



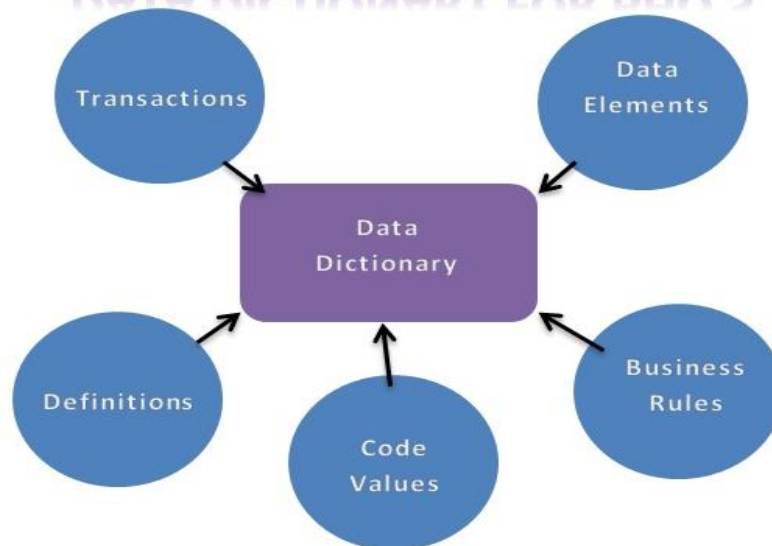
Washington State
Department of Social
& Health Services

DBHR Division of Behavioral
Health and Recovery



BEHAVIORAL HEALTH DATA CONSOLIDATION (BHDC)

DATA DICTIONARY FOR BHO'S



VERSION 1.1
JANUARY 19, 2016

Dictionary Description	Effective Date: 04/01/2016
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OVERVIEW

The is an integrated data store Of the Division of Behavioral Health and Recovery (DBHR) and is provided to reporting agencies throughout the state. Users include county governments, tribes, and organizations that provide DBHR client services.

The purpose of this Data Dictionary is to enumerate and explain each of the fields in each of the tables within the Behavioral Health Data Consolidation (BHDC) data store that are not collected out of ProviderOne This information will be helpful to BHO and Tribal staff in understanding the non-ProviderOne BHDC data system. It will also be of use to developers or those seeking to understand the data structure within non-ProviderOne BHDC data store.

DICTIONARY USE

To find a data element in this Dictionary, you can Ctrl + Click on the element listed under it's corresponding transaction in the Table of Contents. You can return to the table of contents by Ctrl + Click on the link in each header.

General Considerations of Dictionary	Effective Date: 04/01/2016
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REPORTING BHO

Reporting of pertinent transactions/elements is required to come from the BHO providing services. Note, the BHO providing services for a client may be different than the BHO the client is assigned to. This is predicted to occur most commonly when needed services are provided in a BHO outside that which the client is assigned to.

BLANKS/UNKOWNS

Please follow any guidance provided in Transactions or Elements regarding the use of “unknown” or leaving fields blank.

SPECIAL CHARACTERS

Please follow any guidance provided in Transactions or Elements regarding the use of special characters. Except when specified, avoid using special characters.

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Definition:

This chapter summarizes all of the transactions that BHOs can send in to DBHR, based on the scope of their service delivery. X=required

Transaction	Data Elements Contained in the Transaction	MH	SUD (includes out patient, intensive outpatient and all types of residential)	Pre-Intake or Assessment (for MH or SUD)	SUD Withdrawal Management Services (as defined by Washington Administrative Code 388-877B-0100)
Header	BHO ID BATCH NUMBER BATCH DATE	x	x	x	x
Cascade Delete	BHO ID CLIENT ID				
Cascade Merge	BHO ID CLIENT ID				
Client Address	BHO ID CLIENT ID EFFECTIVE DATE ADDRESS LINE 1 ADDRESS LINE 2 CITY COUNTY STATE ZIP CODE	x	x	x	
Client Demographics	BHO ID CLIENT ID EFFECTIVE DATE FIRST NAME MIDDLE NAME LAST NAME ALTERNATE LAST NAME SOCIAL SECURITY NUMBER BIRTHDATE GENDER HISPANIC ORIGIN MILITARY SERVICE PRIMARY LANGUAGE RACE(S) SEXUAL ORIENTATION	x	x	x (only bolded elements are required, other elements can be provided if obtained)	x (only bolded items)
Client Profile	BHO ID CLIENT ID EFFECTIVE DATE EDUCATION EMPLOYMENT MARITAL STATUS PARENTING PREGNANT SMOKING STATUS RESIDENCE SCHOOL ATTENDANCE	X (only bolded elements are required, other elements can be provided if obtained)	x		

	SELF HELP COUNT USED NEEDLE RECENTLY NEEDLE USE EVER				
Program Identification	BHO ID CLIENT ID PROVIDER NPI PROGRAM ID PROGRAM START DATE PROGRAM END DATE	x	x		
Co-occurring Disorder	BHO ID PROVIDER NPI CLIENT ID GAINS DATE SCREEN ASSESSMENT INDICATOR CO-OCCURRING DISORDER SCREENING (IDS) CO-OCCURRING DISORDER SCREENING (EDS) CO-OCCURRING DISORDER SCREENING (SDS) CO-OCCURRING DISORDER ASSESSMENT	x	x		
Authorization	BHO ID PROVIDER NPI CLIENT ID AUTHORIZATION ID AUTHORIZATION DECISION DATE AUTHORIZATION START DATE AUTHORIZATION END DATE AUTHORIZATION DECISION	x	x		x
ASAM Placement	BHO ID PROVIDER NPI CLIENT ID ASAM ASSESSMENT DATE ASAM LEVEL	x	x		x
DMHP Investigation	BHO ID CLIENT ID INVESTIGATION START DATE INVESTIGATION START TIME INVESTIGATION COUNTY CODE INVESTIGATION OUTCOME DETENTION FACILITY NPI LEGAL REASON FOR DETENTION/COMMITMENT RETURN TO INPATIENT/REVOCAION AUTHORITY DMHP AGENCY NPI INVESTIGATION REFERRAL SOURCE INVESTIGATION END DATE	x		x	
ITA Hearing	BHO ID CLIENT ID HEARING DATE HEARING OUTCOME DETENTION FACILITY NPI HEARING COUNTY	x		x	
Service	BHO ID	x	x		

Episode	PROVIDER NPI CLIENT ID EPISODE RECORD KEY SERVICE EPISODE START DATE SERVCE EPISODE END DATE DISCHARGE REASON SERVICE REFERRAL SOURCE				
Substance Use	BHO ID PROVIDER NPI CLIENT ID EFFECTIVE DATE SUBSTANCE (1) AGE AT FIRST USE (1) FREQUENCY OF USE (1) PEAK USE (1) METHOD (1) DATE LAST USED (1) SUBSTANCE (2) AGE AT FIRST USE (2) FREQUENCY OF USE (2) PEAK USE (2) METHOD (2) DATE LAST USED (2) SUBSTANCE (3) AGE AT FIRST USE (3) FREQUENCY OF USE (3) PEAK USE (3) METHOD (3) DATE LAST USED (3)		x		x

Transactions and Definitions	Header 000.01	Return to Table of Contents	Effective Date: 04/01/2016
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Definition:

This transaction is an identifier and is the first record that goes in a native (non 837X12N EDI) batch file. The Header tells what number the batch is, the originator, and the date sent.

Transaction ID:	000.01
ACTION CODE:	N/A
Primary Key:	BHO ID BATCH NUMBER
Body	BATCH DATE

Note: This transaction is required as the first record of each native (non 837X12N EDI) batch file and all batches must be submitted for processing in Batch Number order. There is no action code in this transaction.

Edits:

This transaction will not process if the Batch Date does not have a valid date format or the submitting BHO ProviderOne ID does not represent a BHO with authority to submit directly to DBHR. A blank batch number will generate an error.

Example:

000.01 105020201 00728 20150228

Transaction Errors

23300	Error: BHO ProviderOne ID is not a valid BHO ProviderOne ID. Transaction not posted.
23301	Error: Batch number is blank or non-numeric. Transaction not posted.

Transactions and Definitions	Cascade Delete – 131.03	Return to Table of contents	Effective Date: 04/01/2016
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Definition:

This transaction allows for the mass deletion of non-encounter records for a given consumer. This is referred to as a "Full Cascade Delete."

Full Cascade Delete: This type of delete will remove all non-encounter information about a client. Once processed, the Client ID will be voided and not available for future processing. The RSN Administrator may delegate his/her authority to authorize Full Cascade Deletes to someone who maintains their information system.

Transaction ID:	131.03
ACTION CODE:	N/A
Primary Key:	BHO ID CLIENT ID (The ID to be deleted)
Body	No data in body

Note: There is no action code in this transaction.

Edits:

The transaction will not process if the BHO ProviderOne ID and Client ID are not valid or the Client ID has already been voided. Full Cascade Delete will error if the transaction has not had prior DBHR approval.

Transaction Errors

30042	Error: Full Cascade Delete requires prior DBHR authorization. Transaction not posted.
23107	Error: RSN or Contractor ID not valid. Transaction not posted.
23306	Error: Client id for Contractor has been previously voided.

