Governing Body: **Mid-Valley Behavioral Care Network (MVBCN)**		Pages: 7 Date: 03/14/2009
Subject: **Utilization Management**	Prepared By: MVBCN Clinical Director	Approved By: Department of Human Services – Addictions and Mental Health Division

I. OUTPATIENT SERVICES

Management of outpatient mental health services to OHP members is delegated to each sub-region (county). Each sub-region has developed a Utilization Management policy and procedure which meets the requirements of the MHO Agreement and is specific to the design of the local provider system. These policies are reviewed by MVBCN and forwarded to AMHD for approval. The sub-regions are also responsible for responding to requests for out of panel or out of area outpatient services. Their policies outline the process for issuing Notices of Action when requested services are denied or limited, and for informing consumers of their Appeal rights.

- Each sub-regional Utilization Management process includes specific procedures to safeguard against unnecessary utilization.
- Each sub-region has developed written criteria for evaluating and documenting medical necessity and clinical appropriateness of services.
- Each sub-region outlines the authority and accountability for preauthorization, concurrent review, and discharge.

OHP members covered by the MVBCN are entitled to seek outpatient service from any MVBCN provider agency within the region. Any consumer who feels that the mental health clinician serving them is not meeting their needs has the right to request a Second Opinion. The program manager or clinical supervisor in the provider agency receives and responds to these requests. Second Opinions are provided at no cost to the member, from a qualified mental health practitioner at a provider agency contracted with MVBCN or from a non-participating provider if a qualified mental health practitioner is not available within the panel of contracted agencies.

II. SERVICES TO MEMBERS WITH OTHER MEDICAL CONDITIONS

Assessment: Each assessment shall identify any ongoing health care needs that require coordination between mental health treatment and medical services, or other care management. Such conditions include co-occurring substance use, physical health problems, or other disabling conditions.

Treatment Planning: If the medical condition requires coordination with other health care services, the treatment plan is developed by the consumer and the mental health practitioner in consultation with any medical or other specialists providing care.

Access to Specialty Care: The outpatient provider agency is responsible to facilitate access to medically appropriate mental health specialists for treatment of the individual's condition and identified needs.

Coordination of Care: The outpatient mental health case manager or therapist is responsible for on-going communication and collaboration with the individual's primary care provider and other specialty medical providers. Coordination through the physical health plan's Exceptional Needs Care Coordinator is often helpful. Such coordination and sharing of information shall be conducted within Federal and State laws, rules, and regulations governing confidentiality.

Advance Directives: Individuals may request assistance from a mental health practitioner to develop an Advance Directive which documents their wishes regarding end of life care.

III. CRISIS AND EMERGENCY SERVICES

Each MVBCN sub-region (county) is responsible for providing 24 hour crisis services. In addition, the Northwest Human Services Crisis Hotline provides member services support for MVBCN members and crisis intervention. Members whose conditions are likely to result in need for crisis or inpatient services are provided the opportunity to complete a Crisis Plan outlining their needs in these situations. Crisis respite and other crisis support services are available in the community to assist members to cope with crises.

MVBCN covers all medically appropriate emergency services provided in an acute care facility/setting due to an emergency mental health condition of a member, until the condition is stabilized. No prior authorization is required if a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the individual at risk of serious harm or impairment. MVBCN is responsible to pay for covered services provided as a post-stabilization service provided to maintain, resolve or improve the member's condition, as defined in the current MHO Agreement Part II, Section V, (B)(2)(d)(1-7).

IV. INTEGRATED SERVICES ARRAY FOR CHILDREN AND ADOLESCENTS

This policy describes access to the Integrated Services Array (ISA), a range of service components that are coordinated, comprehensive, and culturally competent. The ISA includes intensive and individualized home and community-based services for children and adolescents with severe mental or emotional disorders whose needs have not been adequately addressed in traditional settings. The ISA integrates inpatient, psychiatric residential and psychiatric day treatment and community-based care. These services are provided in a way to ensure that children and adolescents are served in the most natural environment possible and that the use of institutional care is minimized. The intensity, frequency, and blend of these services are based on the mental health needs of the child.

A. ADMISSION CRITERIA

- The child (up to age 18) must be enrolled in the Mid Valley Behavioral Care Network (MVBCN).
- The child must have a serious mental health need with a DSM mental health diagnosis on or above the funded line of Oregon Health Plan Prioritized List of Health Services. This Axis I diagnosis must be the focus of services and of the treatment plan.

