was wrong. You have a right to a pre-hearing conference with AMHD Representative. You may be able to resolve the problem without a hearing. If the problem is not resolved, you will have a hearing. At a hearing, you can tell the DHS Hearing Officer your position and you can have other people testify for you. The State of Oregon will be represented and can have people testify. The Hearing Officer will issue a proposed order and DHS will make a final decision within 90 days from the date of your request for a hearing.
If you disagree with the decision. You can request a reconsideration or appeal to the Court of Appeals if you disagree with the decision.

Who can help. You can have a lawyer or someone else help you at the hearing. The state will not pay for a lawyer. Your local legal aid office or Disability Rights Oregon (1-800-452-1694) may be able to give you advice or help you with your hearing.

When a decision will be made. DHS must make a decision within 90 days of your request for a hearing.
COMPLAINT APPEAL FORM

If you need this form in a larger print or a different format, call (503) 846-4554

To file an Appeal of a decision about a complaint or grievance complete this form and send it to the address listed on this form. You must file your Appeal within 45 days of receipt of the decision about your grievance. Use the back of this page if you need to. You will receive a written response within 20 calendar days from the date your appeal is received. If you do not agree with the response, you have the right to ask for a Hearing. Your Hearing rights are described on an attached form. If you wish to discuss your Appeal first or if you need assistance, you may call the Washington County QI Coordinator at (503) 846-4554.

IF YOU NEED THIS FORM IN A DIFFERENT FORMAT, SUCH AS LARGE PRINT, AUDIO RECORDING OR BRAILLE, PLEASE CALL 503-846-4554.

Your Name: ___________________________ Date: ___________________________

Client’s Name (if you are not the client): _______________________________________

Address: ________________________________________________________________

City: ________________________ State: _____________ Zip: ______________

Birth Date: ___________________________ OHP Member ID Number: ______________

Please tell us what your complaint was about and the outcome of your complaint.

What do you want done about your complaint and the outcome of the complaint?

(If necessary please use additional space on the back side of this form.)

Is this an emergency? Yes ☐ No ☐ (please check one of these boxes)

You can file this Appeal in several ways:

1. Give the completed Appeal form to your therapist, case manager, or the receptionist at the clinic where you receive services.
2. Send the completed Appeal Form to Washington County Health and Human Services, Attn: QI Coordinator, 155 N. First Avenue, MS #70, Hillsboro, OR 97124.

3. Call Washington County Health and Human Services at (503) 846-4554 to file an Appeal or to request assistance to file an Appeal.

4. If you need more space to answer the questions from the front side of this form, please continue below. You may attach additional pages if needed.

Please tell us about your complaint and the outcome of your complaint.  
CONTINUED FROM FRONT SIDE ↓

What do you want done about your complaint and the outcome of the complaint?  
CONTINUED FROM FRONT SIDE ↓
WASHINGTON COUNTY HEALTH AND HUMAN SERVICES (WCHHS)
MENTAL HEALTH PROGRAM
POLICY AND PROCEDURE

Policy Title: Child and Adolescent Service Intensity Instrument (CASII) and Early Childhood Service Intensity Instrument (ECSII) Administration

Approved: __________________________     __________________
Division Manager                     Date

OBJECTIVE:

To assure that children and adolescents with mental and/or emotional disorders are assessed to determine the most appropriate level of intensity of mental health services.

To match the clinical needs of children and adolescents to available treatment resources.

POLICY:

The Child and Adolescent Service Intensity Instrument (CASII) and the Early Childhood Service Intensity Instrument (ECSII) will be utilized as tools to assist in making decisions on the level of service intensity to meet the needs of children and adolescents with psychiatric disorders.

All youth ages 6-17 seeking intensive mental health services in Washington County will be administered a CASII, and all children ages 0-5 will be administered an ECSII by a clinician trained in their use to assist in determining the appropriate level of service intensity for that youth.

All Washington County Health and Human Services (WCHHS) Child and Adolescent Care Coordinators will be trained by a qualified person to administer the CASII and the ECSII.

WCHHS will assist provider network agencies to obtaining training in the administration of the CASII and the ECSII.

A member of the WCHHS Child and Family team will administer a CASII to every child or adolescent six years of age or older who is referred to Washington
County Wraparound (WCW), which includes the Intensive Service Array (ISA) and the wraparound demonstration project.

An ECSII will be obtained from the current provider, or other person trained in administering the ECSII, for every child under 6 years of age who is referred to WCW.

**PROCEDURES**

**Outpatient Mental Health Services**

Providers of outpatient services sub-contracted by Health Share of Oregon, Washington County, or by WCHHS are not required to use the CASII or ECSII for level of care decisions. Outpatient providers may choose to use these instruments to assist in level of care determinations.

**Washington County Wraparound**

A WCHHS Care Coordinator will administer a CASII for each child or adolescent over the age of 5 and an ECSII for each child under the age of 6 that is referred for an ISA eligibility determination.

The Academy of Child and Adolescent Psychiatry recommends that the ECSII be rated by a clinician who has assessed or observed the child. Therefore, for children under the age of 6, an ECSII will be supplied by the current mental health provider. If there is no current provider, the child will be referred to a sub-contracted outpatient provider for a mental health assessment and ECSII.

The CASII or ECSII score will be one of the tools used in making the eligibility determination but will not be the sole criteria. This will be completed within three business days of a completed referral.

The CASII or ECSII scoring sheet will be sent to the Psychiatric Residential Treatment Service (PRTS) provider for each child referred to a PRTS facility. A CASII or ECSII will also accompany every referral to the Secure Adolescent Inpatient Program (SAIP) or the Secure Children’s Inpatient Program (SCIP).

For youth in WCW, a CASII or ECSII will be administered each time there is a change in the level of care, whenever there is a significant change in the youth’s mental status or functioning, and at discharge from WCW.
OBJECTIVE:

To provide a well functioning mental health service delivery system which insures that providers, community partners and County staff work together to ensure the needs of Washington County consumers are met.

To have a system of care that is client-centered, well-coordinated, seamless and integrated.

To insure that all individuals in need of Washington County funded mental health services are identified and have access to and receive needed services to aid in their rehabilitation and recovery.

POLICY:

Individuals may choose to receive care from any Washington County contracted provider that has the capacity to meet the individual’s assessed mental health treatment needs. Once the individual has made a successful connection with the provider agency as evidenced by completing the initial mental health assessment, the individual will be considered “assigned.” For all assigned cases, providers will have the responsibility to assist consumers to access services by providing outreach, office-based appointments, engagement techniques and other methods likely to improve the chances that those in need will receive services.

Providers may not refuse to provide services to any consumer meeting criteria established by Washington County Policy. If there are reasonable clinical reasons why the provider is unable to provide services that are a good fit for the consumer, arrangements for service to be received at an alternative agency is the mutual responsibility of the consumer, the provider and Washington County.

Providers may terminate their obligation to provide services to assigned consumers ONLY under one or more of the following circumstances:
Revised 2-11-2014

1. The consumer has transferred services to another provider in accordance with Washington County policies on transfer requests within a single authorization period and has attended a first appointment.

2. The provider and consumer have agreed that the consumer no longer needs formal mental health services and has an established natural system of support that is likely to meet their needs.

3. The provider has documented consistent efforts to engage the consumer over a significant period of time which have not been successful AND the consumer is not judged to be at risk for requiring a higher level of care.

4. The consumer moves out of Washington County and referral has been made to a receiving agency.

5. The consumer dies.

In the event that a payment cap has been reached for an individual consumer, providers are expected to continue to provide medically necessary services for the remainder of the authorization period and may not terminate the individual from treatment.

In situations where an OHP client is being terminated from services due to the treatment not meeting medical necessity criteria and the client disagrees with the decision, the provider will issue a Notice of Action in accordance with Washington County policy on Notices of Action.
Washington County Health and Human Services (WCHHS)
Mental Health Program
Policy and Procedure

Policy Title: Client Notice of Action (Denials of Service Authorization or Payment)

Approved: __________________________     __________________________
Division Manager   Date

OBJECTIVE:

To inform clients in an expeditious manner of decisions, or “actions”, regarding the denial, reduction, suspension or termination of requested services, and/or changes/limitations in the amount, duration or scope of requested services.

To ensure that clients, and client representatives, who are requesting authorization for treatment services are informed of authorization decisions and actions regarding the denial, reduction, suspension or termination of requested services, and/or changes/limitations in the amount, duration or scope of requested services.

To ensure that clients are notified of their rights to appeal treatment decisions and actions regarding the denial, reduction, suspension or termination of requested services, and/or changes/limitations in the amount, duration or scope of requested services when they do not agree with the decision or action.

POLICY:

A Notice of Action in a form that meets the Washington County Health Share of Oregon client’s special needs will be issued to the Health Share of Oregon member and/or the member’s representative, and the client’s provider each time one of the following occurs:

A requested service or benefit will be or has been terminated, suspended or reduced;

Changes/limitations are made in the amount, duration or scope of requested services;

Each time a request for service authorization is denied or limited; or
A request for claims payment is denied in whole or in part, in accordance with the requirements defined in the contract between Washington County and Health Share of Oregon or as otherwise may be required by the State of Oregon Health Authority.

A Notice of Action is sent if/when the client or client’s representative is not in agreement with the authorization decision or planned treatment services. When the client indicates agreement with a reduction, suspension or termination of service and/or changes/limitations that are made in the amount, duration or scope of requested services then a Notice of Action is not required. Agreement by the client with proposed changes in the provision of covered services does not constitute a circumstance under which a Notice of Action is required. For example, if a member agrees with a recommended change in medications or a reduction in dosage then a Notice of Action is not indicated. Clients will be notified that they may request a Notice of Action in an alternate format or another language.

Exceptions to advance notice of a decision to deny, suspend, reduce or terminate a requested service may occur under certain circumstances. Exceptions to advance notice include circumstances where:

- The client is not available and cannot be reached;
- Routine changes in medications by a Licensed Medical Practitioner where the client continues to receive medication management services;
- Changes to clinical circumstances that do not rise to the level of a denial or substantive change to the OHP benefit package, and
- Actions relating to services or activities that are not included in the OHP benefit package.

Other circumstances where exceptions to advance notice may exist include clinical decisions and/or service authorization decisions where circumstances require an immediate action and where the client cannot be contacted in a timely manner to provide advance notice of the intended action. In such circumstances reasonable efforts will be made to contact the member as soon as reasonably possible to inform the member of the action. In circumstances where the client is not available or cannot be reached to inform the member of the denial or change in services then a written notice will be forwarded to the member through the mail or other appropriate means of delivering the written document.

Providers will be educated in the Notice of Action process and issue such Notices directly if a service or benefit will be or has been denied, terminated, suspended, or reduced. Washington County will monitor provider compliance through periodic chart reviews, review of complaints and appeals, and/or other
sources of information. Contracted providers will be asked to periodically submit reports to WCHHS documenting when Notices of Action have been issued including the date of the Notice, the type of Action, to whom the notice was sent, and the requested service.

All denials of requests for authorization based on clinical issues or lack of medical appropriateness will be made by qualified mental health professionals with expertise in treating the client’s mental health condition.

PROCEDURE:

A. Components of Notice of Intended Action and Notice of Action

Any Notice of Action issued to a Health Share of Oregon member where Washington County is the assigned entity for management of the member’s mental health benefit will be issued using a format approved by Health Share of Oregon. The Notice of Action form will be submitted to the Addictions and Health Share of Oregon for review and approval prior to implementation. A written Notice of Action issued by Washington County or any contracted providers shall:

a. Be written in language that is understandable to the client.

b. Be provided in an alternative format to meet the client’s special needs if necessary.

c. Notices of Action will include:

1) Statement of the action or intended action and the effective date of the action.

2) Reasons for the action, including but not limited to the following: requested treatment was not covered service, the condition for which the service was requested is not an “above the line” diagnosis, the service required prior authorization and was not pre-approved, the service was not medically appropriate, the service was received in an emergency care setting but did not qualify as an emergency, the person was not a Washington County member at the time of the requested service, or the provider was not a WCHHS MHO approved provider.

3) Client’s or provider’s right to file appeal as required by OAR 410-141-0262 and request an Oregon Health Authority (OHA) Administrative Hearing.
4) A statement of the client’s right to file an appeal or to request a hearing, including a copy of a Hearing Request Form (OHA 443) and Notice of Hearing Rights.

5) How to request an expedited appeal.

6) The right to request continuation of services until a decision is made and the possibility that these services may need to be repaid if the decision is not in the client’s favor.

7) The name and phone number of Washington County staff to contact for assistance, questions, or additional information.

8) For termination, suspension or reduction of previously authorized services, the Notice of Action will be mailed to the member at least 10 days before the date of the action unless:

   a) The client states that he/she no longer wishes services or provides information that requires termination or reduction of services;

   b) The client is admitted to an institution where he/she is ineligible for covered services;

   c) The client’s whereabouts are unknown and the post office returns the mailed Notice of Action;

   d) The date of the Action will occur in less than 10 days in accordance with 42 CFR 483.12(a)(5)(ii) related to discharges from long term care facilities.

9) The period of advance notice may be shortened to 5 calendar days before the effective date of the action if Washington County has facts that indicate an action should be taken because of probable fraud by the client.

10) Washington County may extend the notification period to up to 14 additional calendar days if the client or the provider requests and extension or if WCHHS justifies an need for additional information and how the extension is in the client’s interests.
B. Provider Issued Notice of Action

If current or previously authorized services to a member with OHP benefits managed through Washington County are reduced, suspended or terminated by the provider, the provider will issue a Notice of Intended Action to the member at least ten (10) calendar days before the date of the Action unless conditions set forth in Section A.8 above are met, consistent with the current agreement between Washington County and Health Share of Oregon.

a. This Notice of Action will include specific instructions on the client’s right to appeal the decision to Washington County and how to contact Washington County to initiate an appeal.

b. The Notice of Action will be filed in the client’s chart.

c. Washington County contracted providers will maintain a record of all mailed Notices of Intended Action and Notices of Action.

d. A copy of the Notice of Action will be forwarded to the Washington County Quality Improvement Coordinator.

C. WCHHS Issued Notice of Action

All decisions on service authorization requests will be made within 10 days of the receipt of the request unless an expedited decision is requested. Any service authorization decisions that lead to a reduction, suspension or termination of services and/or changes/limitations in the amount, duration or scope of requested services will be made in accordance with the procedures described above.

a. An extension of 14 additional calendar days may be allowed at the request of the client or provider, or if Washington County needs more clinical information and the extension is deemed to be in the client’s interest.

b. If the time frame is extended by Washington County, the client will be sent a written notice explaining the reason for the extension and the right of the client to file a grievance.

Washington County and/or its designee will review requests for services or claims payment that cannot be authorized at the provider level, other authorized contractors (e.g., Providence Access Triage), or through its contracted Third Party Administrator (i.e., PHTech).
a. This review will determine:
   1) Client eligibility.
   2) If condition is a covered mental health diagnosis.
   3) If the service requested is a covered benefit or funded treatment pair.
   4) Medical appropriateness of requested service.

b. If the client is not eligible for OHP benefits under the terms of the Washington County agreement with Health Share of Oregon at the time the request is made, a Notice of Action may not be required. The person requesting the service may be notified of decisions resulting from such circumstances by phone, fax, or in writing.

c. If more clinical information is needed to make a determination, the person making the request is notified and informed that if the additional information is not received within 14 calendar days, the request may be denied for lack of documentation.

d. Notices of Action will be reviewed by the QI Coordinator, a Senior Mental Health Program Coordinator, and/or Behavioral Health Program Supervisor before mailing.

Expedited Service Requests

a. A client or provider may request an expedited appeal of an authorization decision either verbally or in writing.

b. A client or provider is entitled to an expedited appeal process if the mental status of the client constitutes an emergent or urgent situation and the client’s health and safety is deemed to be at risk and in keeping with the Washington County policies and procedures pertaining to Washington County member’s Appeal rights.

c. If emergent or urgent criteria are met, Washington County clinical staff will make a determination and inform the client and/or provider of the decision within 48 hours of receipt of the request.

d. If emergent/urgent criteria are not met, the client and provider will first be informed verbally of the decision to deny an Expedited Appeal. The client’s appeal would be reviewed in accordance with the Washington County standard appeal process.
Revised 1-9-2014

e. A written notice will be sent to the client and provider informing them of the denial of the expedited appeal request and that the request will determined within the time frame of a routine request.

D. Documentation of Notices of Action/Notice of Intended Action

Documentation of approval or denial of all requests for service that are not automatically approved will be manually entered into the authorization database by Washington County staff.

A copy of each Notice of Action and related documentation will be kept in the client’s file with the following information.

a) Reason for the denial.

b) Date of denial.

c) Date Notice of Action is sent and to whom.

d) Name of person making determination.

e) If a denial decision is also conveyed verbally, the name of the person to whom receiving the decision, and the date and time of the phone contact.

f) A brief description of the reason for the denial will be entered in the “Comments/Notes” section of the authorization request referral in the Washington County authorization/claims processing data base.
Re: NOTICE OF ACTION TO DENY, REDUCE OR STOP A BENEFIT

Dear <MEMBER OR GUARDIAN NAME>:

This Notice is to inform you of a decision about mental health services or benefits for you or the person listed below. This “Notice of Action” will tell you what was decided and your rights under the Oregon Health Plan about this decision.

Member name: ________________________________
Member ID number: __________________________
Provider name: ______________________________
Notice Issued by (name): ______________________

Date of Notice: __________  Effective Date: __________

Washington County Mental Health works with mental health care providers to make sure you get services you are entitled to receive under the Oregon Health Plan (OHP) benefit package. Please know that your mental health benefit package under the Oregon Health Plan, and other factors, may limit what services and supplies are covered.

On <DATE> we received a request from <NAME> for services for the member named above to treat <CONDITION or CIRCUMSTANCE>.

☐ After careful review of the request we are not able to approve the request because:

[Blank space for further details]
<VERY SPECIFIC REASON – use additional pages as necessary>.

– OR –

☐ After careful review of the request we are not able to continue paying for the requested service because:

<VERY SPECIFIC REASON – use additional pages as necessary>.

The reason for the Action as described above includes, but is not limited to, the following reasons:

☐ OAR 410-141-0500(1)(b): The requested treatment or service is not a covered service;

☐ OAR 410-141-263(c)(A): The requested treatment or service requires pre-authorization and it was not pre-authorized;

☐ OAR 410-141-263(c)(C): The requested treatment or service is not a Medically Appropriate service (i.e., not medically necessary or medically needed);

☐ OAR 410-141-263(c)(B): The service or item is received in an emergency care setting and does not qualify as an Emergency Service;

☐ OAR 410-141-263(c)(C): You, or the person named above, was not a Health Share of Oregon Member at the time of the service;

☐ OAR 410-141-263(c)(D) The Provider is not on the Washington County Health Share of Oregon provider panel and prior approval was not obtained for services from this provider;

☐ OAR 410-141-0500(1)(c)(d), and (e): The service is not included on the funded lines of the Prioritized List of Health Services for your condition and/or is for treatment of a diagnosis that appears only on the non-funded lines of the prioritized list.

☐ OAR 410-141-0500(1)(g): The services from an emergency care setting was determined not to meet the definition of Emergency Services;

☐ OAR 410-141-0500(1)(h): The service was provided outside the territorial limits of the United States;

☐ OAR 410-141-0500(i): You, or the person named above, is in the custody of a law enforcement agency or an inmate of a non-medical public institution;

☐ OAR 410-141-0500(j): The service was received while outside the Washington County Health Share of Oregon service area and was not authorized by the Washington County MHO and the service was not for Urgent or Emergency Services.

☐ OTHER REASON (cite applicable OAR): ________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

2
APPEAL AND HEARING RIGHTS

Things you can do if you do not agree with this Notice

If you do not agree with this decision you have the right to:

• File an Appeal with Washington County Mental Health, or

• Request an Administrative Hearing from the State of Oregon DHS Addictions and Mental Health Division Administrative Hearing Hearings Unit in Salem.

You may file an Appeal review of a Washington County appeal decision with Health Share of Oregon, or You may file an Appeal and request an Administrative Hearing at the same time if you wish to do so.

Appeals and Administrative Hearings must be requested within 45 days of the Date of Notice shown above.

To request an Appeal you must complete the Notice of Action Appeal form that is attached with this Notice. Return the signed Appeal form to Washington County Mental Health. Read the instructions below for more information about how to make your request.

Other things you can do:

Note: Doing any of the following things will not give you more time to file an Appeal or ask for an Administrative Hearing.

1. You or your mental health provider may send documents that explain why our denial was wrong to the address in the Plan Contact section below.

2. You may ask your mental health provider about other ways to treat your condition.

3. You may get the information we used in making this decision in writing. To get this information, call the Washington County MHO at the phone number in the Washington County Mental Health Plan Contact section below.
If You Have Questions:

If you have questions, you may contact our Quality Improvement Coordinator by telephone at (503) 846-4554, mail, or by email at the contact information below.

Washington County Mental Health Plan Contact Information:

Mail: Washington County Mental Health
    155 N. First Ave., MS 70
    Hillsboro, OR 97124

Phone: (503) 846-4554 [Monday to Friday, 8 am - 5 pm]
       You may leave a voice message after hours and weekends

Fax: (503) 846-4560

Email: jim_macleod@co.washington.or.us

This document can be provided in other formats, including large print, Braille, and audio recordings. Call the Washington County Quality Improvement Coordinator at 503-846-4554 or TDD 1-800-735-2900 (TTY) to request another format.
Notice of Action Appeal Form

If you want to appeal the Notice of Action decision, if you wish to continue to receive services during the Appeal process, or if you wish to request an “expedited” (fast) Appeal, check the boxes below to tell us your wishes.

☐ (Optional) I am requesting an Appeal on the decision shown in this Notice.

☐ (Optional) I want to continue to receive services during the Appeal process. Please read the “Continuing your benefit” information located in the table titled “How to file an Appeal or request an Administrative Hearing” at the end of this packet before checking this box because you may have to pay for any services you receive if your appeal is denied.

☐ (Optional) I am requesting an expedited (fast) Appeal because: __________
................................................................................................................
................................................................................................................
................................................................................................................
................................................................................................................
................................................................................................................
................................................................................................................
................................................................................................................
................................................................................................................
................................................................................................................

Signed: ________________________________ Date:__________________

Send completed form to: Washington County Mental Health
155 N. First Ave., MS 70
Hillsboro, OR 97124 FAX (503) 846-4560
## How to file an Appeal or request an Administrative Hearing

<table>
<thead>
<tr>
<th>Action:</th>
<th>Filing an Appeal with Washington County MHO</th>
<th>Requesting an Administrative Hearing with AMH</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What it means:</strong></td>
<td>A person who was not involved in the decision will review your appeal. You will receive the appeal decision in a <em>Letter of Appeal Resolution</em> within 16 days. If you still do not agree with our decision on your Appeal, you can request an Administrative Hearing.</td>
<td>You will have a chance to explain to an administrative law judge why you disagree with this decision. You may ask for an Administrative Hearing now, or you may appeal to Washington County MHO and then ask for a hearing if you disagree with the Appeal decision.</td>
</tr>
<tr>
<td><strong>How to do it:</strong></td>
<td>• Call us at the phone number given above; send a letter or email asking for an appeal; or send a completed “Notice of Action Appeal Form” to the address in the Plan Contact section (a copy of this form is included with this notice), or • Complete and sign the “Notice of Action Appeal Form” and send it to the address in the Plan Contact section listed above.</td>
<td>• Fill out and send the enclosed <em>DHS Administrative Hearing Request</em> form to the AMH Hearings Unit, 500 Summer Street NE E-86, Salem, OR 97301. The enclosed <em>Notice of Hearing Rights</em> gives more information about the Hearing process.</td>
</tr>
<tr>
<td><strong>Request Deadline</strong></td>
<td>Both Appeals and Administrative Hearings must be requested <strong>within 45 days</strong> of the Date of Notice shown on the first page of this notice.</td>
<td></td>
</tr>
<tr>
<td><strong>Expedited Appeals or Hearings</strong></td>
<td>If you believe that your problem cannot wait for the normal Appeal or Hearing process, show that you want an “expedited” (fast) Appeal or Administrative Hearing when you make your request. Your request for an expedited Appeal or Hearing will be made in keeping with OAR 410-141-0263(2)(g), OAR 410-141-0265 and/or any other rules or laws that may apply.</td>
<td></td>
</tr>
<tr>
<td><strong>Continuing your benefit</strong></td>
<td>If this denial is for a service or item that you were getting before the Date of Notice, you may have the right to keep getting it during the Appeal and/or Hearing process. <strong>Please know that if you lose your Appeal or Hearing, you may have to pay for the services you get</strong> after the Effective Date listed on the Notice of Action. Let us know</td>
<td></td>
</tr>
</tbody>
</table>
you want to continue your benefit when you make your request. To continue receiving services, you must request to continue your services no later than 10 days after the Date of Notice or by the Effective Date, whichever is later.

<table>
<thead>
<tr>
<th>Help with your Appeal or Administrative Hearing</th>
<th>Contact any of the following if you need help with your Appeal or Hearing:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Your DHS worker. Your worker’s phone number is listed on the first page of your OHP Coverage letter.</td>
</tr>
<tr>
<td></td>
<td>• The OHP Central Office at 800-699-9075, TTY 711.</td>
</tr>
<tr>
<td></td>
<td>• Washington County MHO Customer Services – see the Plan Contact Section on page 4.</td>
</tr>
<tr>
<td></td>
<td>• The Public Benefits Hotline, a service of Legal Aid and the Oregon Law Center at 1-800-520-5292, TTY 711.</td>
</tr>
</tbody>
</table>

*Requests made over the phone must be followed-up in writing

Enclosures:  *DHS Administrative Hearing Request*, DHS 443
Administrative Hearing Request

Department of Human Services (DHS) completes this part

Date of notice: / /  
Date of initial hearing req.: /  
Date 443 rec'd by DHS:  
Program no.:  
Cost center:  
Case number:  
Worker ID:  

Claimant's name:  
Telephone number:  

Address:  
City:  
State:  
ZIP code:  

Claimant is non-English speaking?  

☐ Yes  
☐ No  

Alternate format  

☐ Yes  
☐ No  

If "yes," specify  

Claimant understands:  

☐ Braille  
☐ Audio tape  
☐ Large print  
☐ Diskette  
☐ Oral presentation  

Claimant or claimant's representative completes this part

If you want a hearing for cash, child care, or medical benefits, you or your representative must fill out this form. You also can use this form to ask for a food stamp hearing. An employee at your branch office can help you complete this form.

I am asking for a hearing because I do not agree with the decision to  

☐ Deny  
☐ Charge me with an overpayment  
☐ Other:  

☐ I did receive a written notice to deny my application or to reduce or close  
☐ I did not receive a written notice to deny my application or to reduce or close  

Date of the notice: / /  

Program(s) Involved  

☐ SFPSS  
☐ Medicaid/OHP  
☐ TANF  
☐ GA  
☐ Post-TANF  
☐ ERDC  
☐ Long-Term Care Services  
☐ Food Stamps  
☐ TA-DVS  
☐ Other:  

Briefly explain what the decision was and why you disagree with it.

Before you answer this question, please read "part 2" on the back of this form.

Do you want your benefits to stay the same (not be reduced or stopped) while you wait for the hearing?  

☐ Yes  
☐ No  

(Note: Your benefits may change if something else happens that affects the amount.)

Please read "part 3" on the back of this form for information about expedited hearings.

Check this box if you meet the requirements for an expedited hearing:  

Name of my lawyer or representative:  
Telephone number:  

Address:  
City:  
State:  
ZIP code:  

The administrative law judge may conduct the hearing by phone.

In a telephone hearing, the administrative law judge participates by phone. The client may be at the branch or another place. I understand I will be asked to have an informal conference with an agency representative.

Claimant's signature:  
Social Security number:  
Date:  

The Department is authorized to request your Social Security Number (SSN) under 42 USC 1320b-7(a) and (b), 7 USC 2011-2036, 42 CFR 435.910, 42 CFR 435.920, 42 CFR 457.340(b), and OAR 461-120-0210. Your SSN will be used to locate your file and records. For clients in only the CAWEM, ERDC, REF, and REF M programs, providing a SSN is always voluntary.

DHS completes this part

DHS representative for this matter:  
Issue code:  
Telephone number:  
Date:  

Distribution:  
White: Hearing officer panel  
Canary: Division case file  
Pink: Claimant  
DHS 0443 (8/08)  
Can use (1/08) version
OBJECTIVE:

To establish written rights and responsibilities that are applicable to all Washington County clients.

To inform clients of their rights and responsibilities and to ensure that Washington County clients understand these rights and responsibilities.

To inform contracted providers of Washington County clients’ rights and responsibilities and ensure that contracted providers adhere to Washington County standards pertaining to the rights and responsibilities of Washington County clients.

To ensure that Washington County clients may exercise their rights and responsibilities freely and without retaliation.

To provide appropriate levels of assistance to clients who require assistance to exercise their rights.

POLICY:

It is the policy of Washington County that clients have certain rights and responsibilities that are clearly stated and documented. The rights and responsibilities of Washington County clients will promote the interests and well being of members and will assure that members are treated with dignity and respect. These rights and responsibilities will be communicated to all clients and will be supported and enforced at all levels within the Washington County administrative and service delivery systems.

It is the policy of Washington County that clients are entitled to receive services and to exercise their rights and responsibilities without restrictions based on their religious, cultural or moral grounds. Washington County clients have the right to receive information in alternate formats including foreign language translation,
large print and/or audio or Braille translations for hearing or vision impaired clients.

PROCEDURE:

Washington County will establish the rights and responsibilities of Washington County clients in written form. The written rights and responsibilities will be provided to all members in the Health Share of Oregon Member Handbook and will be made available in alternate formats upon request. A Spanish language version of the Member Handbook will be immediately available upon request. Referral and contact information for non-English speaking service providers will be included in multiple languages at the front of the Washington County Member Handbook. Further, clients who require translation services will be provided with such services without charge. Washington County will retain a list of translators under contract to provide this service. The Member Handbook, including the listing of member rights and responsibilities will be reviewed on an annual basis and will be provided to all Washington County members. As stated in the Member Handbook, these rights and responsibilities include the following:

Client Rights:

- To be treated with dignity and respect.
- To have the same rights and care choices as your providers’ other patients.
- To be encouraged to work with your care team.
- To see your health records.
- To have corrections added to your health information.
- To be active in your treatment plan.
- To talk honestly with your provider about appropriate or medically necessary treatment choices for your conditions, regardless of cost or benefit coverage.
- To refuse services or treatment.
- To be told the consequences of that decision, except for court ordered services.
- To know that information in your medical records is confidential, with exceptions determined by law.
- To sign advance directive forms, such as a living will or a power of attorney. These forms explain the care you want or don’t want if you cannot make these decisions for yourself. They apply to medical, surgical, substance use or behavioral care.
- To know how to appeal a decision or file a complaint with the RAE. To receive a response to your appeal or complaint.
- To receive the level of service that you expect and deserve, as approved by your provider or providers.
• To have a friend, family member or advocate with you during appointments and at other times if you need them, within clinical guidelines.
• To have a language interpreter with you during appointments at no charge to you, if you wish.
• To have information provided in a way that works for you. For example, you can get it in other languages spoken in the plan service area, in Braille, or in large print or other alternate formats such as electronic, etc. If you are eligible for Medicare because of a disability, we must give you information about the plan’s benefits in a way that is best for you.
• To have access to our staff and to translation service, available to members who don’t speak English.
• To receive a notice that tells you how your health information may be used and shared.
• To decide if you want to give your permission before your health information can be used or shared for certain purposes, such as advertising.
• To get a report on when and why your health information was shared for certain purposes.
• To have a stable care team that helps you with complex care needs.
• To make an appointment with a mental health, chemical dependency or family planning provider without first getting a referral from your PCP.
• To get information about your condition, and covered and non-covered services so you can make informed decisions about treatments recommended by your providers.
• To receive written materials describing:
  • Your rights and responsibilities.
  • Your available benefits.
  • How to get services.
  • What to do in an emergency.
• To have written materials explained in a way that you understand.
• To be informed about the coordinated care approach.
• To know how to get coordinated health care.
• To receive necessary and reasonable services to diagnose your medical condition.
• To receive covered services under the Oregon Health Plan that meet generally accepted standards of care and are medically appropriate.
• To get covered preventive services.
• To have access to urgent and emergency services 24 hours a day, seven days a week.
• To have a clinical record that documents:
  • Your conditions.
  • Any services you received.
  • Any referrals your PCP made to specialists.
• To get a second opinion at no cost to you.
Revised 4-7-2014

- To get care and support close to where you live. To get such care from providers who understand your culture.
- To get help when you move from one care setting to another. To get that help in a way that works best for you from providers who understand your culture.
- To keep you out of the hospital and get your mental health care in a comfortable place.
- To have help getting social support services statewide. To get such help from providers who understand your culture.
- To transfer a copy of your clinical record to another provider.
- To be free from any form of restraint or seclusion (isolation) that is not medically necessary or is used by staff to bully or punish you. Staff may not restrain or isolate you for the staff’s convenience or retaliation against you.
- You have the right to report violations to Washington County and to the Oregon Health Plan.
- To receive written notices before a benefit or service level is denied or changed, unless this notice is not required by federal or state regulations.
- To ask for an administrative hearing with the Oregon Health Authority.
- To know as soon as possible that your provider cancelled an appointment with you.
- To receive information about Washington County, our providers, practitioners services and members’ rights and responsibilities.
- To make recommendations about Washington County member rights and responsibilities policy.
- To get information about a network provider’s professional training.
- To request and receive information on the structure and operation of RAE or any physician incentive plan.
- To know that if you believe your rights are being denied or your health information isn’t being protected, you can do either or both of the following:
  - File a complaint with your provider or health insurer.
  - File a complaint with the Client Services Unit of the Division of Medical Assistance Programs. You can call them at 1-800-273-0557 or TTY: 503-378-6791.

**Client Responsibilities.**

- To notify your provider of significant changes in your circumstances that may effect your treatment services;
- To treat your provider and our staff with respect;
- To tell your provider of your mental health treatment needs and concerns;
- To ask questions about things you don’t understand;
Revised 4-7-2014

- To participate in treatment decisions and to be actively involved in developing your treatment plan;
- To follow agreed upon treatment plans;
- To be sure you have approval from us before going to a provider not on our provider list;
- To keep appointments and be on time;
- To call your provider when you are going to be late or can’t keep an appointment;
- To obtain mental health services from us or an approved provider except in an emergency;
- If you are an Oregon Health Plan member, to show your State of Oregon Department of Medical Assistance Programs (DMAP) Medical Care Identification to your provider before services are received;
- To tell your provider, Washington County, and your DMAP worker of a change of address and phone number;
- To assist us in getting payment from other insurance you may have; and
- To inform us and your provider of any changes in your OHP enrollment status.

Washington County clients have the rights to receive services from their choice of contracted providers. Clients have the right to request a change in providers in accordance with Washington County policies and procedures on Transfer Requests within a Single Authorization Period. Contracted providers are required to inform clients of their rights at the time of enrollment in services with the provider. Washington County contracts with providers will require that the provider will post Client Rights, including complaint procedure, in a visible location at service site(s). Provider compliance with the requirement to inform clients of their rights and to support clients in exercising these rights will be reviewed during periodic certification and credentialing site reviews.

Washington County clients have the right to initiate complaints and grievances and to seek resolution for their grievances through the Washington County complaint grievance process, including the right to request a State Fair Hearing in accordance with Washington County Appeal and Hearing Policy and Procedures. Washington County will provide assistance to any client requesting assistance in exercising these rights. Client complaints may be initiated at the provider level, through Washington County Access Line or directly to Washington County in accordance either verbally or in writing with the Washington County Complaints and Grievances policy and procedure. In all cases, members filing a complaint must be treated with respect and dignity regardless of the nature of the complaint.

Washington County clients have the right to contest decisions to deny payment for services, reduce or substantially alter the level of services or otherwise restrict the member’s access to benefits to which the member may be entitled.
Revised 4-7-2014

Washington County Mental Health Organization members will receive a Notice of Action in such instances in accordance with Washington County Client Notice of Action policies and procedures. Members will be notified in writing of service denials and their rights to contest the decision. The notice will include a written statement of the member’s hearing rights and how to exercise these rights, including a copy of the Administrative Hearing Request form. Members requesting assistance in exercising these rights may be provided such assistance by Washington County Mental Health Program staff or representatives without prejudice.

Washington County clients will be provided with written notice of any significant changes relating to their rights and/or information about diminished availability services or termination of providers at least 30 days prior to the effective date of the change. Washington County will make a good faith effort to give written notice of termination of a provider to each enrollee served by the provider.
Washington County Health and Human Services (WCHHS)
Mental Health Program
Policy and Procedure

Policy Title: Complaints and Grievances
Approved: __________________________     _______________
Division Manager    Date

OBJECTIVE:

To promote and protect the rights of Washington County Mental Health Program recipients through an effective and accessible process for resolution of complaints or grievances relating to services and benefits available to Health Share of Oregon members and other individuals receiving services through the Washington County Mental Health system of care.

To inform recipients of mental health services of the availability of the Washington County Mental Health Program complaint process and to educate members in the use of the process.

To assure that clients’ complaints are resolved in a timely manner and that the client is notified of the resolution.

To educate clients in their right to appeal a complaint resolution with which they do not agree and how to initiate an appeal.

To ensure that clients are free from retaliation or negative consequences as a result of filing a complaint or appeal.

POLICY:

For the purposes of this policy, a complaint means a Washington County Mental Health client’s, or the client’s representative, expression of dissatisfaction to Washington County or a contracted provider about any matter other than a reduction, suspension or termination of a requested service. Washington County provides a process for individuals to make complaints concerning Washington County Mental Health services and to ensure contracted providers’ compliance with the Health Insurance Portability & Accountability Act (HIPAA), the Balance Budget Act (BBA), the Health Share of Oregon contract with the Washington County, 42 CFR Part w, and all other federal and state laws, rules and regulations requiring a grievance process. This process allows any complaint from an individual to be received and investigated by Washington County.
It is the policy of Washington County Health that all clients requesting or receiving service through the Washington County mental health service delivery system have the right to file a complaint or to appeal the resolution of a complaint. Additionally, the guardian or legal representative of a Washington County client may submit a complaint or appeal on behalf of the client. Clients will be informed of their rights to initiate a complaint and to appeal decisions relating to their care. Washington County Mental Health program shall provide the client, client’s representative, or provider with an opportunity, before and during the appeals process, to examine the client’s clinical records consistent with state law or other federal regulations governing privacy and confidentiality of mental health records considered during the appeals process. In the event of the death of the client, his/her representative or the client’s estate representative, or provider may participate in the appeals process.

Clients enrolled with the Oregon Health Plan and who are eligible for services managed through Washington County will be informed of their rights to initiate complaints within 30 days of enrollment through the Health Share of Oregon Member Handbook that is mailed to all new members upon enrollment. All clients enrolled in services with contracted provider agencies will also be informed of their rights to initiate a complaint and appeal upon initiation of services with the contracted provider.

The complaint and appeals process will be readily accessible and responsive to the needs and interests of Washington County clients and other persons who receive mental health services through Washington County and its contracted provider system. Clients will be educated in the use of the complaint process through three primary sources: the Health Share of Oregon Member Handbook, newsletters or other informal notices, and by the provider upon entering services.

If the person submitting the complaint is unable to write out the complaint a staff member of the organization receiving the complaint (e.g., a provider, Member Access Line, or Washington County Mental Health program) will assist that person in putting the complaint in writing.

While clients are encouraged to attempt to resolve complaints directly with their provider, clients may also complain directly to Washington County in seeking remedy to a complaint or grievance.

**PROCEDURE:**

A client, the client’s guardian or legal representative, or provider may file a complaint either verbally or in writing on behalf of the client with written consent by contacting any of the following:

- Provider agency clinical or administrative staff;
Washington County Member Access Line;

Washington County Mental Health Program representative;

Washington County Mental Health Program and/or its providers will make available written materials, or alternate forms, to meet special needs of members as necessary to initiate a complaint or appeal.

Timelines for resolution of complaints: Complaints will be addressed as expeditiously as possible. For standard complaints the disposition of the complaint will be completed, and the client will be informed of the disposition, within 5 working days from the date the complaint was received or the client will be notified in writing that a delay of up to 30 days is necessary to resolve the complaint. The written notice to the client for any delay beyond 5 working days will specify the reasons the additional time is necessary.

Disposition of Complaints.

a. An oral decision about a complaint will address each aspect of the client’s complaint and will explain the reason for the decision. The oral decision and explanation will be documented in writing.

b. A written decision must be provided if the client’s complaint was received in writing. The written disposition will review each element of the complaint and will specifically address each element of the complaint, including the reason for the decision.

Complaint Submitted to Mental Health Provider Agencies.

In most instances, clients are encouraged to submit complaints directly to the contracted provider agency where they have requested services or are receiving services. If the client is not receiving services and has a complaint about access to services or other concerns about the services, the member is encouraged to submit the complaint directly to Washington County. Providers who receive complaints from Washington County clients that are not enrolled in services with the provider are expected to provide necessary assistance to assist the member to submit the complaint directly to Washington County. Providers are expected to respond to complaints from individuals as described below.

a. All contracted providers shall have a complaint policy posted in their waiting room or other comparable public access area.

b. When a client begins to receive services, the provider will provide the client with information about how to access the process at both the provider and the plan level. The provider will document in the
client’s individual record that the complaint process has been explained to the person.

c. A client may complain directly to clinical or administrative staff at the provider agency where they have received services. If the client is unable to write out the complaint the agency will provide reasonable assistance to aid the person in putting the complaint into writing, including interpreter services where necessary.

d. A client may authorize a representative to act on his/her behalf or to assist the client in submitting and proceeding with a complaint.

e. If a client wishes a Washington County representative to be present when the complaint is being discussed, Washington County will arrange to meet with the person and the provider in an effort to resolve the complaint.

f. If the complaint involves an OHP client and can be successfully resolved to the complainant’s satisfaction, the provider will fax the details of the resolution to Washington County Mental Health Program for entry into the Complaint Log.

g. If a complaint cannot be resolved at the provider level to the complainant’s satisfaction, the complaint may re-submitted to Washington County for additional review and consideration.

h. In cases when a client is unable to re-establish a therapeutic alliance with the provider agency and all parties agree to a transfer, the client’s services will be transferred to another agency.

i. Providers will maintain a record of complaints and resolutions and forwarded to Washington County Mental Health Program on a monthly basis. The monthly report will identify the date of the complaint, the category of complaint, disposition, and date of resolution of the complaint.

j. Appeals or requests for an additional review of a client’s complaint may not include decision makers involved in previous reviews or decisions pertaining to the complaint.

Complaint Submitted to WASHINGTON COUNTY Member Access Line.

a. Clients may initiate a complaint directly to the Access Line. Complaints to the Access Line may relate to services and activities provided by Access Line or relating to other aspects of the Washington County and Health Share of Oregon benefit package and service delivery system.
b. The Access Line staff member who is initially contacted with an expression of dissatisfaction or concern will clarify with the individual the nature of the complaint and the resolution the person is seeking to the complaint.

c. Complaints received by the Access Line will be forwarded to Washington County no later than the next business day.

Complaint Submitted to Washington County Health and Human Services.