Transactions and Definitions	Cascade Merge – 130.03	Return to Table of Contents	Effective Date: 04/01/2016
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Definition:

This transaction will void a Client id and bar its use in the future. A Client id is voided when the Contractor has established two different identifiers for a single person. The Contractor must identify the Client id to be voided and also identify the Client id to reference in its place.

Transaction ID:	130.03
ACTION CODE:	N/A
Primary Key:	BHO ID CLIENT ID (The ID to be voided)
Body	Referenced CLIENT ID

Note: There is no action code in this transaction.

Edits:

This transaction will not process if the BHO ProviderOne ID or Client IDs are not valid. It will also not process if the Client IDs have been previously voided or the Client IDs are equal.

Transaction Errors

23313	Error: Client ID and Referenced Client ID are equal. Transaction not posted.
22007	Error: Referenced Client id cannot be blank or null. Transaction not posted.
23008	Error: Primary key fields cannot be blank or null. Transaction not posted.
23107	Error: BHO ID not valid. Transaction not posted.
23305	Error: Client Demographic transaction not found for BHO ID, CID. Transaction not posted.
23306	Error: Client id for Contractor has been previously voided.

Transactions and Definitions	Client Demographics 020.06	Return to Table of Contents	Effective Date: 04/01/2016
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Definition:

This is the demographic transaction for full demographic data.

NOTE: “ First Name, Middle Name, Last Name, Social Security Number and Birthdate consummates a unique client identifier, the "Client ID," for a person by the Behavioral Health Organization. These “Client ID” elements must be successfully processed before any other transaction referencing the "Client ID" will be accepted. If “crisis” or pre-intake prevents collection of “Client ID”, then BHO must collect at earliest possible point before submission.

Transaction ID:	020.06
ACTION CODE:	"A" Add "C" Change
Primary Key:	BHO ID CLIENT ID
Body	EFFECTIVE DATE FIRST NAME MIDDLE NAME LAST NAME ALTERNATE LAST NAME SOCIAL SECURITY NUMBER BIRTHDATE GENDER HISPANIC ORIGIN MILITARY SERVICE PRIMARY LANGUAGE RACE(S) SEXUAL ORIENTATION

Edits:

The Client demographic transaction is required at intake/assessment and updated upon change.

This transaction will not process if the Primary Keys are invalid.

Transaction Errors

99999	Error:
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Transactions and Definitions	Client Address 022.01	Return to Table of Contents	Effective Date: 04/01/2016
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Definition:

Client’s current address information collected at intake, and on change.

Transaction ID:	022.01
ACTION CODE:	“A” Add “C” Change “D” Delete
Primary Key:	BHO ID CLIENT ID
Body	EFFECTIVE DATE ADDRESS LINE 1 ADDRESS LINE 2 CITY COUNTY STATE ZIP CODE

Edits:

Required at intake and on change.

This transaction will not process if the Primary Keys are invalid.

Must always report effective date with this transaction.

If client is homeless or unable to provide a street address, report what is available, including city, state or zip code.
This transaction is optional for SUD clients in withdrawal management services, but should be reported if possible.

Transaction Errors

99999	Error:
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Transactions and Definitions	Client Profile 035.08	Return to Table of Contents	Effective Date: 04/01/2016
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Definition:

Additional client characteristics required for all clients. This is collected at admission and discharge (as defined in the SERVICE EPISODE transaction) and updated every 90 days.

Transaction ID:	035.08
ACTION CODE:	"A" Add "C" Change "D" Delete
Primary Key:	BHO ID CLIENT ID
Body	EFFECTIVE DATE EDUCATION EMPLOYMENT MARITAL STATUS PARENTING (required for SUBSTANCE USE DISORDER, optional MENTAL HEALTH) PREGNANT (required for SUBSTANCE USE DISORDER, optional MENTAL HEALTH) SMOKING STATUS RESIDENCE SCHOOL ATTENDANCE SELF HELP COUNT USED NEEDLE RECENTLY NEEDLE USE EVER

Edits:

Must always report Effective Date with this transaction.

This transaction will not process if the Primary Keys are invalid.

Transaction Errors

99999	Error:
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Transactions and Definitions	Program Identification 060.03	Return to Table of Contents	Effective Date: 04/01/2016
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Definition:

A client identified by a BHO may be enrolled in a special Community Mental Health or Substance Use Disorder program. This transaction associates the "Program" with the "Consumer Demographic" transaction. It identifies the start and end dates of participation in special programs. This transaction will not prevent a client from being in 2 or more different programs at a particular agency in the BHDC.

Transaction ID:	060.03
ACTION CODE:	"A" Add "C" Change "D" Delete
Primary Key:	BHO ID CLIENT ID PROVIDER NPI PROGRAM ID PROGRAM START DATE
Body	PROGRAM END DATE

Edits:

This transaction will not process if the Primary Keys are invalid.

Transaction Errors

99999	Error:
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Transactions and Definitions	Co-occurring Disorder 121.03	Return to Table of Contents	Effective Date: 04/01/2016
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Definition:

Co-occurring disorder screening and assessment.

Transaction ID:	121.03
ACTION CODE:	"A" Add "C" Change "D" Delete
Primary Key:	BHO ID CLIENT ID PROVIDER NPI GAINS DATE
Body	SCREEN ASSESSMENT INDICATOR CO-OCCURRING DISORDER SCREENING(IDS) (Required, based on value in Screening Assessment Indicator) CO-OCCURRING DISORDER SCREENING (EDS) (Required, based on value in Screening Assessment Indicator) CO-OCCURRING DISORDER SCREENING (SDS) (Required, based on value in Screening Assessment Indicator) CO-OCCURRING DISORDER ASSESSMENT (Required if the client screens high (2 or higher) on <u>either</u> the IDS or EDS, <u>and</u> on SDS))

Edits:

Required at intake/assessment for all mental health and substance use disorder clients.

This transaction will not process if the Primary Keys are invalid or if the values for the CO-OCCURRING DISORDER SCREENING (IDS), CO-OCCURRING DISORDER SCREENING (EDS), CO-OCCURRING DISORDER SCREENING (SDS) or CO-OCCURRING DISORDER ASSESSMENT are missing or invalid.

There is not an edit requiring the initial EDI service encounter to be processed prior to this transaction.

Transaction Errors

99999	Error:
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Transactions and Definitions	Authorization 023.01	Return to Table of Contents	Effective Date: 04/01/2016
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Definition:

BHO authorization for treatment of a client. This transaction is sent every time a new authorization or re-authorization is requested and an authorization decision made.

Transaction ID:	023.01
ACTION CODE:	"A" Add "C" Change "D" Delete
Primary Key:	BHO ID PROVIDER NPI CLIENT ID AUTHORIZATION DECISION DATE
Body	AUTHORIZATION ID AUTHORIZATION START DATE AUTHORIZATION END DATE AUTHORIZATION DECISION

Edits:

This transaction will not process if the Primary Keys are invalid.

Transaction Errors

99999	Error:
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Transactions and Definitions	ASAM Placement 030.01	Return to Table of Contents	Effective Date: 04/01/2016
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Definition:

A client’s movement through different levels of care.

Transaction ID:	030.01
Action Code:	"A" Add "C" Change "D" Delete
Primary Key:	BHO ID PROVIDER NPI CLIENT ID ASAM ASSESSMENT DATE
Body	ASAM LEVEL

Edits:

Required for all substance use disorder clients, including SUD clients receiving Withdrawal Management Services.

Required at assessment, admission and anytime thereafter that it is collected.

This transaction will not process if the Primary Keys are invalid.

Transaction Errors

99999	Error:
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Transactions and Definitions	DMHP Investigation 160.03	Return to Table of Contents	Effective Date: 04/01/2016
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Definition:

A designated Mental Health Professional (DMHP) is the only person who can perform an ITA investigation that results in a detention and revocation. A crisis worker who is not a DMHP can initiate this investigation but in order for a detention to take place, it is mandated (RCW 71.05 for adults, RCW 71.34 for children 13 and over) that the DMHP investigate and make a determination. Therefore, all investigations reported are derived from the investigation resulting from the findings of a DMHP. Do not report investigative findings of the crisis worker unless the crisis worker is also a DMHP.

The intent of this transaction is to record DMHP investigations only. Activities performed by a DMHP including crisis intervention, case management, or other activities, while important are not collected by this transaction. Each RSN determines which specific actions come under an investigation. The DBHR recommended criteria for when a DMHP activity becomes an 'investigation' is when the decision to investigate has been made and the DMHP reads the person his/her rights. The trigger is reading the person his/her rights.

This transaction identifies all investigations by the DMHP, even if the DMHP is also classified as a crisis worker. An investigation can result in: a detention, which is 72 hours; a return to inpatient facility with a revocation of a court ordered less restrictive alternative (LRA) petition filed; a filing of a petition recommending an LRA extension; a referral for voluntary in-patient or outpatient mental health services, a referral to other community resources; or no action based on mental health needs.

Transaction ID:	160.03
ACTION CODE:	"A" Add "C" Change "D" Delete
Primary Key:	BHO ID CLIENT ID INVESTIGATION START DATE INVESTIGATION START TIME
Body	INVESTIGATION COUNTY CODE INVESTIGATION OUTCOME DETENTION FACILITY NPI LEGAL REASON FOR DETENTION/COMMITMENT (Code value from table below) RETURN TO INPATIENT/REVOCAATION AUTHORITY (Code value from table below) DMHP AGENCY NPI (null allowed) INVESTIGATION REFERRAL SOURCE INVESTIGATION END DATE

Edits:

This transaction will not process if the Primary Keys are invalid.

