Applies To: **UNMH** Component(s): Behavioral Health Responsible Department: Clinical

Title: **Access to and Clinical Admission Guidelines for Outpatient Services**	**Guideline**

Patient Age Group:	( ) N/A	(x) All Ages	( ) Newborns	( ) Pediatric	( ) Adult

DESCRIPTION/OVERVIEW

This guideline will define the criteria for admission to or exclusion from outpatient treatment services. UNMH is committed to providing timely, accessible, and person-centered care through a structured assessment and admissions process. All individuals seeking services will receive an appropriate evaluation and be admitted based on clinical need and available resources. Outlined in this guideline are the requirements for conducting assessments and admissions for clients seeking behavioral health services and the processes that must be followed to assess and admit individuals in need of behavioral health services.

REFERENCES

- *8.321.2 NMAC and the Behavioral Health Policy and Billing Manual*
- *Substance Abuse and Mental Health Services Administration (SAMHSA). (2014). Trauma- Informed Care in Behavioral Health Services. Treatment Improvement Protocol (TIP) Series 57. HHS Publication No. (SMA)14-4816. Rockville, MD: SAMHSA.*
- *NMSA 1978, S 43-1-10: Health Insurance Portability and Accountability Act (HIPAA) to Law Enforcement.*
- The Joint Commission. (2019). *Standard NPSG.15.01.01. Comprehensive accreditation manual for hospitals.* Oakbrook Terrace, IL: The Joint Commission. (Level VII)

AREAS OF RESPONSIBILITY

The Clinical Director will have responsibility for aspects of daily control and coordination of the procedure, authority to approve exceptions to the procedure – if applicable, and procedural implementation – including responsibility for any required electronic or written documentation.

I. Scope

This policy applies to all staff involved in the assessment and admissions process for outpatient Behavioral Health services, including clinical, administrative, and support personnel.

1. Procedures

1.1. SCREENING & ASSESSMENT:

1.1.1. Access to Services:

1.1.1.1. Clients seeking behavioral health services may contact multiple outpatient locations through phone, walk-in, or referral from other providers.

1.1.1.2. The adult outpatient services are accessed via walk-in spaces at the University Psychiatric Center. The youth and pediatric outpatient services are accessed via walk-in at the Lamberton Campus. The specialty addictions services are accessed via walk-in at the ASAP campus location.

1.1.1.3. Clients are encouraged to present to the most appropriate clinical location for their needs 5 days per week during walk-in hours.

1.1.1.4. Initial inquiries will be handled by administrative staff who will collect basic demographic information to create a registration for the initial walk-in service and provide an overview of how services are accessed across the outpatient system as well as what the client will be able to access during the initial visit.

1.1.2. Screening and Triage process:

1.1.2.1. Complete screening within 24 hours of initial contact.

1.1.2.2. Determine urgency and need for immediate intervention or crisis services.

1.1.2.3. Complete nursing triage and brief intervention as appropriate to client requests.

1.1.2.4. Discuss / schedule comprehensive assessment appointment depending on if client will remain with UNMH for outpatient services.

1.1.3. Essential Information Collected during screening and triage:

1.1.3.1. Demographic data and contact information

1.1.3.2. Presenting concerns and current symptoms

1.1.3.3. Insurance status and financial information

1.1.3.4. Primary reason for seeking services

1.1.3.5. Current medications and known allergies

1.1.3.6. History of previous behavioral health treatment

1.1.3.7. Current substance use including tobacco

1.1.3.8. Pregnancy status (if applicable)

1.1.3.9. Critical medical conditions and overdose risk

1.1.3.10. Safety assessment, including suicidal/homicidal ideation

1.1.4. Provisional Diagnosis:

1.1.4.1. A preliminary diagnostic impression based on reported symptoms will be documented in the initial assessment documentation.

1.1.4.2. Any immediate treatment needs and plan / course of care for addressing immediate needs will also be documented and discussed with the client during initial screening.