Washington County Mental Health Program staff who receive a complaint or an expression of dissatisfaction from a client or a client’s legal representative will clarify the nature and circumstances of the complaint and the resolution the individual is seeking to the complaint. If the person is seeking resolution of a complaint (as opposed to simply registering a concern), Washington County will determine the person’s desired outcome to the complaint.

The Washington County Mental Health Program Quality Improvement Coordinator or other designated staff member will review the complaint to determine if additional information is required from the client or client representative. If more information is needed, the client or client’s representative will be notified that additional information is needed and that the grievance decision may be delayed beyond 5 working days and up to 30 days. The additional information must be furnished to Washington County within 14 days or another mutually agreed upon time or the complaint or grievance may be resolved without this information.

Following receipt of a complaint, Washington County Mental Health Program will notify the provider, where applicable, of the complaint to seek the provider’s input on the complaint. Washington County Mental Health Program will determine whether the complaint should be referred to the provider for resolution or whether to pursue resolution of the complaint directly at the Washington County level.

If it is determined that it is unlikely the complaint can be resolved within 5 working days, Washington County Mental Health Program will notify the complainant in writing. This notice must:

1) Be issued as soon as it is known that a delay will occur;

2) Specify the reason for the delay;

3) State when a decision is expected to be made, not more than 30 days from receipt of the initial complaint.
Washington County Mental Health Program staff will notify the client or client representative of the resolution of or decision on complaints or grievances. If the decision is adverse to the client or client representative and relates to denial or reduction of services, a Notice of Action will be issued along with a statement of Appeal and Hearing Rights.

**Documentation of Complaints.**

Washington County Mental Health Program will maintain a complaint log of all complaints submitted by Washington County clients and providers. Information from the complaint log will be aggregated and submitted to Health Share of Oregon within 20 days after the end of each calendar quarter in the format specified in the contract Health Share of Oregon.

All contracted providers are required to have a process for recording and reporting complaints, which will be available to Washington County Mental Health Program upon request. Documentation of complaints will be maintained for a minimum of 7 years from the date of resolution of the complaint.

Providers will supply Washington County Mental Health Program with an aggregate report of complaints received within a 20 days after the end of each month. The provider’s report will include date of the complaint, the category of complaint, disposition, and date of resolution of the complaint and any other information required by the state to comply with the agreement between Washington County and Health Share of Oregon.

Washington County Mental Health Program will review complaint logs submitted by providers to ensure that the response to complaints and the resolution of complaints occur within appropriate time frames.

If Washington County Mental Health Program’s analysis of complaint data indicates that a provider has a disproportionately high volume of complaints or serious complaints relating to ethical or safety concerns, Washington County may initiate further investigation of the provider’s activities relating to client complaints.

The provider agency will be informed in writing of the results of any investigation and any resulting corrective action requirements or recommendations. Washington County may institute corrective actions for a provider or impose other sanctions as deemed appropriate by Washington County Mental Health Program to respond to significant complaint patterns and/or serious incidents.
MEMBER COMPLAINT FORM

If you need this form in a larger print or a different format, call (503) 846-4554

Please complete all of this form, sign and date it. Use the back of this page if you need to. You will receive a written response within 5 calendar days from the date of this form. If you do not agree with the response, you have the right to ask us to change the findings by filing an Appeal. The next page tells you how to do this.

IF YOU NEED THIS FORM IN A DIFFERENT FORMAT, SUCH AS LARGE PRINT, AUDIO RECORDING OR BRAILLE, PLEASE CALL 503-846-4554.

Your Name: ___________________________ Date: ______________________
Client’s Name (if you are not the client): __________________________________________
Address: _________________________________________________________________
City: ___________________ State: ___________________ Zip: ________________
Birth Date: _______________ SSN: ___________ Recipient ID: __________

Please tell us what happened. When did it happen? Who was involved?

Did you receive a Notice of Action? Yes ☐ No ☐ (please check one of these boxes)

What do you want done about it?

(If necessary please use additional space on the back side of this form.)

Is this an emergency? Yes ☐ No ☐ (please check one of these boxes)

You can file this complaint one of three ways:

1. Submit the completed Complaint Form to you’re the program where you receive services.
2. Mail the completed Complaint Form to Washington County Health and Human Services, 155 N. First Avenue, MS #70, Hillsboro, OR 97124.

3. Call Washington County Health and Human Services at (503) 846-4554, Member Services (503) 846-4555, -800-995-0017, or TDD 1-800-735-2900.

4. If you need more space to answer these two sections from the front side of this form, please continue here:

<table>
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<th>Please tell us what happened. When did it happen? Who was involved?</th>
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<td>Did you receive a Notice of Action?</td>
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What do you want done about it? CONTINUED FROM FRONT SIDE ↓

**Note:** You may also file a complaint at any time with the Oregon Health Authority/Addictions and Mental Health Division at: 500 Summer Street NE E86, Salem, OR 97301-1118. This includes your right to file a complaint regarding non-compliance with Advanced Directives or Declaration of Mental Health Treatment.
OBJECTIVE:

To provide coordination of care for WCHHS consumers with unique needs or requiring services from more than one local and/or regional allied agency so that planning and treatment of consumers’ mental health needs is done within the context of the full service array.

To maintain open communication and collaboration with all local and/or regional allied agencies/systems that have responsibility for providing services to WCHHS consumers.

To reduce duplication of services that can occur when consumers access services from multiple agencies.

To effectively manage public funds so that each agency involved in a WCHHS consumer’s care is paying for the services required under their mandate, and not services that could be paid for from another source.

POLICY:

WCHHS consumers with unique needs and consumers who require services from more than one local and/or regional allied agency will receive services coordinated across all agencies.

WCHHS Care Coordinators are responsible for coordinating mental health referrals and authorizations with all providers, referral agents, and allied agencies providing services to WCHHS consumers with unique needs or with multi-system involvement.

 Providers contracted with WCHHS are responsible for appropriate coordination of services for their consumers including (but not limited to): comprehensive strengths-based assessments, individualized treatment planning, intensive community-based outreach and treatment, interagency collaboration, inclusion of the consumer’s natural systems of support, peer support systems (as appropriate), transition planning and aftercare.
Providers will actively pursue obtaining signed Releases of Information from the consumer for all allied agencies involved in their care. Releases of Information are not required when both organizations providing services to the consumer are funded by Health Share of Oregon.

**PROCEDURE:**

All Washington County consumers enrolled in mental health treatment will receive a mental health assessment from a Qualified Mental Health Professional (QMHP). The QMHP will seek to determine if the consumer is receiving service from any other public agency or service provider, including but not limited to Corrections, Aging and Persons with Disabilities (APD), Department of Human Services Child Welfare, Oregon Youth Authority (OYA), Developmental Disabilities, law enforcement, primary care, and/or Juvenile Justice. The mental health assessment must include screening for substance abuse. If the consumer is receiving other services or treatment, the consumer will be asked to sign Releases of Information for all agencies and/or providers involved in the consumer’s care. The QMHP should explain to the consumer the importance of coordination of care and communication with other service providers and encourage the consumer to sign an authorization for Release of Information as appropriate. If the consumer refuses, this refusal will be documented in the consumer’s records. Releases of Information are not required when both organizations providing services to the consumer are funded by Health Share of Oregon.

If the consumer agrees to sign an authorization for Release of Information, the therapist or case manager will contact the appropriate service providers for multi-disciplinary service planning and service coordination as clinically indicated. Coordination with substance abuse providers will be conducted in accordance with WCHHS policy on Treatment of Co-occurring Disorders. Releases of Information are not required when both organizations providing services to the consumer are funded by Health Share of Oregon.

**Coordination with Child Welfare**

WCHHS and DHS-Child Welfare have a Memorandum of Understanding that outlines the agreements and responsibilities of each system. To ensure close collaboration between WCHHS and DHS-Child Welfare, regular avenues of communication are maintained and include:

**System of Care Executive Leadership Council:** The Executive Leadership Council is the governing body for the Washington County Children’s System of Care. This council is comprised of high level decision makers from the system of care who have the authority to make funding and policy decision for the agencies/organizations and meets quarterly. Membership includes, the WCHHS Behavioral Health Division Manager, the District Manager, DHS Child Welfare...
District 16, Director, Washington County Juvenile Department, Field Supervisor, Oregon Youth Authority (OYA) Washington, Columbia, Clatsop, and Tillamook Counties, National Alliance for the Mentally Ill (NAMI) Washington County Executive Director, an Oregon Family Support Network (OFSN) representative, Safe Schools Healthy Students Project Director, Tigard-Tualatin School District, a provider representative, the WCHHS Child and Adolescent Program Supervisor. Other members may be invited as deemed appropriate by the Council.

The Children’s Intensive Service and Wraparound Advisory Council: The DHS Service District Area Manager for Washington County Child Welfare is a member of the Advisory Council, which meets quarterly at a minimum. This meeting includes WCHHS Mental Health staff, representatives from other allied agencies and family members/consumers/family advocates. The purpose of the Advisory Council is system oversight, planning and evaluation, identifying needs and establishing priorities, recommending system improvements, and providing a forum for advocacy.

Child Welfare Advisory Council/Casey Program Collaborative: The Children’s Mental Health Program Supervisor attends this monthly meeting dedicated to oversight and evaluation of the local child welfare system.

System of Care Practice Workgroup: This group includes supervisory representation from DHS Child Welfare, WCHHS, Juvenile Justice and Intensive Treatment providers. The purpose is to share barriers identified at the child and family team level that are not able to be addressed at that level and need higher level intervention.

Alternate Care Committee: A WCHHS Child & Adolescent Care Coordinator attends this regularly scheduled meeting conducted by Child Welfare, Juvenile Justice, and Oregon Youth Authority. This committee reviews and makes recommendations on all out-of-home placements, except routine foster care. This meeting is also available for case consultation for youth with multi-systemic involvement.

Assessments: WCHHS authorizes a mental health screening for every youth placed in substitute care and enrolled in Health Share of Oregon, assigned to Washington County.

Coordination with Washington County Juvenile Department

WCHHS and Washington County Juvenile Department have a Memorandum of Understanding that outlines the agreements and responsibilities of each system.

To ensure close collaboration between the Juvenile Department and WCHHS, regular avenues of communication are maintained and include:
System of Care Executive Leadership Council (described above): The Director of the Washington County Juvenile Department attends this quarterly meeting.

The Children’s Intensive Services and Wraparound Advisory Council (described above): The Director of the Juvenile Department or his/her delegate attends this monthly meeting.

System of Care Practice Workgroup (described above): The Field/Diversion Division Manager or his/her delegate attends this monthly meeting.

Alternate Care Committee (described above): A WCHHS Child and Adolescent Care Coordinator participates in this bi-weekly DHS, Juvenile Justice, and OYA meeting.

Harkins House: Harkins House is a Behavior Rehabilitation Services (BRS) short-term shelter operated by Juvenile Justice. WCHHS sub-contracts with a certified provider to conduct a mental health assessment of each WCHHS OHP eligible child admitted to Harkins House and provide treatment recommendations.

**Coordination with Oregon Youth Authority**

To ensure close collaboration between WCHHS and Oregon Youth Authority (OYA), regular avenues of communication are maintained and include the following WCHHS meetings described previously in this document: System of Care Executive Leadership Council, Children’s Intensive Services and Wraparound Advisory Council (attended by the OYA Regional Manager or his/her delegate), System of Care Practice Workgroup (attended by the OYA Regional Manager or his/her delegate).

A WCHHS Child and Adolescent Care Coordinator participates in the bi-weekly Alternate Care (described above) meeting held by Child Welfare, Juvenile Justice and OYA. WCHHS also frequently consults with Juvenile Justice to arrange for continuing mental health care for children leaving a BRS facility and OYA custody.

**Coordination with Education**

To ensure close collaboration between WCHHS and Washington County School Districts, WCHHS employs a School Mental Health Services Liaison. This position is responsible for serving on Student Threat Assessment and Youth Services Teams, assisting schools in linking students to mental health services and being a general resource to districts in accessing the mental health system.

Regular avenues of communication are also maintained by ad hoc meetings with individual schools districts and the Northwest Regional Education Service District (NWRESD), and participation on various committees including the following
WCHHS meetings described in detail previously in this document: Children’s Intensive Services Advisory Board (attended by a representative selected by the Washington County School Districts and a representative of Northwest ESD.

**Coordination with Community Corrections/Law Enforcement**

WCHHS coordinates services for individuals involved with the criminal justice system in multiple ways. These include, but are not limited to:

- Participation in biweekly team meetings with the Washington County Mental Health Court
- Participation in quarterly special needs meetings facilitated by Washington County Community Corrections
- Regular contact and coordination with the Sheriff’s Office liaison to Mental Health.
- Regular contact and coordination with mental health probation/parole officers to ensure appropriate mental health service delivery
- Employ a Mental Health Liaison located within the Washington County Jail to coordinate aftercare and referral to mental health services for inmates eligible for treatment.
- Participation in Crisis Intervention Team trainings for law enforcement
- Participation in bi-monthly MH/LE coordination meetings involving MH Jail Liaison staff, WCSO MH Sergeant, Hillsboro Police Dept. MH Sergeant and WCSO Patrol Lieutenant.
- Participation in a leadership role of the Washington County Mental Health, Law Enforcement and First Responders Executive Steering Committee.

**Coordination with Disability, Aging and Veterans Services (DAVS):**

To ensure close collaboration with DAVS, WCHHS regularly participates in case consultation and system education. At a minimum, WCHHS provides training to DAVS staff regarding system access, services available and eligibility criteria. These trainings occur annually or as requested by DAVS staff. The WCHHS Care Coordinators are also available to respond to any questions regarding the mental health system and have provided contact information for DAVS staff.

**Coordination with Developmental Disabilities:**

As many clients who have a developmental disability also have a co-occurring mental illness, care for these individuals is coordinated with Developmental Disability staff through individual case consultation with WCHHS Mental Health Care Coordinators. Additionally, WCHHS provides training to Developmental Disabilities staff regarding system access, services available and eligibility criteria. These trainings occur annually or as requested by Developmental Disabilities staff.
Washington County Health and Human Services (WCHHS)
Mental Health Program
Policy and Procedure

Policy Title: Coordination with Physical Health Care Providers and Physical Health Plans

Approved: __________________________     _________________
Division Manager     Date

OBJECTIVE:

To acknowledge the interdependence of physical and behavioral health care needs.

To encourage WCHHS clients and providers to adopt a holistic health perspective.

To coordinate care with primary care providers to enhance clients' health and well being.

To avoid adverse drug interactions among clients receiving services from health care and mental health care providers.

To insure the provision of health, mental health and chemical dependency services in an integrated manner whenever possible.

To assist community systems of care in the development of integrated health homes that meet the needs of clients with behavioral health issues.

POLICY:

Coordination

WCHHS and its sub-contracted providers will coordinate with physical health care providers and Oregon Health Plan (OHP) physical health plans to facilitate access to primary and specialty care appropriate to the member’s needs.

WCHHS shall ensure that in the process of coordinating care, the OHP Member’s privacy is protected consistent with the confidentiality requirements in 45 CFR parts 160 and 164 subparts A and E, to the extent that they are applicable, and consistent with other State law or Federal regulations governing privacy and confidentiality of mental health records.
As allowed under HIPAA, the WCHHS Care Coordinators and Supervisors will coordinate with the physical health plan Exceptional Needs Care Coordinators (ENCCs) when a mutual member is identified as having unique physical or mental health needs.

WCHHS will consult with, and provide assistance and education to physical health care providers in the WCHHS service area in early identification, prevention and treatment of mental disorders, as requested.

WCHHS will look for and promote opportunities for mental health providers to become educated in physical disorders common to persons with mental health disorders.

Integration

WCHHS shall develop, implement and participate in activities supportive of a continuum of care that integrates mental health, addiction and physical health interventions in ways that are seamless and whole to the WCHHS client. Integration activities may span a continuum ranging from communication to coordination to co-management to co-location to the fully integrated, person-centered health care home.

WCHHS shall demonstrate involvement in integration activities such as, but not limited to:

- Facilitation of communication and coordination between physical and behavioral health care providers;
- Enhanced communication and coordination between WCHHS and physical health plans, dental plans, physical health providers, Fully Qualified Health Centers, and chemical dependency providers;
- Implementation of integrated prevention, early intervention and wellness activities;
- Development of infrastructure support for sharing information, coordinating care and monitoring results;
- Use of screening tools, treatment standards, and guidelines that support integration;
- Support of a shared culture of integration across health plans and service delivery systems; and
- Implementation of a system of care approach, incorporating models such as the Four Quadrant Clinical Integration Model of the National Council for Community Behavioral Healthcare.

PROCEDURE:

Responsibilities of WCHHS Sub-contracted Provider Agencies:
Revised 3-7-2014

As part of the intake and assessment process, WCHHS sub-contracted providers determine if the WCHHS client has a Primary Health Provider (PCP). For Health Share of Oregon OHP members, coordination of care and exchange of protected health information is expected between the physical health care provider and the mental health provider. This may be done without a Release of Information given that both providers are operating under Health Share of Oregon agreements. When the member is funded with general fund, the provider will attempt to obtain permission from the member to coordinate care through a written Release of Information.

Sub-contracted provider staff are responsible for informing the PCP in writing of the WCHHS client’s entry into mental health treatment after an appropriate release has been signed (when required). Sub-contracted provider staff are also responsible for informing the PCP in writing of any significant change in the client’s mental status or medications.

Washington County supports a model of care that emphasizes prevention and routine care. Providers are encouraged to assist WCHHS members to receive routine health exams with their PCP even when there is not an immediate health concern.

Clients with no Identified PCP.

The amount of assistance given to a client by WCHHS and/or sub-contracted providers in obtaining a PCP or identifying their assigned PCP will be based on the functioning level of the WCHHS client and the client's need for assistance. Outpatient level of care clients who disclose that they have no PCP will be encouraged by the provider agency and/or WCHHS staff to call their Physical Health Plan’s Member Services to find out the process for obtaining a PCP. If the client is a child or adolescent, their parent or guardian will be encouraged to obtain a PCP for their youth.

Clinicians providing mental health services and supports to WCHHS clients with severe and persistent mental illness (both adult and child/adolescent) are expected to take an active role in seeking PCP services for their clients.

Clients with no insurance coverage for physical health care will be provided with information about “safety net” clinic alternatives.

Clients with Chronic Disease.

WCHHS clients or their guardians are asked to identify any current or chronic medical conditions as part of the mental health assessment.
Revised 3-7-2014

If such a medical disease or disorder is identified, mental health provider staff will follow procedures outlined above to determine if the client is receiving care for this condition from a PCP or a medical specialist.

When medical treatment is being provided by a specialist, provider staff will request the client to sign a Release of Information for that specialist and, if appropriate, the ENCC of the FCHP.

If a WCHHS client identifies a significant physical disease or disorder for which the client is not receiving treatment, the clinician will encourage and/or assist the client to obtain necessary treatment as appropriate. When a client with a significant medical disease or disorder is receiving mental health treatment, the clinician is encouraged to monitor the client’s compliance with their medical treatment plan.

All communication between physical health care providers and sub-contracted provider agencies will be documented in the client’s chart. Evidence of compliance with communication and collaboration between medical providers and the sub-contracted provider agency will be monitored by periodic chart reviews.

**Coordination with Physical Health Plans.**

Communication with physical health plans will most commonly occur between WCHHS staff and the physical health plan’s ENCCs. If a Care Coordinator learns from a provider that a WCHHS OHP member’s mental health or physical disorder is disrupting mental health treatment or contributing to a deterioration in the member’s mental status, or if mental illness is impacting the member’s ability to comply with a medical treatment plan leading to a decline or deterioration in physical health, the Care Coordinator or WCHHS Supervisor may contact the ENCC to request assistance. WCHHS Care Coordinators will also respond as appropriate to ENCC’s requests for assistance in assisting members to access and receive appropriate medical care.
Washington County Health and Human Services (WCHHS)
Mental Health Program
Policy and Procedure

Policy Title: Credentialing and Recredentialing

Approved: __________________________     ______________
Division Manager   Date

OBJECTIVE:

To ensure that mental health services will be provided by qualified persons and organizations.

To ensure that contracted provider organizations and practitioners meet or exceed federal, state and local credentialing standards established by CMMS, the State of Oregon, and Health Share of Oregon.

To ensure that contracted provider agencies have a valid Certificate of Approval issued by the State of Oregon and will provide mental health services in compliance with applicable Oregon Administrative Rules or other acceptable licensure to provide services.

To ensure consistent application of oversight and review standards and practices within the Tri-County region encompassed by Clackamas, Multnomah, and Washington Counties.

POLICY:

Contracted providers and practitioners will meet or exceed credentialing and re-credentialing standards established by Washington County in collaboration with other participating counties consistent with the Risk Accepting Entity (RAE) agreement between Washington County and Health Share of Oregon and in keeping with standards established by the Oregon Health Authority.

Contracted providers that provide services to Washington County clients will be credentialed through the Washington County and/or tri-county credentialing process and will be recredentialled no less frequently than every three years thereafter.

PROCEDURE:
Washington County will conduct periodic credentialing and re-credentialing of contracted provider organizations. These reviews will be conducted in collaboration with other participating counties in the tri-county area. Credentialing of new practitioners may be initiated in keeping with standards described in OAR 301-012-0100 et seq. Credentialing of independent practitioners will be conducted in accordance with the Washington County policies and procedures for Credentialing and Recredentialing of Exceptional Needs Providers upon initial request for the practitioner to become a provider of services to WCHHS members.

Site reviews of contracted provider agencies will occur no less frequently than every three years to verify compliance with contractual expectations and applicable Oregon Administrative Rules (OARs). Washington County also conducts interim record reviews of each program area within each contracted provider two times per year to identify service delivery and record keeping concerns that may arise between periodic credentialing reviews. A representative sample, up to an estimated 10 percent of authorized client records, may be examined through the interim review process annually. Interim reviews will be conducted using standardized review forms. The interim record reviews may result in a more formal site review or more frequent interim reviews for a given provider as deemed necessary and appropriate. Additionally, interim reviews may result in corrective action at the discretion of Washington County.

**Credentialing/Certification Reviews.**

Comprehensive credentialing and certification reviews will be conducted a minimum of every three years for all contracted participating provider agencies through a credentialing protocol established and agreed upon by the 3 counties operating as mental health Risk Accepting Entities (RAEs) of Health Share of Oregon in the tri-county area. Credentialing reviews will follow the established Tri-County review process including review of requested desk audit materials (e.g., policies and procedures, staff lists, etc), inspection of clinical records, review of selected personnel files, and interviews with key personnel. The review of selected personnel records will occur to ensure that providers adequately verify credentials of individuals performing clinical services and to ensure that the provider personnel system appropriately addresses background checks, exclusion from Medicaid participation and primary source verification of clinician credentials. Site reviews will also include a general assessment of the privacy of examining rooms and other protections of client privacy, and compliance with civil rights and Americans with Disabilities Act (ADA) regulations.

Periodic site reviews of participating providers will include a focus on compliance with clinical standards and documentation requirements established in applicable Oregon Administrative Rules and in the RAE Agreement with Health Share of...
Oregon. Toward that end, inspection of selected clinical records will include review of Mental Health Assessments, Individual Service and Support Plans, and Service Notes and periodic progress reviews in accordance with applicable standards. Review of clinical documents will be conducted to assess whether treatment needs and diagnosis are documented in the mental health assessment and provide an adequate basis for development of individualized treatment plans. Implementation of prescribed treatment services as listed on individualized treatment plans will be assessed through review of clinical progress notes for selected records.

Credentialing activities will include review of activities and responsibilities that have been delegated to contracted providers as described in Washington County Delegation of Activities policies and procedures. Delegated areas that may be subject to review include treatment services, utilization management, complaint and grievance activities, Notices of Action, second opinions, and emergency/crisis response activities. Delegated activities may also be subject to ongoing monitoring including provider submission of periodic reporting of complaint/grievance logs, access reports, submission of notice of action and second opinion data, and other reporting as may be required by Washington County.

Washington County will verify whether contracted providers have been excluded from federal Medicaid participation as documented by the HHS Office of Inspector General through the OIG online database. Contracted provider organizations will also be required to report OIG exclusion database findings for employees as a component of their annual practitioner reports submitted to WCHHS. The practitioner report will also provide verification of academic degrees, licenses, and qualifications of employees providing services under the certification of the organization. These qualifications will be subject to periodic review during formal site reviews. Periodic site reviews will include review of provider practices for verification of academic degrees, licenses, and qualifications of employees providing mental health treatment services.

Monthly reporting requirements for contracted providers will include submission of access reports for routine, urgent and emergent service requests. Monthly complaint/grievance reporting requirements for contracted providers will include submission of data pertaining to the number and type of complaints received, time lines for resolution of complaints, and information relating to appeals and hearing requests stemming from unresolved complaints. Contracted providers will submit copies of Notices of Action that are issued to Washington County Health Share of Oregon members and will also complete periodic reporting of notices of action and second opinion requests as may be required by Washington County and/or Health Share of Oregon.

Credentialing and recredentialing of participating providers will include review of policies and procedures regarding the use of seclusion and restraint. Providers
Revised 2-14-2014

of outpatient treatment services will inform members of their rights to be free from the use of seclusion and restraint. Providers that are certified or licensed by the State of Oregon to provide day and residential treatment levels of care that may include seclusion and restraint will have policies and procedures in place to address all aspects of the use of such procedures in accordance with federal and state standards and requirements. Programs that employ the use of seclusion and restraint will demonstrate compliance with applicable state and federal standards for the use of such procedures. Program policies will be reviewed to ensure that procedures are in place for formal designation of individuals who are qualified to prescribe and implement the use of these procedures, monitoring and supervising the use of such procedures and appropriate internal retrospective review of each use of seclusion and restraint. Providers that employ seclusion procedures must have a safe and secure seclusion room consistent with state and community standards for physical safety and to allow appropriate visual monitoring of individuals in seclusion.

Provider policies will include notification of Washington County and/or the Oregon Health Authority of the frequency of use of seclusion or restraint, including any adverse outcomes from the use of such procedures. Adverse events include circumstances of physical injury requiring immediate medical attention by a physician or emergency department. Washington County will act in cooperation with the Oregon Health Authority regarding oversight and monitoring of the use of seclusion and restraint for its members enrolled in services in approved treatment facilities as well as in inpatient hospital and acute care facilities that operate under direct oversight and monitoring by the State of Oregon.

Claims Validation.

As part of the contract compliance review process, and regular fraud waste and abuse monitoring, Washington County in cooperation with other participating Health Share Mental Health RAEs (e.g., Multnomah and Clackamas Counties) will complete regular encounter audit reviews with all contracted providers to verify that covered services are:

- Provided within the scope of license or certification of the contracted provider or institution and within the scope of the provider’s contracted services;
- Billed (including submitted encounter claims) in accordance with the service(s) reflected in the service note(s);
- Properly document place of service(s); and
- Provided with all corresponding clinical documentation (assessment, treatment plan, etc.) present as required by Medicaid Rule(s).
Encounter data audit sample will be collected by each of the regional counties to achieve a minimum of 411 Health Share claim lines reviewed annually in order to constitute a representative Health Share sample size.

Encounter data reviews will occur in concert with the Certificate of Approval review and or Contract Compliance reviews.

Encounter data will be selected for a minimum of 10 Health Share member service records for each of the following service types: Adult Outpatient, Child Outpatient, PSRB, and ICTS. Claims will be identified in the following process:

Plan(s) will generate a list of claims from a look-back period of one year prior the date of audit notification. The sample for the encounter data review shall include the sampled records identified for COA review whenever possible, but may include others to ensure to meet a minimum of 10 records of Health Share members exclusively.

5 claim lines will be randomly identified for each individual Health Share member service record selected for review.

During encounter review, regional staff shall compare claim lines generated by health plan against provider clinical documentation using the encounter review tool (see attachment A) documenting findings for claim line including:

- Client’s First and Last Name
- Client’s OHP number
- Date(s) of Service
- Encounter Claim Number
- Claim Procedure ID
- Adjusted Claim Procedure ID
- CPT code billed with modifier
- Units billed
- Rendering Provider NPI Number
- Name of clinician
- Credential of clinician
- Place of Service Description
- Dollar amount billed, and paid by Health Share Multnomah MH (including any adjustments made to date)
- Procedure status
- EOB Code
- EOB Description

Regional staff shall evaluate all encounter information from the review to substantiate whether:
Revised 2-14-2014

- There was a current Assessment present at the time of the encounter.
- There was a current, valid Service Plan present at the time of the encounter.
- The Service Plan prescribed the encountered service.
- There was a Service Note present for each specific encounter.
- The Service Note(s) present were signed by the billing clinician.
- Documented time of service reflected on Service Note(s) corresponds with number of units billed.
- The Service Note(s) document the place of service that was billed.
- The provider billed the applicable code according to published guidelines and criteria.

Each county shall prepare encounter data for their reviewed claim lines which present discrepancies within 60 days of the encounter data review. Providers will have the option to accept the claim finding or deny the finding. Should the provider accept the finding; payback will be initiated for the claim according to the payback recovery policy.

Should the provider deny the finding the following actions may apply:

- The provider will have 30 days to submit supporting documentation refuting repayment.
- Documentation will be requested that proves sufficient in refuting repayment will not require payback.
- Documentation that does not refute the repayment will initiate payback according to the payback recovery policy.

Credentialing and claims encounter validation activities will be revised on an ongoing basis as necessary to address changes in monitoring and reporting requirements in contracts with the State of Oregon, changes in Oregon Administrative Rules or statutes, and in response to other circumstances as deemed appropriate by Washington County.

Report on Findings.

Periodic credentialing site reviews will result in a written report describing the findings and any recommendations/requirements to improve compliance and timelines for the contracted provider agency to complete these improvements. Providers that are not found to be in substantial compliance with applicable standards may be asked to submit a written Improvement Plan to Washington County to address findings identified during the program review. Written communication regarding findings relating to claims processing, deficiencies
related to documentation of claims paid, or other related errors may occur through a separate format from the credentialing site review report.

Contracted providers that fail to maintain substantial compliance with applicable Oregon Administrative Rules, Oregon Revised Statutes, contractual expectations or other regulatory requirements may be required to submit a Corrective Action Plan and may receive sanctions up to and including revocation of the certificate of approval and/or termination of the contract. Upon identification of serious deficiencies that result in a subcontractor being substantially out of compliance such that a Corrective Action Plan is required, Washington County will notify the Oregon Health Authority within 10 business days of implementing the Corrective Action (Work) Plan, and will provide the following information:

1. Reason(s) for the Corrective Action Plan;
2. Effective date of the Corrective Action Plan;
3. Required resolution of the area(s) of concern; and
4. Intended remedies short of termination should the subcontractor not come into compliance within the required timeframe.

Certificates of Approval will be jointly issued by Washington County and the Oregon Health Authority to provider organizations deemed to be in substantial compliance with applicable Oregon Administrative Rules. Washington County Mental Health Program will provide technical assistance and consultation as appropriate to providers to promote compliance with contractual and regulatory expectations.

Providers that are found to be substantially out of compliance with credentialing standards, claims processing procedures and documentation, or where other circumstances are identified that warrant termination as a participating provider may be informed through written notice that they will no longer be eligible as a provider under contract or written agreement with Washington County. Members receiving services through terminated providers will be notified within 15 days of the provider’s termination as a participating provider and will be provided assistance in obtaining needed services elsewhere with another participating provider.
Washington County Health and Human Services (WCHHS)
Mental Health Program
Policy and Procedure

Policy Title: Credentialing and Recredentialing of Exceptional Needs Providers

Approved: __________________________     _______________
Division Manager    Date

OBJECTIVE:

To ensure that mental health services will be provided by qualified persons and organizations.

Exceptional needs providers will meet credentialing standards established by Washington County.

Recredentialing of exceptional needs providers will be conducted at the discretion of Washington County or when otherwise required by state and/or federal standards.

POLICY:

Exceptional needs providers include individuals and organizations that have the ability, skills or training to provide a needed service directed at treating a covered mental health disorder, but are not a contracted Washington County provider agency or an individual practitioner employed by a contracted mental health provider agency. Exceptional needs providers include organizations, independent practitioners, and non-traditional providers who are identified to provide mental health services to Washington County clients on a case-by-case or on an as-needed basis.

Providers and practitioners will meet credentialing and re-credentialing standards established by WCHHS consistent with the MHO Agreement between Washington County and the State of Oregon Addictions and Mental Health Division. It is the policy of Washington County that service providers and practitioners who provide services to WCHHS clients must be credentialed through the WCHHS credentialing process prior to receiving authorization of payment for services to Washington County clients.
PROCEDURE:

WCHHS will conduct periodic credentialing and re-credentialing of exceptional needs providers. Independent practitioners who are seeking approval as an exceptional needs provider must complete an exceptional needs practitioner credentialing packet which may be obtained by contacting the WCHHS Quality Improvement Coordinator. Credentialing of independent practitioners will be conducted upon receipt of the initial request for the practitioner to become a provider of services to WCHHS members. Re-credentialing of independent practitioners will be conducted no less frequently than every three years. Additional review and verification of practitioner credentials may occur on a more frequent basis at the discretion of WCHHS.

The exceptional needs credentialing application must include copies of applicable professional licenses and/or certificates, a completed provider agreement form, Oregon Practitioner Credentialing Application, and a completed Criminal History Background Check form. The written agreement will specify that the exceptional needs provider agrees to maintain clinical records consistent with OAR 309-016-0000 through 309-016-0230; OR 309-019-0100 through 309-019-0220; and/or other applicable Oregon Administrative Rules. The exceptional needs provider agreement will further indicate that the provider agrees that payment for authorized services will be made in accordance with existing rates for service categories as established by Washington County. The agreement will also require the provider to report any suspected abuse or neglect, significant injury, illness, or accident or if unusual circumstances occur while working with Washington County clients.

Exceptional needs providers must submit a completed Provider Enrollment Disclosure Statement of Ownership and Controlling Interest (i.e., agencies will complete DHS Form #3974 and individual practitioners will complete DHS Form #3974). Additionally, exceptional needs providers must also agree to maintain confidentiality of private client information and protected health information in accordance with federal standards established by the Health Insurance Portability and Accountability Act (HIPAA) (P.L 104-191, 45 CFR Parts 160, 161, and 164), Oregon laws (ORS 179.505 and (ORS 192.515), and applicable Oregon Administrative Rules. A copy of the written agreement with the provider will be retained on file by Washington County.

Exceptional needs providers must demonstrate appropriate clinical credentials and/or competencies to provide services to Washington County clients. Practitioners providing mental health treatment services must provide copies of applicable licenses and must authorize Washington County to contact academic institutions that issued the practitioners academic degree in order to conduct primary source verification of the person’s credentials at the discretion of Washington County. WCHHS will maintain records documenting independent
practitioner academic degrees/licenses, qualifications, criminal history status, and verification that practitioners have not been excluded from participation in Medicaid services due to fraud or other exclusionary criteria. WCHHS will verify whether contracted individuals or provider organizations have been excluded from federal Medicaid participation as documented by the federal Department of Health and Human Services (HHS) Office of Inspector General through an online data base operated the federal Health and Human Services Department (http://exclusions.oig.hhs.gov/). Credentialing of all contracted providers and independent practitioners will include verification of a criminal history background check conducted in accordance with applicable state standards and administrative rules.

Organizations seeking approval as an exceptional needs provider with Washington County may be required to submit additional documentation including copies of agency licenses and/or certification documents, organizational charts and clinical staff lists, verification of status as a Qualified Entity to conduct criminal history checks. Organizations may also be asked to submit additional documentation such as selected policies and procedures, copies of the organization’s consent to treatment form, privacy/confidentiality statement, client rights statement, and the organization’s complaint/grievance forms.

Exceptional needs providers that return complete credentialing documents and that are found to be in compliance with credentialing standards may then be eligible to receive reimbursement for authorized services. Exceptional needs providers that are found to be out of compliance with credentialing standards or where other circumstances are identified that warrant denial or termination as a participating provider will be informed that they are not eligible as a provider under contract or written agreement with Washington County. Clients receiving services through terminated providers will be notified within 15 days of the provider’s termination as an exceptional needs provider and will be offered assistance in obtaining needed services elsewhere with another participating provider.

Credentialing activities will be revised on an ongoing basis as necessary to address changes in monitoring and reporting requirements in contracts with the State of Oregon, changes in Oregon Administrative Rules or statutes, and in response to other circumstances as deemed appropriate by Washington County.
Washington County Mental Health Program
New Provider Enrollment Form

PROVIDER INFORMATION:

Provider Name: ________________________________________________________________

Provider Address: ______________________________________________________________

___________________________________________________ ____________________________

Phone Number: _________________________            FAX: ______________________________

Email: _______________________________________________ ____________________________

Provider Type (e.g., QMHP, MD, Respite, etc): ______________________________________

Is this person a licensed practitioner?    ____ Yes     ____ No

If yes: _____LCSW   ____LPC  _____ PhD   _____ MD   _____ PMHNP   _____ Other : ____________

Specialty Area: __________________________________ _______________________________________

Tax ID #: __________________________________  DMAP ID #: __________________________________

NPI #: ____________________________________   TAXONOMY CODE: __________________________

OVERSIGHT/MONITORING:

Brief description of activities to be performed: ____________________________________________

_________________________________________________________________________________

Who will monitor the activities of this person? __________________________________________

How will oversight/monitoring occur? _________________________________________________

_________________________________________________________________________________

Where will services be provided? ______________________________________________________

_________________________________________________________________________________


Staff Requesting Credentialing: ____________________________ Request Date: ____________

*Please attach additional information or comments as appropriate
WASHINGTON COUNTY MENTAL HEALTH PROGRAM

EXCEPTIONAL NEEDS PROVIDER STATEMENT OF UNDERSTANDING

This statement of understanding is between the Washington County Mental Health Program and the Independent Service Provider named below:

Service Provider Name: ___________________________ 
Address: ________________________________________ 
City, State & Zip Code: __________________________ 
Phone: ___________________________________________ 
Email address: ___________________________________ 
SS#: ______________________  Tax ID: ______________ 
NPI#:  _____________________  DMAP Vendor#:  _____ 
License # (if applicable): ___________________________

*Licensure/Certification (check applicable boxes)

☐ Organization with a Certificate of Approval for Mental Health Services
☐ Individual practitioner with unrestricted professional license in Oregon
☐ Individual/Organization maintains professional liability insurance

*Please attach a copy of applicable professional license and/or organization’s Certificate of Approval

Statement of Work

Service Provider Initials: ________. I/We (Service Provider or organization named above) agree to provide community based mental health treatment services as pre-authorized by Washington County for named individuals under the terms of this statement of understanding. Mental health treatment services to be provided under the terms of this statement of understanding must be pre-authorized and include the following service categories (check applicable boxes):

☐ Outpatient Mental Health Treatment Services
☐ Psychiatric Evaluation, Treatment, and/or Consultation (MD/PMHNP)
☐ Psychological Evaluation and/or Consultation (Licensed Psychologist)
☐ In-home Treatment Services
☐ Other: ___________________________________________
Clinical Documentation

Service Provider Initials: ________. I/We (Service Provider or organization named above) will maintain clinical records consistent with Oregon Administrative Rules (OAR) 309-016-0000 through 309-016-0230, and 309-019-0100 through 309-019-0220, and all other applicable Oregon Administrative Rules. I/we understand that failure to comply with these clinical documentation standards may result in payment denial or payment recovery for services that I/we provide.

[Note: Applicable OARs may be found at the Oregon Secretary of State web site: http://arcweb.sos.state.or.us/banners/rules.htm or by request to Washington County at email address: jim_macleod@co.washington.or.us; phone: (503) 846-4554.]

Payment Schedule

Service Provider Initials: ________. I/We (Service Provider or organization named above) understand that payment for authorized services will be made in accordance with existing rates for service categories as established by Washington County. I understand accept payment rates established by the County as full payment of services rendered.

Billing

Service Provider Initials: ________. I/We (Service Provider or organization named above) will submit a HCFA 1500 claim form or other mutually agreed upon submission method to County’s Third Party Administrator, Performance Health Technology (hereafter referred to as PhTech), for all services rendered. I/we have not been excluded from participation in Medicaid or Medicare services due to fraud, abuse or other violations of state or federal regulations.

Mandatory Abuse Reporting

Service Provider Initials: ________. I/We (Service Provider or organization named above) understand that under state law I am a mandatory reporter of abuse and must promptly report any suspected abuse or neglect to Washington County Mental Health. Child abuse reports will be reported to local child welfare or law enforcement personnel. Reports of abuse of adults will be submitted WCHHS Quality Improvement Coordinator at (503) 846-4554.

Notice of Injury, Illness or Accident (Independent Contractor)

Service Provider Initials: ________. I/We (Service Provider or organization named above) will notify Washington County Mental Health if any clients for whom I am authorized to provide services have a significant injury, illness, or accident or if unusual circumstances occur while I am working with the client.
Confidentiality Statement

Service Provider Initials: _________. I/We (Service Provider or organization named above) understand that I am to maintain full confidentiality of private client information and protected health information in accordance with federal HIPAA standards (P.L 104-191, 45 CFR Parts 160, 161, and 164), Oregon laws (ORS 179.505), and applicable Oregon Administrative Rules. I will not discuss or give out information about clients served or his/her family without written authorization from the client or family unless specifically allowed by law to do so.

Background Check

Service Provider Initials: _________. I/We (Service Provider or organization named above) will submit to a criminal history background check in accordance with requirements set forth by the State of Oregon and any other background checks as deemed necessary by Washington County Mental Health. I/We understand that approval from the State of Oregon Background Check Unit must be received by Washington County as a condition for authorization for payment for services provided by any individual under this statement of understanding. I/We also understand that listing of an individual or program on a federal Medicaid exclusion list is a basis for denial of payment for services funded fully or in part through Medicaid funds for that individual or program.

Conditions of Understanding

By signing this document, I/We (Service Provider or organization named above) will assume all risks and responsibilities that are applicable. This statement of understanding does not extend to services provided by individuals that are not acting under a Certificate of Approval issued to your organization by the State of Oregon or that have not otherwise been approved by Washington County. I/we agree to maintain professional liability insurance for services provided to individuals authorized to receive care and services by Washington County. This statement of understanding may be cancelled by either party at any time for any reason with or without prior notice. Any modification of this statement of understanding must include the date and signature of all parties in order for the revisions to be in force.

Provider: _______________________________ Date: _______

Signature
Provider Enrollment Disclosure Statement
of Ownership and Control Interest
for Entities, Agencies, Facilities and Organizations

Individual Providers or Individuals in a Group of Practitioners: Do not use this form.
Instead, use the DHS 3973 (Disclosure Statement for Individuals).

PURPOSE

The primary use of the Disclosure of Ownership and Controlling Interest Statement is to comply with 42 CFR Part 455 Subpart B and to facilitate monitoring of providers sanctioned by the U.S. Department of Health and Human Services (DHHS) Centers for Medicare and Medicaid Services (CMS), DHHS Office of Inspector General, and/or the Oregon Department of Human Services (DHS).

- Payment cannot be made to any entity in which these providers serve as employees, administrators, operators, or in any other capacity.
- Payment will not be made for any services furnished by, at the medical direction of, or on the prescription of the provider, on or after the effective date of exclusion.

We believe this disclosure statement will assist participating providers in their efforts to ensure that they do not do business with parties currently excluded from participation in federal and state health care programs.