This transaction is to be used to provide more information about a crisis service that resulted in an investigation. An associated crisis intervention encounter, per the "Involuntary Treatment Investigation" service modality, is expected to be received in an "837P transaction."

There are some code value dependencies based on the Investigation Outcome (required). The following table attempts to clarify those dependencies.

	Investigation Outcome* CODE Meaning	Legal Reason for Detention/ Commitment* (Up to 4 Characters)	Return to Inpatient/ Revocation Authority	Inpatient NPI
1	Detention (72 hrs)	A-D at least one required	9	Required
2	Referred to Voluntary Outpatient	Z	9	Blank/Null
3	Referred to Voluntary Inpatient	Z	9	Required
4	Return to Inpatient Facility	A-D or X at least one required	1 or 2 Required	Required

5	Filed Petition Recommending LRA Extension	A-D or X at least one required	9	Blank/Null
6	Referred to Non-mental Health Community Resources	Z	9	Blank/Null
9	Other	Z	9	Blank/Null
10	Referred to Acute Detox	Z	9	Blank/Null
11	Referred to Sub Acute Detox	Z	9	Blank/Null
12	Referred to Sobering Unit	Z	9	Blank/Null
13	Referred to Crisis Triage	Z	9	Blank/Null
14	Referred to Chemical Dependency Intensive Outpatient Program	Z	9	Blank/Null
15	Referred to Chemical Dependency Inpatient Program	Z	9	Blank/Null
16	Referred to Chemical Dependency Residential Program	Z	9	Blank/Null
17	No detention – E&T provisional acceptance did not occur within statutory timeframes	Z	9	Blank/Null
18	No detention – Unresolved medical issues	Z	9	Blank/Null
19	Non-emergent detention petition filed	A-D or X at least one required	9	Blank/Null
20	Did not require MH or CD services	Z	9	Blank/Null
21	Referred for hold under RCW 70.96A	Z	9	Blank/Null
22	Petition filed for outpatient evaluation	A-D or X at least one required	9	Blank/Null
23	Filed petition recommending AOT extension	A-D or X at least one required	9	Blank/Null

Transactions and Definitions	ITA Hearing 162.03	Return to Table of Contents	Effective Date: 04/01/2016
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Definition:

This transaction documents each hearing under the Involuntary Treatment Act filed in a specific county. This excludes filings at a state hospital. If multiple hearings are held for the same person on the same day, record the decision of the court for the most recent hearing. If no decision is made at a hearing and the case is continued to another day, do not record the result of that hearing. Record only those hearings where a court makes a decision, such as to commit, revoke, conditionally release, or dismiss.

It is the responsibility of the BHO, where the investigation occurred, to ensure that if they report an investigation resulting in a detention, where a petition for a hearing also occurred for that consumer, that the associated ITA Hearing is also reported to DBHR. The ITA Hearing transaction should be submitted by the BHO in which the hearing occurred. This may be different than the BHO who reported the ITA Investigation.

This transaction reporting expectation is within 24 hours of the RSN receiving this information due to the importance of this data. This is an exception to the standard contract terms for data reporting timeliness.

Transaction ID:	162.03
ACTION CODE:	"A" Add "C" Change "D" Delete
Primary Key:	BHO ID CLIENT ID Hearing Date
Body	Hearing Outcome Detention Facility NPI (same as that used in the DMHP Investigation transaction) Hearing County

Edits:

This transaction will not process if the Primary Keys are invalid.

Valid hearing date, client ID, hearing county, and hearing outcome are required.

Transaction Errors

99999	Error:
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Transactions and Definitions	Service Episode 170.02	Return to Table of Contents	Effective Date: 04/01/2016
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Definition:

This transaction is to be used to identify a time period in which a consumer is served by a provider, based on their contracting BHO’s authorization to pay for those services within a particular modality. SAMHSA is requiring states to report “client level” data annually, so that outcomes can be compared from one year to the next. This requires each state to be able to identify:

New clients admitted and discharged during the reporting period

- Change in outcome will be measured from admission to the time of discharge

Continuing clients at the beginning and discharged during the reporting period

- Change in outcome will be measured from the beginning of reporting period to the time of discharge

New clients who remain on in the caseload at the end of the reporting period

- Change in outcome will be measured from admission to the end of the reporting period

Continuing clients at the beginning and end of the reporting period

- Change in outcome will be measured from the beginning to the end of reporting period

This transaction was worked out jointly with DBHR and RSN, as the simplest way to for RSNs to report outpatient treatment episodes of care.

Transaction ID:	170.02
Action Code:	"A" Add "C" Change "D" Delete
Primary Key:	BHO ID PROVIDER NPI CLIENT ID EPISODE RECORD KEY
Body	SERVICE EPISODE MODALITY SERVICE EPISODE START DATE SERVICE EPISODE END DATE DISCHARGE REASON SERVICE REFERRAL SOURCE

Edits:

This transaction will not process if the Primary Keys are invalid.

Reporting burden will always fall on the BHO providing service(s). Therefore, when clients are provided service(s) outside their assigned BHO, the responsibility for reporting this data is that of the BHO providing the service(s).

Transaction Errors

99999	Error:
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Transactions and Definitions	Substance Use 036.01	Return to Table of Contents	Effective Date: 04/01/2016
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Definition:

A client history of substance specific information.

Transaction ID:	036.01
Action Code:	"A" Add "C" Change "D" Delete
Primary Key:	BHO ID PROVIDER NPI CLIENT ID
Body	EFFECTIVE DATE SUBSTANCE (1) AGE AT FIRST USE (1) FREQUENCY OF USE (1) PEAK USE (1) METHOD (1) DATE LAST USED (1) SUBSTANCE (2) AGE AT FIRST USE (2) FREQUENCY OF USE (2) PEAK USE (2) METHOD (2) DATE LAST USED (2) SUBSTANCE (3) AGE AT FIRST USE (3) FREQUENCY OF USE (3) PEAK USE (3) METHOD (3) DATE LAST USED (3)

Business Rule:

Must be reported at admission, every 90 days and at discharge. SUD inpatient providers are not exempt from reporting.

Must always report effective date with this transaction.

The substances reported are left to the clinician’s judgement.

The 3 Substances reported at admission must also be reported at discharge, and at the 90-day updates (whether or not they are still using the substance).

The substances must be ranked by relative importance of seriousness of dependency as provided by the client and determined by the counselor.

The following must be included for each of the 3 substances being reported:

- AGE AT FIRST USE (report only at admission and upon change)
- FREQUENCY OF USE
- PEAK USE
- METHOD OF ADMINISTRATION
- DATE LAST USED

If there is no substance 2 or 3, then report “none” for SUBSTANCE (3) and/or SUBSTANCE (2). Also, leave the respective fields AGE AT FIRST USE, FREQUENCY OF USE, PEAK USE, METHOD, and DATE LAST USED blank.

Edits:

This transaction will not process if the Primary Keys are invalid.

Transaction Errors

99999	Error:
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Header	BATCH NUMBER	Return to Table of Contents	Effective Date: 04/01/2016
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Definition:

A sequential number assigned to the batch file by the submitting BHO.

Code Values:

N/A

Business Rules:

When the batch number exceeds 99999, the submitting agency will reset the batch number to 00001.

Field Format:

Length: 5 (fill with leading zeros)

Type: CHAR

Data Element History:

BATCH DATE	Return to Table of Contents	Effective Date: 04/01/2016
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Definition:

Date a batch file of transactions was created by a submitting BHO.

Code Values:

N/A

Business Rules:

Field Format:

Length: 8

Type: DATE (CCYYMMDD)

Data Element History:

Client Address	ADDRESS LINE 1	Return to Table of Contents	Effective Date: 04/01/2016
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Definition:

Indicates the street address where the client currently resides.

Code Values:

N/A

Business Rules:

Required field for all mental health and substance use disorder clients

Optional for SUD clients in withdrawal management services, but should be reported if possible.

If unknown, write “unknown” in this field (ADDRESS LINE 1). Do not put unknown in any of the other Address fields, rather keep the rest of the Address fields blank.

If client is homeless or unable to provide a street address, report what is available, including city, state or zip code. In the case of residence in a tent in the woods, report closest city, state or zip code.

Field Format:

Length: 120

Type: CHAR

Data Element History:

ADDRESS LINE 2	Return to Table of Contents	Effective Date: 04/01/2016
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Definition:

Indicates the street address where the client currently resides.

Code Values:

N/A

Business Rules:

Required field for all mental health and substance use disorder clients, if a 2 line address is appropriate.

Optional for SUD clients in withdrawal management services, but should be reported if possible.

If client is homeless or unable to provide a street address, report what is available, including city, state or zip code. In the case of residence in a tent in the woods, report closest city, state or zip code.

Field Format:

Length: 120

Type: CHAR

Data Element History:

CITY	Return to Table of Contents	Effective Date: 04/01/2016
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Definition:

Indicates the client's current city of residence.

Code Values:

N/A

Business Rules:

Required field for all mental health and substance use disorder clients.

Optional for SUD clients in withdrawal management services, but should be reported if possible.

If client is homeless or unable to provide a street address, report what is available, including city, state or zip code. In the case of residence in a tent in the woods, report closest city, state or zip code.