1.1.5. Initial Service Recommendations:

1.1.5.1. Determine eligibility for CCBHC services.

1.1.5.2. Make referrals for immediate needs.

1.1.5.3. Discuss process and schedule comprehensive assessment.

1.2. **Comprehensive Assessment (Completed within 60 days of admission)**

1.2.1. Clinical Evaluation Components:

1.2.1.1. Onset and Severity of Symptoms

1.2.1.2. Detailed history of presenting problems
1.2.1.3. Timeline of symptom development
1.2.1.4. Current severity and functional impact
1.2.1.5. Factors that alleviate or exacerbate symptoms

1.2.2. Medical and Health Information:
1.2.2.1. Comprehensive health history
1.2.2.2. Current and past medical conditions
1.2.2.3. Surgical history
1.2.2.4. Primary care provider information and last visit
1.2.2.5. Pregnancy status (if applicable)
1.2.2.6. Primary care screening and needs
1.2.2.7. Critical medical conditions requiring monitoring
1.2.2.8. Overdose risk assessment (when applicable)

1.2.3. Medication Information:
1.2.3.1. Current prescription medications
1.2.3.2. Over-the-counter medications
1.2.3.3. Supplements and herbal remedies
1.2.3.4. Medication adherence history
1.2.3.5. Previous psychiatric medication trials and responses
1.2.3.6. Medication allergies or adverse reactions

1.2.4. Insurance and Financial Status:
1.2.4.1. Verification of insurance coverage
1.2.4.2. Benefits determination
1.2.4.3. Co-pays and deductibles
1.2.4.4. Secondary insurance information
1.2.4.5. Eligibility for sliding fee scale
1.2.4.6. Need for financial assistance or counseling

1.2.5. Treatment History and Preferences:
1.2.5.1. Previous behavioral health treatment experiences
1.2.5.2. Perceived helpfulness of past treatments
1.2.5.3. Treatment modalities previously tried
1.2.5.4. Preferences for current treatment approaches
1.2.5.5. Preferences regarding use of technologies for treatment
1.2.5.6. Cultural considerations in treatment planning

1.2.6. Substance Use Assessment:
1.2.6.1. Current substance use patterns (including tobacco)
1.2.6.2. Standardized Alcohol Use screening tool (AUDIT-7)
1.2.6.3. History of substance use
1.2.6.4. Previous substance use treatment
1.2.6.5. Impact of substance use on functioning
1.2.6.6. Readiness for change regarding substance use

1.2.7. Mental Status and Cognitive Functioning:
1.2.7.1. Basic cognitive screening for impairment
1.2.7.2. Memory and concentration assessment
1.2.7.3. Orientation and awareness
1.2.7.4. Thought processes and content
1.2.7.5. Insight and judgment
1.2.7.6. Depression Screening
1.2.7.7. Standardized depression screening tool (PHQ-9)
1.2.7.8. Standardized anxiety screening tool (GAD-7)
1.2.7.9. Standardized PTSD screening tool (PC-PTSD)
1.2.7.10. History of problem episodes
1.2.7.11. Current symptoms
1.2.7.12. Risk factors for mental illness and disorder
1.2.8. Risk Assessment:
1.2.8.1. Suicide risk evaluation
1.2.8.2. Violence risk evaluation
1.2.8.3. Self-harm history
1.2.8.4. History of abuse, neglect, and exploitation
1.2.8.5. Safety planning needs
1.2.9. Psychosocial Assessment:
1.2.9.1. Family history and current living situation
1.2.9.2. Educational and employment history
1.2.9.3. Legal history
1.2.9.4. Cultural and spiritual factors and preferences
1.2.9.5. Support systems and resource access or limitations
1.2.9.6. Financial status and housing stability
1.2.9.7. Standardized Social Determinates of Health Risk Screen (SDOH)
1.2.9.8. Standardized Functional Needs Assessment