Completion and submission of this form is a condition of participation under any of Oregon’s medical assistance or public assistance programs or as a condition of approval or renewal of a contractor agreement between the disclosing entity (Provider) and the appropriate division of DHS under any of the above-titled programs. Failure to submit requested information may result in a refusal by DHS to enroll the provider for encounter purposes or to enter into a provider agreement or contract with any such entity, agency, facility or organization or in termination of existing contracts.

INSTRUCTIONS

The following instructions are designed to clarify certain questions on the form. Instructions are listed in order of question for easy reference. See 42 CFR 455.100 for additional definitions. No instructions have been given for questions considered self-explanatory.

IT IS ESSENTIAL THAT ALL APPLICABLE QUESTIONS BE ANSWERED ACCURATELY AND THAT ALL INFORMATION BE CURRENT. Answer all questions as of the current date. If additional space is needed, attach a sheet referencing the part and question being completed.
### Part 1: Identifying Information

| A. | Specify name of the Provider entity, agency, facility or organization submitting the Provider Enrollment Application and Agreement. |
| B. | Specify in what capacity the entity is doing business. For example: The name of trade or corporation under which they are doing business. This name must match the license name, if applicable. |
| C. | Federal Employer Identification Number (EIN). Enter Provider’s nine-digit employer identification number (EIN) assigned by the IRS in the following format: XX-XXXXXXXX.  
- An EIN is used to identify the accounts of employers and certain others who have no employees.  
- For more information about an EIN, please check [https://www.irs.gov](https://www.irs.gov) for “Employer Identification Numbers” or “EIN”. Whenever this Disclosure Statement requests an employer identification number (EIN) about an individual or entity, it has the same meaning. |
| D. | Check the entity type that best describes the structure of your organization.  
- “Government” or “Tribal” Agencies or Organizations: If a Federal, State, county, city or other level of government, or an Indian tribe, will be legally and financially responsible for Medicaid payments received (including any potential overpayments), the name of that government or Indian tribe should be reported as an owner. In this Disclosure Statement, the provider should identify as having “Ownership or control interests” the key authorized officials of the government or tribal organization responsible for management decisions of the provider with the authority to legally and financially bind the provider/government or tribal agency or organization to the laws, regulations, and program instructions of the Medicaid program. |

### Part 2: Ownership and Control Interests

Use the following definitions to identify the individuals you should enter in parts A, B and D of this section. See 42 CFR 455.100 for additional definitions.

- “Direct ownership interest” is defined as the possession of stock, equity in capital or any interest in the profits of the disclosing entity. See 42 CFR 455.102 to calculate ownership or control percentages.
- “Disclosing entity” is defined as the Medicaid provider (other than an individual practitioner or group of practitioners) requesting enrollment with Oregon medical assistance program, or a fiscal agent.
- “Indirect ownership interest” is defined as ownership interest in an entity that has direct or indirect ownership interest in the disclosing entity. The amount of indirect ownership in the disclosing entity that is held by any other entity is determined by multiplying the percentage of ownership interest at each level. For example, if A owns 10 percent of the stock in a corporation that owns 80 percent of the stock of the disclosing entity, A’s interest equates to an 8 percent indirect ownership and must be reported. Conversely, if B owns 80 percent of the stock of a corporation that owns 5 percent of the stock of the disclosing entity, B’s interest equates to a 4 percent indirect ownership interest in the disclosing entity and need not be reported.
- “Controlling interest” is defined as the operational direction or management of a disclosing entity which may be maintained by any or all of the following devices; the ability or authority, expressed or reserved to amend or change the corporate identity (i.e. joint venture agreement, unincorporated business status) of the disclosing entity; the ability or authority to nominate or
name members of the Board of Directors or Trustees of the disclosing entity; the ability or authority, expressed or reserved to amend or change the by-laws, constitution or other operating or management direction of the disclosing entity; the right to control any or all of the assets or other property of the disclosing entity upon the sale or dissolution of that entity; the ability or authority, expressed or reserved to control the sale of any or all of the assets to encumber such assets by way of mortgage or other indebtedness, to dissolve the entity or to arrange for the sale or transfer of the disclosing entity to new ownership or control. In order to determine percentage of ownership, mortgage, deed of trust, note, or other obligation, the percentage of interest owned in the obligation is multiplied by the percentage of the disclosing entity’s assets used to secure the obligation. For example, if A owns 10 percent of a note secured by 60 percent of the provider’s assets, A’s interest in the provider’s assets equates to 6 percent and must be reported. Conversely, if B owns 40 percent of a note secured by 10 percent of the provider’s assets, B’s interest in the provider’s assets equates to 4 percent and need not be reported.

- “Group of Practitioners” means two or more health care practitioners who practice their profession at a common location (whether or not they share common facilities, common supporting staff, or common equipment).
- “Other disclosing entity” means any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any title V, XVII, or XX of the Act. This includes hospitals, skilled nursing facilities, health maintenance organizations that participate in Medicare (title XVII) and any entity (other than an individual practitioner or group of practitioners) that furnished or arranges for the furnishing of health related services for which it claims payment under any plan or program established under title V or title XX of the Act.
- “Subcontractor” means an individual, agency, or organization to which a disclosing entity has contracted or delegated part of its management functions or responsibilities of providing medical care to its patients; or an individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or lease of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement.

**Part 3: Criminal Offenses.** This section asks about criminal offenses and exclusions. Complete this section for any of the individuals listed in Part 2 of this form.

**Part 4: Status Changes:** Respond to all applicable questions.

**D.** “Management company” is defined as any organization that operates and names a business on behalf of the owner of that business with the owner retaining ultimate legal responsibility for operation of the facility.

**F.** A “chain affiliate” is any freestanding health care facility that is either owned, controlled or operated under lease or contract by an organization consisting of two or more freestanding health care facilities organized within or across State lines which is under the ownership or through any other device, control and direction of a common party. Chain affiliates include such facilities whether public, private, charitable or proprietary. They also include subsidiary organizations and holding corporations. Provider-based facilities such as hospital-based home health agencies are not considered chain affiliates.

**Part 5: Board of Directors:** For organizations that are corporations, this section asks for information about each person on the Board of Directors.
# Provider Enrollment Disclosure Statement
## of Ownership and Control Interest
### for Entities, Agencies, Facilities and Organizations

### 1. Identifying Information

**A. Name of Provider Entity, Facility or Organization**

Street Address: 

Telephone number: 

**B. DBA Name registered with Oregon Secretary of State, if any:** 

**C. Federal Employer Identification Number (EIN):**

*Attach a copy of the IRS confirmation letter showing your Tax ID number and the associated name. DHS will also accept a copy of your Federal Tax Deposit Coupon (Form 941-V).*

**D. Check the entity type that best describes the structure of the enrolling provider entity, agency, facility or organization: Check **only one** box.**

- [ ] For-profit Corporation  
- [ ] Non-profit Corporation  
- [ ] Partnership  
- [ ] Government-owned  
- [ ] Sole Proprietorship  
- [ ] Tribal-owned

### 2. Ownership or control interests

**A. List the name, and address for individuals and the EINs for organizations having direct or indirect ownership or controlling interest in the provider entity (see instructions for definition of ownership and controlling interest).**

Attach additional pages as necessary to list all officers, owners, management and ownership individuals and entities.

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Address</th>
<th>EIN</th>
<th>Entity Type*</th>
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*Entity Type:* In the “Entity Type” field, enter one of the codes listed below for each individual listed.

1: Sole proprietorship  
2: Partnership  
3: Unincorporated Associations  
4: Corporation  
5: Government or tribal  
6: Other (specify):
B. List the name, address and employer identification number of each person or entity with an ownership or controlling interest in any subcontractor in which the disclosing entity has direct or indirect ownership of 5 percent or more.

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<th>Title</th>
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<th>TIN</th>
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C. List those persons named in A or B that are related to each other (spouse, parent, child, sibling, or other family members by marriage or otherwise).

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D. List the name, address, EIN and DHS provider number of any other disclosing entity in which a person with an ownership or controlling interest in the disclosing entity also has an ownership or control interest of at least 5% or more.

For example, are any owners of the disclosing entity also owners of Medicare or Medicaid facilities? (Example, sole proprietor, partnership or members of Board of Directors.)

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<th>Name</th>
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3. Criminal Offenses

A. List the name, title, and address for any person or entity with an ownership or control interest in the disclosing entity, or is an agent or managing employee of the disclosing entity that has been convicted of a criminal offense related to that person’s or entity’s involvement in any program under Medicare, Medicaid or the Title XX services program.

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B. List the name, title, and address of any individual or entity with an ownership or controlling interest in the disclosing entity that has been suspended or debarred from participation in Medicare, Medicaid or Title XX program.

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### Status Changes

A. Has there been a change in ownership or control within the last year?
   - No
   - Yes
   - If Yes, give date:

B. Do you anticipate any change of ownership or control within the year?
   - No
   - Yes
   - If Yes, when?:

C. Do you anticipate filing for bankruptcy within a year?
   - No
   - Yes
   - If Yes, when?:

D. Is this facility is operated by a management company or leased in whole or in part by another organization? Has there been a change in management within the past year?
   - No
   - Yes
   - If Yes, give date of change in operations:
   
   Name, address and EIN of new management organization:

E. Has there been a change in Administrator, Director of Nursing or Medical Director within the last year? If “yes”, please check box below and list date.
   - Administrator
   - Director of Nursing
   - Medical Director
   - Date:
   
   Name of new Administrator, Director of Nursing or Medicaid Director:

F. Is this facility chain-affiliated? If yes, list name, address of Corporation and EIN.

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<th>Name</th>
<th>EIN</th>
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If the answer to (F) is No, was the facility ever affiliated with a chain? If yes, list name, address of Corporation and EIN.

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<th>Name</th>
<th>EIN</th>
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G. Have you increased your bed capacity by 10% or more or by 10 beds, whichever is greater, within the last two years?
   - No
   - Yes
   - If Yes, when?

| Current beds | Prior beds |

### 5. Board of Directors

If the disclosing entity is a corporation (for example, for profit, non-profit, limited liability, or other corporate form), list the name, title, and address of the Directors.

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PROVIDER SIGNATURE

Knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to enroll or contract, or if the Provider already is enrolled, a termination of its agreement or contract.

By signing this Disclosure Statement, you hereby certify and swear under penalty of perjury that (a) you have knowledge concerning the information above, and (b) the information above is true and accurate. You agree to inform DHS or its designee, in writing, within 30 days of any changes or if additional information becomes available.

Name of Authorized Representative ________________________
Title ________________________

Signature ________________________
Date ________________________

REMARKS

Provide any additional information concerning any item or statement on this Disclosure Statement.

Privacy Policy and Disclosure Notice

This privacy policy and disclosure notice explains the use and disclosure of information about providers and the authority and purposes for which taxpayer identification numbers, including Social Security Numbers (SSNs), may be requested and used in connection with Provider enrollment and the administration of DHS medical assistance programs. Any information provided in connection with provider enrollment will be used to verify eligibility to participate as a provider and for purposes of the administration of the program. Any information may also be provided to the Oregon Secretary of State, the Oregon Department of Justice including the Medicaid Fraud Unit, or other state or local...
agencies as appropriate, the Internal Revenue Service, U.S. DHHS Centers for Medicare and Medicaid Services or Office of the Inspector General, or other authorized federal authority. Disclosures for other purposes must be authorized by law, including but not limited to the Oregon Public Records Act. For more information about access to information maintained by the department, contact the Provider Services Unit.

The Department limits its request for and use of taxpayer identification numbers, including SSNs, to those purposes authorized by law and as described in this notice. The Oregon Consumer Identity Theft Protection Act permits DHS to collect and use SSNs to the extent authorized by federal or state law.

Providers must submit the provider’s SSN (for individuals) or a federal employer identification number (EIN) for entities or other federal taxpayer identification number, whichever is required for tax reporting purposes on an IRS Form 1099. Billing providers must submit the performing provider’s SSN (for individuals) or a federal employer identification number (EIN) for entities or other federal taxpayer identification number, in connection with payments made to or on behalf of the performing provider. Providing this number is mandatory to be eligible to enroll as a provider with the Department of Human Services, pursuant to 42 CFR 433.37, the federal tax laws at 26 USC 6041, and OAR 407-120-0320 and 410-141-0120 for purposes of the administration of tax laws and the administration of this program for internal verification and administrative purposes including but not limited to identifying the provider for payment and collection activities. Taxpayer identification numbers for the provider, and individuals or entities other than the provider, are also subject to mandatory disclosure for purposes of the Disclosure of Ownership and Control Interest Statement, as authorized by OAR 407-120-0320(5)(c) and OAR 410-141-0120.

Failure to submit the requested taxpayer identification number(s) may result in a denial of enrollment as a provider and issuance of the provider number, or denial of continued enrollment as a provider and deactivation of all provider numbers used by the provider to obtain reimbursement from DHS or for encounter purposes.

**Complete and return this form with the following forms and any requested documentation:**

- DHS 3972 (Provider Enrollment Request)
- DHS 3975 (Provider Enrollment Agreement)
- Required Provider Enrollment Attachment (if applicable)

**Send all completed provider enrollment material to:**

DMAP Provider Enrollment
500 Summer St NE, E44
Salem OR 97301-1079
Provider Enrollment Disclosure Statement
For Individual Performing Providers or Individuals in a Group of Practitioners

Entities, Agencies, Facilities and Organizations: Do not use this form. Instead, use the DHS 3974 (Disclosure Statement of Ownership and Control Interest).

PURPOSE
The primary use of the Disclosure Statement is to facilitate monitoring of providers sanctioned by the U.S. Department of Health and Human Services (DHHS) Centers for Medicare and Medicaid Services (CMS), DHHS Office of Inspector General, another state, the Oregon Department of Human Services (DHS), or the Oregon Department of Justice Medicaid Fraud Unit. Payment will not be made for any services furnished by, at the medical direction of, or on the prescription of the provider, on or after the effective date of exclusion.

Completion and submission of this form is a condition of participation under any Oregon Department of Human Services’ programs or as a condition of approval or renewal of a contractor agreement between the Provider and the appropriate division of DHS. Failure to submit requested information may result in a refusal by DHS to enter into a provider agreement or contract with the individual performing practitioner or in termination of existing contracts.

IDENTIFYING INFORMATION

1. Enter the provider name and location for this enrollment:

2. Enter the nine-digit Social Security Number (SSN) or Tax Identification Number (TIN) used to report earnings for this provider:

   Attach a copy of the IRS confirmation letter showing your Tax ID number and the associated name. DHS will also accept a copy of your Federal Tax Deposit Coupon (Form 941-V).

   DHS cannot enroll individual providers without proof of their individual Tax ID number.
PROVIDER CERTIFICATIONS

Individual performing providers who not employed by or a part of another business must complete and certify the following:

1. Have you ever been sanctioned\(^1\) or excluded\(^2\) in any state or federal program?  
   - Yes  
   - No  
   If yes, please explain:

2. Have you ever been disciplined\(^3\) in any way by a professional licensing board in any state or any foreign country?  
   - Yes  
   - No  
   If yes, please explain:

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1 “Sanction” is defined as recoupment, payment hold, imposition of penalties or damages, contract cancellations, exclusion, debarment, suspension, revocation, or any other synonymous action.

2 “Exclusion” means that items and services furnished, order or prescribed by a specified individual or entity will not be reimbursed under Medicare, Medicaid and any other federal or state health care program until the individual or entity is reinstated by the appropriate authority.

3 “Disciplined” includes but is not limited to, having a license revoked, suspended, or continued under conditions which are not part of the original license (e.g., licensee may continue to practice but may not prescribe controlled substances; licensee may continue to practice but must pay restitution or other costs, attend continuing education classes, etc.).

“Disciplined” also includes revocation or surrender of a license or agreement not to have a license renewed, in exchange for a Board’s agreement not to seek revocation, suspension, or conditional continuance of a license previously granted.

“Discipline” as defined in this document, is to be broadly construed.
3. Have you ever been convicted of any crime related to any public assistance, Medicare, Medicaid or Title XX programs? Includes situations involving pleas of no contest or other similar pleas upon which a judgment of conviction is entered.

☐ Yes  ☐ No

If yes, please explain. Include the crime, date, and jurisdiction of conviction:

________________________________________________________________________

PROVIDER SIGNATURE

Knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to enroll or contract, or if the Provider already is enrolled, a termination of its agreement or contract.

By signing this Disclosure Statement, you hereby certify under penalty of perjury that (a) you have knowledge concerning the information above, and (b) the information above is true and accurate. You agree to inform the Provider Services Unit or its designee, in writing, of any changes or if additional information becomes available.

________________________________________________________________________

Printed Name of Provider

________________________________________________________________________

Signature of Provider

Date
Privacy Policy and Disclosure Notice

This privacy policy and disclosure notice explains the use and disclosure of information about providers and the authority and purposes for which taxpayer identification numbers, including Social Security Numbers (SSNs), may be requested and used in connection with Provider enrollment and the administration of DHS medical assistance programs. Any information provided in connection with provider enrollment will be used to verify eligibility to participate as a provider and for purposes of the administration of the program. Any information may also be provided to the Oregon Secretary of State, the Oregon Department of Justice including the Medicaid Fraud Unit, or other state or local agencies as appropriate, the Internal Revenue Service, U.S. DHHS Centers for Medicare and Medicaid Services or Office of the Inspector General, or other authorized federal authority. Disclosures for other purposes must be authorized by law, including but not limited to the Oregon Public Records Act. For more information about access to information maintained by the department, contact the Provider Services Unit.

The Department limits its request for and use of taxpayer identification numbers, including SSNs, to those purposes authorized by law and as described in this notice. The Oregon Consumer Identity Theft Protection Act permits DHS to collect and use SSNs to the extent authorized by federal or state law.
Providers must submit the provider’s SSN (for individuals) or a federal employer identification number (EIN) for entities or other federal taxpayer identification number, whichever is required for tax reporting purposes on an IRS Form 1099. Billing providers must submit the performing provider’s SSN (for individuals) or a federal employer identification number (EIN) for entities or other federal taxpayer identification number, in connection with payments made to or on behalf of the performing provider. Providing this number is mandatory to be eligible to enroll as a provider with the Department of Human Services, pursuant to 42 CFR 433.37, the federal tax laws at 26 USC 6041, and OAR 407-120-0320 and 410-141-0120 for purposes of the administration of tax laws and the administration of this program for internal verification and administrative purposes including but not limited to identifying the provider for payment and collection activities. Taxpayer identification numbers for the provider, and individuals or entities other than the provider, are also subject to mandatory disclosure for purposes of the Disclosure of Ownership and Control Interest Statement, as authorized by OAR 407-120-0320(5)(c) and OAR 410-141-0120.

Failure to submit the requested taxpayer identification number(s) may result in a denial of enrollment as a provider and issuance of the provider number, or denial of continued enrollment as a provider and deactivation of all provider numbers used by the provider to obtain reimbursement from DHS or for encounter purposes.

Complete and return this form with the following forms and any requested documentation:

- DHS 3972 (Provider Enrollment Request)
- DHS 3975 (Provider Enrollment Agreement)
- Required Provider Enrollment Attachment (if applicable)

Send all completed provider enrollment material to:

DMAP Provider Enrollment
500 Summer St NE, E44
Salem OR 97301-1079
Washington County Health and Human Services (WCHHS)
Mental Health Program
Policy and Procedure

Policy Title: Criminal Records Checks

Approved: __________________________       ______ ______________

                 Division Manager                 Date

OBJECTIVE:
To ensure that individuals and volunteers employed by or contracted with Washington County Mental Health Program and volunteers have not been convicted of disqualifying crimes that would preclude their working on behalf of Washington County Mental Health Program and its service delivery system.

POLICY:
Washington County will comply with State of Oregon background check requirements for subject individuals (i.e., employees, contracted providers, independent exceptional needs practitioners, non-traditional providers, and volunteers) in accordance with applicable statutes and rules including ORS 181.533 through 181.575 and OAR 407-007-0200 through 407-007-0370. These standards require that subject individuals must complete a background check to verify that the individual is not precluded from working with Washington County clients and has not been convicted of a disqualifying crime. All Washington County Mental Health Program employees and volunteers will have a background check completed through Washington County human resources. All contracted provider organizations and independent service providers will complete a background check and receive a Final Fitness Determination notice prior to working with Washington County clients.

PROCEDURE:
Washington County will maintain approval as a Qualified Entity to process background checks and will designate one or more Qualified Entity Designees (QED) to conduct background checks in cooperation with the State of Oregon Background Check Unit as prescribed by Oregon statutes and administrative rules. Each employee will be required to complete a background check form that
will be reviewed and processed by an Authorized Designee prior to the start of the individual’s employment with Washington County and/or prior to the individual having contact with program clients. Washington County will maintain documentation to verify that all employees and volunteers have received a Final Fitness Determination as required by applicable rules and statutes. The Authorized Designee may, under certain circumstances, approve provisional employment for the individual pending completion of a Final Fitness Determination.

Individual practitioners operating under separate professional services agreements with Washington County will be required to complete a criminal background check and have a Final Fitness Determination issued by the State of Oregon Background Check Unit prior to entering into a service agreement with Washington County. Washington County Mental Health program will designate one or more QEDs to coordinate the background checks for all exceptional needs and non-traditional care providers operating under service agreements with Washington County Mental Health. The background check process will include verification of individual identification information, review of listed arrest and conviction information, and other related content prior to forwarding the background check documentation to the Background Check Unit for further processing. The QED may not approve provisional employment for individuals pending a final determination from the Background Check Unit. Processing of applications for background checks will be conducted by a Qualified Entity Designee through the state online application and data base system (https://crims.oregon.gov/Crims/CrimsWeb.dll/).

Organizations operating under contract with Washington County must maintain certification as a Qualified Entity and must conduct applicable background checks for any employees or volunteers performing services under a contract or payment agreement with Washington County. Verification of the organization’s status as a Qualified Entity must be provided prior to initiation of services for Washington County clients. Approval of Qualified Entity status is subject to review and verification during periodic credentialing reviews and as otherwise deemed necessary or appropriate by Washington County.

In all cases, individuals that have been convicted of a disqualifying crime will be excluded from participation in the provision of services to Washington County Mental Health Program clients. Exceptions to this exclusion may only be made in accordance with standards defined by applicable OARs, such as a weighing test conducted by the State of Oregon Background Check Unit. Verification of an individual’s approval or disqualification will be maintained by Washington County as authorized under ORS 430.735 through 430.768 and OAR 407.045-0250 through 407-045--360.
Washington County Health and Human Services (WCHHS)
Mental Health Program
Policy and Procedure

Policy Title: Crisis Response System

Approved: __________________________     _______________
Division Manager     Date

OBJECTIVE:

To ensure that a system of crisis response is available to all Washington County residents at all times.

To ensure that the crisis response is clinically indicated, appropriate to the level of care required, and provided within the treatment continuum of services currently being offered to the client.

To ensure that Washington County residents have immediate access to an emergency mental health response system which meets emergency treatment needs 24-hours per day, 7-days per week.

POLICY:

It is the policy of WCHHS to maintain an emergency response system that provides Washington County residents with access to emergency mental health services 24-hours per day, 7-days per week. To accomplish this policy, WCHHS will maintain contracts with organizations that provide community-based emergency mental health services that are available and accessible to all county residents. Referral and access to emergency mental health services must be rapid, readily available and responsive to resident’s needs.

For residents who are not enrolled in a mental health provider agency, a mental health crisis line and mobile-capable crisis team will be available to respond to mental health emergencies.

Provider agencies will have a system of crisis response for clients enrolled in their program. At a minimum, the provider agency will have a clinician available by phone for consultation at all times. This individual shall be familiar with the client or shall have the ability to contact clinician(s) familiar with the client.
PROCEDURE:

WCHHS will maintain contracts with qualified providers of emergency mental health services identified through a competitive procurement process. WCHHS contracts include a behavioral health telephone triage service (crisis line) and a mobile capable crisis team to provide crisis intervention and stabilization services for Washington County residents.

Requests for crisis service will be triaged to determine the most clinically appropriate response. Emergency mental health services may include one or more of the following:

- Telephone assessment, triage and consultation
- Face-to-face crisis assessment and evaluation by qualified mental health professionals
- Consultation with families, other professionals, or community partners such as law enforcement and community members
- Medication services including medication management, psychiatric consultation and emergency medication
- Hospital diversion
- Stabilization services/follow-up care, as needed
- Referral to appropriate services
- Flexible funding to assist with emergency housing, transportation or other unmet needs contributing to the crisis episode
- Language/culturally specific services
- Other services as indicated

Washington County residents may initiate a request for emergency mental health services through multiple pathways including the Washington County Crisis Line, contracted mental health providers, and hospital emergency departments. Requests for services may be initiated in person, by telephone, or by other persons expressing the need for emergency services on behalf of the individual. County residents may contact the Washington County Crisis Line or may be seen on location by the contracted mobile capable Washington County Crisis Team.

Service Description:

Crisis Line:
Washington County will maintain a telephone crisis line to respond to and to triage urgent and emergent situations that arise. The line will be staffed by master-level clinicians who are familiar with local resources and who can dispatch the Washington County Crisis Team when clinically indicated.

Crisis line services will include:

- Clinical assessment and triage of all contacts
- Solution-focused interventions and de-escalation as needed
- Crisis response and referral as needed
Information and referral for all contacts
• Documentation of each episode of contact
• Recommendations and referrals for the lowest level of care that is safe and clinically appropriate;
• Referral to Washington County Crisis Team for mobile crisis response services.
• Coordination of care with other community providers

Washington County Crisis Program:
Washington County will maintain a contract with a qualified agency to provide the mobile crisis services to residents who require an onsite response. The crisis program shall include:
- Washington County Crisis Team (WCCT): A program staffed with Qualified Mental Health Professionals who provide crisis assessment and intervention either in the community or clinic based setting.
- Mental Health Response Team (MHRT): A collaboration between Washington County Sheriff’s Office and Washington County mental health, this program pairs a mental health clinician with a deputy to provide rapid, onsite crisis assessment and intervention.
- Intensive Transition Team (ITT): A team which provides intensive case management and connection to treatment for individuals transitioning out of acute care settings or individuals post crisis who need additional supports.

The Washington County Crisis Program will work with children and adults to provide both office-based and community-based crisis assessments, psychiatric assessment with medication management when indicated, and brief services until a client is able to be connected with a local provider. Due to the limited size of the team and the large geographical area of Washington County, the WCCT may not be able to provide a mobile response to every request. Police calls are prioritized and police departments may contact the team directly for assistance in resolving calls involving a mental health crisis. Referrals to the WCCT or MHRT may come from law enforcement, local Emergency Departments (ED), emergency medical response staff and other community members. Referrals will be triaged through the WCHHS Crisis Line except for the case of law enforcement. Referrals to ITT primarily will come from County staff or the other crisis teams.

Washington County Crisis Program services will include:
- Services for residents referred by law enforcement personnel, community members, crisis line clinicians, and residents who are in an emergency department in Washington County who may be able to be diverted to a less intensive level of care in the community;
- On site crisis intervention services at the resident’s location when indicated;
- Urgent clinic-based appointments; and
• Coordination with and referral to community based mental health service providers and inpatient psychiatric acute care facilities.

Examples of situations where it is appropriate to utilize the crisis program include, but are not limited to:

- A client in a local ED who could be discharged to a safe location if support was available to follow-up with the client after discharge.
- A situation where it is unclear if the client is requiring hospitalization and more information is needed. This could be in an ED or in the community.
- A client in the community who is reporting risk factors but who could likely remain safe until contacted by the crisis team.
- A situation where a person not currently served by a provider agency has an immediate need that an agency is unable to respond to quickly enough (i.e. a client just moved into the area and will be out of medication tomorrow and may be too disorganized to get to an intake appointment without some assistance).

Agency Enrolled Clients:
It is the goal of Washington County Mental Health that each provider develops and maintains crisis response capacity for their enrolled clients. A crisis response for an enrolled client may be requested by the Mental Health Crisis Line, local emergency departments, community crisis responders such as law enforcement, community members, directly by the resident or other individuals who have come in contact with an individual in mental health crisis. Crisis response may include:

- Consultation with community providers
- Mental health assessment, either face-to-face or over the phone
- Direct contact with the client including support, coaching, de-escalation, and reality checks
- Arranging for additional services or resources
- Other services as clinically indicated

Enrolled clients who come to the attention of the crisis line shall be referred to their current provider for crisis response. If a client who is enrolled with one of the local provider agencies comes to the attention of the Washington County Crisis Program, the team will contact the provider directly and request assistance in responding to the situation.

In situations where assistance was requested of an agency and the agency was unresponsive, the situation will be documented and the information forward to the appropriate Washington County Program Coordinator for follow-up. A quality review may be performed by WCHHS with the potential of a corrective action plan.
Washington County Health and Human Services (WCHHS)
Mental Health Program
Policy and Procedure

Policy Title: Cultural Competence

Approved: __________________________     _______________
Division Manager                  Date

OBJECTIVE:

To ensure that services are readily accessible and available to individuals of all cultures.

To provide a mental health system that is responsive and respectful for individuals from all cultures, including various ethnicities, sexual minorities and physical disabilities.

To ensure that mental health services are provided in the client’s native language whenever possible.

To ensure access to translation services as necessary.

POLICY:

Washington County recognizes that culture determines our world view and provides a general design for living and patterns for interpreting reality that are reflected in our behavior. Therefore, services that are culturally competent are provided by individuals who have the skills to recognize and respect the behavior, ideas, attitudes, values, beliefs, customs, language, rituals, ceremonies and practices characteristic of a particular group of people.

WCHHS recognizes the need for all mental health services to be delivered in a culturally competent manner. Cultural competence in the delivery of mental health services is defined as:

An ability to understand, communicate with and to provide effective clinical care to people across cultures.

Culture is not limited to race and ethnicity but is also comprised of each individual's unique world view shaped by gender, religion, sexual orientation, physical ability, socioeconomic status, and social groups.
PROCEDURE:

WCHHS supports continual development of culturally competent services within the provider system. Providers are contractually required to provide services in a manner appropriate to the cultural and language needs of each client served.

Washington County is an entity of Health Share of Oregon, who is committed to creating and maintaining an environment that supports cultural competence by promoting respect and understanding of diverse cultures, social groups, and individuals.

To support these efforts within the local community and Health Share, WCHHS:

- Is a member of the Health Share Cultural Competence Committee, participating in the development of cultural priorities, rules, and services for Health Share members, including participation in the Organizational Assessment for Cultural Competence & Health Equity as part of its work to eliminate health disparities and assure that we are providing culturally and linguistically appropriate services;

- Participates as a guest in meetings within the Alliance of Culturally Specific Providers in the Portland Metro area;

- Embraces the County’s hiring practices with a goal of reflecting the cultural make up of our community;

- Participates in community needs assessments, including the evaluation of our provider network to ensure that culturally specific providers are available to meet the needs of our community.
Washington County Health and Human Services (WCHHS)
Mental Health Program
Policy and Procedure

Policy Title: Flexible Funding

Approved: __________________________     ________ _______________
Division Manager   Date

OBJECTIVE:

To ensure that, subject to available resources, flexible funds are used for expenses and services that will increase the likelihood that WCHHS clients will remain in the least restrictive level of care possible.

To ensure that other resources are considered first and that funds are spent in the most fiscally prudent manner possible.

To ensure access to medically necessary services and supports that are not available through the Washington County contracted provider system.

To provide flexible funds to support clients in maintaining successes in the least restrictive setting and level of care. These funds can be used when the child and family team or clinical services team has agreed that the service is necessary to alleviate or prevent the recurrence of signs and symptoms of the covered diagnosis.

POLICY:

Flexible Funding to support treatment goals, aka Therapeutic Flexible Funds (OHP and GF):
Flexible funds may be used for services to support consumers to maintain success in the lowest possible level of care and least restrictive environment. Examples of appropriate services may include:

- bus tickets for clients and their family members to attend therapeutic activities or appointments when medical transport is not available,
- tuition for a community activity or class that will assist in alleviating symptoms of the client’s mental illness,
- books for parents to educate them about their child’s mental illness,
- board games or other therapeutic activity for the home to support positive parent-child or sibling interaction,
- gym memberships to decrease isolation and promote a healthy lifestyle and minimize the impact of medication side effects.
• musical instruments to utilize as a symptom management strategy

In general, flexible funds are not to be used for services that are related to a client’s global well being or basic safety in the home or community unrelated to the client’s mental health. Funding for purposes of safety or well being may be available through DHS/Child Welfare or other community supports. Funds for all flexible expenses are limited to availability at any given time.

Flexible services and supports should be funded with Medicaid dollars when:
- the client is currently Medicaid eligible,
- the service supports a specific treatment plan goal,
- the service is not for a housing related expense.

Flexible services and supports should be funded with General Fund dollars when:
- the consumer is not Medicaid eligible, and/or:
- the service is for a housing related expense, and/or:
- the service is not a rehabilitative Medicaid-covered service such as personal care.

Expenses specifically related to housing may be paid out of dedicated non-Medicaid funding as available. Housing related expenses include:
• rental subsidies
• utilities
• deposits (rental and/or utility)
• food when other resources are not available

Flexible funding for Supported Housing:
These services are currently available to consumers in the following programs and subject to the terms of the individual provider contracts:
• Transition Age Youth programs (TAYIS and EASA)
• ACT
• AMHI

AMHI Flexible Funds:
AMHI staff may authorize the use of flexible funds to address barriers to independent living in the community or discharge from higher levels of care. All flexible supports are subject to continued availability of funding and ongoing supports may be discontinued as funding and competing demands warrant. Clients, family members, providers and other stakeholders should be informed that supports are not guaranteed and offers of support may be discontinued or withdrawn as necessary to manage funds. AMHI staff should approve supports only when other resources, including agency flexible funds, are not available.
Adult Rehabilitation Agency Flexible Funds:
Agency flexible funds are supports and services funded with state General Fund dollars and are to be used in situations where providing housing or additional supports in the community are likely to avoid hospitalization, address critical basic needs, or are likely to assist a client in meeting a treatment objective. Currently these funds are available to adult rehabilitation providers who receive an annual allotment based on available funding and client distribution. There are several uses of flexible funds:

- **Medical/ Physical health:** Supports related to access to physical health treatment that is clinically indicated to assist in the stabilization of the mental health condition. Funds may be used for items such as primary care appointment co-pays or non-psychiatric medication expenses. Funding should not be utilized for services covered by Medicare, Medicaid, private insurance coverage or services that could be provided by a FQHC.

- **Behavioral Health:** Flexible supports that treat a mental health condition but that are not encounterable as a billable service. Examples include:
  - psychiatric medication for individuals with General Fund,
  - associated laboratory expenses related to the prescribing of psychiatric medication,
  - items and supports related to a treatment goal (such as gym memberships to manage medication side effects)
  - respite services provided by non-credentialed individuals,

  These services are only available for clients with Washington County General Fund as their funding source. If the individual has OHP, please access these supports under the OHP contract.

- **Transportation and Travel:** Funding utilized to assist and individual in accessing treatment services. This may include cab fare, bus tickets, and bus passes. This service should only be utilized for individual with Washington County General Fund as their funding. If the individual has OHP, please access these supports under the OHP contract.

- **Community Services and Supports:** Flexible supports such as food, recreational activities, clothing, ID cards, storage fees, etc. These funds should only be utilized when all other resources have been ruled out as options and the client is likely to deteriorate without the support.

- **Community Housing Planning and Assistance (Supported Housing):** Includes rental subsidies, application fees, utilities, deposits, payment for cleaning services (to assist a client in passing a housing inspection), housing establishment items such as furniture and cleaning supplies, moving expenses and emergency shelter to prevent a higher level of care. These funds should only be utilized when all other resources have been ruled out as options and the client is likely to deteriorate and need a higher level of care without the support. This service is available to both clients funded with OHP and Washington County General Fund. Housing flex funds may be used in situations where the client is currently stable however loss of essential housing due to eviction for non-payment of rent is likely to result in an increase in level of care. Housing flexible funds may be used for emergency,
temporary or transitional housing costs, rent assistance, paying rent deposits, application fees, etc. where the use of these funds are likely to prevent a higher level of care. Funds may also be used to cover the cost of essential utilities such as electricity in order to maintain current housing.

**PROCEDURE:**

**ISA and WRAP Non-Crisis Flexible Funding:**
All non-crisis flexible funding requests paid directly by the County will be reviewed by the child and family team facilitated by a WCHHS Care Coordinator. The team must agree that the service is necessary to alleviate or prevent the recurrence of signs and symptoms of the covered diagnosis prior to authorizing expenditure of flexible services funds.

The child and family team will explore and exhaust all other options for potential payment of the flexible service, such as grants, scholarships, donations, family support and other agency resources.

For ISA and Wraparound clients the Child and Family Team will identify and document the need for a particular flexible service in the consumer’s service coordination plan.

For all services paid directly by the County:

- The Care Coordinator will complete the Flexible Funds Request form and submit to the appropriate Mental Health Program Supervisor for approval.

- The Mental Health Program Supervisor will forward the approved requests to WCHHS Sr. Accounting Assistant for processing of the manual check.

**Pre-purchased Goods or Services (AMHI, ISA and Wraparound Only):**
WCHHS may purchase a supply of gift cards to provide timely acquisition of urgently needed items or services that are frequently utilized.

To ensure that these cards are used to alleviate or prevent the recurrence of signs and symptoms of the covered diagnosis for WRAP and ISA clients as documented in the youth’s Service Coordination Plan, the Child and Family Team will identify and document the need for a particular flexible service in the consumer’s service coordination plan.

In all circumstances:

- The Care Coordinator will complete the Flexible Funds Request form and submit to the appropriate Mental Health Program Supervisor for approval.
The Mental Health Program Supervisor will forward the approved requests to WCHHS Sr. Accounting Assistant.

The client or client’s family utilizing the gift card will document the purchases made with card, including receipts, and/or an inventory with date of purchase, item(s) purchased and cost, which will be submitted to the Care Coordinator.

For gas cards, the recipient will be expected to submit a mileage log or other proof of appropriate use of funds prior to receiving a new gas card.

**AMHI Flexible Funds:**
The AMHI Care Coordinator will exhaust other options to cover the expense prior to authorization. The AMHI Coordinator may either authorize an agency to pay for the approved expense with County reimbursement or complete a manual check request for direct payment to a vendor. All expenses are subject to supervisor approval.

**Adult Rehabilitation Agency Flexible Funds:**
All services and supports provided must be clearly related to achieving a treatment goal associated with the presenting mental health condition. Flexible funding supports should be utilized only after all other resources have been ruled out. Provider should explore and exhaust all other options for potential payment of the flexible service, such as grants or scholarships, donations, samples and other agency resources.

Expenditures may be used solely for non-Medicaid reimbursable expenses. This includes supports for individuals who are not currently receiving Medicaid benefits and supports for all persons that are specifically disallowed by Medicaid. Supports that are not reimbursable by Medicaid include:
- Shelter
- Rental subsidies
- Utilities
- Food
- Apartment application fees
- Transitional housing expenses

For individuals who do receive Medicaid benefits, therapeutic supports related to treatment objectives should be funded with Medicaid funds. This may be through FFS billing for services such as peer supports and additional clinical supports or invoicing expenses under a Medicaid contract for Therapeutic flexible funds.

Clients must have an approved Washington County authorization for OHP or GF in PHTech at the time of reimbursement. Funds should always be distributed by the agency directly to a vendor.

Generic medications should be used when available. Provider is strongly encouraged to apply for Prescription Assistance Programs.
A Flexible Funding request form indicating the service, client identifying information, amount of funding and supervisor approval must be included with each reimbursement request. Provider does not need to send copies of receipts or invoices but should retain this information onsite for audit purposes. Records should be retained for a minimum of five years.

Support provided by non-credentialed individuals (i.e. respite) requires monthly invoices which includes number of hours of Flexible Respite services provided, the hourly cost to provide the service and the client name for whom services were provided. Whenever possible provider should utilize peer staff and submit encounterable billing utilizing the peer delivered service code.

Provider shall manage the utilization of funds in such a manner as to ensure funds are available for each service area described above and that funds remain available throughout the contract period. Funds will be allocated based on the number of clients in each service area, historical allocations and specific funding awards.

The provider will submit invoices to the county which will include an itemized total of flexible fund expenditures. In addition, provider will include the corresponding completed flexible fund request forms that establishes that all criteria have been met for use of funds. The County will review the invoice and individual requests to ensure expenses are in line with WCHHS policy prior to reimbursement. The County may request additional information from the provider to ensure that expenses are

Provider is expected to manage the utilization of flexible funds in a manner that ensures funds will remain available throughout the contract period.

**Housing Flexible Funds for ISA and Wraparound:**

Housing Flex Funds are to be used in circumstances where access to housing has the outcome of diverting a rapid escalation of symptoms of a client’s mental illness. Housing flex funds may be used for emergency, temporary or transitional housing costs, rent assistance, deposits, etc. Funds may also be used to cover the cost of essential utilities such as electricity where the loss of the service is likely to jeopardize housing. Funds are not to be used for non-essential expenses or in situations where other resources are available.

Housing Flex Funds should be considered a last resort, and considered only when the family and team have identified housing/utilities as a need, explored a variety of ways to meet the need, and exhausted other options.

- Flex funds must be identified by the child and family team as a way to meet this need, after having exhausted other options.
- Request must be completed in writing on the Housing Flex Fund Request Form by the Care Coordinator.
Revised 2-28-2014

- A plan to sustain the housing/ utility must be identified.
- The need and service must be identified on the client’s ISSP.
- Funds are payable directly to the vendor, and not to the family.
Washington County Health and Human Services (WCHHS)
Mental Health Program
Policy and Procedure

Policy Title: Fraud and Abuse (Medicaid Integrity)

Approved: __________________________       ______ ______________

Division Manager       Date

OBJECTIVE:
To prevent and detect fraud and abuse activities as they relate to the Washington County Mental Health Program activities and services provided under the Oregon Health Plan.

POLICY:
Washington County will comply with Federal and State fraud and abuse prevention and detection regulations. This Fraud and Abuse Requirements Policy applies to Washington County and its subcontractors that receive at least $5,000,000 in annual payments from Washington County.

Washington County will have in place internal controls, policies or procedures capable of preventing and detecting fraud and abuse activities as they relate to the Oregon Health Plan and any other Medicaid funds contracted or managed by Washington County.

Washington County will ensure that its employees and employees of contracted providers are informed of the provisions of the federal False Claims Act and applicable state laws; that its employees are informed of the Washington County Policy for Reporting of Improper Governmental Conduct; and that contracted providers inform their employees of the organizations Code of Conduct or related policies.

PROCEDURE:
Washington County will comply with applicable federal requirements established by 42 USC Section 1902(a)(68) and the Federal Claims Act established under sections 3729 through 3733 of title 31. Washington County reviews its fraud and
abuse policies annually. Washington County has the following Policies and Procedures capable of preventing and detecting fraud and abuse:

**Operational Policies and Procedures.** Washington County will maintain policies and procedures to manage its system of care and to enact practices and safeguards to promote consistent and transparent business practices. These policies and procedures will include the following areas:

- Utilization management (includes prior authorization);
- Selection of Network Providers;
- Member complaint and grievance resolution;
- Provider credentialing and contracting (includes site review and corrective action plans).