Field Format:

Length: 50

Type: CHAR

Data Element History:

COUNTY	Return to Table of Contents	Effective Date: 04/01/2016
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Definition:

Indicates the county where the client currently resides.

Code Values:

Code	Definition	Code	Definition
53001	Adams	53041	Lewis
53003	Asotin	53043	Lincoln
53005	Benton	53045	Mason
53007	Chelan	53047	Okanogan
53009	Clallam	53049	Pacific
53011	Clark	53051	Pend Oreille
53013	Columbia	53053	Pierce
53015	Cowlitz	53055	San Juan
53017	Douglas	53057	Skagit
53019	Ferry	53059	Skamania
53021	Franklin	53061	Snohomish
53023	Garfield	53063	Spokane
53025	Grant	53065	Stevens
53027	Grays Harbor	53067	Thurston
53029	Island	53069	Wahkiakum
53031	Jefferson	53071	Walla Walla
53033	King	53073	Whatcom
53035	Kitsap	53075	Whitman
53037	Kittitas	53077	Yakima
53039	Klickitat	30050	Unknown or out of state

Business Rules:

Required field for all mental health and substance use disorder clients.

Optional for SUD clients in withdrawal management services, but should be reported if possible.

If client is homeless or unable to provide a street address, report what is available, including city, state or zip code (or the closest by proximity).

Field Format:

Length: 5

Type: CHAR

Data Element History:

STATE	Return to Table of Contents	Effective Date: 04/01/2016
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Definition:

Indicates the US postal service standard two-letter abbreviation of the state where the client currently resides.

Code Values:

N/A

Business Rules:

Required field for all mental health and substance use disorder clients.

Optional for SUD clients in withdrawal management services, but should be reported if possible.

If client is homeless or unable to provide a street address, report what is available, including city, state or zip code (or the closest by proximity).

Field Format:

Length: 2

Type: CHAR

Data Element History:

ZIP CODE	Return to Table of Contents	Effective Date: 04/01/2016
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Definition:

Indicates the zip code of the area where the client currently resides.

Code Values:

N/A

Business Rules:

Required field for all mental health and substance use disorder clients.

Optional for SUD clients in withdrawal management services, but should be reported if possible.

If client is homeless or unable to provide a street address, report what is available, including city, state or zip code (or the closest by proximity).

Adding the +4 at the end of the zip code is not needed, but will not cause problems if included.

Field Format:

Length: 10

Type: CHAR

Data Element History:

<p>ASAM Placement</p>	<p>ASAM ASSESSMENT DATE</p>	<p>Return to Table of Contents</p>	<p>Effective Date: 04/01/2016</p>
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Definition:

Date the ASAM level was determined.

Code Values:

N/A

Business Rules:

Required at admission and anytime thereafter that it is collected.

Required for all substance use disorder clients, including SUD clients receiving Withdrawal Management Services.

Field Format:

Length: 8

Type: DATE (CCYYMMDD)

Data Element History:

ASAM LEVEL	Return to Table of Contents	Effective Date: 04/01/2016
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Definition:

Indicates the level of care that the counselor recommends for the client.

Code Values:

Level	Definition
0	Level 0 No further ASAM placement level recommended.
0.5	Level 0.5 Willing to understand how current use affects them. Early Intervention
1	Level 1 Willing to cooperate, needs motivating strategies. Outpatient
2.1	Level 2.1 Resistance high enough to require structured program. Intensive Outpatient
2.5	Level 2.5 Resistance high enough to require structured program. Outpatient with Partial Hospitalization
3.1	Level 3.1 Open to recovery, needs structured environment to maintain. Clinically Managed Low Intensity Residential Services
3.2-D	Level 3.2-D Clinically managed residential withdrawal management sub-acute withdrawal management
3.3	Level 3.3 Little awareness, client needs intervention to engage. Clinically Managed Medium Intensity Residential Services
3.5	Level 3.5 Marked difficulty with opposition to treatment with dangerous consequences if not engaged in treatment. Clinically Managed Med/High Intensity Residential Services
3.7	Level 3.7 Resistance high and impulse control poor despite negative consequences; client needs 24 hour structured setting. Medically Monitored Intensive Inpatient Services (sobering unit)
3.7-D	Level 3.7-D Clinically managed residential withdrawal management acute withdrawal management
4	Level 4 Problems in this dimension do not qualify the client for Level IV series. Medically Managed Intensive Inpatient Services, Detox or Hospital
OST	Level OST OP Resistance high enough to require structured therapy. Opioid Substitution Treatment

Business Rules:

Required at admission and anytime thereafter that it is collected.

Required for all substance use disorder clients, including SUD clients receiving Withdrawal Management Services.

Field Format:

Length: 6

Type: CHAR

Data Element History:

<p>Authorization</p>	<p>AUTHORIZATION DECISION DATE</p>	<p>Return to Table of Contents</p>	<p>Effective Date: 04/01/2016</p>
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Definition:

The date the authorization decision was made by the BHO.

Code Values:

N/A

Business Rules:

Required for all mental health and substance use disorder clients at intake/assessment and when authorization status is updated.

Field Format:

Length: 8

Type: DATE (CCYYMMDD)

Data Element History:

AUTHORIZATION ID	Return to Table of Contents	Effective Date: 04/01/2016
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Definition:

A unique number assigned to an authorization. Created by the BHO. Must be unique within the BHO.

Code Values:

N/A

Business Rules:

Every authorization must have a unique authorization ID.

Field Format:

Length: 40

Type: CHAR

Data Element History:

AUTHORIZATION START DATE	Return to Table of Contents	Effective Date: 04/01/2016
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Definition:

Indicates the start date of the client's authorization for services. Does not indicate the date authorization was requested, but rather the start of the authorization period.

Code Values:

N/A

Business Rules:

Reported for all mental health and substance use disorder clients for whom an authorization is requested.

Field Format:

Length: 8

Type: DATE (CCYYMMDD)

Data Element History:

<p>AUTHORIZATION END DATE</p>	<p>Return to Table of Contents</p>	<p>Effective Date: 04/01/2016</p>
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Definition:

Indicates the end date of the client’s authorization for services.

Code Values:

N/A

Business Rules:

Reported for all mental health and substance use disorder clients who are authorized for services.

Field Format:

Length: 8

Type: DATE (CCYYMMDD)

Data Element History:

AUTHORIZATION DECISION	Return to Table of Contents	Effective Date: 04/01/2016
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Definition:

Indicates BHO decision regarding authorization for treatment. Indicates whether the client met the Access to Care standards or the ASAM criteria and was authorized for services by BHO. Authorization decision does not determine which CPT\HCPC codes can be sent and processed by ProviderOne.

Code Values:

Code	Definition
1	Authorized for Substance Use Disorder
2	Authorized for Mental Health
3	Authorized for Mental Health and authorized for Substance Use Disorder
4	No authorization required as no services following intake were requested
5	Denied/Doesn't meet medical necessity

Business Rules:

Required for all mental health and substance use clients at intake/assessment and whenever authorization status changes.

If a client is authorized at the same time to receive Substance Use Disorder and Mental Health then report both (code 3).

If the client is authorized to receive Substance User Disorder and Mental Health services in separate authorization requests then report each under a separate transaction.

Report regardless of whether or not the client received services.

Field Format:

Length: 2

Type: CHAR

Data Element History:

Effective Date	EFFECTIVE DATE	Return to Table of Contents	Effective Date: 04/01/2016
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Definition:

This field is found in the following transactions and indicates the date the information was collected:

CLIENT ADDRESS
 CLIENT DEMOGRAPHICS
 CLIENT PROFILE
 SUBSTANCE USE

Code Values:

N/A

Business Rules:

Must always be reported within the Client Address, Client Demographics, Client Profile and Substance Use transactions.

Field Format:

Length: 8

Type: DATE (CCYYMMDD)

Data Element History:

Client Demographics	FIRST NAME	Return to Table of Contents	Effective Date: 04/01/2016
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Definition:

Indicates the first/informal names of a client as provided by a BHO. In general, follow the rules of the appropriate culture when determining which name is the last name and which the first name. Consistency is important here, because the last name and first names are both used as elements to uniquely identify the person across the system.

Code Values:

N/A

Business Rules:

Required for all mental health and substance use disorder clients

Field Format:

Length: 35

Type: CHAR

Data Element History:

MIDDLE NAME	Return to Table of Contents	Effective Date: 04/01/2016
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Definition:

Indicates the full middle name of the client. Use the full middle name if available, otherwise use the middle initial.

Code Values:

N/A

Business Rules:

If no middle name is available, leave blank.

Field Format:

Length: 25

Type: CHAR

Data Element History:

LAST NAME	Return to Table of Contents	Effective Date: 04/01/2016
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Definition:

Indicates the surname/family/last name of a client as provided by a BHO. In general, follow the rules of the appropriate culture when determining which name is the surname. Consistency is important here because the last name will be used as one element to uniquely identify the person.

Code Values:

N/A

Business Rules:

Required for all mental health and substance use disorder clients.

Field Format:

Length: 60

Type: CHAR

Data Element History:

ALTERNATE LAST NAME	Return to Table of Contents	Effective Date: 04/01/2016
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Definition:

Indicates any other last name by which the client may have reported.