- The child must have a composite CASII score greater than 19 and demonstrate need for CASII Level of Care 4 or higher on the basis of other risk factors documented in the Needs Profile, including but not limited to:
  (1) Elevating or significant harm to self or others
  (2) Frequent or imminent admission to acute inpatient psychiatric hospitalizations or other intensive treatment services;
  (3) Significant risk of an out of home placement due to mental health symptomatology, or multiple out-of-home placements;
  (4) Caregiver stress due to child's mental health symptomatology;
  (5) School disruption due to mental health symptomatology;
  (6) Exceeding usual and customary services in an outpatient setting (i.e. outpatient services previously provided have not been successful);
  (7) Multiple agency involvement.

B. REFERRAL AND DETERMINATION OF NEED

The process for determining the level of care needed is as follows:

1. Any concerned person may refer a child enrolled with Mid Valley Behavioral Care Network who is suspected of having significant mental health or emotional disorders. Referral sources may include families, allied agencies, schools, juvenile justice, the faith community, and health or behavioral health providers. The ISA determination process will clearly be communicated to families, guardians and community partners. The MVBCN will develop a regional brochure describing the referral and needs determination process as well as a referral form that is descriptive and provides key contact information. In addition, specific communication plans will be developed by sub-committees of the MVBCN's Regional Executive Oversight Committee in order to disseminate this information to distinct stakeholders such as families, the children's system of care, and the faith community and health providers.
2. When a referral is received for a child in DHS custody, the mental health program will fax the Consent to Screening form to the child's DHS caseworker on the day the referral is received. If the Consent is not returned within two days, the mental health program will contact the DHS supervisor for help in facilitating rapid access to screening.
3. Each county's Community Mental Health Program will designate staff to receive referrals and to assist in assembling the referral packet if the child appears to meet basic eligibility criteria for intensive mental health services.
4. A completed referral packet will include the following information:
   - Consent to screening signed by the parent/legal guardian
   - Current Mental Health Assessment completed or updated within the 60 days preceding the referral
   - Contact information for key informants with parent/legal guardian permission for telephone interviews with informants
5. Within 3 working days of receipt of the completed referral packet, the QMHP designated to provide Needs Determination will:
   - Complete a *Child and Adolescent Service Intensity Instrument* (CASII) screening

- Conduct telephone interviews with parents and other key informants familiar with the child's current situation and needs
- Review the Mental Health Assessment
- Complete a Needs Profile

Recommendation of the needed level of care and medically necessary services will be based on professional evaluation of the information listed above. Prioritization will be given to children with the most serious mental health needs.

6. The staff performing the Needs Determination will notify the parents/legal guardian by phone of the services recommended for their child (within 3 working days of receipt of the completed referral packet), and mail written confirmation.
7. If the recommendation is for CASII Level 4 or above, a Care Coordinator is assigned and the date of written parental notification is considered the date of the authorized request for ICTS services.
8. The Care Coordinator shall begin the wrap around process with the primary Child and Family Team (CFT) member(s) and initiate the Service Coordination Plan including any necessary crisis prevention and intervention planning within 14 calendar days. The Service Coordination Plan is completed within 30 days from the Needs Determination decision.

C. MANAGING THE UTILIZATION OF INTENSIVE SERVICES

1. For the time period between level of need determination and implementation of the service plan the service provider shall continue to provide services consistent with the access standards given in the MHO Agreement.
2. The Child and Family Team is responsible for developing, monitoring and modifying the Service Coordination Plan to assure that the appropriate services are available to the child and family. Community-based and flexible services are arranged by the Care Coordinator; any Notices of Action related to these services fall within the responsibility of the CMHP.
3. Requests for higher levels of service (treatment foster care, day treatment, residential treatment) are reviewed by the local Care Coordination Committee for appropriateness prior to facilitation of the placement by the MVBCN Regional CSCI Coordinator. Any Notice of Action related to these services would be issued by the MVBCN.

D. CRITERIA FOR TRANSITION AND DISCHARGE FROM INTENSIVE SERVICES

1. Child/Youth no longer requires services at the CASII Level 4 or above.
   - Each child will have specific written criteria for transition or discharge from intensive services as part of their Service Coordination Plan
   - The Child and Family Team will monitor progress towards the individualized discharge criteria specified in the Service Coordination Plan and develop transition plans to be followed when those goals are met.
   - If the Child and Family Team is not able to come to an agreement regarding the transition plan, the Community Care Coordination Committee will assist in the

resolution.
- The following are common indicators of readiness for transition from intensive services (CASII level of care 4 or above):
  - The child can function in school and community and mental health needs can be met at a lower level of care.
  - Community and family/caregiver supports are in place prior to discharge and are adequate to maintain safe behavior and stability.

2. The family/guardian chooses not to participate in the CFT process.
   - The family has the right to withdraw their child from any services, and to refuse participation in a Child and Family Team.

Family means the biological or legal parents, siblings, other relatives, foster parents, legal guardians, caregivers and other primary relations to the child whether by blood, adoption, legal or social relationship.