**Washington County policy on Reporting of Improper Governmental Conduct**

**Claims:**

Washington County will conduct oversight of contracted providers through review of claims data in periodic management reports. Verification of compliance will also occur through periodic record reviews and in response to complaints or allegations of fraud received by Washington County. The following activities will be in place to support identification of potential instances of fraud and abuse:

- Washington County will maintain agreements with a Third Party Administrator (TPA) for claims payment under contract through Health Share of Oregon (HSO). Contracted providers will submit all claims for payment through the TPA in accordance with established procedures;
- In accordance with the HSO contract, the TPA will comply with all State and Federal law requirements, including laws and regulations pertaining to the detection and reporting of fraud and abuse;
- Washington County will review provider records for indications of improper conduct, falsification of records, or notable billing irregularities during routine site reviews or as otherwise deemed necessary by Washington County;
- Washington County will conduct data surveillance through periodic management reports prepared by its contracted TPA relating to encounter submissions and/or claims paid to contracted providers;
Participation of Suspended or Terminated Providers.

The following persons (or their affiliates as defined in the Federal Requisition Regulations) may not provide the Covered Services provided by Washington County and its sub-contracted providers pursuant to service agreements:

- Persons who are currently suspended, debarred or otherwise excluded from participating in procurement activities under the Federal Requisition Regulation or from participating in non-procurement activities under regulations issues pursuant to Executive Order No. 12549 or under guidelines implement such order.

- Persons or programs that are currently suspended or terminated from the Oregon Medical Assistance Program.

- Persons or programs that are currently excluded from Medicaid participation and listed on the federal EPLS and/or Office of Inspector General Medicaid exclusion list (http://exclusions.oig.hhs.gov).

Washington County and its contracted providers will document employee exclusion status from the online Office of Inspector General Medicaid exclusion list (http://exclusions.oig.hhs.gov) on a monthly basis for each employee as evidence that the person has been screened and has not been excluded from participation in Medicaid funded services. Verification of exclusion checks will be maintained on file for each employee.

Washington County will not refer OHP members or other Medicaid eligible individuals to persons or organizations whose participation in Medicaid or Medicare programs has been suspended or terminated and will not authorize or accept billings for services to OHP members by such persons.

Washington County or its sub-contractors may not knowingly:

- Allow a person whose participation in Medicaid or Medicare programs has been suspended or terminated to serve as a director, officer, partner;

- Enter into an employment, consulting, or other agreement with a person whose participation in Medicaid or Medicare programs has been suspended or terminated for the provision of items and services that are significant and material to Washington County’s service agreement;

- Have a person described as a director, officer, partner or person with a beneficial ownership of more than 5 percent equity of the contracted organization.

Obligations of Subcontracted providers to report to Washington County.
Washington County will require all subcontractors that receive annual payments under contract with Washington County of at least $5,000,000 to establish written policies and procedures pertaining to the prevention and detection of fraud and abuse consistent with section 6023 of the Deficit Reduction Act and 42 USC Section 1902(a)(68). Washington County will encourage subcontractors that receive annual payments under contract with Washington County of less than $5,000,000 to establish policies and procedures pertaining to the prevention and detection of fraud and abuse. All subcontractors may be subject to oversight and inspection by Washington County regardless of the amount of annual payments received by the provider.

Contracted providers will promptly report all suspected and documented fraud and abuse they identify within their program or within the system of care as required in this policy. Contracted providers will permit Washington County, the Medicaid Fraud Control Unit or DHS to inspect, evaluate, or audit books, records, documents, files, accounts, and facilities maintained by or on behalf of Washington County or by or on behalf of any subcontractors, as required to investigate an incident of fraud and abuse.

Subcontracted providers will cooperate with Washington County, the State of Oregon Medicaid Fraud Control Unit and/or Department of Human Services (DHS) investigator(s) during any investigation of fraud or abuse.

Washington County reserves the right to impose sanctions, up to and including termination of contract, with any individual or organization found to have committed fraud or abuse as described above.

Referral Policy.

Washington County is required to promptly refer all verified cases of fraud and abuse, including fraud by employees and sub-contractors of the organization to the Medicaid Fraud Control Unit (MFCU), consistent with the Memorandum of Understanding between the State Department of Human Services (DHS) and the Medicaid Fraud Control Unit. Washington County will refer fraud and abuse and suspected fraud and abuse within Washington County’s network to the Medicaid Fraud Control Unit in accordance with the characteristics defined the HSO Agreement with Washington County. Should Washington County be aware that the Medicaid Fraud Control Unit or DHS Fraud Unit are conducting an investigation, Washington County shall not notify or otherwise advise its subcontractor of the investigation, so as not to compromise the investigation.

Washington County will notify the Oregon Health Authority and Health Share of Oregon of all referrals to MFCU of complaints of fraud and abuse that warrant investigation. Notifications to AMH will contain necessary information as defined in the MHO Agreement. In keeping with HIPAA standards, Washington County
will permit the MFCU or DHS to inspect, evaluate, or audit books, records, documents, files, accounts, and facilities maintained by or on behalf of Washington County or by or on behalf of any subcontractors, as required to investigate an incident of fraud and abuse.

In accordance with the Washington County policy on Reporting of Improper Governmental Conduct, Washington County encourages its employees to report any known or suspected improper conduct. Employees making such reports in good faith shall be free from retaliation and, where appropriate the name of the reporting employee will be held confidential. In the event that Washington County receives a report of suspected fraud or abuse, or learns of an MFCU or DHS Fraud Unit investigation, Washington County will not notify or otherwise advise its subcontractors or any alleged perpetrators of the investigation so as not to compromise the investigation. Washington County will cooperate with Medicaid Fraud Control Unit to complete investigations of allegations of fraud and abuse. Investigations will be conducted either by the Medicaid Fraud Control Unit or by Washington County as appropriate. Investigation activities will occur in a manner consistent with the State of Oregon Medicaid Fraud Control Unit guidelines and policies pertaining to allegations of fraud or abuse or as otherwise established by Washington County.

Training and Education.

Washington County will provide formal training and education to its employees regarding the federal False Claims Act, applicable state laws including the Oregon False Claims Act, and the Washington County Policy for Reporting of Improper Governmental Conduct. Training and education in these areas will include a dissemination of written information about the federal and state False Claims Act, the Oregon False Claims Act, and the Washington County Policy for Reporting of Improper Governmental Conduct. Dissemination of this information to employees will occur at minimum through computer or web-based training formats (e.g., PowerPoint presentation) and links to related informational documents. A designated computer folder will be made available to all employees that includes a PowerPoint training, the text of both the state and federal False Claims Act, and the Washington County Policy for Reporting of Improper Governmental Conduct. All employees involved with Medicaid will be required to submit a signed “attestation” form verifying that they have reviewed the Washington County PowerPoint training, that they have had the opportunity to ask questions, and that they understand the information presented.

Washington County will disseminate a PowerPoint training document to all contracted providers that explains the federal and state False Claims Acts. Contracted providers will also be provided with the text of the federal and state False Claims Acts. Additionally, contracted providers will be required to inform employees of the organization’s code of conduct, as applicable. Contracted
providers will be required to verify annually that employees involved with Medicaid have received training in the state and federal False Claims Acts and the organization’s code of conduct. Contracted provider organizations will be required to verify that each employee has signed an attestation statement confirming that they have received information about the federal and state False Claims Act and the organization’s code of conduct. Additionally, contracted providers will be asked to verify that staff involved with Medicaid have completed training through documentation in the agency’s annual practitioner report that is submitted to Washington County.
Washington County Health and Human Services (WCHHS)
Mental Health Program
Policy and Procedure

Policy Title: Incident Reporting

Approved: __________________________       ______ ______________

Division Manager   Date

OBJECTIVE:
To promote the health, safety, and well being of children and adults receiving mental health services who may be

To promote reporting incidents relating to children and adults receiving mental health services in Washington County.

To ensure that individuals employed by or contracted with WCHHS Mental Health Program and volunteers have been informed of their responsibilities to report suspected incidents of abuse and neglect in accordance with ORS 430.735 through 430.768 and ORS 419B.005 through 419B.050.

To promote reporting incidents relating to children and adults receiving mental health services in Washington County.

POLICY:
It is the policy of the Washington County Mental Health Program staff and contracted providers will report incidents of actual or suspected harm to Washington County and/or the Oregon Health Authority.

Incidents include significant events or circumstances which result in actual or potential risk to clients receiving mental health services through Washington County and contracted providers. Incidents include events relating to significant actions of the part of providers, clients, or community members that result in actual or potential harm to individuals and property. Incidents may also include circumstances of suspected abuse or neglect of an adult or child receiving services. Incidents also include circumstances where client care and client rights may be significantly compromised including stolen or lost medications for residents of licensed facilities, unauthorized disclosures of protected health information, etc.
PROCEDURE:

Washington County employees and/or contracted providers become aware of a significant incident or other circumstances where a client enrolled in services is harmed, threats of harm involving clients receiving services, and/or actual or threatened damage to property the person identifying the incident will cause a report to be made to the Washington County QI Coordinator or other appropriate county employee.

Washington County will receive incident reports and will determine whether additional actions are needed to protect the interests of clients, providers, and/or the county. Incidents that occur in licensed residential facilities and acute care facilities may also be forwarded to the Oregon Health Authority or other licensing entities for further review.

Incidents relating to allegations of abuse or neglect of a child or adult will be addressed in accordance with applicable administrative rules and statutes as described in the Washington County policies and procedures relating to mandatory reporting of abuse. Such incidents may also be forwarded to other agencies for further investigation as warranted.

Where investigations into a reported incident reveal insufficient levels of care or otherwise suggest that the service provider has not provided appropriate services or oversight then a corrective action may be initiated to address the identified concerns. Significant concerns may also be forwarded to other entities including law enforcement, the Oregon Health Authority, and the Health Share of Oregon as deemed appropriate or necessary.
OBJECTIVE:

To ensure the provision of mental health services to children with severe emotional disorders that are child-centered, family-focused, community-based, culturally competent, multi-systemic, comprehensive, well-coordinated and are provided in the least restrictive setting possible.

To ensure that the intensity, frequency, blend, and venue in which intensive mental health treatment services take place are individualized and based on the mental health needs of the youth.

To collaborate with other child serving systems to create a System of Care in which all services to the child and family are integrated, comprehensive and well coordinated.

To reduce duplicative and/or uncoordinated services or activities that can discourage families and create barriers to youth and families in need of services.

To maximize funding available to children and families by collaborating with other systems to ensure those services are not duplicated and by sharing resources as appropriate within each system's mandates.

POLICY:

The System of Care and Wraparound Principles will guide the planning, management and delivery of services for youth found eligible for the Children’s Intensive Treatment Services.

The care coordination provided through the WCHHS Children's Intensive Service Array (ISA) will adhere to the standards of fidelity as defined by the National Wraparound Initiative.
The WCHHS Children's Intensive Service Array will be governed by an Advisory Council comprised of representatives from other child serving systems, family members, youth, and family advocates.

PROCEDURES:

The Intensive Service Array (ISA) is a part of Washington County Wraparound (WCW), which also includes the Wraparound Demonstration Project. The ISA eligibility criteria, screening and determination process will remain distinct from the demonstration project for tracking and funding purposes.

The ISA will provide a range of service components to children and adolescents with severe mental and emotional disorders who meet ISA criteria.

These services include but are not limited to:

- Fidelity based Wraparound Care Coordination by a Washington County Wraparound (WCW) Care Coordinator;
- Intensive Community Based Services, such as home-based stabilization services;
- Respite;
- Non-traditional and flexible services;
- Therapeutic Foster Care;
- Psychiatric Day Treatment;
- Psychiatric Residential Treatment Services,
- Hospital and sub-acute care.

Access to ISA

The WCHHS ISA is available to children and adolescents from birth to age 18 who are enrolled with Health Share of Oregon/Washington County, qualify for mental health services through WCHHS General Fund, or have OHP mental health coverage on an “open card”. The WCHHS ISA is not available to enrollees of FamilyCare CCO. If a referral is made for a youth enrolled with FamilyCare CCO, the referrer should be redirected to apply to the FamilyCare ISA program.

A referral must be made to the Washington County Child and Family Care Coordination Team to determine if a youth is eligible for the ISA. Referrals can be made by any party including, but not limited to parents, family members, educators, treatment providers, Child Welfare, Juvenile Justice and the Oregon Youth Authority.

Eligibility is based on a Child and Adolescent Service Intensity Instrument (CASII) or Early Childhood Service Intensity Instrument (ECSII) score, a covered mental health diagnosis that is the focus of the needed services, treatment needs...
that exceed usual and customary services in an outpatient setting. multi-system involvement, risk of out-of-home placement, and risk of harm to self or others. For details of this process, please refer to the WCHHS Policy, Utilization Management: Intensive Service Array.

If a youth is determined not to be eligible for the ISA, a notification letter is sent to the guardian and referrer, which explains the reason(s) the youth did not qualify for the ISA and treatment recommendations and/or alternatives. A copy of Health Share of Oregon Appeal and Hearing rights accompanies the letter to the guardian.

**Child and Family Team**

When a youth is found eligible for the ISA, WCHHS will notify the family and the referrer and assign a WCW Care Coordinator to the youth and their family. The Care Coordinator will then contact the family to schedule a Child and Family Team meeting within 14 days to develop an initial Integrated Services and Support Plan (ISSP). Members of the Child and Family Team (CFT) are selected by the family and typically consist of the youth (when appropriate), family members (parents, caregivers, extended family or legal guardians), public and private child serving agencies involved with the youth, educators, mental health treatment providers (medical and substance abuse providers when appropriate) and natural community supports identified by the family.

To meet the goals of an integrated and comprehensive System of Care it is advisable and strongly recommended that representatives from Child Welfare, Juvenile Justice/OYA, and Special Education participate in the Child and Family Team when these systems have responsibilities for the youth and family. The WCW Care Coordinator is responsible for facilitating the Child and Family Team and advising the family on the importance of including representatives from the systems identified above when appropriate.

The WCW Care Coordinator will contact the team members identified by the family to learn their perspectives, orient them to the wraparound process, and schedule meetings.

If the client is in need of urgent or emergent intervention, the WCW Care Coordinator will refer the client to an appropriate service provider to stabilize any immediate crises.

The Child and Family Team will meet at intervals agreed upon by the team as long as the child and family are receiving ISA services. The Child and Family Team will meet no less than once every ninety (90) days.

**Program Orientation and Service Delivery**
Upon admission, youth and their families will receive an orientation packet with information about the program, services, philosophy and expectations. The assigned WCW Care Coordinator will review these materials with the family.

Washington County Mental Health does not collect fees from clients and does not require a fee agreement for care coordination services.

All care coordination services will be youth centered, culturally competent and developmentally appropriate based on the youth’s age and current level of functioning. Care Coordinators have access to translation services to ensure linguistically appropriate services as indicated.

Crisis support is available to all youth and families in the Intensive Services program. The provider of crisis support will depend on the services in which the youth and family are participating. All service providers have the responsibility to provide 24 hour crisis support to their clients. In addition, service providers with whom the youth and family are involved will collaboratively develop a crisis support plan and provide it in writing to the family, care provider and any other involved persons. The Washington County Crisis Line is available as backup, and is available 24 hours per day, seven days per week. For more information, please refer to the policy on Crisis Response.

**Integrated Services and Support Plan**

A primary responsibility of the Child and Family Team is to identify youth and family strengths, needs, short-term goals and long-term goals, which are then documented in a Integrated Services and Support Plan (ISSP).

The Child and Family Team work collaboratively and share responsibility for developing, implementing, monitoring, and evaluating the ISSP. The WCW ISSP is not the same as and does not replace service and support plans developed by the providers of the services. Rather, the WCW ISSP identifies the responsibilities of each team member, what services will be provided to accomplish the goals, and who will provide these services. Treatment providers must still develop individual service and support plans specific to the services and interventions they provide.

The WCW ISSP includes:

- The child and family’s strengths in multiple domains;
- Family vision;
- A team mission statement;
- Strengths, needs, short- and long-term goals, and outcome indicators;
- A Safety Plan;
- A Behavior Support Plan;
- Transition and Discharge Criteria.; and
- Responsibilities of each team member.
The safety plan will identify crisis resources, action steps, specific responsibilities of designated persons, and communications protocols.

The behavior support plan includes specific actions/interventions, a target completion date, and the person responsible for implementing the intervention. Actions and interventions may include a combination of existing or modified services, newly created services, natural supports, and community resources to help the child and family meet their stated goals.

The Child and Family Team selects and decides on the intensity and venue of the agreed upon services. The above components are documented in the WCW ISSP, which is distributed to each member of the Child and Family Team.

The Child and Family Team meets at agreed upon times to monitor the youth and family's progress, and to revisit and update the ISSP. Updated CASII and ECSII scores will be obtained each time there is a significant change in the youth's mental health status or functional level and prior to discharge.

### Transition and Discharge from ISA

Authorization for ISA services is under continuous review. At a minimum, the WCW Care Coordinator will re-determine ISA eligibility every ninety (90) days. A youth will be discharged from the ISA when they are no longer eligible for the ISA or when discharge criteria established by the CFT have been met.

If a youth is no longer eligible for the ISA or when a team determines that the youth is nearing completion of the identified goals and is approaching meeting the discharge criteria outlined in the ISSP, the WCW Care Coordinator will guide the Child and Family Team to create a transition plan.

The transition plan will identify professional services and natural community supports that will continue after the youth no longer meets ISA eligibility criteria and transitions to a lower level of care. If not already part of the Child and Family Team, providers of continuing care will be brought into the team so that the youth and family can become familiar with them and to assist in planning the transition.

The transition plan will also include a post-ISA crisis management plan that identifies crisis resources and includes action steps, specific responsibilities, and communications protocols.

When transition planning is complete and the youth has met their discharge criteria, the youth will be authorized for a lower level of care. The WCW Care Coordinator will contact the family at agreed upon time intervals to ensure that the family is continuing to experience success and to provide support if necessary.
**Family and Youth Involvement**

Washington County supports family and youth voice and engages in ongoing recruitment of family members and youth interested in providing input to the development of services to youth and families. Washington County endeavors to include youth and family members on the Children's Intensive Services and Wraparound Advisory Council, the System of Care Practice Workgroup, and other ad hoc meetings or committees.

To support efficient and family and team driven service planning, WCW Care Coordinators are able to directly authorize treatment services and can do so within the child and family team meeting. When there is disagreement within a child and family team that is not able to be resolved at the team level, the case can be brought to the System of Care Practice Workgroup for system level consultation. This can be done at a regularly scheduled meeting or an ad hoc meeting at the Care Coordinator’s request.
**Washington County Health and Human Services (WCHHS)**  
**Mental Health Program**  
**Policy and Procedure**

**Policy Title:** Mandatory Abuse Reporting

**Approved:**

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<th>Division Manager</th>
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**OBJECTIVE:**

To promote the health and safety of children and of adults receiving mental health services who may be victims of abuse and/or neglect.

To ensure that individuals employed by or contracted with Washington County Mental Health Program and volunteers have been informed of their responsibilities to report suspected incidents of abuse and neglect in accordance with ORS 430.735 through 430.768 and ORS 419B.005 through 419B.050.

To promote reporting of actual or suspected abuse of children and adults in keeping with mandatory reporting requirements established by the State of Oregon.

**POLICY:**

Oregon state law mandates that certain individuals are mandatory reporters of abuse and that these individuals must make reports if they have reasonable cause to suspect abuse or neglect. Washington County Mental Health Program employees and volunteers are considered to be mandatory reporters under this policy. Mandatory reporters, while acting in an official capacity, who come in contact with an adult receiving community mental health services or an elderly or developmentally disabled adult they suspect have been abused or neglected, must report the suspected abuse. Washington County Mental Health Program staff will be informed of their responsibility as mandatory reporters to report suspected abuse and neglect of children and for adults receiving mental health services. It is the policy of the Washington County Mental Health Program that employees will report incidents of suspected abuse and neglect to appropriate entities including law enforcement, the State of Oregon Office of Investigations and Training, and/or designated abuse investigators authorized by Washington County to receive and investigate allegations of abuse and neglect.
PROCEDURE:

Washington County will inform all employees and volunteers of the Washington County Mental Health Program upon hiring or start of volunteer service of their responsibility to report incidents of suspected abuse and neglect of children, the elderly, developmentally disabled adults and adults receiving mental health services through Washington County and its contracted provider system. All employees and volunteers will receive information described in this policy regarding applicable definitions of abuse and neglect and how to initiate a report when they identify instances of suspected abuse and neglect.

Reporting Abuse of an Adult.

For the purpose of this policy and as specified by Oregon Revised Statutes, the term “Adult” means a person 18 years of age or older with a mental illness who is receiving services from a community program or facility. Washington County and its provider system is a recognized community program such that this definition of “Adult” applies to individuals receiving services that are provided or funded through Washington County. The term “Adult” also applies to an individual who receives services in a residential treatment home, residential care facility, adult foster home or is in a facility approved by the State of Oregon Addictions and Mental Health program office as a provider of acute care or crisis respite services when the adult is in the custody of the facility pursuant to ORS 426.072.

In accordance with ORS 430.735 to 430.765, abuse of an adult means one or more of the following:

(a) Abandonment, including desertion or willful forsaking of a person with a developmental disability or the withdrawal or neglect of duties and obligations owed a person with a developmental disability by a caregiver or other person.

(b) Any physical injury to an adult caused by other than accidental means, or that appears to be at variance with the explanation given of the injury.

(c) Willful infliction of physical pain or injury upon an adult.

(d) Sexual abuse of an adult.

(e) Neglect.

(f) Verbal abuse of a person with a developmental disability.

(g) Financial exploitation of a person with a developmental disability.
(h) Involuntary seclusion of a person with a developmental disability for the convenience of the caregiver or to discipline the person.

(i) A wrongful use of a physical or chemical restraint upon a person with a developmental disability, excluding an act of restraint prescribed by a physician licensed under ORS chapter 677 and any treatment activities that are consistent with an approved treatment plan or in connection with a court order.

(j) An act that constitutes a crime under ORS 163.375, 163.405, 163.411, 163.415, 163.425, 163.427, 163.465 or 163.467.

(k) Any death of an adult caused by other than accidental or natural means.

For the purposes of this policy and procedure “Neglect of an Adult” means failure to provide the care, supervision or services necessary to maintain the physical and mental health of an adult that may result in physical harm or significant emotional harm to the person; failure of a caregiver to make a reasonable effort to protect an adult from abuse; or withholding of services necessary to maintain the health and well-being of an adult which leads to physical harm of an adult.

When a report is required, a report shall be made to the Washington County Mental Health Program or the Washington County Developmental Disabilities Program designee, or to an appropriate law enforcement agency within the county. If known, the report should include the following information:

(a) The name, age and present location of the allegedly abused adult;

(b) The names and addresses of persons responsible for the adult’s care;

(c) The nature and extent of the alleged abuse, including any evidence of previous abuse;

(d) Any information that led the person making the report to suspect that abuse has occurred plus any other information that the person believes might be helpful in establishing the cause of the abuse and the identity of the perpetrator; and

(e) The date of the incident.

Reporting Abuse of a Child.

By law, mandatory reporters must report suspected abuse or neglect of a child regardless of whether or not the knowledge of the abuse was gained in the reporter’s official capacity. In other words, the mandatory reporting of abuse or neglect of children is a 24-hour obligation.
For the purpose of this policy the term “Child” means an unmarried person who is under 18 years of age.

“ Abuse of a Child” means one or more of the following:

(A) Any assault, as defined in ORS chapter 163, of a child and any physical injury to a child which has been caused by other than accidental means, including any injury which appears to be at variance with the explanation given of the injury.

(B) Any mental injury to a child, which shall include only observable and substantial impairment of the child's mental or psychological ability to function caused by cruelty to the child, with due regard to the culture of the child.

(C) Rape of a child, which includes but is not limited to rape, sodomy, unlawful sexual penetration and incest, as those acts are described in ORS chapter 163.

(D) Sexual abuse, as described in ORS chapter 163.

(E) Sexual exploitation, including but not limited to:

(i) Contributing to the sexual delinquency of a minor, as defined in ORS chapter 163, and any other conduct which allows, employs, authorizes, permits, induces or encourages a child to engage in the performing for people to observe or the photographing, filming, tape recording or other exhibition which, in whole or in part, depicts sexual conduct or contact, as defined in ORS 163.665 and 163.670, sexual abuse involving a child or rape of a child, but not including any conduct which is part of any investigation conducted pursuant to ORS 419B.020 or which is designed to serve educational or other legitimate purposes; and

(ii) Allowing, permitting, encouraging or hiring a child to engage in prostitution, as defined in ORS chapter 167.

(F) Negligent treatment or maltreatment of a child, including but not limited to the failure to provide adequate food, clothing, shelter or medical care that is likely to endanger the health or welfare of the child.

(G) Threatened harm to a child, which means subjecting a child to a substantial risk of harm to the child's health or welfare.

(H) Buying or selling a person under 18 years of age as described in ORS 163.537.

(I) Permitting a person under 18 years of age to enter or remain in or upon premises where methamphetamines are being manufactured.
(J) Unlawful exposure to a controlled substance, as defined in ORS 475.005, that subjects a child to a substantial risk of harm to the child’s health or safety.

(b) “Abuse” does not include reasonable discipline unless the discipline results in one of the conditions described in paragraph (a) of this subsection.

When a report is required, a report shall be made to the local child welfare office or to an appropriate law enforcement agency within the county. If known, the report should include the following information:

(a) The names and addresses of the child and the parents of the child or other persons responsible for care of the child,

(b) The child’s age,

(c) The nature and extent of the abuse, including any evidence of previous abuse,

(d) The explanation given for the abuse; and

(e) Any other information that the person making the report believes might be helpful in establishing the cause of the abuse and the identity of the perpetrator.

Individual staff who identify the need to make a report of suspected abuse may seek consultation from their supervisor or other qualified persons. Informing a supervisor or seeking consultation from another person does not discharge the responsibility to initiate an abuse report. The individual making the report will document the abuse report including the date of the report, the person to whom the report was made, and any pertinent information regarding the abuse allegation.

Mandatory Reporter definition for suspected abuse of an Adult or Child.

In accordance with ORS 419B.005 and ORS 430.735(12) all employees and volunteers within the Washington County Mental Health program and contracted providers are considered to be “public or private officials” as a result of their employment with the county. As such, all employees and volunteers within the Washington County Mental Health program system of care are considered to be mandatory reporters of suspected or actual abuse or neglect of an Adult.

As defined by these statutes a “Public or private official” includes but is not limited to:
“Employee of the Department of Human Services or Oregon Health Authority, county health department, community mental health program or community developmental disabilities program or private agency contracting with a public body to provide any community mental health service.”

Additional information about the definition of a Public Official and mandatory abuse reporting of an Adult may be found on the Oregon Secretary of State website at:


Additional information about the definition of a Public Official and mandatory abuse reporting of a Child may be found on the Oregon Secretary of State website at:


Employees and/or volunteers of Washington County Mental Health Program and service providers within the Washington County mental health system of care are encouraged to seek consultation from program supervisors or the Washington County Quality Improvement Coordinator at (503) 846-4554 if they have questions or concerns about whether or how to report abuse of neglect.
Washington County Health and Human Services (WCHHS)
Mental Health Program
Policy and Procedure

Policy Title: Medication Management  
Approved: __________________________     _______________

Division Manager     Date

OBJECTIVE:
To ensure that treatment is individualized and based on each client’s mental health needs.
To ensure access to medically appropriate services effective in treating covered mental health conditions.
To respect client choice in selecting providers for therapy and medication management.

POLICY:
The Washington County resident must be eligible for funding through the Oregon Health Plan (OHP) Health Share of Oregon, assigned to Washington County or meet eligibility for Washington County General Fund in accordance with Washington County policy.

WCHHS recognizes that medication management alone may be appropriate in the course of some clients' treatment.

WCHHS believes that medication management is part of medically appropriate services for mental health clients.

Medically appropriate services and supplies are defined as services and supplies which are required for: prevention (including preventing a relapse), diagnosis or treatment of mental disorders; and which are appropriate and consistent with the diagnosis, consistent with treating the symptoms of a mental illness or treatment of a mental disorder, appropriate with regard to standards of good practice and generally recognized by the relevant scientific community as effective, not solely for the convenience of the Member or provider of the service or supply, and the most cost effective of the alternative levels of covered services or supplies which can be safely and effectively provided to the Member in Provider's judgment.
The Oregon Health Plan Health Share Agreement also assures that Members have:

- The right to receive information on available treatment options and alternatives presented in a manner appropriate to the OHP Member's condition and ability to understand.
- The right to be actively involved in the development of Treatment Plans
- The right to participate in decisions regarding his or her health care, including the right to refuse Covered Services.

These requirements assume that client's requests for medication management services are honored when clinically appropriate and that they are provided in the absence of other services when those services are not clinically indicated.

**PROCEDURE:**

Eligible persons requesting medication only services will be offered an assessment appointment with a Qualified Mental Health Professional through a contracted provider organization or, where appropriate, through an approved exceptional needs provider. It may be communicated to the client that treatment plan recommendations can be discussed upon the completion of the assessment.

Upon the completion of a comprehensive behavioral health assessment, Providers shall develop treatment plans collaboratively with the client and other appropriate treatment team members including agency medical staff.

If there is agreement between the client and the provider that treatment with medication alone is medically appropriate and likely to be successful, a treatment plan for medication management only may be completed.

If there is disagreement that medication alone is likely to be successful or that it is not medically appropriate and the provider and client are unable to agree on a plan, the provider will issue a Notice of Action for service denial in accordance with WCHHS policy on Notice of Actions.

In cases of requests for medication alone, primary care physicians may be consulted to explore the possibility of medication needs being addressed within primary care.

It is expected that in most provider agencies, non-medical staff will be assigned to a client’s case for the purpose of documentation of treatment plans and reviews and to manage any case management or crisis management that may unexpectedly arise.
OBJECTIVE:

To ensure that General Funds are managed in a fiscally prudent manner and are reserved for those most in need.

To ensure that reimbursement is for treatment of a covered mental health condition.

To ensure that reimbursement is for a clinically indicated, medically necessary treatment intervention where the service provided is appropriate to the degree of impairment, current symptoms, and treatment history.

To ensure that medication costs are reimbursed with general fund dollars only in situations where there are no alternative resources available.

To ensure a prompt response to requests for reimbursement.

POLICY:

General Funds will only be used to pay for prescription psychiatric medications in situations where there are no alternative resources available and the medication is clinically necessary.

Contracted agencies will be provided with a medication flexible funding allocation that allows them to internally prioritize medications for General Fund clients. For Rehabilitation/SPMI providers, this medication flexible funding is integrated in the general Flexible Funding allocation.

The following are general guidelines for providers in the use of medication flexible funding:
Providers should make reasonable efforts to identify other sources of funding before using General Fund dollars to pay for medication. These sources may include but are not limited to:

- Client resources (i.e., paying out of pocket)
- Family resources
- Medication samples from providers
- Prescription assistance programs

General Funds to cover co-payments may be considered in the following situations:

- The client has an approved authorization for services as well as private third party resources such as insurance but is unable to pay the prescription co-payments. In this situation coverage will be for the co-pay only.
- The client has been approved for a prescription assistance program however there is a medication co-payment required and the client is unable to afford the co-payment and there are no other resources available.

Laboratory work that is associated with psychiatric medication may be paid for using flexible funding when there were no other resources available to pay for necessary labs, and the laboratory work is related to treating a psychiatric condition.

Only psychiatric medications that are covered by the Oregon Health Plan may be paid for with General Fund dollars.

Providers should use generic alternatives whenever possible for rehabilitation services. The Adult Outpatient service type requires the use of generics due to the limited budget available to these providers.

If generic alternatives are not used, then the Licensed Medical Professional (LMP) prescribing the medication to be reimbursed by General Fund should document the rationale for use of the medication in agency records.

Documentation will include:

- Why lower cost alternatives such as generics are not indicated
- How the prescribed medication/lab is related to the psychiatric presentation

Providers should request OHP rates from pharmacies in an effort to avoid paying full retail costs whenever possible. Providers will make every effort to identify and use pharmacies that offer prescriptions at a reduced rate.

**PROCEDURE:**

Medications may be invoiced at cost to the Program Coordinator within the flexible funds allocation identified in provider contracts. Contractor must submit a
Revised 3-17-14

properly signed Request for Payment on contractor letterhead or billing form for Medication Reimbursement.

All contract payments are subject to the availability of funds and will be paid subsequent to County receipt of the monthly payment from the State of Oregon.

All completed invoices will be reviewed within two weeks of receipt by the county.

Provider will send additional LMP documentation to support the request for reimbursement when requested by the County.

In situations where the request is denied, the County will notify the provider either by phone or in writing of the denial and will indicate the reason for the denial. Providers will have the opportunity to resubmit requests for reimbursement.
Washington County Health and Human Services (WCHHS)
Mental Health Program
Policy and Procedure

Policy Title: Personnel Qualifications and Credentialing

Approved: __________________________     __________________________

Division Manager     Date

OBJECTIVE:

To ensure that employees of the Washington County Mental Health Program have the necessary credentials and competencies to perform assigned responsibilities and tasks.

To ensure that program administrators demonstrate competence in leadership, program planning and budgeting, fiscal management, supervision of program staff, personnel management, program staff performance assessment, use of data, reporting, program evaluation, quality assurance, and developing and coordinating community resources.

To ensure that clinical supervisors demonstrate competence in leadership, wellness, oversight and evaluation of services, staff development, service planning, case management and coordination, utilization of community resources, group, family and individual therapy or counseling, documentation and rationale for services to promote intended outcomes and implementation of all provider policies.

POLICY:

It is the policy of WCHHS that employees of the Washington County Mental Health Program will meet credentialing and qualification standards established by the State of Oregon and Health Share of Oregon. Documentation of employee credentialing and qualifications will be documented at the time of hire and will be maintained in personnel records.

PROCEDURE:

The Washington County Mental Health Program will adhere to county policies and procedures relating to recruitment, hiring, and other personnel activities.
Employees will participate in training and orientation activities established by the county and by the mental health program upon initial hire and periodically thereafter as deemed appropriate by the program.

Background Checks.

Background checks will be conducted for all employees of the Washington County Mental Health Program at the time of hire. Background checks will include verification through the Office of Inspector General website to verify that the employee’s name has not been placed on the federal Medicaid exclusion list. Criminal history background checks will be conducted for all employees through the State of Oregon Criminal Background Unit and as described in the Washington County Mental Health Program policy and procedure for Criminal Records Checks. Documentation of a final fitness determination will be placed in the employee’s personnel record.

Clinical Staff Competencies.

Washington County will verify the competencies and credentials of employees that provide and/or oversee mental health services at the time of hire. Competencies and credentials for such employees will be assessed to ensure the employee meets or exceeds credentialing standards as described below.

- Qualified mental health associates (QMHAs) must demonstrate the ability to communicate effectively, understand mental health assessment, treatment and service terminology and apply each of these concepts, implement skills development strategies, and identify, implement and coordinate the services and supports identified in a Service Plan. QMHAs must (1) bachelor’s degree in a behavioral science field; or (2) have a combination of at least three years of relevant work, education, training or experience; or (3) be an intern from a credentialed or accredited graduate level educational program in a behavioral health field that is recognized by the state of Oregon. Verification of the required competencies will be documented in the individual employee file.

- Qualified mental health professionals (QMHPs) must demonstrate the ability to conduct an assessment, including identifying precipitating events, gathering histories of mental and physical health, substance use, past mental health services and criminal justice contacts, assessing family, cultural, social and work relationships, and conducting a mental status examination, complete a DSM diagnosis, write and supervise the implementation of a Service Plan and provide individual, family or group therapy within the scope of their training. QMHPs must (1) have a bachelor’s degree in nursing and licensed by the State or Oregon; (2)
have a bachelor’s degree in occupational therapy and licensed by the State of Oregon; or (3) have a graduate degree in psychology, social work, recreational, art, or music therapy. Verification of the required competencies will be documented in the individual employee file.

- Clinical supervisors must meet QMHP requirements and have completed two years of post-graduate clinical experience in a mental health treatment setting.

Documentation.

Documentation of verification of individual employee competencies and credentials will be maintained in personnel records for each program staff member. The documentation will include the employee’s current job description; copies of relevant licensure or certification; and diploma or certified transcripts. Employees will participate in training and orientation activities upon entering employment through the Washington County Mental Health Program as described in the policy and procedure titled Staff Orientation and Training. Verification of orientation and training will be maintained in an employee file.
WASHINGTON COUNTY HEALTH AND HUMAN SERVICES (WCHHS)
Mental Health Program
Policy and Procedure

Policy Title: Quality Assurance and Quality Improvement

Approved: __________________________     __________________

Division Manager     Date

OBJECTIVE:

To establish and implement a Quality Assurance and Performance Improvement (QAPI) process that addresses the needs of Washington County clients.

To monitor the effectiveness of Washington County in relation to over and under utilization of services.

To establish processes for gathering and considering information from stakeholders.

To communicate findings to providers relating to opportunities for improvement, to assess overall quality of services available to Washington County clients, and to identification of areas for improvement.

POLICY:

It is the policy of Washington County that a Quality Assessment and Performance Improvement (QAPI) process will be implemented to monitor performance and identify areas for improvement with input from providers, consumers and clients, and other community stakeholders. The QI process will comply with contract requirements between Washington County and Health Share of Oregon and contract and regulatory requirements established by the Oregon Health Authority.

PROCEDURE:

Washington County will implement Quality Assurance and Performance Improvement standards consistent with the contract between Washington County and Health Share of Oregon and with applicable Oregon Administrative Rules (OARs). Washington County will assist and cooperate with in the development
and implementation of a Quality Assurance and Performance Improvement program and measures as developed by Health Share of Oregon. Washington County will implement data reporting systems necessary for Health Share to measure its performance on outcomes, quality, and efficiency measures. Washington County will participate with Health Share in the implementation of identified Performance Improvement Projects (PIP) as designed by Health Share in clinical and non-clinical areas that are expected to have favorable effect on health outcomes and member satisfaction. Washington County will require sub-contacted service providers to cooperate with Health Share by providing access to records and facilities for the purpose of periodic audits and professional reviews relating to covered services for Medicaid eligible clients.

Washington County will designate a qualified individual to serve as the Washington County Quality Improvement Coordinator. The designated person will have the necessary training and experience to develop and implement the Washington County Quality Improvement Plan. The QI Coordinator will meet criteria as a Qualified Mental Health Professional (QMHP) as defined by Oregon Administrative Rules and the Mental Health Organization Agreement. Additionally, the Quality Improvement Coordinator will serve as the Washington County Compliance Officer in regard to fraud and abuse concerns. The Washington County Quality Improvement Coordinator will participate as a member of the statewide Medical Directors and QI Committee.

Washington County will convene a Performance Improvement Committee that will include contracted providers, representatives of clients served including adult consumers and parents of children in service, and other stakeholders. The Washington County QI process will seek input from committee members and other sources of information regarding recommendations and opportunities for improvement. The Washington County QIC will communicate to providers and other interested stakeholders about Washington County’s performance and outcomes. The Washington County QI Committee will meet on a monthly basis and a minimum of once per quarter. QI Committee meetings will be scheduled at a time and place convenient for Washington County QI Committee members. Washington County may provide subsidies for consumer members of the committee to support their attendance and participation. The Washington County QI committee may be incorporated or otherwise participate in tri-county compliance and quality committees as deemed appropriate.

The Quality Improvement Committee will also serve as the Washington County Compliance Committee in regard to fraud and abuse concerns. Allegations or findings of fraud and abuse that rise to the level of a serious and substantial non-compliance with fiscal management, claims and clinical documentation standards that may result in substantial overpayment may be referred to the Quality Improvement Committee for further review and monitoring. The committee will make recommendations for action or improved oversight and monitoring to
address fraud and abuse allegations as deemed appropriate to the committee and its membership.

The QI program for Washington County will include a focus on access to services, outcomes and performance measures, and utilization of services. Washington County will incorporate measurable objectives and benchmarks in the domains of access to care, quality of services, integration and coordination, outcomes, prevention education and outreach, credentialing, and quality management. The Washington County QI process will include monitoring of complaints/grievances, appeals and hearing requests as part of the QI process. Washington County will also implement mechanisms to detect both underutilization and over utilization of services. The Washington County QI process will include mechanisms for soliciting client feedback through annual surveys and/or related mechanisms for obtaining input from clients in a manner that is broadly representative of Washington County.

Additionally, the Washington County Quality Improvement Coordinator will participate as a member of the statewide QI Committee.
**Washington County Health and Human Services (WCHHS)**
**Mental Health Program**
**Policy and Procedure**

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**OBJECTIVE:**

To ensure access for clients to obtain a second opinion when clinically justified.

To ensure a prompt response to requests for service authorization.

**POLICY:**

When a client disagrees with the clinical assessment or treatment provided by either their primary clinician and/or a Licensed Medical Provider (LMP) within a contracted provider agency or by an exceptional needs provider, the client may request a second opinion. Clients will be offered a second opinion by an alternative clinician within the existing provider agency or with another practitioner as deemed appropriate.

A second opinion from a Qualified Mental Health Professional (QMHP) clinician or LMP outside of the current assigned provider agency will be considered in situations where the client is receiving services by a contracted Washington County provider and is not able to come to an agreement about the course of treatment with their primary provider or the client is unwilling to meet with another clinician within the current provider agency.

Requests for a second opinion from a QMHP or LMP outside of the provider agency may be considered as an Exceptional Need request and will be handled in accordance with the Washington County policy on Exceptional Needs Requests.

**Guidelines:**

- Client has had at least one session with their assigned QMHP or LMP at their current provider agency;
- Client has been encouraged to talk about any concerns with their current QMHP or LMP;
- The client’s primary clinician will attempt to resolve the concern by exploring the basis of the concern with the client. In situations where the concern is
Regarding the LMP, the primary clinician may act as an advocate for client and sit in with client to support them in discussing their concerns with their LMP;
- If client's concerns are not resolved, the clinical team may support a request from client for a second opinion outside of the provider agency;
- Client must agree to sign a release of information for the second opinion provider and allow records to be released to that provider prior to the scheduled appointment; and
- Authorization for a second opinion will be for a single assessment/evaluation with the expectation that the two professionals will communicate about recommendations for client’s ongoing treatment with the primary provider.

**PROCEDURE:**

All requests for a second opinion outside of the assigned provider agency should be submitted in writing to a Washington County Care Coordinator. The request should provide the following information:

- The client’s current presentation
- The client’s mental health history
- Client’s concern about recommended course of treatment by current provider and documentation that client has addressed concerns with the provider
- Documentation of attempts to resolve the client’s concerns by referring client to another clinician within the agency

A qualified Washington County representative will review the request using the exceptional needs authorization procedure and make a decision with 14 days. The Washington County representative will assist in identifying an appropriate provider for the second opinion and authorize the service. The referring agency is expected to send a signed release of information to the secondary provider along with client’s clinical records for review.

Clients may request a second opinion either orally or in writing to their current provider or directly to Washington County. Providers may make arrangements for a second opinion among its existing staff if the client agrees that this would meet their request for a second opinion. If the client and participating provider do not reach agreement about the requested second opinion, or if the client indicates a desire to seek a second opinion elsewhere, the provider will notify Washington County of the request for a second opinion and their efforts to respond to the request. Additionally, the client may contact Washington County directly to request assistance in obtaining a second opinion at any time, regardless of whether the provider has attempted to resolve the request.