Code Values:

N/A

Business Rules:

Required for all mental health and substance use disorder clients, if client has an alternate last name.

If a client has multiple last names, choose one.

Field Format:

Length: 60

Type: CHAR

Data Element History:

SOCIAL SECURITY NUMBER	Return to Table of Contents	Effective Date: 04/01/2016
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Definition:

A number assigned by the Social Security Administration which identifies a person.

Code Values:

N/A

Business Rules:

Required for all mental health and substance use disorder clients
Leave blank if unknown or refused.

Do not allow entries that are obviously invalid, for example:

123456789

000000000

111111111

222222222

333333333

444444444

555555555

666666666

777777777

888888888

999999999

Field Format:

Length: 9

Type: CHAR

Data Element History:

BIRTHDATE	Return to Table of Contents	Effective Date: 04/01/2016
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Definition:

Indicates the date a person was born.

Code Values:

N/A

Business Rules:

Required for all mental health and substance use disorder clients

If DOB is not available, enter 29991231, which is the value used by the ProviderOne Medicaid Billing system for missing DOB.

Field Format:

Length: 8

Type: DATE (CCYYMMDD)

Data Element History:

GENDER	Return to Table of Contents	Effective Date: 04/01/2016
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Definition:

Indicates a person's self-identified gender.

Code Values:

Code	Definition
1	Female
2	Male
4	Transgender
5	Intersex: Person born with characteristics of both
6	Unknown

Business Rules:

Required for all mental health and substance use disorder clients.

Only one option allowed.

Collected at intake or assessment and whenever status changes.

Field Format:

Length: 2

Type: CHAR

Data Element History:

HISPANIC ORIGIN	Return to Table of Contents	Effective Date: 04/01/2016
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Definition:

Indicates the Hispanic origin of the client (e.g. Mexican, Puerto Rican, Cuban, Central American or South American, or other Spanish origin or descent, regardless of race). Hispanic denotes a place of origin or cultural affiliation rather than a race (i.e. a person can be both white and Hispanic or black and Hispanic and so on).

Code Values:

Code	Definition
709	Cuban
000	Hispanic - Specific Origin Unknown
722	Mexican
998	Not of Hispanic Origin
799	Other Specific Hispanic (e.g., Chilean, Salvadoran, Uruguayan)
727	Puerto Rican
999	Unknown

Business Rules:

Required for all mental health and substance use disorder clients at intake/assessment and whenever status changes.

Only one option allowed.

Field Format:

Length: 3

Type: CHAR

Data Element History:

MILITARY SERVICE	Return to Table of Contents	Effective Date: 04/01/2016
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Definition:

Indicates if the client has ever served as an active member in the U.S. military,.

Code Values:

Code	Definition
1	Yes
2	No

Business Rules:

Required for all mental health and substance use disorder clients at intake/assessment and whenever status changes.

Report code 1 (Yes) regardless of length of service or if the client was dishonorably discharged.

Field Format:

Length: 2

Type: CHAR

Data Element History:

PRIMARY LANGUAGE	Return to Table of Contents	Effective Date: 04/01/2016
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Definition:

Indicates the primary speaking language of the client as used in the home, if that language is not English.

Code Values:

Code	Definition
23	Amharic
33	Arabic
15	American Sign Language
06	Cambodian
16	Cantonese
34	Other Chinese Not Cantonese or Mandarin
26	Czech
35	Dutch
25	Farsi
24	Finnish
12	French
14	German
21	Greek
36	Gujarati
32	Hindi
08	Hmong
17	Hungarian
10	Ilocano
37	Indian
38	Italian
01	Japanese
02	Korean
39	Lakota Sioux
05	Laotian
40	Malay
07	Mandarin
41	Marathi
27	Mien
42	Norwegian
99	Other Languages
20	Polish
30	Puyallup
19	Romanian
18	Russian
29	Salish
09	Samoan
03	Spanish
11	Tagalog
31	Thai
22	Tigrigna
43	Ukrainian
04	Vietnamese
28	Yakama

Business Rules:

Required for all mental health and substance use disorder clients at intake/assessment and whenever status changes.

Field Format:

Length: 2

Type: CHAR

Data Element History:

RACE(S)	Return to Table of Contents	Effective Date: 04/01/2016
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Definition:

Indicates the race(s) the client identifies as. Race categories are based on the US Department of Health and Human Services implementation collection standards for race and ethnicity with the addition of 3 categories: Cambodian, Laotian, and Middle Eastern.

Code Values:

Code	Definition
021	American Indian/ Alaskan Native
031	Asian Indian
040	Black or African American
604	Cambodian
605	Chinese
608	Filipino
660	Guamanian or Chamorro
032	Native Hawaiian
611	Japanese
010	White
612	Korean
613	Laotian
801	Middle Eastern
034	Other Asian
033	Other Pacific Islander
050	Other Race
999	Not Provided

Business Rules:

Required for all mental health and substance use disorder clients at intake/assessment and whenever status changes.

Select one or more categories, if a person selects more than 1 code, enter each one in sequence.

If client does not identify with any of the coded races, then code "050" for Other Race.

If information is not available or unknown, then code "999".

Field Format:

Length: 3

Type: CHAR

Data Element History:

SEXUAL ORIENTATION	Return to Table of Contents	Effective Date: 04/01/2016
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Definition:

Indicates a person's voluntarily stated sexual orientation.

Code Values:

Code	Definition
4	Bisexual Term for women and men whose sexual/affectional identity is oriented to members of both the same and opposite sex.
9	Choosing not to disclose Use when an individual is uncomfortable or unwilling to disclose their sexual orientation.
3	Gay/Lesbian/Queer/Homosexual Attraction to persons of the same sex.
1	Heterosexual Attraction to persons of the opposite sex
5	Questioning Term generally used for adolescents who may be in the process of becoming more comfortable with their sexual orientation identification. Usually describes a youth who may be exploring identifying as gay/lesbian in a culture that generally assumes identification as heterosexual.

Business Rules:

Only one option allowed.

Required for all mental health and substance use disorder clients at intake/assessment and whenever status changes.

Do not collect for individuals under age 13.

Field Format:

Length: 2

Type: CHAR

Data Element History:

Client Profile	EDUCATION	Return to Table of Contents	Effective Date: 04/01/2016
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Definition:

Indicates the educational achievement of the client. Report the current grade level (i.e. if in 8th grade, report code 11).

Code 15 indicates client is completing fourth year of high school, and does not have a high school diploma or GED.

Code 16 indicates client has high school diploma or GED, but no college.

Code 20 indicates client is in their fourth year of college.

Code 21 indicates client has Bachelor's Degree, but no graduate school.

Code Values:

Code	Definition
1	No formal schooling
2	Nursery school, pre-school, head start
3	Kindergarten, Less than one school grade
4	Grade 1
5	Grade 2
6	Grade 3
7	Grade 4
8	Grade 5
9	Grade 6
10	Grade 7
11	Grade 8
12	Grade 9
13	Grade 10
14	Grade 11
15	Grade 12
16	High School Diploma or GED
17	1st Year of College/University (Freshman)
18	2nd Year of College/University (Sophomore) or Associate Degree
19	3rd Year of College/University (Junior)
20	4th Year of College (Senior)
21	Bachelor's Degree
22	Graduate or professional school - includes Master's and Doctoral degrees, medical school, law school, etc.
23	Vocational School - includes business, technical, secretarial, trade, or correspondence courses which provide specialized training for skilled employment.
97	Unknown

Business Rules:

Required for all mental health and substance use disorder clients at admission, discharge and updated every 90 days

Field Format:

Length: 2

Type: CHAR

Data Element History:

EMPLOYMENT	Return to Table of Contents	Effective Date: 04/01/2016
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Definition:

Indicates the client's current employment or primary daily activity as per Washington Administrative Code 458-20-267. If the client engages in multiple employment or daily activities, report the highest level of employment or activity.

Code Values:

Code	Definition
01	FULL TIME – works at least 35 hours per week; includes members of the Armed Forces, and clients in full-time Supported Employment
02	PART TIME – works less than 35 hours per week; includes clients in part-time Supported Employment
03	UNEMPLOYED – defined as actively looking for work or laid off from job (and awaiting to be recalled) in the past 30 days
05	EMPLOYED – FULL TIME/PART TIME– full time or part time status cannot be ascertained
Use the appropriate valid code for the specified classification of a person who is 'Not in the Labor Force,' defined as not employed and not actively looking for work during the past 30 days (i.e. people not interested to work or people who have been discouraged to look for work).	
14	HOMEMAKER
24	STUDENT
34	RETIRED
44	DISABLED
64	OTHER REPORTED CLASSIFICATION (e.g. volunteers)
74	SHELTERED/NON-COMPETITIVE EMPLOYMENT
96	NOT APPLICABLE
97	UNKNOWN
98	NOT COLLECTED

Business Rules:

Required for all mental health and substance use disorder clients.

Collected at admission and discharge and updated every 90 days.

“Highest level of employment or activity” corresponds to the value code (i.e. code 01, FULL TIME is a higher level than code 02, PART TIME).

Only use Code 98 (NOT COLLECTED) if unable to collect because crisis phone service or pre-intake service was provided.

Field Format:

Length: 2

Type: CHAR

Data Element History:

MARITAL STATUS	Return to Table of Contents	Effective Date: 04/01/2016
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Definition:

Indicates the current marital status of the client.