V. INPATIENT PSYCHIATRIC SERVICES

Inpatient Services -- Expected Practices

A face-to-face assessment by MVBCN staff or delegate is required prior to endorsement of an emergency admission and agreement to authorize payment. (If an MVBCN member is admitted without prior screening, the hospital should request a screening immediately.) During business hours, the MVBCN Inpatient Liaison will consult with county crisis staff on appropriateness of potential hospital admissions, advise that staff on specific alternatives to hospital care, and assist staff in arranging appropriate admissions to hospital or alternative care. After hours hospitalization decisions are delegated to the county crisis screeners. The MVBCN Inpatient Liaison is responsible to authorize payment for acute care psychiatric facilities and alternative placements. MVBCN is also responsible for issuing any required Notice of Action related to inpatient services or alternatives.

Acute psychiatric care is appropriate to resolve a serious behavioral health problem, usually a crisis or severe and rapid deterioration in functioning. Treatment at a lower level of care has been tried or given serious consideration. Available alternative treatment is determined to be unsafe or ineffective. The clinical assessment must document that the emergency is a result of a mental condition (diagnosis included in current DSM) and that the inpatient care is medically appropriate. The diagnosis and treated condition of admitted OHP members must be covered by the Oregon Health Plan in order to qualify for payment by MVBCN.

Emergency Admission Criteria

A. Axis I or II diagnosis using current DSM <u>and</u>

<u>Either</u>

B. Imminent dangerousness (must be a direct product of the DSM diagnosis) as evidenced by any of the following:

   1. High risk for self destructive acts secondary to severe psychiatric symptoms; or

2. Significant life-threatening attempt to harm self or others within the past 24 hours with continued imminent risk; or
3. Specific plan to harm self or others with clear intention, high lethality, and availability of means; or
4. Level of suicidality that cannot be safely managed at a lower level of care;

<u>Or</u>

C. Inability to care for self as evidenced by:

For adults:

1. Inadequate level of functioning outside of an inpatient setting; <u>and</u>
2. Impairment of judgment, impulse control, and/or perception arising out of an acute psychiatric disorder, indicating the need for hospital-level continuous monitoring and intervention to stabilize.

For youth under 18 years of age:

1. Inadequate level of functioning outside of an inpatient setting; <u>and</u>
2. Impairment of judgment, impulse control, and/or perception arising out of an acute psychiatric disorder, indicating the need for hospital-level continuous monitoring and intervention to stabilize, <u>and/or</u>
3. Severe, sustained or pervasive inability to attend to age appropriate responsibilities, and/or severe deterioration of family and school functioning too intensive to be evaluated or treated at a lower level of care.

<u>Guidance in Use of Hospital Services for Special Populations</u>

D. Evidence of Early Psychosis (for specialized services at Salem Hospital only):

1. Has been experiencing psychosis for at least 7 days; and
2. Evidence of the first psychotic symptoms within the past 12 months; and
3. Psychotic symptoms are not known to be caused by the temporary effects of substance intoxication

E. Trauma Survivors (usually diagnosed with PTSD, DID or BPD, and frequent user of police, hospital and emergency services):

1. For trauma survivors in the acute phase of the disorder, the function of suicidality is frequently to communicate distress, regulate and relieve emotional pain, and manage relationship issues of abandonment and intimacy.
2. A decision to hospitalize in these situations should be carefully weighed and will be evaluated by the MVBCN Inpatient Liaison. The best evidence available indicates that psychiatric hospitalization is usually not helpful and does not significantly reduce suicidal risk. It is essential, however, that necessary outpatient services be available to these individuals as the appropriate substitute for hospitalization.
3. Outpatient treatment must be available, consistent, timely and well coordinated. The necessary components include: crisis plans that are well developed with the consumers as

partners and are shared with the crisis providers; crisis respite available 24 hours a day; and mental health services available the next business day.

4. Sanctuary would be used as a planned event, which means a consumer would not ordinarily be hospitalized during a crisis episode but rather a planned admission to respite or hospital could be used to decrease suicidal behavior and dependency on inpatient care. Sanctuary is meant to be short-term, usually lasting no more than 72 hours.
5. Hospitalization may need to be considered when the situation is highly unpredictable. This would likely occur if crisis responders are not familiar with the individual or their patterns of behavior or there are significant disinhibitors present (factors that destabilize a person's behavior), such as active psychosis, mania, or the presence of brain injury.

Continued Stay Criteria

A. Persistence of symptoms continues with active treatment focus on reduction of symptoms that presented at admission, and/or

B. The emergence of additional problems consistent with admission criteria, and/or

C. Treatment with new medication requiring additional time for stabilization.

D. Re-certification of need for inpatient care by physician every 60 days after initial or previous certification.