Requests for a second opinion received directly by Washington County will be addressed on a case by case basis. If the client’s request can be resolved by the current provider, Washington County will attempt to facilitate this resolution.
the request for a second opinion cannot be addressed by the current provider or if the client does not wish for the second opinion to be made by the provider, Washington County will facilitate access to another approved provider. Approved providers include contracted provider agencies and, when necessary due to no participating provider available to meet the client’s needs, an approved non-participating provider. Washington County will attempt to honor the client’s preferences about who will provide the second opinion where possible, but retains the right for a second opinion to be provided by a contracted provider whenever available.

Washington County or the contracted provider will inform the client of the outcome of the second opinion request in writing. If the outcome is not what the client requested, a Notice of Action may be issued to the client in those instances where the outcome results in a denial, suspension, reduction or termination of a covered service. The client will be informed of their right to appeal the decision through the established grievance and appeal process.
**OBJECTIVE:**

To ensure that Washington County and contracted providers maintain service delivery policies and procedures applicable to the services provided by the county and its contracted service delivery system. To ensure that services provided within the Washington County service delivery system are provided in keeping with contractual and other regulatory standards. To ensure that services are provided to individuals in keeping with their assessed clinical needs and in accordance with their rights.

**POLICY:**

All providers of mental health treatment services under the Washington County system of care must develop and implement the following policies and procedures:

(A) Fee agreements;
(B) Confidentiality and compliance with HIPAA, Federal Confidentiality Regulations (42 CFR, Part 2), and State confidentiality regulations as specified in ORS 179.505 and 192.518 through 192.530;
(C) Compliance with Title 2 of the Americans with Disabilities Act of 1990 (ADA);
(D) Grievances and Appeals;
(E) Individual Rights;
(F) Quality Assessment and Performance Improvement;
(G) Crisis Prevention and Response; and
(H) Incident Reporting.

**PROCEDURE:**

Provider organizations offering mental health services funded or otherwise approved by Washington County must develop service delivery policies listed
above as required by applicable Oregon Administrative Rules. The service
delivery policies must be formally adopted as part of the organizations policy and
procedure manual and must be made available to employees at the time of hire
and periodically thereafter. Additionally, these policies must be available to
individuals and family members upon request.

Washington County will adopt individual policies to address the required topic
areas as listed above. Adopted policies are subject to review on an annual basis
or more frequently as deemed appropriate or necessary by the county. Service
delivery policies of contracted providers are subject to periodic review by
Washington County as part of periodic credentialing site reviews and through
other activities as deemed appropriate by the county. Contracted providers may
be subject to corrective action requirements for instances where required service
delivery policies are determined to be missing or insufficient to address the intent
of these standards.
WASHINGTON COUNTY HEALTH AND HUMAN SERVICES (WCHHS)
MENTAL HEALTH ORGANIZATION
POLICY AND PROCEDURE

POLICY TITLE: School Based Mental Health Services

APPROVED: ____________________________       ____________________________

Division Manager    Date

OBJECTIVE:
To provide mental health services in locations that are convenient for youth and their families and effectively remove barriers to access.

To ensure that mental health services are client and family driven and that client choice is respected.

To ensure that mental health services are comprehensive and individualized to client and family needs.

POLICY:

WCHHS contracts with multiple child and family outpatient mental health providers, some of which locate clinicians in a variety of school settings, in various roles. In order to ensure that clients have access to the full array of services necessary to meet their individualized needs and to ensure client choice, WCHHS requires that clients are informed of all their treatment options including other contracted provider agencies that are available to meet their needs as part of an initial screening occurring in a school setting. Clients qualifying for Child and Family Level C outpatient services or higher will be referred out of the school setting to a contracted mental health agency that has the full array of outpatient mental health services.

Since school based mental health clinicians are not available during the summer break, clients who are assessed as needing ongoing treatment beyond the end of the school year should be referred to a contracted provider agency providing services in the community or mental health clinic location to ensure there is no disruption in services.

PROCEDURES
After an initial screening to determine the need for mental health services, school based mental health clinicians should ensure that clients and their families have been informed of all contracted mental health services for which the client may be eligible. If the initial screening indicates the client’s need is consistent with a brief, non-intensive intervention, the client may receive a mental health assessment and services by the school based clinician consistent with Washington County policy on Utilization Management for Outpatient and Rehabilitation Services.

If the initial screening indicates that the client’s service need either requires an intensity that exceeds Child and Family Outpatient Level B or the expected duration of service will extend beyond the school year, the client will be referred to a contracted provider agency providing services in the community or mental health office. The client will be offered assistance in connecting with the provider agency of their choice.
Washington County Health and Human Services (WCHHS)
Mental Health Program
Policy and Procedure

Policy Title: Third Party Resources and Liens

Approved: __________________________     ________ _______________
Division Manager                     Date

OBJECTIVE:

To provide responsible stewardship of public funds by developing procedures to ensure that Oregon Health Plan (OHP) or other public mental health funds are the payer of last resort.

To coordinate care and benefits for Washington County Health and Human Services (WCHHS) clients, who are eligible for Medicare, have Third Party Resources, or when another party may be liable for a personal injury.

POLICY:

As part of Health Share of Oregon (HSO) and a Risk Accepting Entity (RAE) managing Medicaid mental health, WCHHS Mental Health is the payer of last resort when there is other insurance, Medicare, Veterans Administration benefits or other Third Party Resources available. This principle also applies to other public funds administered by WCHHS.

WCHHS Mental Health will take all reasonable actions to pursue recovery of Third Party Resources for Covered Services. “Third Party” is defined as any individual, entity, or program that is, or may be liable to pay all or part of the cost of any Covered Service furnished to an OHP Member.

WCHHS requires all sub-contracted providers to follow this policy to the extent that it applies to mental health services that they provide to WCHHS clients.

All medical services provided by qualified Medicare providers, including physicians, nurse practitioners, licensed clinical social workers, and licensed psychologists, will first be billed to Medicare for dually eligible clients.
PROCEDURE:

Identifying Third Party Resource

Third Party Resources and Personal Injury Liens mean any payments, benefits, or other resources available from a Third Party, including but not limited to:

a. Private health insurance or group health plan;
b. Employment-related health insurance;
c. Medical support from absent parents;
d. Workers’ compensation;
e. Medicare;
f. Automobile liability insurance;
g. Other federal programs such as Veterans Administration, Armed Forces Retirees and Dependent Act (CHAMPVA), Armed Forces Active Duty and Dependents Military Medical Benefits Act (CHAMPUS), and Medicare Parts A and B, unless excluded by statute;
h. Claims, judgments, settlements or compromises in relation to personal injuries where the Covered Services paid by WCHHS constitute assistance, as these terms are defined in ORS 416.510;
i. Another state’s Title XIX, Title XXI, or state-funded Medical Assistance Program;
j. Personal estates.

Indian Health Service (IHS) is the payor of last resort for services provided to OHP Members pursuant to 42 CFR 136.61 and is not considered a Third Party Resource.

Services provided to OHP Members at a tribal facility operated under a “638” agreement pursuant to the Memorandum of Agreement between IHS and CMS is a payor of last resort and is not considered a Third Party Resource.

Reporting

HSO has delegated to WCHHS to the responsibility to track third party collection information and is required to report this information to for inclusion in the OHP Coordination of Benefits and Subrogation Recovery Section on the Quarterly Report, Report L.8 of Exhibit L.

WCHHS shall document efforts, successful or unsuccessful, to ensure accuracy of such reports and make records available for audit and review upon request.
WCHHS shall notify the Health Insurance Group, P.O. Box 14023, Salem, Oregon 97309, within thirty (30) days from the time that WCHHS learns that an OHP Member might have other health insurance.

WCHHS shall immediately report that an OHP Member has a potential third party claim for personal injuries, or has made a claim or begun an action to enforce such claim, as those terms are defined in ORS 416.510, to the OHP Member’s caseworker and DHS’ Personal Injury Liens Unit, P.O. Box 14512, Salem, OR 97309-0416.

**Determining the Liability of Third Party Resource**

WCHHS and/or their sub-contracted providers will request OHP members with Third Party Resources to cooperate in securing payment from the Third Party Resource, except when the client asserts good cause as defined in OAR 461-120-0350.

WCHHS and/or its subcontractors will not refuse to provide covered services to an Oregon Health Plan client because of a Third Party Resource’s potential liability for payment of the covered service. Sub-contractors are also required to provide covered services regardless of potential third party liability for payment.

If WCHHS and/or its subcontractors are unable to gain cooperation from the OHP Member or OHP Member Representative or a Third Party Resource in pursuing the Third Party Resource, or if the OHP Member asserts good cause; WCHHS shall notify the Medical Payment Recovery Unit, P.O. Box 14023, Salem Oregon 97309, of their refusal to cooperate, and provide such records and documentation as may be requested from the Medical Payment Recovery Unit.

**Claims Processing and Third Party Liability**

WCHHS requires that sub-contracted providers bill Third Party Resources first for all covered services furnished to a WCHHS client.

Upon receipt of a claim from a provider, if based on eligibility data on the date/s of a covered service or WCHHS claims payment history for the six months preceding the date/s of covered services, it is known or likely that client has a Third Party Resource and there is no indication that the provider has attempted to bill a third party, then the claim shall be denied and returned to the provider with instruction to attempt collection from the liable third party.

When medical expenses arise from the negligent or intentional act of some third party, and the client is pursuing a claim for client’s injuries, WCHHS asserts that
the primary responsibility for payment lies with the third party that caused the expenses to be incurred and shall actively assert its right of subrogation.

WCHHS will not delay payment to provider after provider notifies WCHHS that it cannot obtain recovery from a Third Party Resource after making reasonable efforts, or cannot obtain information or cooperation needed from the client or client representative. Upon such notification, WCHHS shall process the claim as a valid claim; however, WCHHS may pursue alternative remedies for recovery.

Claims with possible or undetermined Third Party Liability are processed on a “Pay and Chase” basis. Claims shall be paid while the investigation is being pursued. Once Third Party Liability has been determined, if necessary WCHHS shall request refunds or utilize its right of subrogation from the primary carrier.

All claims for clients who are identified as having Third Party Liability are flagged for special handling to assure that claims are paid or denied correctly.

WCHHS will request refund and/or reimbursement from providers and facilities on all related claims paid in error or prior to WCHHS’s knowledge of Third Party Liability.

When engaging in Third Party Resource recovery actions, WCHHS and its subcontractors will comply with federal and state confidentiality requirements pursuant to Part II, Section XXII, including without limitation, the federal (42CFR and state (ORS 426.460 and ORS 179.595) confidentiality laws and regulations governing the identity and client records of OHP members. Addictions and Mental Health Division of the State of Oregon Department of Human Services (AMH) considers the disclosure of AMH member claims information in connection with WCHHS’s Third Party Resource recovery actions a purpose that is directly connected with the administration of the Medicaid program.

WCHHS shall not request an assignment of right to recovery or assignment of a lien from a client or client representative. When a third party may be liable for a personal injury to an HSO member, WCHHS may pay the claims and place a lien against a judgment, settlement, or compromise. Once WCHHS has made the payment for covered services, and a lien has been sought, no additional billing or claim for enhanced reimbursement (e.g., balance billing) to the third party or to the OHP Member or their financially responsible representative will be made.

WCHHS shall comply with 42 USC 1395y(b), which gives Medicare the right to recover its benefits from employers and workers’ compensation carriers, liability insurers, automobile or no fault insurers, and employer group health plans before any other entity including WCHHS or its subcontractor.
Where Medicare and WCHHS have paid for services, and the amount available from the Third Party Resource is not sufficient to satisfy the claims of both programs to reimbursement, the Third Party Resource must reimburse Medicare the full amount of its claim before any other entity, including WCHHS or its subcontractor, may be paid.

If the Third Party Resource has reimbursed WCHHS or its subcontractor, or if an OHP Member, after receiving payment from the Third Party Resource, has reimbursed WCHHS or its subcontractor, the WCHHS or its subcontractor must reimburse Medicare up to the full amount the WCHHS/subcontractor received, if Medicare is unable to recover its payment from the remainder of the Third Party Resource payment.

Any such Medicare reimbursements described above are the WCHHS’s responsibility on presentation of appropriate request and supporting documentation from the Medicare carrier. WCHHS shall document such Medicare reimbursements in its report to HSO.

When engaging in Third Party Liability recovery actions, WCHHS shall comply with, and require its Subcontractors or agents to comply with all applicable federal and State confidentiality requirements, which are detailed in the contract between HSO and WCHHS.
**Washington County Health and Human Services (WCHHS)**

**Mental Health Program**

**Policy and Procedure**

**Policy Title:** Timely Access to Services

**Approved:** __________________________     ________ ______________

Division Manager        Date

**OBJECTIVE:**

To ensure that individuals eligible for mental health services funded through Washington County are able to access services in a timely manner.

To ensure that Washington County contracted providers of community mental health services offer services in a timely manner and/or provide appropriate referral information to facilitate access within the Washington County contracted provider panel.

**POLICY:**

Washington County contracted providers will offer timely access to services for individuals that are eligible for Washington County funded services. For the purpose of this policy and procedure, timely access to services includes the offer of a requested service that specifies an identified date, time, and location that the requested service is made available. Timely access to services is defined as follows:

Timely access to routine community treatment services (service levels A, B, and C) means the offer of an initial intake appointment within 14 calendar days of the initial service request. Routine service requests for service levels A,B, and C include circumstances where there is not an identifiable risk of harm, the need for inpatient treatment or out of home care is not imminent, and the individual requesting services can reasonably be expected to wait for the initial service without foreseeable risk.

If a Washington County contracted provider is not able to provide timely access to services the provider will take appropriate steps to inform the individual seeking services of other resources appropriate to the person’s need for mental health services. For urgent/emergent situations, other appropriate services may include referral to the Washington County crisis service or to a hospital emergency department as necessary to prevent injury or serious harm.
Individuals seeking services will have the choice to receive services to seek services elsewhere or to accept an appointment with the provider at a later date.

Access Monitoring for higher levels of care (e.g., service level D and ACT service) is monitored through the Washington County utilization management process. Refer to the Washington County utilization management policies and procedures for crisis services, ISA/wraparound, exceptional needs, and inpatient services for these levels of care.

**PROCEDURE:**

Individuals seeking Level A, B, or C community mental health treatment services (refer to Utilization Management policies and procedures for level of care criteria and standards) that are funded in whole or in part through the Washington County contracted provider system may request services from any Washington County contracted provider in person or by phone. Contracted providers will accept service requests during their routine hours of operation and will facilitate access to requested services commensurate with the individual’s circumstances and treatment needs. If the provider determines that the client is not appropriate for the type or scope of services available through the agency (e.g., a child seeking services through an adult service provider) then the provider will offer referral information for the Washington County Access Line and to other contracted providers that are appropriate to the needs of the individual seeking services. Contracted providers are expected under the terms of the contract with Washington County to offer timely access to services in keeping with the individual’s circumstances and treatment needs. If a provider offers an initial service in keeping with expected time frames but the client chooses a later date then it is appropriate to honor the client’s request.

When a provider receives a request for community treatment services, the provider will seek to determine the nature and urgency of the individual’s treatment needs. Individuals requesting routine community mental health treatment services will be offered an initial service appointment within 14 days of the request. Appointments will be offered within 48 hours for individuals with urgent treatment needs and within 24 hours for individuals with emergent treatment needs as described above. Individuals requesting services will be informed of the date, time, and location for the initial appointment and, where possible, the individual will also be given the name of the clinician that will provide the service.

When a provider is not able to offer timely access to services the provider will offer information to allow the individual seeking care to make an informed choice about waiting for a later appointment or seeking services elsewhere. If the provider is not able to offer timely access to services then the individual must be offered referral information to other appropriate providers within the Washington
County contracted provider system. Such referrals will include information about each of the contracted providers in Washington County that provide the requested service and how to contact the Washington County Access Line for further assistance. Referral information under such circumstances will include the name of the provider, the address and/or general location of the provider, and phone number. In circumstances where the individual elects to wait for a later appointment with the same provider then the next available appointment will be offered in addition to referral information for other providers. Individuals seeking services from the provider have freedom of choice among participating providers but may elect to remain on the wait list with the initial provider. Contracted providers will ensure that program staff who receive service requests and staff who coordinate access to services are informed of the expectation to provide timely access to services and to provide appropriate referral information when access cannot be offered within expected time frames. If a provider is unable to schedule an appointment within 24 hours in an emergency situation, a referral to the Washington County crisis team or nearest emergency department will be made.

Contracted providers are expected to offer timely access to services in keeping with benchmarks set by Washington County. Monitoring of timely access to services will include online submission of monthly access reports by each contracted provider. The provider access report is due on the 15th of each month. The access report will follow a standardized format established by among participating Health Share of Oregon entities, including Washington County, and will include at a minimum the number of service requests for children and adults requesting routine mental health services and the number of individuals requesting services who were offered timely access to services. Each provider is to provide access information for Levels A, B & C services for their Medicaid and General Fund clients over the prior month. Providers submit this report at: https://www.surveymonkey.com/s/Tri-County-Access

When a contracted provider determines that access benchmarks cannot be met the provider will notify Washington County of the situation. Providers that do not meet benchmarks for timely access to services may be required to submit a performance improvement plan to address access concerns. Repeated and/or ongoing inability to meet benchmarks for timely access to services may result in a more formal corrective action plan including potential sanctions or penalties at the discretion of Washington County.
Objective:

To honor client and family choice in the selection of a mental health provider.

To allow for a change of mental health provider when appropriate.

To provide culturally competent mental health care convenient to the client’s living location.

Policy:

WCHHS’s business model supports a single primary provider within a treatment authorization period.

Requests for transferring care to an alternate provider will be honored in situations where doing so will reduce a barrier to treatment access.

A WCHHS Care Coordinator must authorize all requested changes of Primary Auth Agencies and transfers to a different service type within a single authorization period.

Procedure:

Requests for Transfer to an Alternative Provider

The client, a parent or guardian, a client representative, or the provider may initiate requests for transfers between agencies and/or service types.

Transfer requests will be directed to a WCHHS Care Coordinator who will review the basis of the request.

The WCHHS Care Coordinator may discuss the reasons for the request with the client or client representative and both participating providers to determine if the request meets the criteria for transfer.
The WCHHS Care Coordinator will take care to determine that the request is in the best interests of the client.

Requests based on the following will routinely be approved:
- The client has not started treatment with the authorized agency;
- The location of the authorized agency presents a barrier to treatment;
- Services that are more culturally appropriate is available at a different provider agency;
- An alternate service type is more clinically appropriate for the client.

The following presenting concern will be treated as a complaint, regardless of whether transfer is authorized, and forwarded to the WCHHS Quality Improvement Coordinator for disposition:

A client or client representative is requesting a transfer because of dissatisfaction with the delivery of service by an agency. Examples of this include, but are not limited to:
- Frequent unreturned phone calls;
- Frequent cancelled appointments;
- Lack of timely access to care provider.

The WCHHS Care Coordinator may contact the authorized agency to establish the validity of the complaint and gather information.

The WCHHS Care Coordinator may work with the provider and client to determine if the problem can be resolved without transfer to a different provider.

If the WCHHS Care Coordinator determines the complaint to be valid, or if resolution cannot be reached between provider and client, the WCHHS Care Coordinator may authorize the transfer request.

The client or client representative may request transfer because of disagreement with the treatment they are receiving from the provider. The WCHHS Care Coordinator will discuss the treatment issues with either the client or client representative and the provider before authorizing transfer.

The WCHHS Care Coordinator will encourage the client to discuss their concerns with the provider directly and may offer to assist the client if appropriate. The WCHHS Care Coordinator may suggest transfer to another clinician within the agency if the client refuses to discuss the issue with their current clinician.

If previous options have failed, the WCHHS Care Coordinator may authorize transfer after obtaining agreement from both the transferring and receiving provider.
If the request is determined to be not in the best interest of the client, the WCHHS Care Coordinator may deny the transfer. When a requested transfer is denied, a Notice of Action will be issued to the client in accordance with WCHHS policy on Notice of Actions.

Authorization of Transfer

If transfer is approved, the WCHHS Care Coordinator will change end date of the existing Initial Auth Lead Agency authorization. The WCHHS Care Coordinator will submit and approve an assessment authorization to the new provider.

Both providers will be notified of these actions.
Washington County Health and Human Services (WCHHS)
Mental Health Program
Policy and Procedure

Policy Title: Treatment of Co-Existing Disorders

Approved: __________________________     __________________________
Division Manager    Date

OBJECTIVE:

To promote awareness and recognition of the relationship between mental health and substance use disorders.

To acknowledge that recovery from mental health disorders and recovery from substance abuse are commonly interdependent.

To insure appropriate treatment access and coordination of care for WCHHS clients with both a mental health disorder and a substance abuse disorder.

POLICY:

Given the high prevalence of alcohol and drug use among persons with mental health conditions and the effect of alcohol and drug use on mental health conditions, all those seeking mental health services should be screened for the presence of a co-occurring substance use disorder.

Given the particularly high prevalence of substance use disorders among persons with Severe and Persistent Mental Illness (SPMI), all practitioners serving persons with SPMI need competence in assessing alcohol and drug issues.

Research indicates that treatment of substance use disorders for individuals who have a severe and persistent mental illness is most effective when integrated with mental health services. Washington County supports treatment of co-existing disorders for persons with SPMI through integrated treatment approaches that are provided within one treatment system.

PROCEDURE:

WCHHS and its sub-contracted providers will screen all clients with mental health conditions for concurrent substance abuse disorders. The initial Mental Health Assessment will document this screening in accordance with the applicable Oregon Administrative Rule’s governing mental health assessment practices and
general community standards of care. Traditional screening tools for alcohol and drug use include the Michigan Alcoholism Screening Tool (MAST), the CAGE assessment and the Dartmouth Assessment Life Style Instrument. A case manager, therapist or other treatment personnel may also screen for substance use disorders via client interview.

If a client is positive on the screening, a comprehensive substance disorder assessment using American Society of Addiction medicine (ASAM) criteria should be completed, unless the client refuses. A mental health provider may refer the client to a qualified chemical dependency provider to complete the assessment if necessary.

Treatment recommendations resulting from the assessment should be discussed with the client. It is the expectation that the mental health provider will educate the client on the impact of substance use/abuse on their mental health disorder and treatment.

For clients with a serious and persistent mental illness receiving services, it is expected that service goals related to substance use disorders will be integrated into the client’s service plan.

For all other clients with an identified co-occurring substance use disorder, treatment may be integrated, concurrent or a referral to a substance use disorder treatment program may be made if necessary. The mental health clinician will request the client to sign a Release of Information for the substance abuse treatment provider. If the client refuses to sign a Release of Information the refusal will be documented in the client’s chart.
**Washington County Health and Human Services (WCHHS)**

**Mental Health**

**Policy and Procedure**

<table>
<thead>
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**OBJECTIVE:**

To ensure that civilly committed persons under Trial Visit serve their remaining commitment term in the least restrictive, most natural setting that will safely meet their treatment needs.

To provide appropriate care and monitoring for persons who are under Trial Visit, and to prevent serious, imminent and dangerous deterioration of the persons' mental health.

**POLICY:**

A committed person will only be considered for a Trial Visit if it is determined safe and necessary by the Washington County Trial Visit Monitor or designee.

Each person being placed on a Trial Visit will be assigned a case manager and/or an exceptional needs care coordinator (ENCC) to monitor adherence to the Trial Visit. Any violations of the Trial Visit will be immediately reported to the Washington County Trial Visit Monitor or designee.

If it is determined that the committed person on a Trial Visit has violated a condition of the Trial Visit, is in need of acute hospital care and is unwilling or unable to participate in such care voluntarily, or is in need of a modification to the Trial Visit Conditions, a Trial Visit Revocation Hearing will be initiated.

**PROCEDURE:**

A. Initiation of the Trial Visit

When a committed person has been deemed ready for discharge by the hospital treatment team and is recommended for a Trial Visit, the Trial Visit Monitor or designee will complete the *Washington County Conditions of Trial Visit* document, and will ensure that the committed person has an opportunity to participate in the development of the discharge plan. While it may be clinically advisable, the Trial Visit Monitor or designee is not required to obtain the consent or signature of the committed person for a Trial Visit.
This document will include those services, supports, and rules necessary to best ensure positive clinical outcomes, and to best ensure the safety of the committed person and his/her community. The document will also include the address of the committed person, the names and contact information of the ENCC, case manager, mental health provider agency, Trial Visit Monitor, and after-hours emergency contact.

The assigned ENCC and/or case manager will each review the Trial Visit with the committed person, answer any questions the person may have regarding the document, and provide a copy of the document to him/her.

The Trial Visit will go into effect once the document has been filed with the Court and the committed person has been discharged from the hospital.

B. Monitoring of the Trial Visit

Prior to the committed person being placed on a Trial Visit, the Monitoring of Trial Visit Instructions is faxed to the person’s case manager. The instructions include a copy of the Trial Visit, a blank Report of Trial Visit Violation, and the Request for Revocation of Trial Visit form. Per the instructions, the case manager is to notify the Trial Visit Monitor as soon as the provider becomes aware of any Trial Visit violation. In situations where the client is exhibiting symptoms of decompensation or increased risk to public safety, the provider will contact the Washington County Mental Health Crisis Line which is available 24 hours a day, seven days a week, (503) 291-9111. The Crisis Line, acting as an extension of Washington County Mental Health, will assess the need for immediate response and engage crisis intervention services when indicated, which could include initiating a Director’s Custody and Police Officer Custody. A summary of the contact will be faxed to Washington County Mental Health on the next business day. If the client is in need of acute hospital care, the Provider will follow its agency’s policy and procedures for such situations.

The Trial Visit Monitor or designee will document any reported violations to the Trial Visit and file with the committed persons record.

C. Revocation Process

When it is in the best interest of the committed person to be in a more restrictive treatment setting, the Trial Visit Monitor or designee shall request a revocation hearing.
**WASHINGTON COUNTY HEALTH AND HUMAN SERVICES (WCHHS)**
Mental Health Program
Policy and Procedure

**Policy Title:** Use of General Fund as a Secondary Payor

**Approved:** __________________________     ________ _______________
Division Manager   Date

**OBJECTIVE:**

To ensure that General Funds are managed in a fiscally prudent manner and are reserved for those most in need.

To ensure that reimbursement is for clinically indicated and medically necessary treatment interventions where the service provided is appropriate to the degree of impairment, current symptoms and treatment history.

To ensure that services provided are reimbursed through General Funds only in situations where all other funding sources have been exhausted and there are no alternative resources available.

**POLICY:**

Criteria for Washington County General Fund eligibility:

- Washington County resident;
- Family income is below WCHHS established percentage of federal poverty guideline. This guideline may be raised or lowered based on availability of funds or specific risk factors;
- No insurance or significantly underinsured (i.e. insurance benefit is exhausted or inadequate to provide the basic services needed); and
- Cannot be adequately served by other community resources (i.e. free or low cost counseling/ healthcare, primary care clinics, etc.).

Underinsured is defined as having Medicare or a commercial insurance plan that does not cover mental health services.

The service types that are eligible for General Fund may change depending on availability of funding. Decisions on which services are eligible for funding with General Fund dollars will be guided by the philosophy of funding services for the most disabled first.
Services may be requested directly, with no referral necessary to access mental health services. Adolescents age fourteen and older may request service authorization without parent/guardian consent, in accordance with applicable ORS. Pre-authorization of General Fund eligibility is required in accordance with current Washington County policy.

Decisions to authorize or deny services that require pre-authorization will be made within 14 days of the receipt of the request unless an expedited decision is requested.

**PROCEDURE:**

For information about pre-authorization and clinical criteria, please refer to the WCHHS Policy on Utilization Management for Outpatient and Rehabilitation Services.

**Child and Family Outpatient Services:**

Clients with a commercial insurance plan that does have a mental health benefit may be served through any of the Washington County Child and Family Outpatient providers as long as the client meets the General Fund criteria as outlined above.

**Adult Rehabilitation Services:**

Clients with Medicare may be served through any of the Washington County Rehabilitation providers as long as the individual meets all the General Fund criteria as outlined above. For individuals who currently have Commercial Insurance, clients must have significant case management needs in order to minimize danger to self, danger to others or to meet basic needs. In addition, the insurer must have no resources for addressing case management needs within their panel. Provider must make a good faith effort to obtain payment from the Commercial Insurance for any services rendered.
Washington County Health and Human Services (WCHHS)
Mental Health Program
Policy and Procedure

Policy Title: Use of General Fund for Household of One and Uninsured ISA Clients

Approved: __________________________     _______________
          Division Manager       Date

OBJECTIVE:
To ensure that fiscal resources are available for services, subject to available funds, for those children and adolescents who are most in need, with the goal of reducing the risk of clients requiring higher levels of care and/or placement out of the home.

POLICY:
Household of One is defined as a youth who does not qualify for the Oregon Health Plan or Washington County General Fund, but may have a period of OHP eligibility during, and for a limited period post, admission to a Psychiatric Residential Treatment Services (PRTS) facility. Youth would only become OHP eligible in PRTS if their commercial insurance benefit was exhausted prior to discharge.

Washington County receives a limited amount of State General Fund dollars to fund mental health services for ISA youth who are not Medicaid eligible. Some of these youth have a commercial insurance benefit or other third party resource and this must always be exhausted first.

General Funds cannot be used to fund Acute Care, Subacute Care, Psychiatric Residential Treatment, or co-pays for these services.

PROCEDURE:
The WCHHS Care Coordinator should ensure that client’s commercial insurance benefit or other third party resources are explored and that available resources are accessed first. They will also ensure that the child and family team are aware of the available third party resources.

When additional services are deemed medically necessary by the WCHHS Care Coordinator, the provider will attempt to get authorization from the commercial
insurance provider and submit any claims for covered services to the commercial plan first. If services or a portion of services are not covered, the provider may submit an Explanation of Benefits (EOB) to WCHHS Third Party Administrator to obtain reimbursement for authorized services.

**Home-Based Stabilization:**

- If a member’s OHP eligibility ends, he or she may receive up to 180 days maximum of HBS services through General Fund.

**Psychiatric Day Treatment:**

Up to 30 days of day treatment can be authorized using General Fund resources for clients who are Household of One OR who qualify for WCHHS General Fund when all of the following are met:

- The time is used for a transition to the client’s local school setting or for the school district to begin funding the day treatment service; and
- The client has been enrolled in and attending Day Treatment as part of their service plan in the ISA; and
- The client is losing their OHP eligibility due to either:
  - Reunification with family through a child welfare case
  - Change in income or employment status of guardian causing the child to no longer qualify for OHP

General Fund should not be used for Day Treatment in situations where clients lose OHP enrollment due to noncompliance with enrollment paperwork or when providers fail to recognize a change in client’s enrollment status.

**Medication Co-pays:**

Subject to available funds, a child and family may be authorized for coverage secondary to commercial insurance benefits of medication co-payments through General Fund dollars when the following criteria are met:

- Client is a household of one youth who is receiving medication management by a Licensed Medical Practitioner through their commercial insurance plan (not at one of our contracted provider agencies).
- The co-pay for the client’s medication is prohibitive, such that the family cannot ensure the client consistently has their prescribed medication.
- The family is at or below 400% of Federal Poverty Limit.
- The family has applied for a scholarship if one is available.
- WCHHS pre-authorized the payment of the co-pay and reimburses the family when provided a receipt.
- WCHHS and the family identify a plan for the family to fund medication co-pays after the client is no longer ISA eligible.
**OBJECTIVE:**
To ensure that clients are provided care in the least restrictive, most natural setting that will safely meet their treatment needs.

To promote clients' healthy functioning within their natural system of support.

To provide appropriate care for clients who are a danger to themselves or others, and to prevent serious, imminent and dangerous deterioration of the client's mental health consistent with 42 CFR 456.

**POLICY:**

All non-emergency admissions to inpatient/acute care must be pre-authorized.

All decisions to limit authorization of initial/continued stay will be made by a WCHHS Care Coordinator in consultation with the WCHHS Psychiatric Consultant.

WCHHS will ensure services are individualized, consumer-driven, strengths-based, flexible, coordinated, culturally competent and provided in the least restrictive and most normal setting possible. Level of care shall be determined by current symptoms, degree of impairment, safety concerns, and the extent of available family and community based support. Higher levels of care shall only be considered in the absences of an appropriate community plan.

The following procedure is consistent with Health Share of Oregon’s Inpatient Utilization Management Policy and its objectives:
- As each client and their situation is unique, best practice involves individualized discharge planning and a flexible, collaborative approach
- Identify and minimize barriers to discharge from acute care
- Achieve the most efficient process possible for hospital Utilization Review (UR) staff
- Align with other standardization work in the Behavioral Health System
• Collaboratively manage the system and move clients to the least restrictive setting
• Engage and activate community resources/providers
• Health Share-Risk Accepting Entity (RAE) Utilization Management (UM) staff should blend the UM and Care Coordination functions and incorporate discharge planning
• Support achievement of follow up appointments within 7 days

ADMISSION PROCEDURE:

**Notification and Pre-authorization Procedures**

1. Where available, all UM staff has remote access to regional hospital EMR's.

2. The requirement for a Pre-authorization for inpatient admission is also an opportunity to mobilize community resources and look at a least restrictive, clinically appropriate environment for Health Share members.

3. All Admission Criteria Must be Met
   - Client must have or be suspected of having a covered primary mental health disorder covered by the Oregon Health Plan that is the cause of the signs and symptoms that make consideration of hospitalization necessary.
   - Substance use or Intoxication must be ruled out as the primary cause of the signs and symptoms that lead to the request for hospitalization. Future state will include a standardized assessment tool, not yet identified, to be utilized in the emergency department to determine when a 48 hour hold is appropriate.
   - The client must be medically stable and medical causes have been ruled out as the source of the mental or behavioral symptom.
   - Less restrictive levels of care must have been explored, including increasing the intensity of treatment, and demonstrated to be less likely to be effective, more intrusive, unavailable or too dangerous.
   - Admission cannot be strictly for the purpose of temporary housing or due to homelessness.

At least one of the following is present:
   - A clear and reasonable inference of danger to self or others
   - Dangerous assaultive or other uncontrolled behavior, including extensive damage to property, not due to substance abuse
   - Inability to provide for basic needs, safety and welfare
   - Acute deterioration in mental health functioning causing exacerbation of other medical conditions
• The need for regulation of psychotropic medication that cannot be safely done without 24-medical supervision

4. Eligibility not determined until after admission:
   Once the hospital determines an admitted client is a Health Share member, they contact the appropriate RAE for authorization. If client is still on the unit, UM staff will confirm eligibility and review clinical for approval on that same day. If approved, authorization will be retroactive to the day of admission. If client has already discharged, UM staff will make a determination within 10 business day after receiving the clinical documentation.

All requests for authorization for an inpatient admission for clients with Health Share of Oregon assigned to Washington County must be made through the Health Share Washington County Member Access Line or the Washington County Crisis Line.

The Access Line or Crisis Line clinician who receives the phone call requesting admission will gather relevant clinical data. The clinician will provide consultation and resources to the caller regarding alternatives to hospitalization such as respite care, crisis team follow-up or intensive outpatient services in order to ensure that less restrictive options have been ruled-out prior to considering inpatient care. If the inpatient admission requested is for a condition other than a mental health condition, the Access Line clinician can provide direction about contacting a physical health plan for authorization.

If the call is during regular business hours, Access/Crisis Line staff will attempt to contact the WCHHS Care Coordinator to discuss the case. If the Care Coordinator is unavailable, the Access/Crisis Line staff will proceed with authorizing the admission as clinically indicated.

If alternatives to hospitalization have been ruled out, and the admission meets the definition of an emergency situation (see below) or meets medically necessary criteria (see below), Access/Crisis Line staff may authorize the admission for a time period equivalent to the next business day.

An emergency situation is defined as:

“A mental health condition manifesting itself by acute symptoms of sufficient severity such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (1) serious jeopardy to the health of the OHP Member, (2) serious impairment of bodily function, or (3) serious dysfunction of any bodily organ or part. An “Emergency Medical Condition” is determined based on the presenting symptoms (not the final diagnosis) as perceived by a prudent layperson (rather than a Health Care Professional) and includes cases in which the absence of
immediate medical attention would not in fact have had the adverse results described in the previous sentence.”

A Notice of Mental Illness (i.e. mental health “hold”) is always defined as an emergency.

Medically necessary criteria is defined as:

Medically appropriate (medically necessary) services and supplies are defined as services and supplies which are required for: prevention (including preventing a relapse), diagnosis or treatment of mental disorders; and which are appropriate and consistent with the diagnosis, consistent with treating the symptoms of a mental illness or treatment of a mental disorder, appropriate with regard to standards of good practice and generally recognized by the relevant scientific community as effective, not solely for the convenience of the Member or Contractor of the service or supply, and the most cost effective of the alternative levels of Covered Services or supplies which can be safely and effectively provided to the Member in Contractor’s judgment.

If the admission is not an emergency as defined above, the WCHHS Care Coordinator or Access/Crisis Line staff will review medical necessity criteria as defined herein, and authorize if the admission is deemed medically necessary. In cases when admission is not deemed medically necessary, prior to denying authorization, the case shall be reviewed, and the decision approved, by the WCHHS Consulting Psychiatrist.

If an admission occurs without authorization from Washington County, payment is not guaranteed. If Washington County, in consultation with the Consulting Psychiatrist, determines that the services provided were not in fact Emergency Services as defined above, and/or were not medically necessary, payment will be denied and a Notice of Action will be issued when the individual is covered by WCHHS OHP.

In cases where agreement is reached that a client can be successfully diverted to a less restrictive setting, the request for authorization for inpatient admission is cancelled.

The clinical information gathered by the Access/Crisis Line clinician should be faxed immediately to the WCHHS Care Coordinator, whether or not the Care Coordinator has been notified by phone and/or spoken with the Access Line clinician. The individual’s OHP their prime Identification number must be included on the phone assessment form.

**UM/ Continued Stay Review Procedures**
1. UM staff will review clinical record from hospital prior to requesting any additional information. This will be a desk based review via EMR remote access rather than on-site or requiring any paperwork to be faxed (except in situations where remote access to EMR is not available).

2. UM staff will contact hospital UR staff via phone. If no additional information needed, the UM staff will determine the number of days for authorization of continued stay. At that time, if additional days are needed based on clinical review, UM staff will approve. The number of days between clinical reviews will be individualized based on the situation.

If additional information is needed this can be achieved via quick telephone call to hospital UR staff to supplement what is in the clinical record.

3. UM staff will take responsibility for communicating with hospital UR staff regarding authorization for continued stay and communicating with hospital social worker for discharge planning as appropriate.

Criteria for Continued Stay:
Despite reasonable therapeutic efforts, clinical evidence indicates at least two of the following:
- The persistence of problems that resulted in the admission to a degree that continues to meet admission criteria.
- The emergence of additional problems that meet admission criteria.
- A severe reaction to medication or the need for further monitoring and adjustment of dosage that requires 24 hour medical supervision.
- Daily progress notes document that the client’s mental health problem(s) are responding to or are likely to respond to the current treatment plan.
- Evidence of active treatment including modification of treatment plan where progress is limited.
- No less restrictive level of care that would meet the client’s and public’s need for safety is accessible.
- The client’s continued care is not for the primary purpose of temporary housing or due to homelessness.

Referrals to Long Term Care (LTC)
When the UM staff determine that an individual is appropriate for LTC, the hospital staff will submit a referral packet within three business days of notification. For Medicaid clients, if approved for LTC, the state picks up payment for acute care from the date they received the referral.

Determination for Admission to LTC per OAR 309-091-0000:
State hospital level of care is determined appropriate when the individual’s condition or symptoms have not improved in an acute care setting despite having received comprehensive psychiatric and medical assessment, treatment and/or community services typical for a psychiatric illness or psychiatric emergency.

Prior to referral for admission to a state hospital, the individual should have received:
   a. A comprehensive medical assessment to identify conditions that may be causing, contributing to, or exacerbating the mental illness;
   b. Services from an appropriate medical professional for the treatment and stabilization of any medical or surgical conditions that may be contributing to or exacerbating the mental illness and
   c. Treatment in an acute setting within the parameters of the most recent version of the American Psychiatric Association Practice Guidelines for the Treatment of Psychiatric Disorders.

In addition there must be evidence of additional treatment and services having been attempted, including:
   a. Use of evidence-based or promising psychosocial interventions which were delivered in relevant, culturally-competent, strength-based, person-centered and trauma-informed manners, which adequately treated the assessed and/or expressed needs of the individual. When requested by the individual, treatments should include members of the individual’s family, support network and/or peers;
   b. Documentation of ongoing review and discussion of options for discharge to non hospital levels of care and
   c. Documentation of services and supports attempted by the responsible party to divert admission and establish treatment and recovery in a non-hospital setting.

Exclusion Criteria and Exceptions:
State hospitals are intended to provide recovery-oriented intervention for individuals experiencing symptoms related to a severe, persistent and disabling mental illness.

Admissions must not be based upon a primary diagnosis of the following related conditions:
   a. An acute or existing medical or surgical condition which requires primary placement in a medical setting and which cannot be safely or adequately treated within a state hospital facility;
b. Delirium;
c. Pervasive Developmental Disorder;
d. Intellectual Developmental Disorder;
e. Substance Use or Substance Abuse Disorder or
f. Personality Disorder

Holds and 14 Day Diversions:

Involuntary Commitment Program (ICP) staff have different roles than UM staff with regard to assessing clients for continued stay. The role of the ICP staff is to determine whether the clients meets the legal criteria for dangerousness and makes a recommendation for a hearing or not. Regardless of this process, the UM staff will continue to conduct utilization review based on medical necessity criteria and does not guarantee payment if the UR staff determines the client does not meet medically necessity but the ICP staff is recommending a hearing. However, UM staff will work closely with ICP staff and make every effort to coordinate and communicate continued stay and discharge planning. ICP staff will communicate with UM staff when they are no longer recommending a hearing.

Coordination and Discharge Planning

1. UM staff will determine whether the client is connected to a community mental health provider. If they are connected to a provider, UM staff will notify provider on 1st business day after admission. This will be done via secure email to a pre-established contact for each program. The emailed form will include the following information:

   • Client name, Medicaid ID, Date of Admit, Hospital Contact information

   UM staff will also alert the hospital of any existing community mental health provider to which client is connected.

   [When a patient registry or other web based care management system is fully functional within Health Share this will be revised accordingly.]

2. Community mental health providers are then expected to make contact with the hospital social worker within one business day following notification. If the hospital social worker has not heard by the end of the first business day, they should contact community mental health provider directly.

3. When UM staff find that a client is not connected to a provider they will refer to ITT on the 1st business day following admission. ITT will contact the inpatient unit in every case to assess the need for intervention.
4. UM staff will then “change hats” to facilitate care coordination/ discharge planning. UM staff will ensure that the following occur, though the person responsible may include others such as providers, hospital social workers or other system case managers:
   a. The community mental health provider has been notified and has contact the hospital or client.
   b. The client is in the right level of care, and if not, is referred to the recommended level.
   i. If no provider, ITT has made contact with hospital and client. Barriers to discharge are examined and collaboratively addressed.
   c. If client is affiliated with a provider the next appointment has been scheduled within 7 days of anticipated discharge.
   i. A psychiatric services appointment is scheduled AND there is a plan to ensure adequate medication supply until the appointment.

5. When Adult Mental Health Initiative (AMHI), Integrated Services Array (ISA) or Wraparound Care Coordinators are involved, they may take the lead in discharge planning and coordination with the hospital social worker. It is the expectation that community providers are also engaged throughout the stay and involved in the discharge plan for enrolled clients.