Code Values:

Code	Definition
1	Single or Never married: Includes clients who are single or whose only marriage was annulled
2	Now married or Committed Relationship: Includes married couples, those living together as married, living with partners, or cohabiting
3	Separated: Includes married clients legally separated or otherwise absent from spouse because of marital discord
4	Divorced: Includes clients who are not in a relationship and whose last relationship was a marriage dissolved by judicial declaration
5	Widowed: Includes clients who are not in a relationship and whose last relationship was a marriage and their spouse died.
97	Unknown

Business Rules:

Only one option allowed.

Required for all mental health and substance use disorder clients.

Collected at admission, discharge and updated every 90 days.

Field Format:

Length: 2

Type: CHAR

Data Element History:

PARENTING	Return to Table of Contents	Effective Date: 04/01/2016
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Definition: Indicates whether a client has dependent children. Dependent children are defined as 6 years of age or younger. “Parenting” indicates some form level of custodial or child support responsibility (i.e. part-time custody or when there is not custody, but parent pays child support).

Code Values:

Code	Definition
Y	Yes
N	No

Business Rules:

Required for female Substance Use Disorder clients only, optional for all other substance use disorder or mental health clients.

Collected at admission, discharge and updated every 90 days.

Field Format:

Length: 1

Type: CHAR

Data Element History:

PREGNANT	Return to Table of Contents	Effective Date: 04/01/2016
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Definition:

Indicates whether a client is pregnant.

Code Values:

Code	Definition
Y	Yes
N	No

Business Rules:

Required for all female clients who receive Substance Use Disorder services and optional for mental health clients.

Collected at admission, discharge and updated every 90 days

Field Format:

Length: 1

Type: CHAR

Data Element History:

SMOKING STATUS	Return to Table of Contents	Effective Date: 04/01/2016
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Definition:

Indicates a client's smoking status. In this case, vaping is not considered a form of smoking.

Code Values:

Code	Definition
1	Current smoker
2	Former smoker
3	Never smoked

Business Rules:

Required for all mental health and substance use disorder clients

Collected at admission, discharge, and updated every 90 days.

Field Format:

Length: 1

Type: CHAR

Data Element History:

RESIDENCE	Return to Table of Contents	Effective Date: 04/01/2016
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Definition:

Indicates client's primary residence over the last thirty days preceding date of collection.

Code Values:

Code	Definition
1	HOMELESS – person has no fixed address; includes homeless, shelters
2	FOSTER HOME/FOSTER CARE – individual resides in a foster home. A foster home is a home that is licensed by a county or State department to provide foster care to children, adolescents, and/or adults. This includes therapeutic foster care facilities. Therapeutic foster care is a service that provides treatment for troubled children within private homes of trained families.
3	RESIDENTIAL CARE – individual resides in a residential care facility. This level of care may include a group home, therapeutic group home, board and care, residential treatment, rehabilitation center, or agency-operated residential care facilities
4	CRISIS RESIDENCE – a time-limited residential (24 hours/day) stabilization program that delivers services for acute symptom reduction and restores clients to a pre-crisis level of functioning
5	INSTITUTIONAL SETTING – individual resides in an institutional care facility with care provided on a 24 hour, 7 days a week basis. This level of care may include skilled nursing/ intermediate care facility, nursing homes, institute of mental disease (IMD), inpatient psychiatric hospital, psychiatric health facility, veterans' affairs hospital, or state hospital.
6	JAIL/CORRECTIONAL FACILITY – individual resides in a jail and/or correctional facility with care provided on a 24 hour, 7 days a week basis. This includes a jail, correctional facility, detention centers, and prison.
7	PRIVATE RESIDENCE , For adults only: this category reflects the living arrangement of adult clients where "independent"/"dependent" status is unknown. Otherwise, use "independent living"/"dependent living" as appropriate.
8	INDEPENDENT LIVING – For adults only: this category describes adult clients living independently in a private residence and capable of self-care. It includes clients who live independently with case management support or with supported housing supports. This category also includes clients who are largely independent and choose to live with others for reasons not related to mental illness. They may live with friends, spouse, or other family members. The reasons for shared housing could include personal choice related to culture and/or financial considerations.
9	DEPENDENT LIVING – For adults only: this category describes adult clients living in a house, apartment, or other similar dwellings and are heavily dependent on others for daily living assistance
10	PRIVATE RESIDENCE , For children only – use this code for all children living in a private residence regardless of living arrangement.
11	OTHER RESIDENTIAL STATUS
97	UNKNOWN

Business Rules:

Required for all mental health and substance use disorder clients

Use "UNKNOWN" if a particular situation does not fit in one of the categories

Codes for "PRIVATE RESIDENCE – adult only", "DEPENDENT LIVING", and "INDEPENDENT LIVING" should be used for adult clients only (age 18 and over)

Children / Adults who live in family foster homes and therapeutic foster homes should use "FOSTER HOME/FOSTER CARE" and **NOT** "PRIVATE RESIDENCE"

Although reported every 90 days, the living situation indicates where the client was the majority of the time in the preceding 30 days. It is optional to report this element on a more frequent basis in order to capture a change in residence.

Field Format:

Length: 2
Type: CHAR

Data Element History:

SCHOOL ATTENDANCE	Return to Table of Contents	Effective Date: 04/01/2016
--------------------------	---	-------------------------------

Definition:

Indicates if the client has attended any form of school within the last 3 months.

Code Values:

Code	Definition
Y	Yes, client has attended school at any time in the past 3 months
N	No, client has not attended school at any time in the past 3 months

Business Rules:

Required for all mental health and substance use disorder clients, regardless of age.

Collected at admission, discharge, and updated every 90 days.

Field Format:

Length: 1

Type: CHAR

Data Element History:

SELF HELP COUNT	Return to Table of Contents	Effective Date: 04/01/2016
------------------------	---	-------------------------------

Definition:

Indicates the average number of times in a week the client has attended a self-help program in the thirty days preceding the date of collection. Includes attendance at AA, NA, and other self-help/mutual support groups focused on recovery from Substance Use Disorder and dependence.

Code Values:

Code	Definition
1	No attendance
2	Less than once a week
3	About once a week
4	2 to 3 times per week
5	At least 4 times a week
97	Unknown
6	Not Collected

Business Rules:

Required for clients receiving Substance Use Disorder services; optional for clients receiving Mental Health services.

Collected at admission and discharge and updated every 90 days.

Field Format:

Length: 2

Type: CHAR

Data Element History:

USED NEEDLE RECENTLY	Return to Table of Contents	Effective Date: 04/01/2016
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Definition:

Indicates if the client has injected illicit or unprescribed drugs in the last 30 days.

Code Values:

Code	Definition
Y	Yes
N	No

Business Rules:

Required field for SUBSTANCE USE DISORDER clients; optional for mental health clients.

Collected at admission and discharge and updated every 90 days.

Field Format:

Length: 1

Type: CHAR

Data Element History:

NEEDLE USE EVER	Return to Table of Contents	Effective Date: 04/01/2016
------------------------	---	-------------------------------

Definition:

Indicates if the client has ever used needles to inject illicit or unprescribed drugs.

Code Values:

Code	Definition
1	Continuously
2	Intermittently
3	Rarely
4	Never

Business Rules:

Required field for all Substance Use Disorder; optional for mental health clients.

Collected at admission, discharge, and updated every 90 days.

Field Format:

Length: 2

Type: CHAR

Data Element History:

<p>Co-Occurring Disorder</p>	<p>GAINS DATE</p>	<p>Return to Table of Contents</p>	<p>Effective Date: 04/01/2016</p>
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Definition:

Date a GAINS screening or assessment (or both) was recorded.

Code Values:

N/A

Business Rules:

Required at intake/assessment for all mental health and substance use disorder clients.

Field Format:

Length: 8

Type: DATE (CCYYMMDD)

Data Element History:

SCREEN ASSESSMENT INDICATOR	Return to Table of Contents	Effective Date: 04/01/2016
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Definition:

An indicator used to identify if a Co-occurring Disorder transaction is used to report GAINS screening scores, a GAINS assessment or both.

Code Values:

Code	Definition
A	GAINS Assessment
S	GAINS Screening
B	Both

Business Rules:

Required at intake/assessment for all mental health and substance use disorder clients.

Field Format:

Length: 1

Type: CHAR

Data Element History:

CO-OCCURRING DISORDER ASSESSMENT	Return to Table of Contents	Effective Date: 04/01/2016
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Definition:

Indicates the Co-occurring Disorders Assessment quadrant value.

Code Values:

Code	Definition
1	Less severe mental health disorder/Less severe substance use disorder
2	More severe mental health disorder/Less severe substance disorder
3	Less severe mental health disorder/More severe substance disorder
4	More severe mental health disorder/More severe substance disorder
9	No Co-occurring treatment need

Business Rules:

Required at intake/assessment for all mental health and substance use disorder clients only if the client screens high (2 or higher) on either the IDS or EDS, and on SDS.

Field Format:

Length: 2

Type: CHAR

Data Element History:

CO-OCCURRING DISORDER SCREENING (IDS)	Return to Table of Contents	Effective Date: 04/01/2016
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Definition:

The IDS score is one of 3 produced upon completion of the co-occurring disorders screening process. The IDS score is one of three scores from the outcome of a screening using GAIN Short Screen (GAIN-SS) tool.