1.3. **Standardized Assessment Tools (use depends on location)**
1.3.1. For Adults:
1.3.1.1. Patient Health Questionnaire (PHQ-9) for depression
1.3.1.2. Generalized Anxiety Disorder Scale (GAD-7)
1.3.1.3. AUDIT-C for alcohol use
1.3.1.4. DAST-20 for drug use
1.3.1.5. Columbia-Suicide Severity Rating Scale (C-SSRS)
1.3.1.6. Montreal Cognitive Assessment (MoCA) for cognitive screening
1.3.1.7. Primary Care PTSD Checklist (PC-PTSD)
1.3.1.8. PTSD Checklist (PCL-5)
1.3.1.9. NIDA Quick Screen for substance use
1.3.2. For Youth:
1.3.2.1. PHQ-A (Adolescent version) for depression
1.3.2.2. Screen for Child Anxiety Related Disorders (SCARED)
1.3.2.3. CRAFFT for substance use
1.3.2.4. Columbia-Suicide Severity Rating Scale (C-SSRS)
1.3.2.5. Pediatric Symptom Checklist (PSC)
1.3.2.6. Child PTSD Symptom Scale (CPSS)
1.3.2.7. ADHD Rating Scale-5

1.3.2.8. Brief Cognitive Assessment Tool for Children

1.4. **Technology Use Assessment**

1.4.1. Access to and comfort with technology
1.4.2. Preferences for telehealth services
1.4.3. Experience with health-related mobile applications
1.4.4. Interest in technology-assisted treatment options
1.4.5. Barriers to technology use
1.4.6. Privacy concerns related to technology use

1.5. **Diagnostic Formulation**

1.5.1. DSM-5 diagnosis
1.5.2. Rule-out conditions
1.5.3. Contributing factors
1.5.4. Differential diagnosis considerations

2. **TREATMENT PLANNING**

2.1. Development Timeline

2.1.1. Initial treatment plan must be completed within 7 days of comprehensive assessment
2.1.2. Treatment plan reviews conducted at minimum every 90 days

2.2. Treatment Plan Components

2.2.1. Identified strengths and needs
2.2.2. Measurable goals and objectives
2.2.3. Specific interventions and frequency
2.2.4. Responsible providers
2.2.5. Timeline for goal achievement
2.2.6. Discharge criteria
2.2.7. Crisis / Safety plan if applicable
2.2.8. Coordination of care plan

2.3. Recovery and Support Services Assessment

2.3.1. Need for and openness to self-help groups
2.3.2. Peer support service needs
2.3.3. Family support evaluation
2.3.4. Openness to family participation in treatment
2.3.5. Group therapy appropriateness
2.3.6. Community resource needs

2.4. Client Participation and Signature

2.4.1. Documentation of client participation in treatment planning
2.4.2. Client electronic signature or attestation indicating agreement with plan
2.4.3. If client refuses to attest, documentation of refusal and reason
2.4.4. Copy of treatment plan provided to client

2.5. Interdisciplinary Team Review

2.5.1. Review of assessment and treatment plan by relevant team members
2.5.2. Documentation of team input
2.5.3. Identification of primary treatment provider
2.5.4. Care coordination planning

3. **EVIDENCE-BASED TREATMENTS AVAILABLE**

3.1. For Adults:

3.1.1. Pharmacological Medication Management

3.1.2. **Cognitive Behavioral Therapy (CBT)**
3.1.3. Dialectical Behavior Therapy (DBT)
3.1.4. Motivational Interviewing (MI)
3.1.5. Cognitive Processing Therapy (CPT)
3.1.6. Illness Management and Recovery (IMR)
3.1.7. Assertive Community Treatment (ACT)
3.1.8. Medication-Assisted Treatment (MAT)
3.1.9. Integrated Dual Diagnosis Treatment (IDDT)
3.1.10. Problem-Solving Therapy
3.1.11. Interpersonal Therapy (IPT)
3.1.12. Acceptance and Commitment Therapy (ACT)
3.1.13. Mindfulness-Based Cognitive Therapy (MBCT)
3.1.14. Prolonged Exposure Therapy
3.1.15. Cognitive Behavioral Therapy for Psychosis (CBT-P)
3.1.16. Seeking Safety
3.1.17. Psychosocial Rehabilitation
3.1.18. Group psychotherapy
3.1.19. Couples and Family therapy
3.1.20. Humanistic/ Supportive Counseling
3.1.21. Brief Psychodynamic Psychotherapy