6. Care Conferences/Multi-disciplinary team meetings should be held in any of the following scenarios when deemed appropriate in order to better coordinate discharge planning:
   a. Discharge placement is not identified
   b. There is disagreement among the clinical team about the course of care
   c. Greater than three admits in the last 6 months
   d. Disagreement about discharge planning with guardian(s) or treatment provider
   e. Other systems are involved such as DD, Child Welfare, etc.

The UM staff and hospital staff will coordinate scheduling and invitations for care conferences. This should be done as soon as one of the above issues are identified and should allow for team members to participate in person or via telephone. Participants may include but are not limited to: client, family, inpatient LMP, outpatient LMP, outpatient mental health provider, guardian, DD case manager, child welfare case worker, AMHI or ISA Care Coordinator, UM staff, hospital social worker.

**Discharge Procedures**

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At point of discharge, UM staff will ensure that a secure email is sent to the outpatient provider with the following information:

- Client Name, Medicaid ID, Date of Discharge, Discharge Medications and dosages, any pertinent available lab results, recommended level of care at discharge. A full discharge summary summarizing hospital course and treatment recommendations should be made available to the community mental health provider within 7 days of discharge from the hospital.

**Denial of Authorizations for Inpatient Acute Care**

All denials of authorization for inpatient care will be determined by a WCHHS Care Coordinator in consultation with the WCHHS Psychiatric Consultant. A Notice of Action will be issued for all OHP denials consistent with Washington County policy on Notice of Actions.

**Medicare or Commercial Insurance Primary, WCHHS OHP Secondary**

All procedures are the same as described above for WCHHS OHP members for whom Medicare or commercial insurance is the primary payer.

When it is discovered that a WCHHS member has commercial insurance, WCHHS will seek to determine the name of the insurance, the policyholder, the group number and ID. Washington County will generally request that members with commercial insurance are disenrolled from the managed Medicaid mental health plan to avoid duplication of care coordination and utilization management.

In situations where the client is dually eligible with both Medicare and OHP, Medicare will be primary payer, however WCHHS OHP is financially responsible for:

- Medicare patient responsibility;
- Medicare patient responsibility for Attending Physician, if applicable;
- Entire stay if client has exceeded their lifetime Medicare inpatient benefit.

WCHHS Care Coordinators must be involved in UR throughout the entire hospitalization.

Regardless of whether the initial authorization was obtained through the WCHHS Member Services Line, the hospital UR staff is responsible for identifying WCHHS OHP secondary members and notifying a WCHHS Care Coordinator on the first business day following admission.

**Claims Payment Authorization**
Revised 3-1-14

The WCHHS Care Coordinator enters the authorization including admission and discharge date (or date that stay is authorized until) into the WCHHS Third Party Administrator claims payment system.

A separate authorization for the attending psychiatrist is entered for WCHHS contracted provider hospitals. Attending psychiatrist fees are included in the per diem for non-contract hospitals.
Washington County Health and Human Services (WCHHS)
Mental Health Program
Policy and Procedure

Policy Title: Utilization Management: Inpatient for General Fund

Approved: __________________________     _______________
Division Manager     Date

OBJECTIVE:

To ensure that consumers are provided care in the least restrictive, most natural setting that will safely meet their treatment needs.

To promote consumers’ healthy functioning within their natural system of support.

To provide appropriate care for consumers who are a danger to themselves or others, and to prevent serious, imminent and dangerous deterioration of the client’s mental health consistent with 42 CFR 456.

To prioritize funds within statutory requirements and budgetary constraints.

POLICY:

All non-emergency admissions to inpatient/acute care must be pre-authorized.

Funds will be prioritized to serve consumers at imminent risk of harm to self or others.

Only individuals with no other resources, including commercial insurance, VA coverage, Medicare or Medicaid, will be funded with General Fund dollars for inpatient care.

WCHHS will ensure services are individualized, consumer-driven, strengths based, flexible, coordinated, culturally competent and provided in the least restrictive and most normal setting possible. Level of care shall be determined by current symptoms, degree of impairment, and the extent of family and community safety and support. Higher levels of care shall only be considered in the absences of an appropriate community plan.
ADMISSION PROCEDURE:

Requests for Admission

All requests for authorization for an inpatient admission for clients with no other source of funding must be made through the Washington County Crisis Line.

The WCHHS Crisis Line clinician who receives the phone call requesting admission will gather relevant clinical data. The Crisis Line clinician will provide consultation and resources to the caller regarding alternatives to hospitalization such as respite care, crisis team follow-up or intensive outpatient services in order to ensure that less restrictive options have been ruled-out prior to considering inpatient care. The WCHHS Crisis Line will also gather information to determine that Washington County is the County of residence for the individual for whom inpatient care is being sought.

If the client is clearly a Washington County resident, has no alternative funding source and the admission meets the definition of an emergency situation (see below) or meets medically necessary criteria (see below), WCHHS Crisis Line staff may authorize the admission based on current prioritized funding for a time period equivalent to the next business day.

An emergency situation is defined as:

“A mental health condition manifesting itself by acute symptoms of sufficient severity such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (1) serious jeopardy to the health of the OHP Member, (2) serious impairment of bodily function, or (3) serious dysfunction of any bodily organ or part. An “Emergency Medical Condition” is determined based on the presenting symptoms (not the final diagnosis) as perceived by a prudent layperson (rather than a Health Care Professional) and includes cases in which the absence of immediate medical attention would not in fact have had the adverse results described in the previous sentence.”

A Notice of Mental Illness (i.e. mental health “hold”) is always defined as an emergency and will be authorized when it is determined that the individual is a Washington County resident.

Medically necessary criteria is defined as:

Medically appropriate (medically necessary) services and supplies are defined as services and supplies which are required for: prevention (including preventing a relapse), diagnosis or treatment of mental disorders; and which are appropriate and consistent with the diagnosis, consistent with treating the symptoms of a mental illness or treatment of a
mental disorder, appropriate with regard to standards of good practice and generally recognized by the relevant scientific community as effective, not solely for the convenience of the Member or Contractor of the service or supply, and the most cost effective of the alternative levels of Covered Services or supplies which can be safely and effectively provided to the Member in Contractor’s judgment.

If the admission is not an emergency as defined above, the WCHHS Care Coordinator or Crisis Line staff will review medical necessity criteria as defined herein, and authorize based on current funding priority if the admission is deemed medically necessary.

Funding for inpatient admission shall be prioritized in the following manner with the highest priority first:

- Notice of Mental Illness/Hold (always covered)
- Set-over for commitment hearing
- Guardianship admission that would meet hold criteria if the individual did not have a guardian
- Committed but not approved for the state hospital
- Guardianship admission that would meet commitment criteria if the individual did not have a guardian, and not currently approved for the state hospital
- On a 14 day diversion
- Voluntary but would meet hold criteria if the individual wasn’t willing to be admitted
- Voluntary or guardianship admission and would not meet hold criteria

Funding priority will be determined quarterly based on the percentage of funds spent, projected incurred liability and the continued availability of funds.

If an admission occurs without authorization from Washington County, payment is not guaranteed. If Washington County, in consultation with the Consulting Psychiatrist, determines that the services provided were not in fact Emergency Services as defined above, and/or were not medically necessary, payment will be denied.

In cases where agreement is reached that a consumer can be successfully diverted to a less restrictive setting, the request for authorization for inpatient admission is cancelled.

The clinical information gathered by the WCHHS Crisis Line clinician should be faxed immediately to the WCHHS Care Coordinator, whether or not the Care Coordinator has been notified by phone and/or spoken with the Crisis Line clinician.
Continued Stay Authorization

It is the hospital’s responsibility to identify Washington County indigent individuals and call the WCHHS Care Coordinator on the first business day following admission to obtain authorization for continued stay unless otherwise agreed upon in contract. Only the period between admission and the next business day are considered authorized at the time of admission.

Hospital Utilization Review Staff should contact the Care Coordinator by phone and provide the following information (may be left on voice mail):

- Admit date
- Presentation at admission
- Current mental status
- Treatment goals for hospitalization
- Legal status
- Current medication
- Attending physician (Providence system only)

In addition, the hospital UM staff should fax a face sheet to the Washington County Care Coordinator which includes the consumer’s current address, DOB and SSN.

If medical appropriateness criteria are met and the admission falls within the current approved prioritization of funding, the WCHHS Care Coordinator will extend the authorization.

**Concurrent Review.**

The WCHHS Care Coordinator will continue to evaluate the consumer’s mental health status at pre-determined intervals throughout the hospitalization. Utilization Review (UR) will occur every two days except as otherwise agreed upon by both the WCHHS Care Coordinator and facility utilization review staff.

Time between UR contacts may be lengthened or shortened depending on clinical presentation and other external factors.

The WCHHS Care Coordinator may ask the facility to provide copies of current treatment records.

Hospital staff will be expected to assist the consumer with Medicaid enrollment as applicable.

Through concurrent review, the WCHHS Care Coordinator will assess:

- Whether the consumer meets the criteria for continued stay
- The timeliness of interventions
- Coordination with outpatient providers
• Delays in service or discharge
• Change in legal status that may impact payment availability

Any delays in service or discharge for reasons other than member acuity may result in a denial of payment for the days in question.

Facility UR staff should contact the Care Coordinator upon the consumer’s discharge with the following information:
• Follow-up appointments
• Discharge medication
• Discharge date
• Disposition

Coordination with Outpatient Providers.

When the WCHHS Care Coordinator receives notification of the admission of a consumer, the Care Coordinator will determine if the consumer is currently receiving mental health services through a WCHHS provider. If so, the Care Coordinator will inform the mental health provider that the consumer has been admitted to acute care.

The WCHHS Care Coordinator will communicate with the mental health provider to assure that the provider is collaborating with the hospital in discharge planning.

Medical Unit Admissions for Psychiatric Presentations

Initial Authorization, Concurrent Review, and Coordination with Outpatient Provider procedures are the same as outlined above when a WCHHS consumer is admitted to a medical unit of an acute care facility for a psychiatric reason while awaiting admission to a psychiatric unit.

Denial of Authorizations for Inpatient Acute Care

All denials of authorization for inpatient care will be determined by a WCHHS Care Coordinator in consultation with the WCHHS Psychiatric Consultant.

Claims Payment Authorization

Upon initial approval, the WCHHS Care Coordinator will create a General Fund eligibility record in PHTech if one does not already exist. The General Fund ID will be communicated to the hospital for billing purposes. The WCHHS Care Coordinator will enter the authorization including admission and discharge date (or date that stay is authorized until) into the WCHHS Third Party Administrator claims payment system. A copy of the authorization including the client ID will be faxed to the hospital UM staff.
A separate authorization for the attending psychiatrist is entered for WCHHS contracted provider hospitals. Attending psychiatrist fees are included in the per diem for non-contract hospitals.

**CLINICAL CRITERIA FOR INPATIENT ADMISSION:**

**INITIAL ADMISSION**

The adult must have or be suspected of having a covered primary mental health disorder that is the cause of the signs and symptoms that make consideration of hospitalization necessary.

- Intoxication must be ruled out as the cause of the signs and symptoms that lead to the request for hospitalization.
- The client must be medically stable and medical causes have been ruled out as the source of the mental or behavioral symptoms.

At least one of the following is present:

- A clear and reasonable inference of danger to self or others;
- Dangerous assaultive or other uncontrolled behavior, including extensive damage to property, not due to substance abuse;
- Inability to provide for basic needs, safety and welfare.
- The need for regulation of medication that cannot be safely done without 24-medical supervision.

Less restrictive levels of care must have been explored, including increasing the intensity of treatment, and demonstrated to be less likely to be effective, more intrusive, unavailable or too dangerous. Failure of less restrictive levels of care can be evidenced by:

- Intensification of symptoms such that the consumer demonstrates behavior described above.
- Multiple inpatient admissions within a short period of time.
- Lack of therapeutic response to medication resulting in behaviors described above.
- Increasing frequency and intensity of community contacts has not improved symptoms or function.

Inpatient treatment must be active, defined by the Center for Medicare and Medicaid Services (CMS) as: aggressive, consistent implementation of a program of individualized treatment services which has been specifically designed to facilitate discharge to a less restrictive setting as rapidly as possible.

- Treatment must be likely to be effective for stabilization and/or improvement of the signs and symptoms produced by the mental disorder.
• Discharge planning begins at admission and involves the consumer, the consumer’s family and community supports, unless contra-indicated as harmful to the consumer’s mental health or the consumer refuses.
• Outpatient mental health follow-up is established before the consumer is discharged.
• Consumer’s care cannot be strictly custodial or a solution to homelessness.

CONTINUED STAY CRITERIA

Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following:
• The persistence of problems that resulted in the admission to a degree that continues to meet admission criteria.
• The emergence of additional problems that meet admission criteria.
• Attempts at re-entry into the community have resulted in or are likely to result in exacerbation of the signs and symptoms of the mental illness.
• A severe reaction to medication or the need for further monitoring and adjustment of dosage that requires 24 hour medical supervision.

Daily progress notes document that the consumer’s mental health problem(s) are responding to or are likely to respond to the current treatment plan.

No less restrictive level of care that would meet the consumer’s and public’s need for safety is accessible.

The consumer’s care is not limited to custodial care.
Washington County Health and Human Services (WCHHS)
Mental Health Program
Policy and Procedure

Policy Title: Utilization Management: Child and Adolescent Sub-Acute Care

Approved: __________________________     __________________________
Division Manager                     Date

OBJECTIVE:

To ensure that clients are provided care in the least restrictive, most natural setting that will safely meet their treatment needs.

To promote clients' healthy functioning within their natural system of support.

To provide appropriate care for clients who are a danger to themselves or others, and to prevent serious, imminent and dangerous deterioration of the client's mental health.

POLICY:

All non-emergency admissions to subacute care must be pre-authorized.

WCHHS will ensure services are individualized, client and family driven, strengths based, flexible, coordinated and culturally competent and provided in the least restrictive and most normal setting possible. Level of service intensity shall be determined by current symptoms, degree of functional impairment, extent of family and community safety and supports and guided by the CASII and child and family team when one exists. Higher levels of care shall only be considered when appropriate alternative resources in the community are not available.

PROCEDURE:

Children and adolescents often have special developmental characteristics and needs which require continued stabilization in a secure setting but no longer
meet the criteria for continued stay in an acute care facility. WCHHS contracts with qualified providers of children's sub-acute services.

Referrals to Sub-Acute

A referral to sub-acute care may be requested by an acute care facility when a child or adolescent is ready for discharge to less intensive care but there is a need for:

- Continued stabilization of behavior;
- Continued medication monitoring;
- Including family and outpatient providers in treatment planning and interventions to safely transition the youth into the community.

The hospital social worker will inform the WCHHS Care Coordinator of the recommendation to step a client down into sub-acute care.

The WCHHS Care Coordinator will determine if the youth meets criteria for sub-acute care and if so, inform the hospital of approval of the recommendation.

The hospital social worker will contact the sub-acute facility for bed availability and fax the appropriate clinical information.

A WCHHS Care Coordinator may also generate referrals to sub-acute when a client is in need of stabilization and no inpatient beds are available OR the client has been evaluated at an emergency department and not found to meet criteria for an inpatient admission.

Admission to sub-acute may be utilized when there is a need for a comprehensive mental health assessment that cannot be safely provided in the community. For youth in the ISA, this includes exploring the capacity of contracted ICTS providers to provide the intensity of services necessary to divert a subacute/acute admission.

All sub-acute admissions will be reviewed by a WCHHS Care Coordinator. If approved, the Care coordinator will contact the sub-acute facility to arrange the admission.

If a referral to subacute comes to the WCHHS Crisis Line or Member Services Line after hours the WCHSS Member Services Clinician will contact a WCHHS Clinician from the contact list in the Member Access Line Handbook and present clinical information to get approval for authorization. Authorization for subacute cannot be done without approval from a designated WCHHS staff.

Initial authorization for sub-acute admission is three days.
Utilization Review (UR) will occur every two days except as otherwise agreed upon by the WCHHS Care Coordinator and the facility UR staff. Time between UR contacts may be lengthened or shortened depending on clinical presentation and other factors.

WCHHS Child and Adolescent Care Coordinator will review clients with the WCHHS Consulting Psychiatrist when their length of stay has reached 14 days and at least weekly thereafter.

Clinical Criteria for Subacute Admission:

A. In addition to the criteria described in the Inpatient Utilization Management Policy (see IP Utilization Management Policy) section A, the youth must present with the following:

1. Behaviors attributable to their mental health diagnosis that are dangerous to self and/or others, or

2. Bizarre behavior attributable to their mental health diagnosis that are grossly inappropriate to the youth's stage of development, or

3. The need for a mental health assessment or evaluation that cannot be safely provided in a less restrictive setting, and

4. The client has been evaluated at an emergency department and found to not meet criteria for inpatient admission.

Continued Stay Criteria (Must meet ALL of the following):

A. Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following:

1. The persistence of problems that resulted in admission to a degree that continues to meet admission criteria;

2. Additional problems have emerged that meet admission criteria;

3. Attempts at re-entry into the community (e.g. overnight passes) have resulted in or are likely to result in exacerbation or re-emergence of the signs and symptoms of the mental illness;

4. A severe reaction to medication or the need for further monitoring and adjustment of dosage that requires 24 hour medical supervision.
B. Daily progress notes document that the child/adolescent’s mental health problem(s) are responding to or are likely to respond to the current treatment plan.

C. No less restrictive level of care that would meet the child/adolescent and their family’s need for safety is accessible.

D. Continued stay is not for the convenience of the family or other agencies involved in the youth’s care or solely for the purpose of finding placement.

Entry of Authorization Admission

The WCHHS Care Coordinator enters the admission and discharge date (or date that continued stay is approved until) into the WCHHS Third Party Administrator claims payment system for both acute and sub-acute admissions.
OBJECTIVE:

To provide twenty-four hours per day, seven days per week access to crisis respite and planned respite services for children and adolescents as an alternative to a higher level of care or when there is a risk of the child being placed outside their home or foster care placement due to symptoms of their mental illness.

POLICY:

WCHHS views crisis respite for children and adolescents as a safety net service and, subject to availability of funds, makes it available to any Washington County resident meeting the following criteria:

- Client is under the age of eighteen;
- Natural and informal supports (such as extended family, friends, neighbors, church members, etc) have been explored and are not available or adequate;
- A mental health, non-substance abuse diagnosis is the focus of the needed intervention;
- The primary presenting concerns must be psychiatric in nature and not solely for temporary placement/housing or for routine childcare needs;
- Current living situation is contributing to psychiatric symptoms and a temporary break from the living situation would reasonably defuse the stressors;
- The child is not in need of a higher level of care.

For Oregon Health Plan members assigned to Health Share Washington County and those youth that are eligible for General Fund outpatient services, planned respite is available as an intervention to maintain at-risk community placements. This should be part of an outpatient or other mental health treatment plan and must be pre-authorized by a WCHHS Care Coordinator.

Clients accessing planned respite must meet the following criteria:
Client is under the age of eighteen;
Caregiver stress is consistently high due to the demands of caring for the youth due to the youth’s symptoms of mental illness;
Natural and informal supports (such as extended family, friends, neighbors, church members, etc) have been explored and are not available or adequate;
A mental health, non-substance abuse diagnosis is the focus of the needed intervention;
The primary presenting concerns must be psychiatric in nature and not solely for temporary placement/housing or for routine child care needs;
Planned respite has been identified on the client’s mental health treatment plan or plan of care;
The child is not in need of a higher level of care.

SERVICE DESCRIPTION:

Out of home respite care is used as a less restrictive alternative to psychiatric residential treatment, subacute and inpatient levels of care. It is typically provided in a foster home setting, though may be provided in a shelter or other facility. It may also be used for children who are at risk of being placed outside of their home or foster care placement due to symptoms of their mental illness. Out of home respite may be used in circumstances where there is an exacerbation or escalation of difficult, unsafe or destructive behavior due to family stress or conflict. The services may also be appropriate in cases of caregiver stress related to the demands of the youth’s symptoms of mental illness in order to provide a break that may avoid out of home placement or loss of a workable foster care placement. It may be scheduled and planned in advance or occur in an unplanned, crisis situation.

PROCEDURE:

Respite services must be pre-authorized by the WCHHS Member Access Line, the WCHHS Crisis Line, or by a WCHHS Care Coordinator based on the above criteria. Once authorized, the Access Line or the WCHHS Care Coordinator will contact the Respite provider agency to alert them of the authorized referral. A current mental health assessment will be faxed as soon as it is available to the respite provider.

The Respite provider agency is then expected to coordinate admission for the client into respite care.

Crisis respite authorization is valid for up to four days and cannot be extended.

A WCHHS Care Coordinator will enter the authorization into the WCHHS claims database for OHP members assigned to Health Share Washington County, and will fax a written authorization for non-WCHHS OHP members to the respite provider.
**For respite authorizations to agencies other than the identified Respite provider agency, please see WCHHS policy on Exceptional Needs Authorizations.
Washington County Health and Human Services (WCHHS)
Mental Health Program
Policy and Procedure

Policy Title: Utilization Management: Children’s Psychiatric Day Treatment Services (PDTs)

Approved: __________________________     ____________________
Division Manager     Date

OBJECTIVE:

To provide timely access to medically necessary Psychiatric Day Treatment Services (PDTs) for eligible Washington County residents, with the goal of transition to a less restrictive setting when clinically appropriate.

To ensure that mental health services are client and family driven, provided in the least restrictive setting, and integrated into the child’s individualized services and support plan (ISSP).

POLICY:

WCHHS promotes family-driven treatment planning, where decisions to refer clients to PDTs are made by a child and family team that is facilitated by a Washington County Care Coordinator and includes representation from the client’s school district.

PDTs shall be written into the child’s ISSP, including the reason(s) for admission and the specific criteria for discharge.

Utilization Review is ongoing and completed by the Washington County Care Coordinator. Length of stay in PDTs is variable, based on the individual child and family needs, but generally does not exceed nine months.

SERVICE DESCRIPTION:

Psychiatric Day Treatment services are comprehensive, interdisciplinary, community-based programs consisting of psychiatric oversight, individual, milieu and family treatment and therapeutic activities integrated with an accredited education program. Services are clinically and developmentally appropriate and are provided in the medically appropriate amount, intensity and duration for each admitted child, specific to the child’s diagnosis, level of functioning and the acuity and severity of the child’s psychiatric symptoms. Psychiatric Day Treatment
Revised 1-21-14

providers operate under a Certificate of Approval issued by the Addictions and Mental Health Division.

Services include 24 hour, seven days per week treatment responsibility for admitted children and on-call capability at all times to respond directly or by referral to the treatment needs of admitted children.

**PROCEDURE:**

**Admission Criteria**

- The client is eligible for Washington County’s Intensive Service Array (see WCHHS policy on Intensive Service Array (ISA) for description and eligibility criteria).
- The client must have OHP and be a member of Health Share of Oregon and assigned to Washington County or meet the General Fund requirements for Household of One (see WCHHS policy on Use of General Fund for Household of one and uninsured ISA clients)
- The Child and Family Team agree on this intervention as the most appropriate.
- CASII or ECSII score is used in the decision making process and is minimally in the Level 4 range.
- A less intensive (outpatient) setting is not sufficient to successfully treat the child’s mental health condition.
- Day Treatment is not being recommended primarily due to poor achievement of educational goals due to the child’s mental health condition.
- The need for PDTS is driven by a covered diagnosis
- The referral to PDTS is not solely to provide daytime structure (such as during summer break).

WCHHS Care Coordinator will fax clinical information, CASII or ECSII and ISSP to the PDTS facility.

Initial PDTS authorization is for 90 days.

**Continued Stay**

Continued stay is authorized by a WCHHS Care Coordinator and is reviewed every 30 days. Authorization of for PDTS will be entered for a maximum of 90 days at a time. Utilization Review is done in the context of a quarterly treatment review with the family/guardian and a WCHHS Care Coordinator present, and/ or within a Child and Family Team meeting.

Continued stay is reviewed and approved by the WCHHS Psychiatric Consultant when length of stay has reached nine months. Additional stay beyond this is
reviewed and approved at intervals agreed upon by the Psychiatric Consultant and WCHHS Care Coordinator thereafter and documented in a progress note.

The WCHHS Care Coordinator shall document that a utilization review was completed and continued stay was authorized in a progress note in the client’s file. Changes to the ISSP shall be documented on the plan as needed.

Continued Stay Criteria

- Documentation is obtained from the PDTS provider indicating whether the client’s mental health symptoms that led to the admission, or as identified post-admission, are responding to or are likely to respond to the treatment plan. This may be reflected in a change in CASII or ECSII score (within a domain or overall).
- Documentation reflects ongoing discharge planning consistent with the discharge criteria in the ISSP.
- A transition plan has been developed and has a timeline for implementation.
- Attempts at re-entry into a less restrictive school setting have resulted in exacerbation or re-emergence of symptoms of the mental illness that cannot be mitigated with school and community supports.
- Documentation reflects that treatment goals cannot be achieved in a less restrictive setting.
- The client is not in need of a higher level of care.

Discharge Criteria

Discharge criteria will include the following:

- The Child and Family Team agree that school and community-based services and natural or informal supports are in place to sustain or improve the client’s current level of functioning; and
- The client’s symptoms of mental illness that necessitated admission have resolved to the point that school and community-based services and support can sustain the client in their current condition; and
- The client has had successful attempts at re-entry into the school setting; OR
- The Child and Family Team and PDTS treatment team agree that maximum benefit has been achieved by the PDTS stay; OR
- The client requires a higher level of care than can be provided in the PDTS program

The CASII or ECSII is re-administered by a County Care Coordinator and is used in discharge planning by guiding the level of service intensity to be provided post-discharge and during the transition.
Revised 1-21-14

Discharge planning is intended to be an ongoing process, driven by the child and family team, and including all community providers and school representatives as necessary. Discharge planning will be revisited regularly during monthly Child and Family Team meetings.
Washington County Health and Human Services (WCHHS)
Mental Health Program
Policy and Procedure

Policy Title: Utilization Management: Exceptional Needs

Approved: __________________________     _______________
Division Manager   Date

OBJECTIVE:

To ensure that eligible Washington County residents with mental health needs that require specialized treatment services not available through the contracted provider panel receive appropriate treatment.

To provide continuity of care to prevent disruption in the mental health treatment of eligible Washington County residents who are in treatment with a non-participating provider when such disruption might be damaging to their treatment gains.

POLICY:

The Washington County resident must be eligible for funding with Health Share of Oregon OHP assigned to Washington County or Washington County General Fund.

WCHHS will evaluate the need for exceptional needs services on a case-by-case basis. Decisions will be made in accordance with Washington County Practice Guidelines.

Individuals being considered for an exceptional needs authorization must meet the criteria for medical appropriateness for the level of treatment being requested.

All utilization management decisions will be made by a qualified mental health professional that has the appropriate clinical expertise in treating the member’s mental health condition.

All non-participating providers approved to deliver services to WCHHS clients must be credentialed in accordance with WCHHS Credentialing and Recredentialing of Exceptional Needs Providers Policy.
Authorization for general fund exceptional needs is contingent on the availability of funding given multiple competing demands for limited resources.

**PROCEDURE:**

A WCHHS Care Coordinator will conduct utilization review on all requests for exceptional needs/specialty services and requests for treatment with non-participating providers.

When available, clinical documentation will be submitted and will include a Mental Health Assessment completed in the last sixty (60) days, a treatment plan with measurable objectives, and the target date for completion of those treatment goals.

If the member is currently receiving treatment with a non-participating or exceptional needs provider, that provider must submit clinical documentation explaining why the treatment cannot or should not be obtained through a participating provider.

The Care Coordinator may request additional information to assist in making a decision to authorize care.

**Authorization Process:**

If the client meets clinical criteria for an Exceptional Needs Service, the Care Coordinator will negotiate the rate for services based on the current WCHHS fee-for-service rates.

If the Exceptional Needs provider has not been previously authorized by WCHHS, the Care Coordinator will send a credentialing packet and notify the Quality Improvement Coordinator that a packet has been sent. Please refer to the policy on Credentialing and Recredentialing of Exceptional Needs Providers for more information.

If the provider is not already included in the claims payment system, the Care Coordinator will complete a new provider enrollment form and fax this to the Third Party Administrator (TPA) to enter the provider into the system.

Once the Exceptional Needs Provider is credentialed, the Care Coordinator will complete an exceptional needs letter authorizing treatment with that provider, the duration of the authorization, and the reimbursement rate and send this to the provider. Authorizations will not be backdated more than 60 days, and will not provide payment for any requests that are denied.
Revised 1-27-2014

The Care Coordinator will enter an authorization for payment into the contracted Third Party Administrator's (TPA) electronic claims payment system.

Members may be authorized to a Lead Agency and concurrently receive specialty/exceptional needs services when clinically indicated and as approved by a Washington County Care Coordinator.

If request for authorization for exceptional needs/specialty services or treatment with a non-participating provider is denied for a Health Share of Oregon OHP client, the Care Coordinator will send a Notice of Action in accordance with the WCHHS policy on Notice of Actions.

When treatment by an Exceptional Needs Provider exceeds one year, the current mental health assessment and treatment plan will be reviewed by the WCHHS consulting psychiatrist for approval of continued treatment. This approval will be reflected by a signature on the written authorization for continued services. This will occur annually for the entire duration of treatment with the exceptional needs provider.
Washington County Health and Human Services (WCHHS)
Mental Health Program
Policy and Procedure

Policy Title: Utilization Management: Home-Based Stabilization

Approved: __________________________     _______________
           Division Manager   Date

OBJECTIVE:

To provide timely access to medically necessary Home Based Stabilization (HBS) services for youth and families of Washington County, with the goal of transition to less intensive services.

To ensure that mental health services are client and family driven, provided in the least restrictive setting, and integrated into the child’s long term service coordination plan.

POLICY:

WCHHS promotes family-driven treatment planning, such that decisions about referring clients to HBS are made by a child and family team facilitated by a Washington County Care Coordinator.

HBS shall be written into the child’s Individualized Services and Support Plan (ISSP), including the reason(s) for admission. Specific discharge criteria from the HBS level of care are also clearly identified in the ISSP.

Utilization Review is ongoing and completed by a Washington County Care Coordinator. Length of stay in HBS is expected to be approximately six to nine months, though it may vary based on the individual client’s needs.

SERVICE DESCRIPTION:

Home Based Stabilization Services are comprehensive, individualized and family-specific service packages that are an alternative to psychiatric residential treatment, subacute and inpatient care. Services are provided in accordance with the Wraparound and System of Care principles and will be tailored in frequency, intensity and duration to the specific needs of the child and family, in consultation with the Child and Family Team and the WCHHS Care Coordinator. Service intensity will be matched to level of need and may at some times be daily contact. Crisis support from the program staff is available twenty four hours per day, seven days per week. The goal of the service is to maintain or reintegrate
children and adolescents in their home and community, increase the child and family’s natural and informal supports, and reduce out-of-home placements that are the result of mental health issues. Services are provided in the home and community rather than an office setting.

**PROCEDURE:**

**Admission Criteria**

Admission criteria for HBS include the following:

- The client is eligible for the Intensive Service Array or Wraparound (see WCCHS policies on Intensive Service Array (ISA) and Wraparound Demonstration Project for the procedure for description and eligibility criteria)
- The Child and Family Team agree on this intervention as the most appropriate
- HBS is likely to alleviate symptoms and/or improve functioning
- Child and Adolescent Service Intensity Instrument (CASII) or Early Childhood Service Intensity Instrument (ECSII) score is used in the decision making process and is in the Level 4 range or above
- Covered diagnosis on the prioritized list that is the focus of the needed services
- Current serious to severe functional impairment in multiple areas
- Treatment intensity at a lower level of care is insufficient to maintain functioning
- Service needs require substantial care coordination due to the involvement of multiple systems (i.e. Child Welfare, Special Education, Juvenile Justice)
- Significant risk of out-of-home placement or currently homeless due to symptoms of mental illness
- Elevating or serious risk of harm to self or others
- Treatment is not directed primarily to resolve placement issues OR behavior, conduct or substance abuse problems

Initial authorization will be valid for up to 90 days.

**Continued Stay Criteria**

Continued stay is authorized by the assigned WCHHS Care Coordinator and is reviewed every 30 days. Utilization Review is done based on regular communication with all team members, including service providers and parent/guardian. Utilization Reviews are approved by the WCHHS Children’s Mental Health Program Supervisor at six month intervals.

The WCHHS Care Coordinator shall complete a HBS Utilization Review form every 90 days and file in the clinical record. Changes to the service coordination plan shall be documented on the plan and updated as needed.
Criteria:

- There is evidence that the individual’s mental health symptoms that led to the referral are responding to treatment and/or evidence of engagement and participation in treatment by the child and family.
- There is evidence that services have focused on developing natural supports and empowering the family and caregivers to develop skills and strategies to meet the client’s needs.
- Treatment is clearly focused on the goals outlined in the Service Plan and discharge planning is active and ongoing.
- There is documentation that treatment goals cannot be achieved with a lower level of service intensity.
- Continued service needs require substantial care coordination due to the involvement of multiple systems.
- There is continued need for crisis support due to extended or frequent crisis episodes.
- Discharge from Home Based Stabilization including discharge criteria and potential time frames, has been discussed in the child and family team.

Discharge Criteria

- The Child and Family Team agree that outpatient and any other community-based services, as well as natural support systems, are in place to sustain or improve the client’s current level of functioning; and
- The client’s symptoms of mental illness that necessitated admission have resolved to the point that a lower level of service intensity and support can sustain the client in their current condition; OR
- The client requires a higher level of care than can be provided with HBS (e.g. Psychiatric Residential Treatment Services); OR
- The Child and Family Team and HBS treatment team agree that maximum benefit has been achieved by HBS program

The CASII or ECSII is re-administered by a County Care Coordinator and is used in discharge planning by guiding the level of service intensity to be provided post-discharge and during the transition.

Discharge planning is intended to be an ongoing process, driven by the child and family team, and including all community providers and school representatives as necessary.
WASHINGTON COUNTY HEALTH AND HUMAN SERVICES (WCHHS)
MENTAL HEALTH PROGRAM
POLICY AND PROCEDURE

**Policy Title:** Utilization Management: Intensive Service Array (ISA)

**Approved:** __________________________     _______________
Division Manager     Date

**OBJECTIVE:**

To provide integrated mental health services to Washington County children and adolescents with severe emotional disorders, in collaboration with our system of care partners, which are child-centered, family-driven, community-based, culturally competent, multi-systemic, comprehensive, well coordinated and which are provided in the least restrictive setting possible.

Services will be individualized and family-centered, with the goal of maintaining or reintegrating the child or adolescent into the home and community and/or treatment in lower levels of care.

**POLICY:**

All clients referred to the Intensive Service Array (ISA) will be screened for eligibility within in three business days. Notification of the results of the determination will be provided in writing to the guardian and to the referent. Those clients who are found eligible for the ISA will be provided with a WCHHS Care Coordinator who will facilitate the development of a Child and Family Team. All clients in the ISA will receive fidelity Wraparound supports provided by a Wraparound Care Coordinator who will have a maximum of 15 clients. The Care Coordinator will meet with the family/guardian, person who made the referral and other team members within 14 days. This team will develop a comprehensive Individualized Service and Support Plan (ISSP), which will follow the client through various levels of care and/or programs within the ISA to facilitate coordination of care and a transition back to a lower level of service intensity.

Washington County Care Coordinators will use the Child and Adolescent Service Intensity Instrument (CASII) and Early Childhood Service Intensity Instrument (ECSII) to guide clinical decisions around eligibility for ISA and level of service intensity within the ISA.

**SERVICE DESCRIPTION:**
The ISA is a range of mental health services that are coordinated, comprehensive, culturally competent, family driven and child centered. Services are individualized and may be provided in the home, school, community or residential facility. Care is integrated in a way that ensures that youth and adolescents are served in the most natural, least restrictive environment possible.

Services within the ISA include, but are not limited to:
- Fidelity Wraparound Care coordination by a Washington County Mental Health Wraparound Care Coordinator
- Psychiatric residential treatment
- Psychiatric day treatment
- Inpatient or subacute care
- Home or facility based respite care
- Home based stabilization services
- Flexible services as needed

The intensity, frequency, type, and location of the services are based on the individual needs of the child and their family.

**PROCEDURE:**

**Admission Criteria**

Referrals for ISA eligibility screening may come from families, clients, teachers, associated agency representatives, etc. Completed referrals will be screened within three business days and the guardian and referent will be notified of the outcome and recommendations. A completed referral packet will include a referral form (considered a request for Intensive Services), signed Consent for ISA Screening and Services, signed Consent for Release of Confidential Information, signed Notice of Receipt of Privacy Practices, a mental health assessment completed within the past 60 days, and other relevant documentation when available.

For clients age 0-17 to be eligible for the ISA:

Clients must meet all of the following criteria:
- CASII or ECSII score of 19 or above,
- Exceeds usual and customary services in an outpatient setting,
- Mental health “above the line” diagnosis is the focus of the needed services

Additional Considerations:
- Multiple agency involvement (Juvenile Justice, Special Ed, Child Welfare, DD),
- Significant risk of out of home placement,
- Recent or multiple out of home placements,
Frequent or imminent admission to Acute inpatient psychiatric hospitalizations or other intensive treatment services, 
- Significant or chronic caregiver stress,
- School or childcare disruption due to mental health symptoms,
- Elevating or significant risk of harm to self and/or others.

Additional Considerations for Children Age Birth to Five
- History of abuse or neglect,
- Parental poverty, substance abuse, mental health needs, or domestic violence,
- Significant relationship disturbance between parent(s),
- Child showing significant risk factors for more serious emotional/behavioral challenges (e.g. developmental delays, problems with self regulation, and/or social relationships).

Once a client is determined ISA eligible, a County Care Coordinator will be assigned who will be responsible for utilization management and discharge planning.

Continued Stay Criteria

The client's ISSP will be reviewed at least every 90 days within the context of a child and family team. The child and family team will meet at least every 30 days.

The WCHHS Care Coordinator shall document that a utilization review was completed and continued ISA eligibility was established in a progress note in the client's file.

Criteria for continued ISA eligibility include:

- The client’s CASII or ESCII score is 19 or above;
- Symptoms of a mental health “above the line” diagnosis continue to be the primary focus of treatment;
- The client’s symptoms of mental illness that necessitated admission into the ISA continue to require a level of service intensity that cannot be provided in a lower level of care;
- The child and family team support continued treatment in the ISA

Discharge Criteria

A client’s ISSP will be reviewed at least every 90 days within the context of a child and family team.

Clients meeting the following criteria will be discharged from the ISA:
The Child and Family Team agree that outpatient and any other community-based supports, as well as natural support systems, are in place to sustain or improve the client’s current level of functioning; and
• The client’s symptoms of mental illness that necessitated admission into the ISA have resolved to the point that a lower level of service intensity and support can sustain the client in their current condition;
• The client is not at significant risk of out-of-home placement; OR
• The Child and Family Team agrees that maximum benefit has been achieved in the ISA program.

The CASII or ECSII is re-administered by a County Care Coordinator and is used in discharge planning by guiding the level of service intensity to be provided post-discharge and during the transition.

Discharge planning is intended to be an ongoing process, driven by the child and family team, and including all community providers and school representatives as necessary.
Washington County Health and Human Services (WCHHS)
Mental Health Program
Policy and Procedure

Policy Title: Utilization Management: Older Adult Services

Approved:

Division Manager Date

OBJECTIVE:

To ensure that mental health services are individualized, consumer and family driven, strengths-based, flexible, coordinated, culturally competent and medically necessary.

Clients are served in the most normative, least restrictive, least intrusive level of care appropriate to their history, degree of impairment, current symptoms and extent of family and community supports.

To ensure that service intensity is individually tailored to client need.

To respect client choice in the selection of a mental health provider.

To ensure that mental health services are based on a recovery, strengths based model and that the client is the primary determiner of treatment goals.

To ensure a prompt response to requests for service authorization.

POLICY:

The following Policy and Procedure applies to both Health Share of Oregon, assigned to Washington County (OHP) members and persons without insurance or significantly underinsured who meet the criteria to receive funding for mental health treatment services from the WCHHS General Fund.

Assignment to Levels of Care and procedures for authorization will vary between Health Share Washington County members and persons without insurance who meet criteria for MH services through WCHHS General Fund. For Health Share Washington County members, please refer to the Utilization Management policy for OHP members. For General Fund services, please refer to the UM policy for GF.

Criteria for WCHHS General Fund eligibility:
Washington County resident;
- Family income is below WCHHS established percentage of federal poverty guideline. This guideline may be raised or lowered based on availability of funds or specific risk factors;
- No insurance or significantly underinsured (i.e. insurance benefit is exhausted or inadequate to provide the basic services needed); and
- Cannot be adequately served by other community resources (i.e. free or low cost counseling/healthcare, primary care clinics, etc.).

The service types that are eligible for General Fund may change depending on availability of funding. Decisions on which services are eligible for funding with General Fund dollars will be guided by the philosophy of funding services for the most disabled first.

Services may be requested directly, with no referral necessary to access mental health services.

Decisions to authorize or deny services that require pre-authorization will be made within 14 days of the receipt of the request unless an expedited decision is requested.

PROCEDURE:

Access:
Eligible Washington County residents have open and direct access to agencies on the WCHHS provider panel. Eligible persons can access treatment by contacting contracted providers directly, being referred from an allied agency, or by calling either the WCHHS Access Line at 503-291-1155 or the Washington County Crisis Line at 503-291-9111 for help identifying and accessing a mental health provider most likely to be appropriate to their needs.

No pre-authorization for the initial assessment is necessary for individuals who do not currently have a mental health provider. Approval from a Washington County Care Coordinator is required for individuals with an existing authorization to another mental health program in order to ensure payment for service.

All Washington County OHP members and persons eligible for WCHHS General Fund, or their representatives, including providers, may request an assessment for mental health treatment.

Eligibility:
Services will only be authorized for those individuals with an eligible mental health diagnosis who either have OHP with Health Share of Oregon, assigned to Washington County as the Risk Accepting Entity (RAE) or for individuals who are determined to meet the eligibility criteria for General Fund services. The provider
must determine eligibility at the time of the initial assessment and at the time of reauthorization, when applicable.

Eligibility for funding by the WCHHS General Fund must be elicited by the provider during an intake screening and the Income Verification Form must be completed, signed by the client or guardian and submitted to WCHHS with the request for authorization.

Screening and Emergent/Urgent Response:
Provider agencies will screen all referrals to assess the urgency of the presenting situation and will respond within appropriate timelines as defined in their contract. The screening agency may determine, based on client presentation, that an alternative agency is a more clinically appropriate match and may refer the client to that WCHHS provider.

Clients identified as needing crisis services are provided appointments within timeframes identified by the urgent and emergency response screening or within 24 hours of contact, whichever is shorter. Urgent appointments (within 48 hours), may also be provided when indicated. Either may be accessed by calling the WCHHS Member Access Line at 503-291-1155 or the WCHHS Crisis Line at 503-291-9111.

Covered Services:
Health Share of Oregon, assigned to Washington County OHP and General Fund clients are entitled to a mental health assessment and to appropriate and medically necessary mental health treatment provided by a credentialed provider. The Oregon Health Plan covers diagnoses listed on the state’s prioritized list of covered conditions. Covered outpatient services include a range of treatment modalities approved for payment by the Oregon Health Plan.