Code Values:

Code	Definition
0	IDS Score of 0
1	IDS Score of 1
2	IDS Score of 2
3	IDS Score of 3
4	IDS Score of 4
5	IDS Score of 5
8	Refused
9	Unable to Complete

Business Rules:

When reporting the outcome of a completed screening, a value between 0 (zero) and 5 must be provided for the IDS score.

Use 8 to indicate the client refuses to participate in the specific scale.

Use 9 to indicate the client is unable to complete the specific scale.

Field Format:

Length: 2

Type: CHAR

Data Element History:

CO-OCCURRING DISORDER SCREENING (EDS)	Return to Table of Contents	Effective Date: 04/01/2016
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Definition:

The EDS Score is one of 3 produced upon completion of the co-occurring disorders screening process. The EDS score is one of three scores from the outcome of a screening using GAIN Short Screen (GAIN-SS) tool.

Code Values:

Code	Definition
0	EDS Score of 0
1	EDS Score of 1
2	EDS Score of 2
3	EDS Score of 3
4	EDS Score of 4
5	EDS Score of 5
8	Refused
9	Unable to Complete

Business Rules:

When reporting the outcome of a completed screening, a value between 0 (zero) and 5 must be provided for the EDS score.

Use 8 to indicate the client refuses to participate in the specific scale.

Use 9 to indicate the client is unable to complete the specific scale.

Field Format:

Length: 2

Type: CHAR

Data Element History:

CO-OCCURRING DISORDER SCREENING (SDS)	Return to Table of Contents	Effective Date: 04/01/2016
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Definition:

The SDS Score is one of 3 produced upon completion of the co-occurring disorders screening process. The SDS score is one of three scores from the outcome of a screening using GAIN Short Screen (GAIN-SS) tool.

Code Values:

Code	Definition
0	SDS Score of 0
1	SDS Score of 1
2	SDS Score of 2
3	SDS Score of 3
4	SDS Score of 4
5	SDS Score of 5
8	Refused
9	Unable to Complete

Business Rules:

When reporting the outcome of a completed screening, a value between 0 (zero) and 5 must be provided for the SDS score.

Use 8 to indicate the client refuses to participate in the specific scale.

Use 9 to indicate the client is unable to complete the specific scale.

Field Format:

Length: 2

Type: CHAR

Data Element History:

DMHP Investigation	INVESTIGATION START DATE	Return to Table of Contents	Effective Date: 04/01/2016
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Definition:

Indicates the date the individual was advised of their rights under RCW 71.05/71.34.

Code Values:

N/A

Business Rules:

An individual can have only one investigation start date during a single encounter.

Only collected for persons being investigated under the Involuntary Treatment Act.

Field Format:

Length: 8

Type: DATE (CCYYMMDD)

Data Element History:

INVESTIGATION START TIME	Return to Table of Contents	Effective Date: 04/01/2016
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Definition:

Time of day an investigation was started. This is used to separate multiple investigations for the same person on the same day.

Code Values:

N/A

Business Rules:

Only collected for persons being investigated under the Involuntary Treatment Act. Submit investigation start time anytime an Investigation Start Date is submitted.

Submit time values using a 24-hour clock.

Field Format:

Length: 4

Format: TIME (HHMM)

Data Element History:

2015-11-30: added data element

INVESTIGATION COUNTY CODE	Return to Table of Contents	Effective Date: 04/01/2016
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Definition:

Indicates the county in which a person was investigated under the Involuntary Treatment Act.

Code Values:

Code	Definition	Code	Definition
53001	Adams	53041	Lewis
53003	Asotin	53043	Lincoln
53005	Benton	53045	Mason
53007	Chelan	53047	Okanogan
53009	Clallam	53049	Pacific
53011	Clark	53051	Pend Oreille
53013	Columbia	53053	Pierce
53015	Cowlitz	53055	San Juan
53017	Douglas	53057	Skagit
53019	Ferry	53059	Skamania
53021	Franklin	53061	Snohomish
53023	Garfield	53063	Spokane
53025	Grant	53065	Stevens
53027	Grays Harbor	53067	Thurston
53029	Island	53069	Wahkiakum
53031	Jefferson	53071	Walla Walla
53033	King	53073	Whatcom
53035	Kitsap	53075	Whitman
53037	Kittitas	53077	Yakima
53039	Klickitat	30050	Unknown or out of state

Business Rules:

Only collected for persons being investigated under the Involuntary Treatment Act

Field Format:

Length: 5

Type: CHAR

Data Element History:

INVESTIGATION OUTCOME	Return to Table of Contents	Effective Date: 04/01/2016
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Definition:

Indicates the outcome of a DMHP investigation.

Code Values:

Code	Definition
1	Detention to MENTAL HEALTH facility (72 hours as identified under the Involuntary Treatment Act, RCW 71.05).
2	Referred to voluntary Outpatient mental health services.
3	Referred to voluntary Inpatient mental health services.
4	Returned to Inpatient facility/filed revocation petition.
5	Filed petition-recommending LRA extension.
6	Referred to non-mental health community resources.
7	Detention to Secure Detox facility (72 hours as identified under RCW 70.96B)
9	Other.
10	Referred to acute detox.
11	Referred to sub-acute detox.
12	Referred to sobering unit.
13	Referred to crisis triage.
14	Referred to chemical dependency intensive outpatient program.
15	Referred to chemical dependency inpatient program.
16	Referred to chemical dependency residential program.
17	No detention – E&T provisional acceptance did not occur within statutory timeframes
18	No detention – Unresolved medical issues
19	Non-emergent detention petition filed
20	Did not require MH or CD services
21	Referred for hold under RCW 70.96A
22	Petition filed for outpatient evaluation
23	Filed petition recommending AOT extension

Business Rules:

Code "1" if the person was informed of their rights and involuntarily detained. A person may have been informed of their rights and may have decided to be treated voluntarily (code 2, 3, or code 10 – 16)

Only collected for persons being investigated under the Involuntary Treatment Act

Field Format:

Length: 2

Type: CHAR

Data Element History:

DETENTION FACILITY NPI	Return to Table of Contents	Effective Date: 04/01/2016
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Definition:

This field is found in the following transactions and indicates the NPI for the facility where a detention occurs:

DMHP INVESTIGATION
ITA HEARING

Code Values:

N/A

Business Rules:

Only collected for persons being investigated under the Involuntary Treatment Act.

Field Format:

Length: 10
Type: CHAR

Data Element History:

LEGAL REASON FOR DETENTION/COMMITMENT	Return to Table of Contents	Effective Date: 04/01/2016
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Definition:

Indicates the reason for detention/commitment.

Code Values:

Code	Definition
A	Dangerous to Self
B	Dangerous to Others
C	Gravely Disabled
D	Dangerous to property
X	Revoked for reasons other than above
Z	NA- person was not involuntarily detained under ITA

Business Rules:

Up to 4 options may be submitted per detention.

Only collected for persons being investigated under the Involuntary Treatment Act

Field Format:

Length: 1

Type: CHAR

Data Element History:

RETURN TO INPATIENT/REVOCATION AUTHORITY	Return to Table of Contents	Effective Date: 04/01/2016
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Definition:

Identifies the basic reason for revoking a person. See RCW 71.05.340(3)(a) & (b).

Note: This element is specific to returning a consumer under LRA to inpatient treatment and the filing of a revocation petition. It distinguishes legal criteria used for person on LRA being returned to inpatient treatment. Use code "9" for all cases where the person is placed on LRA or not committed.

Code Values:

Code	Definition
1	DMHP determined detention during course of investigation per RCW 71.05.340(3)(a).
2	Outpatient provider requested revocation per RCW 71.05.340(3)(b) or RCW 71.34 for kids.
9	N/A

Business Rules:

Only collected for persons being investigated under the Involuntary Treatment Act

Field Format:

Length: 2

Type: CHAR

Data Element History:

DMHP AGENCY NPI	Return to Table of Contents	Effective Date: 04/01/2016
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Definition:

Indicates the NPI for the Agency that employs the DMHP that provides ITA investigation services.

If DMHP is employed by multiple agencies then report only one of the agencies.

If DMHP is from BHO who do not have NPI then report BHO ID.

Code Values:

N/A

Business Rules:

Only collected for persons being investigated under the Involuntary Treatment Act

Field Format:

Length: 10

Type: CHAR

Data Element History:

INVESTIGATION REFERRAL SOURCE	Return to Table of Contents	Effective Date: 04/01/2016
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Definition:

Indicates the source of the referral for an ITA investigation.

Code Values:

Code	Definition
8	<u>Law Enforcement</u>
2	<u>Hospital</u>
5	<u>Legal Representative:</u> The person with legal responsibility over/for the individual
1	<u>Family:</u> Spouse, parent, child, sibling
3	<u>Professional:</u> Physician, Behavioral Health Treatment Provider, Child/Adult Protective Services
7	<u>Social Service Provider</u>
4	<u>Care Facility:</u> Assisted Living, adult family homes, nursing homes, behavioral health residential setting, rehabilitation facility
9	<u>Community:</u> landlord, business, neighbors
6	<u>School:</u> primary, secondary, or post-secondary school
10	<u>Other</u>

Business Rules:

Only collected for persons being investigated under the Involuntary Treatment Act.