3.2. For Youth:

3.2.1. Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
3.2.2. Parent-Child Interaction Therapy (PCIT)
3.2.3. Multisystemic Therapy (MST)
3.2.4. Functional Family Therapy (FFT)
3.2.5. Cognitive Behavioral Therapy for Adolescents
3.2.6. Dialectical Behavior Therapy for Adolescents (DBT-A)
3.2.7. Motivational Enhancement Therapy (MET)
3.2.8. Adolescent Community Reinforcement Approach (A-CRA)
3.2.9. Child-Parent Psychotherapy (CPP)
3.2.10. Attachment-Based Family Therapy (ABFT)
3.2.11. Brief Strategic Family Therapy (BSFT)
3.2.12. Seeking Safety
3.2.13. Group psychotherapy
3.2.14. Couples and Family therapy
3.2.15. Humanistic/ Supportive Counseling
3.2.16. Brief Psychodynamic Psychotherapy

4. DOCUMENTATION REQUIREMENTS

4.1. Assessment Documentation

4.1.1. Completed initial assessment documentation
4.1.2. Comprehensive assessment documentation
4.1.3. Signed consent forms and Release of Information
4.1.4. Completed screening tools
4.1.5. Diagnostic formulation
4.1.6. Medical necessity documentation

4.2. Treatment Plan Documentation

4.2.1. Completed treatment plan form with all required elements

4.2.2. Client electronic attestation or documentation of refusal
4.2.3. Evidence of client participation in development
4.2.4. Documentation of plan reviews and updates
4.2.5. Evidence of interdisciplinary input

4.3. Progress Notes / Treatment Documentation

4.3.1. Documentation of services provided
4.3.2. Progress toward treatment goals
4.3.3. Changes in client status
4.3.4. Plan modifications when applicable
4.3.5. Next steps in treatment

5. **QUALITY ASSURANCE**

5.1. Timeliness Monitoring

5.1.1. Initial assessment within 24 hours of first contact
5.1.2. Comprehensive assessment within 60 days of admission
5.1.3. Treatment plan within 7 days of comprehensive assessment
5.1.4. Treatment plan reviews every 90 days

5.2. Completeness Review

5.2.1. Regular audits of assessment and treatment plan documentation
5.2.2. Verification of required elements
5.2.3. Review of diagnostic accuracy and service matching

5.3. Client Satisfaction Measurement

5.3.1. Administration of satisfaction surveys
5.3.2. Collection of feedback regarding assessment process
5.3.3. Review of grievances related to assessment or treatment planning

6. **RESPONSIBILITY**

6.1. Clinical Services Director**:** Overall responsibility for policy implementation and compliance
6.2. Treatment Providers: Assessment and Treatment plan development and implementation
6.3. Quality Assurance Clinical Managers: Monitoring compliance with policy requirements

Policy Review

This policy will be reviewed annually or more frequently as needed to ensure compliance with changing regulations and best practices.

Definitions

- **Initial Assessment**: A preliminary evaluation conducted at first contact to determine immediate needs and establish provisional eligibility.
- **Comprehensive Assessment**: A detailed evaluation completed within 60 days of admission that forms the foundation for treatment planning.
- **Treatment Plan**: A collaborative, person-centered document that outlines goals, interventions, and services based on assessment findings.

SUMMARY OF CHANGES

No changes made. Reviewed only.

KEY WORDS

Exclusion criteria, admission criteria, adult program

Item	Contact	Date	Approval
Owner	Director; Medical Director		
Consultant(s)	Nursing Supervisor		
Committee(s)	Leadership Committee		[**Y** or N/A]
Nursing Officer	[Name], Chief Nursing Officer		[Y or **N/A**]
Medical Director/Officer	[Name, Department (or Chief Medical Officer)]		[Y or **N/A**]
Human Resources	[Name], HR Administrator, [UNMH or UNM]		[Y or **N/A**]
Finance	[Name, Title], [UNMH or HSC]		[Y or **N/A**]
Legal	[Name, Title], [UNMH or HSC]		[Y or **N/A**]
Official Approver	[Name, Title, Area]		Y
Official Signature	**Director; Medical Director**		
2nd Approver (Optional)			
Signature		[Day/Mo/Year]	
Effective Date			
Origination Date			
Issue Date	Clinical Operations Policy Coordinator		