Outpatient services for OHP members and persons meeting General Fund criteria include:
• Evaluation and consultation
• Individual, family and group therapy
• Medication management
• Case management
• Other Services as clinically indicated

Utilization Management:
Utilization Management is a primary responsibility of contracted providers. Additionally, utilization management review will be conducted by a WCHHS Care Coordinator at times and intervals indicated by the specific service and level of care. Utilization management may also take place when transfers between levels of care are requested.
Provider will manage utilization throughout the authorization period to ensure that the client is assigned to the correct level of care as indicated by medical necessity and that the services provided are consistent with that level of care.

In situations where the authorization is paid FFS, including General Fund, and the provider has reached the maximum dollar amount for the authorization prior to the end of the authorization period, and the client does not qualify for a higher level of care, the provider is expected to continue to provide medically necessary services. Authorization for payment exceeding payment caps will be made only for Older Adult Rehabilitation, in the case of exceptional need, and when preauthorized by a Washington County Care Coordinator.

WCHHS Care Coordinators may monitor utilization and treatment by site visits or attendance at treatment team meetings at their discretion.

Authorizations for specific providers may be terminated in accordance with the WCHHS policy on Terminations and Transfers.

All authorized services will be entered into the authorization database. This is generally done by the Provider Agency.

**Client Description:**
Older Adult services are generally provided to individuals over the age of 55 who have an ‘above the line’ mental health disorder that may be either transitory or chronic in nature. Individuals who are younger than 55 may also be served in this program if the nature of their presentation limits their ability to receive services within an adult outpatient or rehabilitation program. Services are provided at two levels, Older Adult Outpatient and Older Adult Rehabilitation.

Older Adult Outpatient clients often present with more episodic conditions that are often responsive to a more traditional therapeutic approach. Clients are generally able to learn and utilize skills to decrease symptoms. Enrollment is expected to be brief or episodic and goal oriented, though clients may continue to receive medication management or other support on an ongoing basis. Clients may return to treatment as symptoms/stressors warrant. Although generally targeting individuals age 55 or older, age exceptions are made when clinically indicated.

Clients who are enrolled in Older Adult Rehabilitation/SPMI services often have presenting disorders that are chronic in nature. Clients in this category may present with psychotic, major affective disorders or significant cognitive deterioration with a co-occurring covered mental health disorder and are generally considered disabled to the extent that their functioning is limited in areas such as employment, interpersonal relationships, community negotiation and attending to personal needs. Clients may also present with transient mental health conditions however due to external circumstances are unable to be seen in a clinic setting. Examples may include individuals living in a care facility who,
as a result of significant co-morbid physical health conditions, are unable to leave their residence. Although generally targeting individuals age 55 or older, age exceptions are made when clinically indicated.

**Service Description:**
Services are modified in several distinct ways from other outpatient and rehabilitation programs. First, the services are geared toward adults in the later stages of their life and the clinicians have specialized knowledge of the challenges faced by those individuals. Second, clinicians are adept at diagnosing and treating dementia and other organic conditions. Finally, services are provided in a variety of settings including clinic, nursing home, and the client’s residence. Individual therapy, which traditionally is provided in a clinic setting, may be provided in the client’s residence due to mobility constraints. Special attention is placed on mobility concerns and therefore clients who are homebound, regardless of age, may be served by this program.

Services may include evaluation, consultation, assessment, interpreter services, clinical service coordination, case management, crisis intervention, skills training, medication evaluation and management, individual, family and group therapy. Flexible service approaches will also be incorporated, tailored to the specific treatment needs of each individual. Attention to housing needs, supported employment or vocational opportunities, transportation and peer support will be included in treatment planning. Clients shall be included in all service planning and delivery.

**General Fund Clinical Criteria:**
**Older Adult Outpatient Clinical Criteria:**
The adult must have a mental disorder covered by the Oregon Health Plan, and:

EITHER (all of the following):

A. There is only mild to moderate functional impairment in the following areas:
   - Activities of daily living
   - Occupational/educational functioning
   - Community negotiation
   - Social relations

B. A short-term, goal-focused or skill-building therapeutic intervention can be expected to be reasonably effective in alleviating symptoms and/or improving functioning.

C. There is no other equally effective, more conservative, or less costly course of treatment available or suitable for the person requesting service.

OR:
One of the following:

- Adults for whom a mental disorder cannot be ruled out (assessment only)
- The adult has a severe persistent mental health disorder for which maintenance treatment is required to maintain optimal symptom relief and/or functioning.
- Referral by a Primary Care Provider for medication evaluation and consultation only.

**Older Adult Rehabilitation/SPMI Clinical Criteria:**

**EITHER:**

Individuals who are generally 55 years of age or older who meet both of the criteria below:

A. Diagnosed with an OHP covered, non-substance use, severe mental disorder defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM). Severe mental disorders include schizophrenia, major affective and paranoid disorders, and other disorders that manifest persistent psychotic symptoms or marked functional impairment other than those caused solely by substance abuse.

B. Disabled by the mental disorder to an extent which limits consistent functioning in at least two of the following areas:

1) **Home environment:** Cannot independently attend to shelter needs, personal hygiene, nutritional needs, and home maintenance.
2) **Community negotiation:** Cannot independently and appropriately utilize community resources for shopping, recreation and other needs.
3) **Social relations:** Cannot establish and maintain supportive relationships.
4) **Productivity:** Cannot maintain employment sufficient to meet personal living expenses or engage in other appropriate activities.

**OR:**

The client meets criteria for Older Adult Outpatient services and has significant mobility impairment such that mental health services must be provided in the client’s place of residence.

**Health Share of Oregon Clinical Criteria:**

Please refer to Health Share of Oregon’s Level of Care guidelines for information about assignment to a level of care.
OBJECTIVE:

To ensure that mental health services are individualized, consumer and family driven, strengths-based, flexible, coordinated, culturally competent and medically necessary.

To ensure that clients are served in the most normative, least restrictive, least intrusive level of care appropriate to their history, degree of impairment, current symptoms and extent of family and community supports.

To ensure that service intensity is individually tailored to client need.

To respect client choice in the selection of a mental health provider.

To ensure that mental health services are based on a recovery oriented, strengths-based model and that the client is the primary determiner of treatment goals.

To ensure a prompt response to requests for service authorization.

To ensure that Health Share policy is integrated into Washington County procedures.

POLICY:

The following Policy and Procedure applies to Health Share of Oregon OHP members assigned to Washington County.

Services may be requested directly, with no referral necessary to access mental health services. Adolescents age fourteen and older may request service authorization without parent/guardian consent, in accordance with applicable ORS.
Decisions to authorize or deny services that require pre-authorization will be made within 14 days of the receipt of the request unless an expedited decision is requested.

**PROCEDURE:**

**Access:**
Eligible Washington County residents have open and direct access to agencies on the WCHHS provider panel. Eligible persons can access treatment by contacting contracted providers directly, being referred from an allied agency, or by calling either the WCHHS Access Line at 503-291-1155 or the Washington County Crisis Line at 503-291-9111 for help identifying and accessing a mental health provider most likely to be appropriate to their needs.

No pre-authorization for the initial assessment is necessary for individuals who do not currently have a mental health provider. Approval from a Washington County Care Coordinator is required for individuals with an existing authorization to another mental health provider.

All Washington County OHP members or their representatives, including providers, may request an assessment for mental health treatment.

**Eligibility:**
Ongoing services will only be authorized for those individuals with a covered mental health condition who have Health Share of Oregon and are assigned to Washington County. The provider must determine eligibility at the time of the initial assessment and at the time of reauthorization, when applicable.

**Screening and Emergent/Urgent Response:**
Provider agencies will screen all referrals to assess the urgency of the presenting situation and will respond within appropriate timelines as defined in their contract. The screening agency may determine, based on client presentation, that an alternative agency is a more clinically appropriate match and may refer the client to that WCHHS provider.

Clients identified as needing crisis services will be provided appointments within time frames identified by the urgent and emergency response screening or within 24 hours of contact, whichever is shorter. Urgent appointments (within 48 hours), may also be provided when indicated. Either may be accessed by calling the WCHHS Member Access Line at 503-291-1155 or the WCHHS Crisis Line at 503-291-9111 or by contacting a provider agency directly.

**Covered Services:**
Revised 3-17-14

Health Share of Oregon, Washington County OHP clients are entitled to a mental health assessment and to appropriate and medically necessary mental health treatment provided by a credentialed provider. Oregon Health Plan covers mental health diagnoses listed on the state’s prioritized list of covered conditions.

Outpatient mental health services for OHP members include:

- Evaluation and consultation
- Individual, family and group therapy
- Medication management
- Case management
- Other Services as clinically indicated

Utilization Management:
Utilization Management is a primary responsibility of contracted providers. Additionally, utilization management will be conducted by a WCHHS Care Coordinator at times and intervals indicated by the specific service and level of care. Utilization management will also take place when transfers between levels of care are requested.

Provider will manage utilization throughout the authorization period to ensure that the client is assigned to the correct level of care as indicated by medical necessity and that the services provided are consistent with that level of care. In situations where the Provider has reached the maximum dollar amount for the authorization prior to the end of the authorization period, and the client does not qualify for a higher level of care, the Provider is expected to continue to provide medically necessary services.

WCHHS Care Coordinators may monitor utilization and treatment by site visits or attendance at treatment team meetings at their discretion.

Authorizations for specific providers may be terminated in accordance with the WCHHS policy on Terminations and Transfers.

All authorized services will be entered into the authorization database. This is generally done by the Provider Agency.

Most Health Share of Oregon assigned to Washington County clients will be assigned to the levels of care (A-D) as detailed in the Health Share of Oregon Level of Care Utilization Management Guidelines. All services and assignment to a Level of Care will be supported by a behavioral health assessment and necessary documentation to support both the client's level of need and response to treatment. Contractor will be expected to display 75% inter-rater reliability in their assignment of clients to the new levels of care. Contractor shall demonstrate inter-rater reliability based on internal concurrent review of no less
CHILD AND ADOLESCENT OUTPATIENT SERVICES

Service Definition:
Child and Family Outpatient treatment includes Levels A-C that are outlined in the “Health Share Regional Level of Care Guidelines.” Criteria and service expectations for each are described in detail in these guidelines. All services and assignment to a Level of Care will be supported by a behavioral health assessment and necessary documentation to support both the client’s level of need and response to treatment.

Services may include evaluation, consultation, assessment, interpreter services, clinical service coordination, case management, crisis intervention, skills training, medication evaluation and management, coordination of services by non-traditional providers, individual, family and group therapy. Services will be provided in the setting that is most accessible to the child and family, which may include a mental health clinic, the facilities of other components of the service system, the family’s home or other community settings, or the child’s school. Services will be provided at the level of intensity prescribed by the integrated services and support plan and level of care assignment. Flexible service approaches will also be incorporated, tailored to the specific treatment needs of each individual, and families will be included in service planning and delivery.

Clinical Criteria:

- An OHP covered “above-the-line” DSM IV, non-substance use diagnosis is the focus of the needed mental health treatment.
- Treatment is not directed primarily to resolve placement issues related to abuse, neglect or caregiver incapacity OR behavior, conduct or substance use problems.
- Treatment is likely to alleviate symptoms and/or improve functioning
- Cannot be adequately served by other community resources (i.e. primary care clinics, substance abuse treatment programs, other community resources).

Initial Authorization Requests

No clinical review for pre-authorization for outpatient services is required for any of the three levels of care. Authorization requests should be entered into PHTech after the initial assessment and treatment plan has been completed. Requests that are entered more than 60 days after the initial appointment will not
Revised 3-17-14

be backdated beyond the 60-day period (i.e. the WCHHS Care Coordinator will backdate an authorization up to 60 days prior to the date the request is entered into PHTech.) Each level of care has a separate authorization period and maximum payment amount. No additional dollars will be added to the authorization during the authorization period.

OHP authorization requests for each level of care will auto-approve when entered in a timely manner (i.e. within 60 days of the start date) into the WCHHS authorization database. OHP requests do not require submission of documentation to WCHHS. OHP authorization requests should be entered by the provider agency into the WCHHS authorization database.

If the Care Coordinator denies the requested level of care or authorizes a different level of care than requested by the client, and the client is not in agreement, a Notice of Action will be sent to the client and the provider in accordance with Washington County Notice of Action policy.

Re-authorization
When the expiration date of the current authorization is approaching and the client continues to meet medical necessity criteria for treatment, the provider will enter another Lead Agency request into the authorization database. All OHP authorization requests for child and adolescent outpatient services should auto-approve when entered timely in a timely manner (i.e. within 60 days of the start date).

If the Care Coordinator denies the requested level of care or authorizes a different level of care than requested by the member, and the member is not in agreement, a Notice of Action will be sent to the member and the provider in accordance with Washington County Notice of Action policy.

ADULT OUTPATIENT SERVICES

Service Definition
Adults in outpatient services frequently present with episodic conditions that are mild to moderate in severity and often responsive to traditional therapeutic approaches. Examples of frequently presenting diagnoses include dysthymic disorders, anxiety disorders, depression and trauma related disorders. Clients are generally able to learn and utilize skills to decrease symptoms. Treatment is expected to be brief or episodic and goal oriented; though clients may continue to
receive medication management or other support on an ongoing basis. Clients may return to treatment as symptoms/stressors warrant.

Services provided to individuals in Adult Outpatient include:
- Evaluation and consultation
- Individual, family and group therapy
- Medication management
- Case management
- Other services as clinically indicated

Clinical Criteria:

A. The adult must have a mental health disorder defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Health Disorders (DSM), and which is included as an “above the line” diagnosis on the Oregon Health Plan (OHP) “Prioritized List of Mental Health Conditions;”

B. There is only mild to moderate functional impairment in the following areas:
- Activities of daily living
- Occupational/educational functioning
- Community negotiation
- Social relations;

C. A short-term, goal-focused or skill-building therapeutic intervention can be expected to be reasonably effective in alleviating symptoms and/or improving functioning;

D. There is no other equally effective, more conservative, or less costly course of treatment available or suitable for the person requesting service.

E. Or One of the Following:
- Adults for whom a mental disorder cannot be ruled out (assessment only).
- The adult has a severe persistent mental health disorder for which maintenance treatment is required to maintain optimal symptom relief and/or functioning.
- Referral by a Primary Care Provider for medication evaluation and consultation only.

Initial Authorization Requests
No clinical review for pre-authorization is required for adult outpatient services. Authorization requests should be entered into PHTech after the initial
assessment and treatment plan has been completed. Requests that are entered more than 60 days after the initial appointment will not be backdated beyond a 60-day period (i.e. the WCHHS Care Coordinator will backdate an authorization up to 60 days from the date the request was received.)

The authorization period will be for six months. No additional dollars will be added to the authorization during the authorization period. OHP authorization requests should be entered by the agency into the WCHHS authorization database, PHTech. If there is no existing authorization in the system, the request should auto-approve. No additional documentation is needed by WCHHS.

If an OHP authorization is denied, and the client is not in agreement, the Care Coordinator will send a Notice of Action in accordance with Washington County Notice of Action policy.

Re-authorization

If the client is still in treatment near the expiration date of the current authorization, the provider should make a determination about whether continued treatment is clinically indicated and medically necessary. If the provider believes continued treatment is indicated, the agency will enter a new authorization request into PHTech.

ADULT Severe and Persistent Mental Illness SPMI SERVICES

Service Definition:
Clients for whom SPMI services are appropriate present with disorders that are severe and chronic in nature and may require either ongoing or repeated engagement in services to manage symptoms and psychosocial stressors. Clients in this category may present with psychotic, major affective disorders or significant cognitive deterioration and are generally considered disabled to the extent that their functioning is limited in areas such as employment, interpersonal relationships, community negotiation and activities of daily living. The impacts on functioning are not primarily caused by substance intoxication, abuse or dependence. Contacts are often in the community rather than in a clinic setting.

Services to be Provided:
- Evaluation and consultation
- Flexible case management services that vary in intensity depending on level of need
- Medication management
- Care coordination; access to other services or entitlements
• Wrap-around services which may include in-home flexible respite, peer supports and crisis response
• Therapeutic contacts may include support, skills training, group therapy, and individual therapy
• Outreach
• Other services as clinically indicated

Services are provided at the level of care based on the mental health assessment from the provider. There are five Levels of Care for Adult SPMI: Level A MRDD/Meds Only, Level B, Level C, Level D, and ACT (Assertive Community Treatment). Criteria and service expectations for Levels A, B, C, and D are described in detail in Attachment B: Health Share Levels of Care for Adults. Level A MRDD/Meds Only is a service for either SPMI individuals whose condition is stable and only require medications or clients presenting with both a covered mental illness and a developmental disability. Generally the latter individuals receive the majority of their case management needs through Developmental Disabilities and the services provided by mental health is targeted primarily toward medication management and care coordination.

Clinical Criteria:

Individuals who are 18 years of age or older who meet both of the criteria below:

A. Diagnosed with a severe mental disorder defined in the most current edition of the Diagnostic and Statistical Manual of Mental Health Disorders (DSM), and are included on the Oregon Health Plan (OHP) “Prioritized List of Mental Health Conditions”. Severe mental disorders include schizophrenia, major affective and paranoid disorders, and other disorders that manifest persistent psychotic symptoms other than those caused solely by substance abuse.

B. Impacted by the mental health disorder to an extent which limits consistent functioning.

Initial Authorization Requests
All levels of care will auto-approve when submitted in a timely manner with the exception of Level D and ACT. Level D and ACT require preauthorization with a clinical review by a WCHHS Care Coordinator is required for all requests for adult rehabilitation services. Authorization should be submitted in PHTech after the initial assessment and treatment plan has been completed. Provider must fax the initial mental health assessment and treatment plan to WCHHS for review by a care coordinator to establish rehabilitation eligibility. Requests that are submitted more than 60 days after the initial appointment will not be backdated beyond the 60-day period (i.e. the WCHHS Care Coordinator will backdate an
authorization up to 60 days from the date the request is received.) The authorization period will be for one year. Authorization for payment exceeding payment caps will be made only for ACT, in the case of exceptional need, and when preauthorized by a Washington County Care Coordinator.

All OHP authorization requests should be entered by the provider agency into the PHTech authorization database. If there is no existing rehabilitation or outpatient authorization in the system OHP authorization requests for each level of care will go to “received” status when entered timely in a timely manner (i.e. within 60 days of the start date). All other status results (such as “denied”) should be discussed with a WCHHS Care Coordinator.

If an OHP authorization is denied, and the client is not in agreement, the Care Coordinator will send a Notice of Action in accordance with Washington County Notice of Action policy.

Re-authorization
No clinical review is required for additional annual authorizations for treatment with the exceptions of Level D and ACT. When the expiration date of the current authorization is approaching, the provider will verify that the client continues to meet criteria for rehabilitation services and when indicated will enter another annual authorization request into the PHTech All OHP authorization requests with the exception of Level D and ACT should auto-approve when entered timely in a timely manner (i.e. within 60 days of the start date).

If the Care Coordinator denies the requested level of care or authorizes a different level of care than requested by the member, and the member is not in agreement, a Notice of Action will be sent to the member and the provider in accordance with Washington County Notice of Action policy.
OBJECTIVE:

To ensure that mental health services are individualized, consumer and family driven, strengths-based, flexible, coordinated, culturally competent and medically necessary.

To ensure that clients are served in the most normative, least restrictive, least intrusive level of care appropriate to their history, degree of impairment, current symptoms and extent of family and community supports.

To ensure that service intensity is individually tailored to client need.

To respect client choice in the selection of a mental health provider.

To ensure that mental health services are based on a recovery oriented, strengths-based model and that the client is the primary determiner of treatment goals.

To ensure a prompt response to requests for service authorization.

POLICY:

The following Policy and Procedure applies to persons without insurance or significantly underinsured who meet the criteria to receive mental health treatment services funded by the WCHHS General Fund.

Criteria for WCHHS General Fund eligibility:

- Washington County resident;
- Family income is below WCHHS established percentage of federal poverty guideline. This guideline may be raised or lowered based on availability of funds or specific risk factors;
- No insurance or significantly underinsured (i.e. insurance benefit is exhausted or inadequate to provide the basic services needed); and
• Cannot be adequately served by other community resources (i.e. free or low cost counseling/healthcare, primary care clinics, etc.).

The service types that are eligible for General Fund may change depending on availability of funding. Decisions on which services are eligible for funding with General Fund dollars will be guided by the philosophy of funding services for the most disabled first.

Services may be requested directly, with no referral necessary to access mental health services. Adolescents age fourteen and older may request service authorization without parent/guardian consent, in accordance with applicable ORS.

Decisions to authorize or deny services that require pre-authorization will be made within 14 days of the receipt of the request unless an expedited decision is requested.

PROCEDURE:

Access:
Eligible Washington County residents have open and direct access to agencies on the WCHHS provider panel. Eligible persons can access treatment by contacting contracted providers directly, being referred from an allied agency, or by calling the Washington County Crisis Line at 503-291-9111 for help identifying and accessing a mental health provider most likely to be appropriate to their needs.

No pre-authorization for the initial assessment is necessary for individuals who do not currently have a mental health provider. Approval from a Washington County Care Coordinator is required for individuals with an existing authorization to another mental health provider.

All persons eligible for WCHHS General Fund, or their representatives, including providers, may request an assessment for mental health treatment.

Eligibility:
Ongoing services will only be authorized for those individuals with a covered mental health condition who are determined to meet the eligibility criteria for General Fund services. The provider must determine eligibility at the time of the initial assessment and at the time of reauthorization, when applicable.

Eligibility for funding by the WCHHS General Fund must be elicited by the provider during an intake screening and the Income Verification Form must be completed, signed by the client or guardian and submitted to WCHHS with the request for authorization.
Provider shall assist client with enrolling in benefits through Cover Oregon and the Affordable Care Act. Provider will routinely check for OHP eligibility for all GF clients. At a minimum, provider will check for OHP eligibility quarterly for all clients with GF authorizations. Providers will make reasonable efforts to assist all clients who are eligible for OHP in applying for the benefit.

Screening and Emergent/Urgent Response:
Provider agencies will screen all referrals to assess the urgency of the presenting situation and will respond within appropriate timelines as defined in their contract. The screening agency may determine, based on client presentation, that an alternative agency is a more clinically appropriate match and may refer the client to that WCHHS provider.

Clients identified as needing crisis services will be provided appointments within time frames identified by the urgent and emergency response screening or within 24 hours of contact, whichever is shorter. Urgent appointments (within 48 hours), may also be provided when indicated. Either may be accessed by calling the WCHHS Member Access Line at 503-291-1155 or the WCHHS Crisis Line at 503-291-9111 or by contacting a provider agency directly.

Covered Services:
Eligibility for GF treatment services require a covered mental health diagnoses listed on the state’s prioritized list of covered conditions.

Outpatient mental health services for persons meeting General Fund criteria include:
- Evaluation and consultation
- Individual, family and group therapy
- Medication management
- Case management
- Other Services as clinically indicated

For adults who will likely be Medicaid-eligible on January 1, 2014 through the Affordable Care Act, medication may be offered, however access may be limited and providers will need to manage to a medication budget.

Utilization Management:
Utilization Management is a primary responsibility of contracted providers. Additionally, utilization management will be conducted by a WCHHS Care Coordinator at times and intervals indicated by the specific service and level of care. Utilization management will also take place when transfers between levels of care are requested.

Provider will manage utilization throughout the authorization period to ensure that the client is assigned to the correct level of care as indicated by medical necessity and that the services provided are consistent with that level of care. In
situations where the Provider has reached the maximum dollar amount for the authorization prior to the end of the authorization period, and the client does not qualify for a higher level of care, the Provider is expected to continue to provide medically necessary services.

WCHHS Care Coordinators may monitor utilization and treatment by site visits or attendance at treatment team meetings at their discretion.

Authorizations for specific providers may be terminated in accordance with the WCHHS policy on Terminations and Transfers.

All authorized services will be entered into the authorization database. This is generally done by the Provider Agency.

CHILD AND ADOLESCENT OUTPATIENT SERVICES

Service Definition:
Washington County will provide mental health services to children and adolescents which are client-centered, family-focused, community-based, culturally competent, multi-systemic, comprehensive, well coordinated and provided in the least restrictive setting possible. The Child and Adolescent Service System Principles (CASSP) will guide the planning, management and delivery of mental health services to children and adolescents in Washington County.

Outpatient services are provided at three levels, based on the treatment needs identified in the initial mental health assessment from the provider. Authorization periods vary according to the level of care. The levels and authorization periods are:

• Brief Treatment/Recovery Maintenance 1 year
• Outpatient Services 6 months
• Intensive Outpatient Services 3 months

These levels are described in detail in Attachment A: Washington County Levels of Care for Children and Families.

Clinical Criteria:
• An OHP covered “above-the-line” DSM IV or 5, non-substance use diagnosis is the focus of the needed mental health treatment.
• Treatment is not directed primarily to resolve placement issues related to abuse, neglect or caregiver incapacity OR behavior, conduct or substance use problems.
• Treatment is likely to alleviate symptoms and/or improve functioning
• Cannot be adequately served by other community resources (i.e. primary care clinics, substance abuse treatment programs, other community resources).

Initial Authorization Requests
No clinical review for pre-authorization for outpatient services is required for any of the three levels of care. Authorization requests should be entered into PHTech after the initial assessment and treatment plan has been completed. Requests that are entered more than 60 days after the initial appointment will not be backdated beyond the 60-day period (i.e. the WCHHS Care Coordinator will backdate an authorization up to 60 days prior to the date the request is entered into PHTech.) Each level of care has a separate authorization period and maximum payment amount. No additional dollars will be added to the authorization during the authorization period.

General Fund authorization requests require an Authorization Request form and Income Verification form, which are sent to the county for review and verification of General Fund eligibility. The Authorization Request form must be fully completed—authorization request forms that are not complete may be returned to the provider and not processed. If a General Fund eligibility record exists in the PHTech database, the provider should enter all authorization requests at the time documentation is sent to WCHHS. If there is not an existing eligibility record for the client in PHTech, one will be created and the authorization entered by PHTech. The provider will receive notification by email of the GF ID and authorization.

Re-authorization
When the expiration date of the current authorization is approaching and the client continues to meet medical necessity criteria for treatment, the provider will enter another Lead Agency request into the authorization database.

For General Fund, the provider must submit the following documentation to a WCHHS Care Coordinator:

• Completed Authorization Request Form
• Income Verification Form
• Evidence that the child has applied for Healthy Kids but has been found ineligible

A WCHHS Care Coordinator will review this documentation to ensure that the individual continues to meet General Fund eligibility. After the review, WCHHS will change the authorization in the system to either “Approved” or “Denied” and notify the provider by email.
ADULT OUTPATIENT AND ADULT BRIEF STABILIZATION SERVICES

Adult Outpatient Service Definition
Adults in outpatient services frequently present with episodic conditions that are mild to moderate in severity and often responsive to traditional therapeutic approaches. Examples of frequently presenting diagnoses include dysthymic disorders, anxiety disorders, depression and trauma related disorders. Clients are generally able to learn and utilize skills to decrease symptoms. Treatment is expected to be brief or episodic and goal oriented; though clients may continue to receive medication management or other support on an ongoing basis. Clients may return to treatment as symptoms/stressors warrant.

Services provided to individuals in Adult Outpatient include:
• Evaluation and consultation
• Individual, family and group therapy
• Medication management
• Case management
• Other services as clinically indicated

Eligibility Criteria:
The adult must:
• have a mental disorder covered by the Oregon Health Plan
• have no other form of insurance/coverage (including Medicare/VA)
• be a legal resident of Washington County and either
  1) be likely eligible for Medicaid in 2014 through The Affordable Care Act (legal resident of Oregon and income <133% of FPL)
  —OR—
  2) have recently had contact with the crisis or acute care system and have an income under 250% of the FPL, including undocumented individuals. Contact must be evidenced by at least one of the following:

a. Client was admitted to an inpatient psychiatric unit for mental health concerns (not primarily substance induced or detoxification) within the past two months.

b. Client has contacted the Washington County Crisis line in acute distress and has identified clear safety risk factors to the point that the Crisis Line has dispatched either the Crisis Team or the Washington County MHRT or directed the client to an ED for safety.
c. Client has been seen in the community by the Washington County Crisis Team for immediate intervention of a crisis episode.

d. Client has been seen by the Washington County MHRT for a mental health crisis intervention.

e. Client has presented in acute distress to an ED for a mental health concern (not primarily substance induced or detoxification) at least twice in the past two months.

**Clinical Criteria:**

EITHER (all of the following):

A. There is only mild to moderate functional impairment in the following areas:
   - Activities of daily living
   - Occupational/educational functioning
   - Community negotiation
   - Social relations

B. A short-term, goal-focused or skill-building therapeutic intervention can be expected to be reasonably effective in alleviating symptoms and/or improving functioning.

C. There is no other equally effective, more conservative, or less costly course of treatment available or suitable for the person requesting service.

OR (one of the following):

- Adults for whom a mental disorder cannot be ruled out (assessment only)
- The adult has a severe persistent mental health disorder for which maintenance treatment is required to maintain optimal symptom relief and/or functioning.
- Referral by a Primary Care Provider for medication evaluation and consultation only.

**Adult Brief Stabilization Service Description:**

Adults typically present with episodic conditions that are mild to moderate in severity and often responsive to traditional therapeutic approaches. Examples of frequently-presenting diagnoses include dysthyemic disorders, anxiety disorders, depression and trauma related conditions. Clients are generally able to learn and utilize skills to decrease symptoms.

Services will be brief (1-4 sessions) for a short-term intervention with longer-term needs being addressed through referral to other community resources. Generally
services will consist of a brief solution-focused therapeutic intervention to assist the client in managing their current symptoms/stressor with an emphasis on linking the client to other community resources for low or no-cost counseling, medication management, and other community supports when indicated.

Medication management will not be an offered benefit; however a single psychiatric assessment and subsequent consultation when requested by a primary care physician who is providing medication management services may be provided.

**Eligibility Criteria:**
The adult must
- have no other form of insurance/coverage (including Medicare and VA)
- be a resident of Washington County
- be low-income (between 134% and 250% of FPL unless undocumented. If undocumented, income must be between 0 and 250% of FPL).

**Clinical Criteria:**
The adult must have a mental disorder covered by the Oregon Health Plan, the adult meets current General Fund criteria for services per Washington County policy, and:

EITHER (all of the following):

A. There is only mild to moderate functional impairment in the following areas:
   - Activities of daily living
   - Occupational/educational functioning
   - Community negotiation
   - Social relations

B. A short-term, goal-focused or skill-building therapeutic intervention can be expected to be reasonably effective in alleviating symptoms and/or improving functioning.

C. Client does not meet the clinical criteria for Rehabilitation Services

OR:
- Referral by a Primary Care Provider for medication evaluation and consultation only.

**Initial Authorization Requests**
No clinical review for pre-authorization is required for adult outpatient services. Authorization requests should be entered into PHTech after the initial assessment and treatment plan has been completed. Requests that are entered more than 60 days after the initial appointment will not be backdated beyond a
60-day period (i.e. the WCHHS Care Coordinator will backdate an authorization up to 60 days from the date the request was received.)

A provisional authorization of three months will be entered for all new clients and existing clients whose authorizations ended between 12/21/13 and 3/1/14. During this provisional authorization period, providers are expected to actively assist clients in enrolling in Cover Oregon for either OHP or private insurance.

The authorization period will be for three months. No additional dollars will be added to the authorization during the authorization period.

The clinical and income criteria for General Fund Adult Outpatient may change depending on the availability of funding and prioritization of services. Providers must insure clients meet GF eligibility criteria as well as clinical criteria prior to service delivery. An authorization request form and income verification form are required to be submitted to the WCHHS Adult Services Care Coordinator prior to each authorization approval.

**Re-authorization**

When the expiration date of the existing authorization is approaching and the client continues to meet medical necessity criteria for treatment, the provider will enter another Lead Agency request into the authorization database.

For General Fund, at the time that the provisional authorization is approaching expiration, the provider must submit the following documentation to a WCHHS Care Coordinator:

- Completed Authorization Request Form
- Income Verification Form (General Fund only)
- Evidence that the adult has applied for Cover Oregon but has been found ineligible

A WCHHS Care Coordinator will review this documentation to ensure that the individual continues to meet General Fund eligibility. After the review, WCHHS will change the authorization in the system to either “Approved” or “Denied” and notify the provider by email. If it becomes evident that the Cover Oregon system is experiencing delays that are impacting eligibility determination, the Care Coordinator may extend the length of the existing provisional authorization or authorize another provisional authorization depending on the expected length of delay.

**ADULT REHABILITATION SERVICES**

**Service Definition:**

Clients for whom rehabilitation services are appropriate present with disorders that are severe and chronic in nature and may require either ongoing or repeated
engagement in services to manage symptoms and psychosocial stressors. Clients in this category may present with psychotic, major affective disorders or significant cognitive deterioration and are generally considered disabled to the extent that their functioning is limited in areas such as employment, interpersonal relationships, community negotiation and activities of daily living. The impacts on functioning are not primarily caused by substance intoxication, abuse or dependence. Contacts are often in the community rather than in a clinic setting.

Services to be Provided:

- Evaluation and consultation
- Flexible case management services that vary in intensity depending on level of need
- Medication management
- Care coordination; access to other services or entitlements
- Wrap-around services which may include in-home flexible respite, peer supports and crisis response
- Therapeutic contacts may include support, skills training, group therapy, and individual therapy
- Outreach
- Other services as clinically indicated

Services are provided at the level of care based on the mental health assessment from the provider. There are four Levels of Care for Adult Rehabilitation: Level I, Level II, and Level III (most intensive). Criteria and service expectations for Levels I, II and III are described in detail in Attachment B: Washington County Levels of Care for Severely and Persistently Mentally Ill. Criteria for each level include a Level of Care Utilization System (LOCUS) score.

Clinical Criteria:

Individuals who are 18 years of age or older who meet both of the criteria below:

A. Diagnosed with a severe mental disorder defined in the most current edition of the Diagnostic and Statistical Manual of Mental Health Disorders (DSM), and are included on the Oregon Health Plan (OHP) “Prioritized List of Mental Health Conditions”. Severe mental disorders include schizophrenia, major affective and paranoid disorders, and other disorders that manifest persistent psychotic symptoms other than those caused solely by substance abuse.

B. Impacted by the mental health disorder to an extent which limits consistent functioning in at least two the following areas:
- **Home environment:** Cannot independently attend to shelter needs, personal hygiene, nutritional needs, and home maintenance.
- **Community negotiation:** Cannot independently and appropriately utilize community resources for shopping, recreation and other needs.
- **Social relations:** Cannot establish and maintain supportive relationships.
- **Productivity:** Cannot maintain employment sufficient to meet personal living expenses or engage in other appropriate activities.

**Initial Authorization Requests**

Preauthorization with a clinical review by a WCHHS Care Coordinator is required for all initial requests for adult rehabilitation services. Subsequent continued stay requests do not require a clinical review. Provider must fax the initial mental health assessment, treatment plan, Authorization Request form, and Income Verification form to WCHHS for review by a care coordinator to establish rehabilitation eligibility. The Authorization Request form must be fully completed—authorization request forms that are not complete may be returned to the provider and not processed. If a General Fund eligibility record exists in the PHTech database, the provider should enter an authorization request at the time documentation is sent to WCHHS. If there is not an existing eligibility record for the client in PHTech, one will be created and the authorization entered by PHTech. The provider will receive notification by email of the GF ID and service authorization.

The initial authorization will be a provisional 3 month authorization allowing the provider to assist the client in enrolling in benefits through Cover Oregon.

Requests that are submitted more than 60 days after the initial appointment will not be backdated beyond the 60-day period (i.e. the WCHHS Care Coordinator will backdate an authorization up to 60 days from the date the request is received.) The authorization period will be for one year. Each level of care has a separate maximum payment amount. No additional dollars will be added to the authorization for Level I, or Level II during the authorization period. Authorization for payment exceeding payment caps will be made only for Adult Rehabilitation Level III ICS, in the case of exceptional need, and when preauthorized by a Washington County Care Coordinator.

For all authorization requests, if the level of care requested is different from that determined by the LOCUS score, the provider will submit written clinical reasoning and justification for the discrepancy. In cases where there is a discrepancy and no documentation has been submitted to justify the discrepancy, the authorization status will be changed to “Additional Information..."
Revised 3-20-14

Requested” and the provider will be notified by email. The provider must send written documentation justifying the level of care selected. The WCHHS Care Coordinator will review these documents and approve an authorization for Level I, Level II or Level III--ICS. Notification will be sent to the provider via email through WCHHS Third Party Administrator.

Re-authorization

No clinical review is required for additional annual authorizations for treatment. When the expiration date of the current authorization is approaching, the provider will verify that the client continues to meet criteria for rehabilitation services and when indicated will enter another annual authorization request into the PHTech database.

For General Fund, the provider must submit the following documentation to a WCHHS Care Coordinator:

- Completed Authorization Request Form
- Income Verification Form
- For individuals who continue to be uninsured, evidence that the individual has applied for Cover Oregon and been found ineligible or are able to demonstrate that they would not qualify for benefits through Cover Oregon.

A WCHHS Care Coordinator will review this documentation to ensure that the individual continues to meet General Fund eligibility. After the review, WCHHS will changed the authorization in the system to either “Approved” or “Denied” and notify the provider by email.

If the level of care requested is different from that determined by the LOCUS score, the provider will submit written clinical reasoning and justification for the discrepancy. Authorizations that have been auto-approved will be reviewed to see if the LOCUS and the level of care are in agreement. In cases where there is a discrepancy and no documentation has been submitted to justify the discrepancy, the authorization status will be changed to “Additional Information Requested” and the provider will be notified by email. The provider must send written documentation justifying the level of care selected. The WCHHS Care Coordinator will review these documents and approve an authorization for MRDD Rehab, Level I, Level II or Level III--ICS. Notification will be sent to the provider via email through WCHHS Third Party Administrator.

Transitional Aged Programs for Youth

EARLY ASSESSMENT AND SUPPORT ALLIANCE (EASA)

Client Description:
EASA is an early psychosis intervention program for clients between the ages of 15-24 who are experiencing early symptoms of psychosis. Client eligibility for the EASA is based solely on age and clinical presentation. Insurance status is not a factor in determining whether a client can be served. Not all clients presenting with symptoms of psychosis may be appropriate and an accurate differential diagnosis will be necessary to ensure that clients will benefit from the program. Clients with diagnoses of schizophrenia, bipolar disorder with psychosis and other primary psychotic disorders are considered most likely to benefit from the program, while clients presenting with psychosis secondary to a medical condition or substance abuse may likely benefit from a referral to a more appropriate treatment setting.

All clients referred to the program are eligible for screening, which is concurrent with the engagement process and may include a full assessment and diagnosis. Those who are not found appropriate for the EASA will be successfully linked by program staff to an appropriate resource.

Service Description:
The EASA program is an intensive case management model of engagement, outreach and community education that combines the following evidence based and best practices: Assertive Community Treatment, Multi-family Psycho-education, Wellness Management and Recovery, Cognitive Behavioral Therapy, focused clinical case management, Supported Employment and Education, Low Dose Prescribing Protocols and integrated attention to substance use. Program staff shall be trained in the above practices as well as in early episode differential diagnosis.

All youth and young adults referred to the program shall be engaged in a strengths-based, relationship oriented approach. Engagement, assessment and differential diagnosis happen concurrently and clients are not officially enrolled into treatment services until there is mutual agreement on treatment. Clients will have an average length of stay in this program of two years, which shall be explained at the initiation of services to youth and their families. The anticipated outcome is a transition to services of lesser intensity with continued engagement in treatment. All program compliance, including medication, is voluntary. Clients will not be terminated due to noncompliance or missed appointments, rather program staff will continue to do outreach to those youth and attempt to re-engage them in treatment while maintaining contact with the family as well.

Engaged family members are considered essential partners on the treatment team and critical to the client’s success. In all cases, continuing efforts will be made over time to obtain a signed release of information for family members. During this process program staff shall have frequent and consistent contact with family members to offer support and education. Family members will often make the first phone call and should be engaged as partners from the initial contact
and be provided support and consultation prior to the client enrolling in treatment services.

All families will be encouraged to participate in multi-family psycho-education groups and when necessary this group shall be offered in Spanish and in locations convenient for the target group of families.

Clients in this service will sometimes require hospitalization or detention and program staff will continue to make frequent contact with clients at these facilities to offer continued support and ensure a smooth transition back into the community.

TRANSITION AGE YOUTH INTENSIVE SERVICES PROGRAM (TAYIS)

Client Description:
The target population will be youth and young adults, ages 16-24, who have a significant mental illness that is impacting their ability to successfully function in the community and achieve normal developmental milestones. These are youth/young adults who would benefit from a developmentally appropriate, individualized treatment approach that focuses on teaching the skills necessary to achieve independent living, vocational and other goals.

Clients will often be referred from the Intensive Service Array and have a history of system involvement and institutional care. Clients may also be identified by other community providers, acute and subacute care facilities.

Service Description:
The program is community-based, and utilizes a strengths-based case management approach. Staff will also be trained in Dialectical Behavior Therapy and Motivational Interviewing and provide individually tailored services that are youth/young adult and family driven. The program includes specialists in Supported Housing and Supported Employment/Education, who will facilitate clients securing and maintaining stable housing and employment or education. The program also includes access to an LMP for psychiatric services.

Services may include evaluation, consultation, assessment, interpreter services, clinical service coordination, case management, crisis intervention, skills training, medication evaluation and management, individual, family and group therapy. The TAYIS program will adopt a treatment approach that encourages client responsibility, builds upon client strengths, encourages the development and use of natural supports and is focused on decreasing client dependence on the mental health system. Goals will focus on long-term gains in functioning in multiple areas of a client’s life.
Length of stay in the program will vary based on individual need, however the maximum for youth admitted under age 18 is three years, and for youth admitted at age 18 or older it is two years.

**Admission Criteria:**

- Client must be a resident of Washington County and between ages 16 and 24
- Client must have either WCHHS OHP, Open Card OHP or qualify for Washington County General Fund services at 250% or below of the FPL.
- Client must have a CASII or LOCUS score of 17 or above at the time of admission
- Client must present with a mental health condition that contributes to a significant impairment in their ability to function independently in the community
- The mental health condition must be EITHER:
  - A Severe and Persistent Mental Illness (SPMI) in that the disorder is severe and chronic in nature and may require either ongoing or repeated engagement in services to manage symptoms and psychosocial stressors Clients in this category may present with psychotic, major affective disorders or significant cognitive deterioration and are generally considered disabled to the extent that their functioning is limited.
  - OR
  - An above-the-line diagnosis that has contributed to multiple system involvement and significant periods of inpatient or residential care.
- If the client meets criteria for SPMI, symptoms are severe enough to significantly impact their ability to function in the community. For example, the client demonstrates serious impairment in their ability to obtain and maintain housing, meet basic needs such as obtaining food and/or develop independent living skills.
- For other conditions that do not meet SPMI criteria, the individual must have a significant history of institutionalization (multiple admissions to inpatient or subacute, or continuous placement in psychiatric residential and/or correctional institutions totaling 2 or more years of institutional care
within the 5 year period immediately prior to referral) or a significant trauma history leading to impairment of independent living skill acquisition.

- There is evidence of significant interruption in obtaining developmental milestones, including educational attainment, due to the mental health condition.

All initial requests for admission to the TAYIS program must submitted to WCHHS for clinical review and pre-authorization. Subsequent annual authorizations will not require a clinical review.

**AUTHORIZATION:**

**Initial Authorization Requests:**
Preauthorization with a clinical review by a WCHHS Care Coordinator is required for all initial requests for TAYIS or EASA clients. A three month provisional authorization will initially be made available to the provider to assist in enrolling the client in Cover Oregon to obtain either private insurance or Oregon Health Plan.

Subsequent continued stay requests do not require a clinical review. Authorization should be submitted in PHTech after the initial assessment and treatment plan has been completed. Provider must fax the initial mental health assessment and treatment plan to WCHHS for review by a care coordinator to establish eligibility. Requests that are submitted more than 60 days after the initial appointment will not be backdated beyond the 60-day period (i.e. the WCHHS Care Coordinator will backdate an authorization up to 60 days from the date the request is received.) The ongoing authorization period will be for one year for TAYIS and two years for EASA. Authorization for payment exceeding payment caps will be made only in the case of exceptional need, and when preauthorized by a Washington County Care Coordinator.

In addition to clinical documentation, TAYIS General Fund authorization requests require an Authorization Request form and Income Verification form, which are sent to the county for review and verification of General Fund eligibility. The Authorization Request form must be fully completed. Authorization request forms that are not complete may be returned to the provider and not processed. If a General Fund eligibility record exists in the PHTech database, the provider should enter an authorization request at the time documentation is sent to WCHHS. If there is not an existing eligibility record for the client in PHTech, one will be created and the authorization entered by PHTech. The provider will receive notification by email of the GF ID and service authorization.
Re-authorization
No clinical review is required for additional annual authorizations for treatment. When the expiration date of the current authorization is approaching, the provider will verify that the client continues to meet criteria for the service and when indicated will enter another annual authorization request into the PHTech database.

For TAYIS General Fund, the provider must submit the following documentation to a WCHHS Care Coordinator:

- Completed Authorization Request Form
- Income Verification Form

A WCHHS Care Coordinator will review this documentation to ensure that the individual continues to meet General Fund eligibility. After the review, WCHHS will changed the authorization in the system to either “Approved” or “Denied” and notify the provider by email.

For EASA General Fund, the provider must enter the auth request into PHTech and notify the appropriate care coordinator for review and approval.
## Attachment A

**Washington County Outpatient Levels of Care for Children and Families**

Note: This portion of the document borrows liberally from CASII documentation. Acknowledgment to the authors of these documents.

<table>
<thead>
<tr>
<th>Levels of Care</th>
<th>Brief Treatment/Recovery Maint.</th>
<th>Outpatient Services</th>
<th>Intensive Outpatient Services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Admission Criteria</strong></td>
<td><strong>Must meet all the following:</strong></td>
<td><strong>Must meet all of the following:</strong></td>
<td><strong>Must meet all of the following:</strong></td>
</tr>
<tr>
<td></td>
<td>• Functional impairment in one or more areas within the last year</td>
<td>• Current significant functional impairment in at least one important area (home, school, peer relationships) due to symptoms of a mental health disorder OR recent suicidal/self-harm ideation or behavior</td>
<td>• Significant risk of harm to self or others, OR risk of placement out of the home due to symptoms of mental health disorder</td>
</tr>
<tr>
<td></td>
<td>• Natural supports, educational programs, other available social services, community resources, or primary care management are insufficient to maintain functioning</td>
<td>• Treatment intensity at lower level of care is insufficient to maintain functioning</td>
<td>• Treatment intensity at lower level of care is insufficient to maintain functioning</td>
</tr>
<tr>
<td></td>
<td>• Child or adolescent has successfully completed treatment at a more intensive level of care and needs assistance in maintaining gains, OR does not need more intensive or restrictive services than those offered at this level</td>
<td>• Child or adolescent has successfully completed treatment at a more intensive level of care and needs assistance in maintaining gains OR does not need more intensive or restrictive services than are offered at this level</td>
<td>• Child or adolescent has successfully completed treatment at a higher level of care and needs assistance in maintaining gains OR does not need more intensive or restrictive services than are offered at this level</td>
</tr>
<tr>
<td></td>
<td>• Composite CASII score: 10-13</td>
<td></td>
<td>• Composite CASII score: 14-16</td>
</tr>
</tbody>
</table>

<p>| <strong>Service Description</strong> | This level of service is intended for those stepping down from higher levels of care who need minimal system involvement to maintain their current level of function OR need brief intervention to return to a previous level of functioning. | This level of care most closely resembles traditional office based practice and requires limited use of community-based services. | It is at this level that services begin to become more complex and more coordinated. The use of <strong>case management</strong> is required at this level. |
| | Examples include children or adolescents who need ongoing medication services for a chronic condition OR brief crisis counseling to resolve mild or transient situations or conditions. | Services are goal directed, strengths-based, and typically <strong>brief or episodic</strong>. | The use of child and family teams to develop Individualized Service Plans also begins, using mostly informal community supports such as church or self-help groups and “Big Brothers/Big Sisters.” |
| | Primarily office-based and/or medication management services, with problem solving and support provided as needed. | Services include assessment; individual, group or family therapy; consultation; interpreter services; medication evaluation and management; and family education and support. | This level requires more frequent contact between providers of care and the youth and his family as the severity of disturbance increases. |
| | Services mobilize family strengths and reinforce linkages to natural supports. | Treatment reflects use of identified evidence-based practices for specific conditions. | Treatment reflects use of identified evidence-based practices for specific conditions. |
| | | Service type considerations should include the age, size, and manageability of the child or adolescent, and the family and community resources available | |</p>
<table>
<thead>
<tr>
<th>Levels of Care</th>
<th>Brief Treatment/Recovery Maint.</th>
<th>Outpatient Services</th>
<th>Intensive Outpatient Services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Focus/Activities</strong></td>
<td>Assessment and Plans of Care consider the extent to which families can mobilize natural supports in the community. Time-limited professional interventions, as well as ongoing case management and follow-up medication services may be provided. Support services consist mainly of natural supports in the community, including extended family, family friends and neighbors, church and recreational programs, 12-step and other self-help programs, school-sponsored programs, and employment.</td>
<td>Treatment consists primarily of individual, group, and family therapies with active family participation in treatment planning and implementation. Medication, evaluation and management may be an essential element. Child and adolescent psychiatrists and psychosocial nurses are part of the primary treatment team for medication services and 24-hour backup. Selected adjunct interventions (e.g., occupational, recreational, vocational, and/or expressive therapies) are made available as indicated. Support provided largely through natural supports within the community, including extended family, friends, and neighbors; church and recreational programs; 12 step and other self-help groups; school sponsored programs; and employment.</td>
<td>Case management is a core service provided at this level of care. Services incorporate individual, group, and family therapy. Services begin to incorporate the use of child and family teams as service coordination becomes more complex. Child and adolescent psychiatrists and psychiatric nurse practitioners are part of the treatment team providing regular consultation, medication services, and 24-hour backup. Selected adjunct interventions (e.g., occupational, recreational, vocational, and/or expressive therapies) may be used as indicated. Referrals for clinical services for other family members may be needed. Transition planning for discharge to a lower level of care is a part of the service plan. Services are provided at times that meet the needs of the family, including non-traditional periods (e.g., evenings and weekends). Services emphasize natural and culturally congruent supports within the community, such as extended family, neighborhood, church groups, self-help groups and community employers. Families may have difficulty accessing supports without assistance due to the complexity of their child or adolescent’s problems. Families may need support for financial, housing, child-care, vocational, or education services.</td>
</tr>
<tr>
<td><strong>Care Environment</strong></td>
<td>Typically provided in a traditional mental health setting (e.g., office or clinic), or in facilities of other components in the system of care.</td>
<td>Services may be provided in a traditional mental health setting (e.g., office or clinic), in facilities of other components of the service system, or in other community settings.</td>
<td>Services may be provided in a mental health clinic or clinician’s office, but often are provided in other components of the system of care with mental health consultation. The service site should have the capacity for short-term management of aggressive or other endangering behavior.</td>
</tr>
<tr>
<td>Levels of Care</td>
<td>Brief Treatment/Recovery Maint.</td>
<td>Outpatient Services</td>
<td>Intensive Outpatient Services</td>
</tr>
<tr>
<td>---------------</td>
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</tr>
<tr>
<td><strong>Contact Guidelines</strong> (Note: These service amounts have been developed without reference to the availability of funds)</td>
<td>Monthly to quarterly contact.</td>
<td>Treatment intensity ranges from one contact every other week, to two contacts/visits per week</td>
<td>Treatment intensity ranges from 3 contacts to several contacts per week. Service intensity averages approximately three days per week.</td>
</tr>
<tr>
<td><strong>Authorization Period</strong></td>
<td>1 year</td>
<td>6 months</td>
<td>3 months</td>
</tr>
</tbody>
</table>
### Washington County Levels of Care for Severely and Persistently Mentally Ill Adults

Note: This document borrows liberally from the National Association of Case Management Practice Guidelines; “Oregon Adult MH Case Management Evidence Based Practice Conceptualization” Discussion Draft (2/24/04), OMHAS; and LOCUS Level of Care Utilization System for Psychiatric and Addiction Services, American Association of Community Psychiatrists. Acknowledgment to the authors of these documents.

<table>
<thead>
<tr>
<th></th>
<th>Rehab Level I</th>
<th>Rehab Level II</th>
<th>Rehab Level III (ICS)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Definition</strong></td>
<td>Least intensive level of care provided to consumers who are least at risk and are largely able to self-manage their illness. Services may consist of primarily office-based, medication management services and/or ongoing maintenance services for relapse prevention. Focus is on problem solving and supportive services as needed. May include consumer-run support groups or aftercare groups.</td>
<td>Goal directed, strengths-based case management and rehabilitative services that are recovery and outcome oriented. Services include comprehensive assessment and treatment planning where goals and specific interventions to achieve them, and methods to address outcome are specified; linkage with other services and supports as needed and coordination of care among them; advocacy in obtaining entitlements and access to services. Services include assessment, outreach, consultation, case management, money management, interpreter services, medication evaluation and management, daily structure and support, skills training, family education and support, crisis respite, coexisting disorders treatment, consumer advocacy, relapse prevention, hospital diversion, crisis intervention and supported housing.</td>
<td>Most intensive level of care providing frequent and comprehensive support to the most severely disabled adults 24 hours per day, 7 days a week, chiefly in natural community settings. Staff directly provides case management, psychiatric services, counseling, housing support, substance abuse treatment, employment, and rehabilitative services. Treatment is proactive, intensive and sustained, utilizing assertive engagement techniques aimed at ensuring that consumers maintain contact with services, reduce the extent of admissions and seek improvement with social functioning and quality of life. Program has policies for no refusal or case closure due to treatment failure or non-compliance. Services are provided by a team for 24-hour coverage and mutual support. Team meets frequently to plan and review services for each client.</td>
</tr>
<tr>
<td>Admission Criteria (Consumer should generally meet most criteria to be placed at that level of care)</td>
<td>Rehab Level I</td>
<td>Rehab Level II</td>
<td>Rehab Level III (ICS)</td>
</tr>
<tr>
<td>---</td>
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</tr>
<tr>
<td>• Extended period with no hospitalizations or major crisis episodes.</td>
<td>• Consumers with severe mental illness with some recent (1-2 years) of hospitalization history</td>
<td>Severely mentally ill with one or more of the following indicators:</td>
<td></td>
</tr>
<tr>
<td>• Moderate to mild dysfunction but largely able to self-manage disability and medications</td>
<td>• Consumer’s symptoms significantly impact daily functioning and may be only partially controlled.</td>
<td>• High use of acute hospitalization (e.g., 2 or more admissions per year) or psychiatric emergency services</td>
<td></td>
</tr>
<tr>
<td>• Client is generally at baseline and functioning level is fairly good given the individual’s presentation.</td>
<td>• Consumer may have had a recent crisis episode however was able to stabilize with increased support.</td>
<td>• Recent extended hospitalization or crisis episode</td>
<td></td>
</tr>
<tr>
<td>• Low psychosocial stress, housing and benefits are generally stable.</td>
<td>• May have multiple system involvement (i.e. probation, significant medical condition impacting mental health condition, PSRB, etc.) that require some coordination by a CM.</td>
<td>• Severe deficits in skills needed for community living as well as a high degree of impairment due to symptoms of illness</td>
<td></td>
</tr>
<tr>
<td>• Client is able to navigate system with minimal support.</td>
<td>• Consumer has skill and resource deficits that impair their ability to achieve personal goals.</td>
<td>• Intractable, (i.e., persistent or very recurrent) severe major symptoms (e.g., affective, psychotic, suicidal)</td>
<td></td>
</tr>
<tr>
<td>• Client has extended period of abstinence if a co-occurring disorder exists.</td>
<td>• Consumer requires assistance in navigating the community to meet basic needs of housing, food, benefits, etc.</td>
<td>• High risk or a recent history of criminal justice involvement</td>
<td></td>
</tr>
<tr>
<td>• Client may have multiple system involvement however little coordination is required.</td>
<td>• Consumer may currently be experiencing significant psychosocial stress such as homelessness, no income, etc.</td>
<td>• Inability to meet basic survival needs or residing in substandard housing, homeless, or at imminent risk of becoming homeless</td>
<td></td>
</tr>
<tr>
<td>LOCUS Score</td>
<td>10 to 16 3 or less on Stress, Support and Engagement scales and 2 or less on all other scales</td>
<td>17 to 19 generally 2 to 3 on all scales</td>
<td>20+ generally 3 to 4 on all scales</td>
</tr>
<tr>
<td>Caseload/Mode</td>
<td>40-60 persons per case manager</td>
<td>25-30 persons per case manager</td>
<td>No more than 15 persons per case manager. Caseload may be assigned to individual case managers or team as a whole</td>
</tr>
<tr>
<td>Associated Evidence Based Practices</td>
<td>Rehab Level I</td>
<td>Rehab Level II</td>
<td>Rehab Level III (ICS)</td>
</tr>
<tr>
<td>-------------------------------------</td>
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</tr>
<tr>
<td>Strengths Based Case Management</td>
<td>WMR</td>
<td>WMR</td>
<td></td>
</tr>
<tr>
<td>Maintenance IDDT groups</td>
<td>DBT</td>
<td>DBT</td>
<td></td>
</tr>
<tr>
<td>Maintenance WMR groups</td>
<td>Supported Employment</td>
<td>Supported Employment</td>
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<tr>
<td>Supported Employment</td>
<td>Supported Housing</td>
<td>Supported Housing</td>
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<tr>
<td>Supported Housing</td>
<td>Strengths-Based Case Management</td>
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<td></td>
</tr>
<tr>
<td></td>
<td>IDDT</td>
<td>IDDT</td>
<td></td>
</tr>
</tbody>
</table>

| Contact Expectations | Monthly to quarterly contact. Minimum of 4 face-to-face and 8 telephone contacts per year | 1-2 contacts per week, may be face to face, group or telephone contacts | Minimum of 4 contacts per week, 2 must be face to face |

| Percentage of total clients | 45% | Not to exceed 40% | Not to exceed 15% |

| Setting | Office-based | Combination of office and community | Community, minimal office-based services |

| Availability | Available for crisis prevention/intervention 40 hours per week with back-up arrangements at other times. | Available for crisis prevention/intervention 40 hours per week with back-up arrangements at other times. | Crisis response available 24/7 |

<p>| Focus/Activities | Focuses on maintaining stability and independence by providing a link to services, an interface with psychiatric and medication services and crisis prevention and intervention. Provides single point of contact to mental health system and its resources, with emphasis on natural community supports, coordination and linking. | Focuses on obtaining recovery outcomes through maximizing strengths and developing, implementing, coordinating and adjusting consumer-centered comprehensive service plan. Provides and coordinates services and resources to meet objectives of plan, including skills training, outreach, consultation, money management, medication evaluation and management, daily structure and support, coexisting disorders treatment, consumer advocacy, family education and support, relapse prevention, hospital diversion, crisis intervention and supported housing. | Utilizing engagement principles, focuses on obtaining basic supports, decreasing symptoms, increasing periods of independence, building support networks and minimizing or eliminating periods of crisis or severe dysfunction. Minimizes illness and focuses on consumer strengths. Consumers are coached in setting their own goals and identifying realistic steps in order to achieve the goals. Emphasis on utilization of natural community supports. Participates in hospital admissions and discharge planning. Work with consumer’s support network including family, landlords, employers, etc. Includes supported housing, supported employment activities, and stage-wise coexisting disorders treatment |</p>
<table>
<thead>
<tr>
<th>Expected Outcomes</th>
<th>Rehab Level I</th>
<th>Rehab Level II</th>
<th>Rehab Level III (ICS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consumer satisfaction with personal life domains and continued stability as measured by no hospitalizations and a continued decrease in frequency and duration of crisis episodes. Increased personal independence in any life domain. Sustained recovery from substance abuse. Consumer satisfaction.</td>
<td>Increased community tenure, decreased crisis episodes, increase in time spent working or in school, increase in social contacts, increase in personal satisfaction and independence. Achievement of independent or semi-independent living arrangements. Reduced impairment from substance abuse. Consumer satisfaction.</td>
<td>Increased community tenure and reductions in the frequency or length of crisis or hospital services. Also, housing stability, decrease in symptoms and side effects, increased social integration, reduced impairment from substance abuse and decrease in level of care needed or desired. Consumer satisfaction.</td>
<td></td>
</tr>
</tbody>
</table>

| Authorization/Continued Stay | | | |
|-----------------------------|----------------|----------------|
| Initial authorization: 1 year and every year thereafter as person chooses to have continued linkage to mental health system. | Initial authorization, reauthorizations: 1 year. Continued stay depends on progress with rehabilitation goals and desire for further recovery progress. | Initial authorization, reauthorization: 1 year. Continued stay based on degree of symptom and crisis reduction and/or positive response to treatment. |

**Movement to Level II:**
Increase in symptoms or decline in functioning accompanied by motivation towards a more goal oriented recovery process.

**Movement to Level III:**
Significant increase in hospitalizations and crisis episodes, initiation or return to substance abuse, significant exacerbation of symptoms lasting more than 60 days.

**Termination of Services:**
Consumer choice, significant degree of independence and self-management, strong positive family or significant other involvement.

**Movement to Level I:**
Consumer can largely self-manage illness. No hospitalizations for 18 months, no crisis episodes for 6-12 months, or consumer chooses a less intensive level of services

**Movement to Level III:**
Increase in symptoms, increase in hospitalizations or crisis episodes, major life event or trauma requiring prolonged increased support.

**Indications for movement to a less intensive level of service are:**
Sustained increased level of functioning; increased independence.

Decrease in symptoms, crisis episodes, and hospitalizations, or increased satisfaction with life domains accompanied by decrease in crises and symptoms.
**Washington County Health and Human Services (WCHHS)**  
**Mental Health Program**  
**Policy and Procedure**

**Policy Title:** Utilization Management: Psychiatric Residential Treatment Services (PRTS)

**Approved:** __________________________     _______________
Division Manager   Date

**OBJECTIVE:**

To provide timely access to medically necessary Psychiatric Residential Treatment Services (PRTS) for eligible Washington County residents, with the goal of transition to a less restrictive setting as soon as clinically appropriate.

To ensure that mental health services are client and family driven, provided in the least restrictive setting, and integrated into the child’s long term service coordination plan.

**POLICY:**

WCHHS promotes family-driven treatment planning, such that decisions about referring clients to PRTS are made by a child and family team facilitated by a WCHHS Care Coordinator.

PRTS shall be written into the child’s Individualized Services and Support Plan (ISSP), including the reason(s) for admission. Specific discharge criteria from the PRTS level of care are also clearly identified in the Service Coordination Plan.

Utilization Review is ongoing and completed by the Washington County Care Coordinator. Utilization Review will be completed during and/or prior to Child and Family Team meetings that will be held every two weeks at minimum while a child is in PRTS. Length of stay in PRTS is variable, based on the individual child and family needs.

“Assessment and Evaluation” (A&E) beds are not used by WCHHS for Oregon Health Plan members. Additional assessments or testing needed in a PRTS setting shall be pre-authorized on a fee-for-service basis by the WCHHS Care Coordinator.
SERVICE DESCRIPTION:

Psychiatric Residential Treatment services are 24 hour, seven days per week structured treatment services designed to improve an eligible child’s functioning and to achieve the child’s reintegration back to the community at the earliest appropriate time.

PROCEDURE:

Admission Criteria

- The client is eligible for the Intensive Service Array, in accordance with WCHHS Intensive Service Array (ISA) policy (Please refer to the Utilization Management for the Intensive Service Array Policy);
- The client must have OHP and be a member of Health Share of Oregon and assigned to Washington County;
- The Child and Family Team agree on this intervention as the most appropriate;
- The need for PRTS is driven by a covered DSM IV diagnosis;
- Serious emotional disturbance or mental health condition that requires active psychiatric treatment 24 hours/7 days a week for safety and stabilization or medication changes that can only occur at this level of care.
- Primary presenting problem that is considered responsive to PRTS and is: active psychosis, risk of harm to self or others, or mental health condition at a level of acuity or severity that it is impacting all areas of life and functioning;
- Treatment resources in the community are inadequate to meet the child’s treatment needs;
- Mental health diagnosis covered by the Oregon Health Plan Prioritized List of Health Services and paired with PRTS that would be the focus of treatment;
- Admission is not solely for purposes of placement or at the convenience of the family, the provider or other child serving agencies;
- CASII or ECSII Level of Service Intensity Determination outcome of Level 5 or higher;
- Certificate of Need (CONS) completed prior to admission which certifies the need for this level of care.

Preferred but not required: a written recommendation from the treating psychiatrist indicating: 1) the need and/or reason for a residential level of care; 2) why a less acute level of care would not be sufficient to address the psychiatric need; 3) the benefit to the child and family from this recommended treatment episode.

Primary diagnoses not “paired” with PRTS on the Oregon Health Plan Prioritized List of Health Services and generally not considered for authorization:
- Attention Deficit Hyperactivity Disorder
- Adjustment Disorder
Substance Abuse
• Developmental Disability

In addition, the following are contraindicated for admission to PRTS:

• Diagnoses not found responsive to or best practice to treat in PRTS:
  o Reactive Attachment Disorder
  o Oppositional Defiant Disorder
  o Conduct Disorder

• Behaviors, independent of a covered mental health diagnosis or related to RAD or ODD, not found to be responsive to PRTS:
  o Bullying
  o Physical aggression
  o Sexual offending
  o Property destruction
  o Fire setting
  o Truancy
  o Running away
  o Pattern of defiant behavior

WCHHS Care Coordinator will fax clinical information, CASII or ECSII, CONS or Letter of Approval, and ISA Plan of Care to the PRTS facility.

**Continued Stay Criteria**

Continued stay is authorized by the assigned County Care Coordinator and is reviewed at a minimum of every 30 days. Utilization Review is done in the context of a treatment review with the family/guardian with a WCHHS Care Coordinator present and/ or within a Child and Family Team meeting.

Continued stay is reviewed and approved by the WCHHS Psychiatric Consultant after the initial 90 days and at intervals agreed upon between the Psychiatric Consultant and WCHHS Care Coordinator thereafter, and documented in a progress note.

The WCHHS Care Coordinator shall document that a utilization review was completed and continued stay was authorized in a progress note in the client’s file. Changes to the Plan of Care shall be documented on the Plan of Care and updated as needed. Utilization review documentation shall include:

• The PRTS provider has measurable indicators of whether the client’s mental health symptoms that led to the admission, or as identified post-admission, are responding to the treatment plan. This may be reflected in a change in CASII or ECSII score (within a domain or overall)
Revised 1-29-14

- Documentation is obtained from the PRTS provider of ongoing discharge planning related to the discharge criteria in the Plan of Care.
- The client’s record documents any attempts at re-entry into the community (e.g. overnight or day passes) that have resulted in exacerbation or re-emergence of symptoms of the mental illness and cannot be mitigated with community supports.
- The treatment plan documents that treatment goals cannot be achieved in a less restrictive setting.
- Continued stay is not due to the convenience of family or other entities and is not solely for placement.
- The Child and Family Team determines that the child requires a secure inpatient program such as Secure Children’s Inpatient Program (SCIP) or Secure Adolescent Inpatient Program (SAIP) and the client has been accepted and is on the wait list.

Re-administration of the CASII or ECSII by a WCHHS Care Coordinator will not occur less frequently than every 90 days. The CASII or ECSII should aid in the continued stay decision, specifically in relation to changes in the score within each domain.

**Discharge Criteria**

Discharge criteria will include the following:

- The Child and Family Team determines that the child/adolescent has met treatment goals and is able to function successfully in the home, school and community; **and**
- Child’s mental health needs can be met at a lower level of service; **or**
- The family withdraws the child from services; **or**
- The family chooses not to engage in services; **or**
- Child and Family Team determine that the child and/or family is not fully able to engage in services and recommends discharge.
- When a client's symptoms are not responding to treatment and the recommendation after review with WCHHS psychiatric consultant is a referral to Long Term Care (e.g. Secure Children’s Inpatient Program, Secure Adolescent Inpatient Program or Stabilization and Transition Services), the WCHHS Care Coordinator will initiate a referral to the Addictions and Mental Health Division Child and Adolescent Mental Health Specialist.

The CASII or ECSII is re-administered by a County Care Coordinator and is used in discharge planning by guiding the level of service intensity to be provided post-discharge and during the transition.

Discharge planning is intended to be an ongoing process, driven by the child and family team, and including all community providers and school representatives as
necessary. Discharge planning will be revisited at each Child and Family Team meeting, which will be held at a minimum of every two weeks.
OBJECTIVE:

To ensure clients are assigned to the appropriate level of care and that services provided are matched in type and intensity to the client's individual need.

POLICY:

Provider will manage utilization throughout the authorization period to ensure that the client is assigned to the correct level of care as indicated by medical necessity and that the services provided are consistent with that level of care. In situations where the Provider has reached the maximum dollar amount for the authorization prior to the end of the authorization period, and the client does not qualify for a higher level of care, the Provider is expected to continue to provide medically necessary services.

Utilization management is a primary responsibility of contracted providers. Certain utilization management activities will be conducted by a WCHHS Care Coordinator at times and intervals indicated by the specific service and level of care. Please refer to the Utilization Management policy for each specific service type for more information. Utilization management will also take place when transfers between levels of care are requested.

Washington County Care Coordinators will also monitor utilization and treatment through regular retrospective clinical record review, as well as site visits or attendance at treatment team meetings at their discretion.

PROCEDURE:

Outpatient and Rehabilitation Programs

Washington County will perform a minimum of one retrospective clinical record review per calendar year, per program. A minimum of 8 records or 2.5% of the total authorized clients per program each calendar year, whichever is greater, will
be reviewed. Programs that have less than 40 clients enrolled at the time of the review will have a minimum of 5 clinical files reviewed per year.

Records will be selected in the following manner:
- A minimum of two records that have low billing to cap ratios
- A minimum of two records that have high billing to cap ratios
- A minimum of four randomly selected records

In programs where there are multiple levels of care (i.e. rehab and child outpatient), files will be selected in the following manner:
- A minimum of two records that have low billing to cap ratios from each level of care
- A minimum of two records that have high billing to cap ratios from each level of care
- A minimum of two records where the client’s level of care was changed mid-auth period (unless no level of care changes occurred)
- A minimum of six randomly selected records

For programs that serve both OHP and General Fund clients, care will be taken to ensure that records from both funding sources are reviewed.

Programs other than Outpatient and Rehabilitation will be reviewed at the discretion of the Program Coordinator/ Program Supervisor.

Reviews of all programs will focus on the following areas:
- Clinical match between the client’s clinical needs and the level of care to which the client is assigned
- Coordination of care with PCP and other providers
- The “Golden Thread” where the progress notes reflect implementation of the treatment plan and the treatment plan is directly related to the presenting clinical concern as documented in the mental health assessment.

Each record review will be documented using the attached Utilization Management review form. This form will be completed in the process of the review and kept on file for future reference. Providers will receive a copy of the review and will be provided an opportunity to correct concerns identified in the review, if possible. If there are serious concerns identified, Washington County may require a written improvement plan and/or require that existing authorizations be modified to reflect the clinically appropriate level of care.

If during the initial annual review there are areas of concern identified, a follow up review will be conducted later in the year. These will typically be scheduled six months after the initial review. If there are no areas of concern identified, the program will not have another retrospective review until the following year.
If, during the course of the review, any of the following are found: chronic concerns present for more than 2 reviews, intentional misrepresentation, repeated mis-assignment to a level of care higher than indicated, pattern of missing or late documentation, or suspected incidents of fraud or abuse, consistent with WCHHS policy on Fraud and Abuse, Washington County will take immediate action. A comprehensive site review will be conducted with a representative sample of all Washington County files. This site review may result in a corrective action plan, reimbursement of paid claims, or contract termination.
## Washington County Mental Health
### UM Review
**Updated 8/30/2010**

<table>
<thead>
<tr>
<th>Agency:</th>
<th>Date of Review:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client Name:</td>
<td>Reviewer(s):</td>
</tr>
<tr>
<td>Service (LOC):</td>
<td>Auth Reference #:</td>
</tr>
<tr>
<td>Auth Start Date:</td>
<td>Auth End Date:</td>
</tr>
</tbody>
</table>

**Reason File was Selected:**

**File Contents:**

<table>
<thead>
<tr>
<th>Item</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Mental Health Assessment?</td>
<td></td>
</tr>
<tr>
<td>Current ISSP?</td>
<td></td>
</tr>
<tr>
<td>Current LOCUS/CASII/ECSIII? Score:</td>
<td></td>
</tr>
<tr>
<td>Current ROI for PCP?</td>
<td></td>
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<tr>
<td>Additional ROIs?</td>
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<tr>
<td>Declaration of MH Treatment?</td>
<td></td>
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<tr>
<td>Signed Member Rights?</td>
<td></td>
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<tr>
<td>Consent for Treatment?</td>
<td></td>
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<tr>
<td>Grievance Form?</td>
<td></td>
</tr>
</tbody>
</table>

**GF ONLY: Client meets current GF criteria?**

- [ ] Yes
- [ ] No
- [ ] N/A-OHP

**Assessment:** (use initial assessment or initial with most recent annual assessment update)

- [ ] Biopsychosocial info supporting the diagnosis
- [ ] Mental Health Conditions
- [ ] Substance Use (ASAM)
- [ ] Chronic Medical Concerns
- [ ] Problem Gambling
- [ ] Suicide Potential
- [ ] Symptoms related to trauma conditions
- [ ] Zero to Five Considerations

**Individual Service and Support Plan:** (use most recent plan)

- [ ] Interventions are directly tied to treating presenting concern
- [ ] Interventions match the intensity of service type
- [ ] ISSP shows evidence that the client was involved in developing the plan
- [ ] ISSP includes criteria for service conclusion

**ISSP includes timelines for:**

- [ ] Review of Progress
- [ ] Timeline for ISSP Update

**The following are present and readily identifiable:**

- [ ] Goals are consistent with assessed need
- [ ] Intervention is identified
- [ ] Frequency of contact is clear
- [ ] Duration of treatment is clear
- [ ] Objective is identified
- [ ] Outcome is measurable

**Service Documentation:** (select a one month sample)

**Service notes:**

- [ ] Sample Period Start Date: End Date:
- [ ] Service notes match billing in PHTech

**Periodic Progress Review:**

- [ ] Describe Progress toward Intended Outcome
- [ ] Review includes significant events or changes in the client’s life
- [ ] Progress Reviews are consistent with timelines identified in ISSP
Utilization Management:

Paid to date: $  Projected payment at end of auth period: $

Payment in Relation to Assigned Level of Care (select one):
☐ Significantly Low  ☐ Average  ☐ Significantly High (will exceed max $)

Practice Guidelines:

Are the Interventions consistent with Practice Guidelines for the diagnostic profile?
☐ Yes  ☐ No  ☐ N/A: no guideline for presentation

Items found to be good:

Areas of improvement/concern:

General Comments:

Overall Treatment/Assignment to Level of Care?
☐ Consistent with Washington County Policy
☐ Inconsistent with Washington County Policy—review with clinical supervisor
Washington County Health and Human Services (WCHHS)
Mental Health Program
Policy and Procedure

Policy Title: Variance Provision

Approved: __________________________     _______________
Division Manager     Date

OBJECTIVE:

To ensure that mental health services are provided by qualified persons and organizations.

To provide a mechanism for review and approval of requests for exceptions for practices that do not conform to the standards established by Oregon Administrative Rules and/or the contractual agreement between Washington County and Health Share of Oregon.

POLICY:

Washington County will consider variance requests to existing standards established by Oregon Administrative Rules and will act upon such requests in a manner that is intended to promote and preserve an effective and appropriate mental health system of care.

Contracted provider organizations and practitioners, where applicable, may request approval for a variance to specified standards based upon an identified need and proposed alternative practices. Variance requests should include information that describes the need for the variance including, but not limited to, a lack of resources to implement standards identified in OARs and/or circumstances where the proposed alternative practices would result in improved services or outcomes for clients. Additionally, otherwise qualified individuals may be approved through a formal variance process to provide mental health services based upon review of their training and competencies and identified community needs.

All variance requests are subject to the review and approval of Washington County and, where required, the State of Oregon Addictions and Mental Health Division (AMH).
PROCEDURE:

Washington County will accept requests for variances to standards described in applicable Oregon Administrative Rules as allowed by these rules and in accordance with agreements between Washington County, AMH, and/or Health Share of Oregon. Providers seeking a variance to existing standards may submit a written request for a variance directly to Washington County for consideration. Variance requests must include the reason for the variance request, the specific standard to which the variance is being sought, proposed alternatives to the existing standards, and the proposed duration of the variance. Applicants may also be asked to provide a plan and timetable for achieving compliance with the standard to which the variance applies.

Washington County will evaluate variance requests in relation to the information included in the variance request and other factors as deemed appropriate by Washington County. Washington County may request additional documentation or clarification of the variance request as deemed necessary. If Washington County agrees with the reason for the variance request and the proposed alternatives then the variance request will either be forwarded to AMH for final approval or, where allowed, Washington County will act upon the variance request directly. Variance requests submitted to AMH for consideration will be decided at the discretion of AMH. Variance requests that may be acted upon directly by Washington County will be decided at the discretion of Washington County.

The State of Oregon Addictions and Mental Health Division (AMH) has determined programs operating as Community Mental Health Programs (CMHPs) as part of a Medicaid managed care entity may have flexibility to determine that a person’s education, experience, competence and supervision are adequate to permit the person to provide mental health services to clients enrolled in the managed care. This does not apply to services for Medicaid eligible individuals who have “open card” status or are otherwise not affiliated with the CCO.

Variance requests pertaining to clinician educational qualifications and/or clinical competence criteria, as described in applicable Oregon Administrative Rules and/or the agreement between Washington County and Health Share of Oregon and the Oregon Health Authority, may be issued for named individuals at the discretion of Washington County and/or AMH. The State of Oregon Addictions and Mental Health Division will retain final authority to issue variances for services reimbursed through Medicaid for clients that are (1) not enrolled in mental health managed care, (2) for services reimbursed with Medicaid funds on a fee-for-service basis, or for services reimbursed with General Fund dollars. Variance requests to provide services under these circumstances must first be
approved by Washington County prior to being forwarded to AMH for final disposition.

Variance requests relating to qualifications for individuals providing services to clients enrolled with Washington County for managed mental health care may be evaluated directly by Washington County for the purpose of approving payment for services provided by these individuals. Variance decisions pertaining to practitioner qualifications will be based on a determination that the person subject to the variance has the education, experience, and competence to enable the person to perform assigned duties and that appropriate provisions are in place for clinical supervision of the individual. Variance approvals may be time limited and may be subject to other restrictions as specified by Oregon Administrative Rules or statutes.

A written variance approval or denial letter will be issued to the requesting individual or organization describing the outcome of the variance request. Written approval of a variance may include additional requirements or conditions in addition to the proposed alternative practices listed in the initial variance request. Washington County reserves the right to revoke or modify a variance at its discretion or based upon changing circumstances. It is the responsibility of the recipient of the variance or the recipient’s employer to submit a request to extend or modify a variance prior to the expiration of the variance.
# Washington County Mental Health Program
## Variance Request Form

<table>
<thead>
<tr>
<th>Provider Requesting Variance:</th>
<th>____________________ ________________________</th>
</tr>
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<tbody>
<tr>
<td>Address:</td>
<td>________________________________________________</td>
</tr>
<tr>
<td>City:</td>
<td>______________________ Zip Code: ________________</td>
</tr>
<tr>
<td>Phone:</td>
<td>__________________________ Fax: __________________</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Contact Person Name:</th>
<th>________________________________</th>
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</thead>
<tbody>
<tr>
<td>Contact Person Office Location:</td>
<td>________________________________</td>
</tr>
<tr>
<td>Phone:</td>
<td>__________________________ Email: __________________</td>
</tr>
</tbody>
</table>

## Type of Variance Request:

- QMHP: _____
- QMHA: _____

Other (Specify):

| ______________________________ |
|______________________________|
|______________________________|

## Standard(s) to which the variance is being sought:

- OAR: ______________________ OAR: ______________________

- OAR: ______________________ OAR: ______________________

Other (Specify):

| ______________________________ |
|______________________________|
|______________________________|
|______________________________|
*Reason for the variance request: __________________________________________
_________________________________________________ ___________________
_________________________________________________ ___________________
_________________________________________________ ___________________
_________________________________________________ ___________________

*Proposed Alternative Practices/Limitations and Duration of Requested Variance:
_________________________________________________ ___________________
_________________________________________________ ___________________
_________________________________________________ ___________________
_________________________________________________ ___________________
_________________________________________________ ___________________
_________________________________________________ ___________________

*Please attach supporting documents that are pertinent to the variance request as needed. For example, copies of transcripts, resume, license, proposed alternative clinical forms, etc.

Send completed Variance Request to:

Jim MacLeod
Washington County QI Coordinator
155 N. First Ave., MS 70
Hillsboro, OR 97124

I am requesting that the variance request described above be approved.

________________________________                                   _____________
Authorized Signature      Date
Washington County Health and Human Services (WCHHS)
Mental Health Program
Policy and Procedure

Policy Title: Wraparound Demonstration Project

Approved: __________________________     _______________
Division Manager     Date

OBJECTIVE:
To aid in the development of an integrated system of care in Oregon by participating as a site in the Statewide Children’s Wraparound Initiative.

To ensure that services are family driven, youth guided, community-based, culturally competent, multi-systemic, comprehensive, well coordinated, outcome driven and provided in the least restrictive setting possible.

To ensure active family and youth voice at all levels of the program and provide a forum to resolve conflict that arises within the team.

To ensure data collection and outcomes monitoring in order to inform continued program development.

POLICY:
The System of Care and Wraparound principles will guide program implementation and service delivery for youth and families participating in the Wraparound Demonstration. Family and youth voice is evident at all levels of the Wraparound program.

Washington County will provide a high-fidelity Wraparound process to youth and families in the Wraparound Demonstration. Families and youth will be oriented to the services and the program philosophy upon admission to the Wraparound program.

Washington County will participate in ongoing workforce development training and fidelity monitoring activities offered through the demonstration project.

Washington County’s Wraparound Program will be governed by the Children’s Intensive Services and Wraparound Advisory Council, which is comprised of representatives from other child serving systems, family members, youth and advocates.
Washington County will routinely collect data in order to monitor outcomes and participate in statewide sharing of information and lessons learned in order to inform the Statewide Wraparound Initiative implementation.

**PROCEDURE:**

Washington County will provide a Wraparound Care Coordinator with a Master’s Degree in a behavioral health field to each eligible youth and family. Care Coordinators will have caseloads of 15 or fewer clients and will be trained in the Wraparound model. Youth will be screened for eligibility by the Wraparound Review Committee, which is comprised of representatives from Mental Health, Child Welfare, Juvenile Justice, and family and youth participants. Criteria for eligibility are subject to change during various phases of statewide implementation.

Workforce development provided to all Washington County Care Coordinators and Family Partners includes, but is not limited to, training in the following elements of Wraparound:

- Wraparound 101 with community partners
- Child and family team meeting facilitation skills
- Family and youth driven care
- Utilizing Family Partners
- Phases of child and family teams
- Strengths and Needs Assessments
- Developing and using natural supports
- Working with cross system mandates
- Cultural and linguistic competence
- Engaging transition age youth

**Program Orientation and Service Delivery**

Upon admission, youth and their families will receive an orientation packet with information about the program, services, philosophy and expectations. The assigned Wraparound Care Coordinator will review these materials with the family.

Washington County Mental Health does not collect fees from clients and does not require a fee agreement for Care Coordination services.

All Care Coordination services will be youth and family centered, culturally competent and developmentally appropriate based on the youth’s age and current level of functioning. Care Coordinators have access to translation services to ensure linguistically appropriate services as indicated.

All Care Coordination services provided will be documented in the youth’s clinical record, which will include, at a minimum, a mental health assessment, individual
services and supports plan (ISSP), crisis support (safety) plan, and reviews of progress as prescribed on the ISSP.

Crisis support is available to all youth and families in the Wraparound program. The provider of crisis support will depend on the services in which the youth and family are participating. All service providers have the responsibility to provide 24 hour crisis support to their clients. In addition, service providers with whom the youth and family are involved will collaboratively develop a crisis support plan and provide it in writing to the family, care provider and any other involved persons. The Washington County Crisis Line is available as backup, and is available 24 hours per day, seven days per week. For more information, please refer to the policy on Crisis Response.

**Transition and Service Conclusion**

When a Care Coordinator has discussed transition from the Wraparound program in a child and family team meeting and everyone is in agreement, the Care Coordinator and child and family team will develop a transition plan. The transition plan will include connection to follow up treatment services that are deemed appropriate. The Care Coordinator will complete a Service Conclusion Summary that will go into the clinical record.

**Data Collection and Fidelity Monitoring**

Washington County Wraparound Care Coordinators ensure the completion of the Wraparound Progress Review and Behavior and Emotional Rating Scale (BERS) within 30 days of admission for each youth, and every 90 days thereafter.

Washington County will ensure this information is shared with other demonstration sites and will share lessons learned to inform statewide implementation.

**Family and Youth Involvement**

Washington County supports family and youth voice and engages in ongoing recruitment of family members and youth interested in providing input to the development of services to youth and families. Washington County endeavors to include youth and family members on the Wraparound Advisory Council, Wraparound Review Committee, and other ad hoc meetings or committees. In addition, Washington County provides Family Partners to interested families in the Wraparound program in order to assist family members in having their voice drive the service plan.

To support efficient and family and team driven service planning, Wraparound Care Coordinators are able to directly authorize treatment services and are able to do so independently, within the child and family team meeting.

**Handling Disagreements in the Child and Family Team**
When there is disagreement within a child and family team that is not able to be resolved at the team level, the case can be brought to the Washington County Practice Workgroup for system level consultation. This can be done at a regularly scheduled meeting or an ad hoc meeting at the Care Coordinator’s request. Any member of the team can alert the Care Coordinator that they would like to pursue problem resolution at the Practice Workgroup. When possible Washington County will make efforts to have a Family Partner present at that meeting. Clients who are members of the team, or their representatives, may also file a grievance when there is a disagreement with the Child and Family Team (please refer to the WCHHS grievance policy and procedure).