Field Format:

Length: 2

Type: CHAR

Data Element History:

INVESTIGATION END DATE	Return to Table of Contents	Effective Date: 04/01/2016
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Definition:

Indicates the date the DMHP secured provisional acceptance from an E&T provider, or made the determination not to detain an individual under RCW 71.05/71.34.

Code Values:

N/A

Business Rules:

The INVESTIGATION START DATE cannot be greater than the INVESTIGATION END DATE
Only collected for persons being investigated under the Involuntary Treatment Act

Field Format:

Length: 8

Type: DATE (CCYYMMDD)

Data Element History:

<p>ITA Hearing</p>	<p>HEARING DATE</p>	<p>Return to Table of Contents</p>	<p>Effective Date: 04/01/2016</p>
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Definition:

Indicates the date of an Involuntary Treatment Act court hearing.

Code Values:

N/A

Business Rules:

Only reported for clients who receive an Involuntary Treatment Act Hearing

Field Format:

Length: 8

Type: DATE (CCYYMMDD)

Data Element History:

HEARING OUTCOME	Return to Table of Contents	Effective Date: 04/01/2016
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Definition:

Indicates the type of commitment, if any, as a result of a court order.

Code Values:

Code	Definition
0	Dismissed
1	14 Day Commitment
2	90 Day Commitment or extension
3	180 Day Commitment or extension
4	90 Day LRA or LRA extension
5	180 Day LRA or LRA extension
6	Agreed to Voluntary Treatment
7	Revoke LRA
8	Reinstate LRA
9	3 Day Commitment under Joel's Law
10	Dismissal of petition filed under Joel's Law
11	Order for outpatient evaluation within 72 hours for Assisted Outpatient Treatment
12	180 Day Assisted Outpatient Treatment Order
13	365 Day Assisted Outpatient Treatment Order

Business Rules:

Only reported for clients who receive an Involuntary Treatment Act hearing

Field Format:

Length: 2

Type: CHAR

Data Element History:

HEARING COUNTY	Return to Table of Contents	Effective Date: 04/01/2016
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Definition:

Indicates the county where a court hearing was held.

Code Values:

Code	Definition	Code	Definition
53001	Adams	53041	Lewis
53003	Asotin	53043	Lincoln
53005	Benton	53045	Mason
53007	Chelan	53047	Okanogan
53009	Clallam	53049	Pacific
53011	Clark	53051	Pend Oreille
53013	Columbia	53053	Pierce
53015	Cowlitz	53055	San Juan
53017	Douglas	53057	Skagit
53019	Ferry	53059	Skamania
53021	Franklin	53061	Snohomish
53023	Garfield	53063	Spokane
53025	Grant	53065	Stevens
53027	Grays Harbor	53067	Thurston
53029	Island	53069	Wahkiakum
53031	Jefferson	53071	Walla Walla
53033	King	53073	Whatcom
53035	Kitsap	53075	Whitman
53037	Kittitas	53077	Yakima
53039	Klickitat		

Business Rules:

Only reported for clients who receive an Involuntary Treatment Act Hearing

Field Format:

Length: 5

Type: CHAR

Data Element History:

Program Identification	PROGRAM START DATE	Return to Table of Contents	Effective Date: 04/01/2016
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Definition:

The date the client enrolled into a program designated by a program code.

Code Values:

N/A

Business Rules:

Required for MENTAL HEALTH and SUBSTANCE USE DISORDER clients who are enrolled in a special program

A program code must exist in order to have a program start date

Field Format:

Length:8

Type: DATE (CCYYMMDD)

Data Element History:

PROGRAM END DATE	Return to Table of Contents	Effective Date: 04/01/2016
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Definition:

The date the client's enrollment in a program designated by a program code ended.

Code Values:

N/A

Business Rules:

Required for MENTAL HEALTH and SUBSTANCE USE DISORDER clients who are enrolled in a special program

A program code must exist in order to have a program end date

Field Format:

Length: 8

Type: DATE (CCYYMMDD)

Data Element History:

PROGRAM ID	Return to Table of Contents	Effective Date: 04/01/2016
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Definition:

Indicates the program in which a client is enrolled.

Code Values:

Code	Definition
1	PACT Program for Assertive Community Treatment
2	CDDA (COMM)
3	CDAAs (LS)
5	MTFC Multi-Dimensional Treatment Foster Care
10	Children's Evidenced Based Pilot
11	Jail Services
15	Fidelity Wraparound
17	Assertive Community Treatment (ACT) NOTE: Use code 1 to report WA-PACT
28	<p>Wraparound with Intensive Services (WISe): A range of service components that are individualized, intensive, coordinated, comprehensive, culturally competent, home and community based services for children and youth who have a mental disorder that is causing severe disruptions in behavior interfering with their functioning in family, school or with peers requiring:</p> <ul style="list-style-type: none"> The involvement of the mental health system and other child-serving systems (i.e. Juvenile justice, child-protection/welfare, special education, developmental disabilities), Intensive care collaboration and Ongoing intervention to stabilize the child and family in order to prevent more restrictive or institutional placement. <p>WISe team members demonstrate a high level of flexibility and accessibility in accommodating families by working evenings and weekends, and by responding to crises 24 hours a day, seven days a week. The service array includes intensive care coordination, home and community based services and mobile crisis outreach services based on the individual's need and the cross system care plan* developed by the Child and Family Team. Care is integrated in a way that ensures that youth are served in the most natural, least restrictive environment. The intended outcomes are individualized but usually include increased safety, stabilization and community integration to ensure that youth and families can live successfully in their homes and communities.</p> <p>*Cross System Care Plan: An individualized, comprehensive plan created by a Child/Family Team that reflects treatment services and supports relating to all systems or agents with whom the child is involved and who are participating on the CFT. This plan does not supplant, but may supplement the official treatment plan that each system maintains in the client record.</p>
29	<p>Housing and Recovery through Peer Services (HARPS): Services intended to support individuals in the housing of their choice, with leases in their name. Services are focused on assisting the individual to achieve stability and maintain their tenancy, including engagement and care coordination for the individual's whole health and rehabilitative needs to live independently in the community. Identifying housing options, contacting prospective landlords, scheduling interviews, assisting with applications, and assistance with subsidy applications and supporting the individual once housed in collaboration with or on behalf of an individual. Mediate landlord- tenant, roommate, and neighbor issues. Skills training on interpersonal relations and landlord tenant rights/laws. These services should be client-specific.</p> <p>Note: Active only for Grays Harbor, North Sound, and Spokane RSNs.</p>
30	<p>Supported Employment Program: Services that support individuals with behavioral health issues, who desire to be employed in the community. Services follow the principles of the SAMHSA evidence based practice also known as Individual Placement and Support.</p> <ul style="list-style-type: none"> Competitive employment is the goal. Supported Employment is integrated with treatment. Eligibility is based on the individual's choice; people are not excluded because of their symptoms or current substance usage. Attention to the individual's job preferences. Benefits counseling is important. Rapid job search after the individual expresses their desire to work. Job development through the development of employer relationships. Time-unlimited support.
31	<p>Ticket to Work Program: The development of an individual work plan that supports a person with their employment goals and assigns the individual's Ticket to the Social Security approved DBHR Employment Network. Individuals can receive TTW services simultaneously with</p>

	other services from any behavioral health program.
32	TANF Supported Employment Pilot Project Supported Employment pilot project for TANF population in North Sound Mental Health Administration RSN.
19	Functional Family Therapy: A phasic program where each step builds on one another to enhance protective factors and reduce risk by working with both the youth and the family. The phases are engagement, motivation, assessment, behavior change, and generalization
20	Illness Self-Management/Illness Management & Recovery: Illness Self-Management (also called illness management or wellness management): Is a broad set of rehabilitation methods aimed at teaching individuals with a mental illness, strategies for collaborating actively in their treatment with professionals, for reducing their risk of relapses and re-hospitalizations, for reducing severity and distress related to symptoms, and for improving their social support. Specific evidence-based practices that are incorporated under the broad rubric of illness self management are psycho-education about the nature of mental illness and its treatment, "behavioral tailoring" to help individuals incorporate the taking of medication into their daily routines, relapse prevention planning, teaching coping strategies to managing distressing persistent symptoms, cognitive-behavior therapy for psychosis, and social skills training. The goal of illness self-management is to help individuals develop effective strategies for managing their illness in collaboration with professionals and significant others, thereby freeing up their time to pursue their personal recovery goals.
21	Integrated Dual Disorders Treatment: Dual diagnosis treatments combine or integrate mental health and substance abuse interventions at the level of the clinical encounter. Hence, integrated treatment means that the same clinicians or teams of clinicians, working in one setting, provide appropriate mental health and substance abuse interventions in a coordinated fashion. In other words, the caregivers take responsibility for combining the interventions into one coherent package. For the individual with a dual diagnosis, the services appear seamless, with a consistent approach, philosophy, and set of recommendations. The need to negotiate with separate clinical teams, programs, or systems disappears. The goal of dual diagnosis interventions is recovery from two serious illnesses.
23	Multi-systemic Therapy: MST views the individual as nestled within a complex network of interconnected systems (family, school, peers). The goal is to facilitate change in this natural environment to promote individual change. The caregiver is viewed as the key to long-term outcomes
25	Supported Housing: Services to assist individuals in finding and maintaining appropriate housing arrangements. This activity is premised upon the idea that certain clients are able to live independently in the community only if they have support staff for monitoring and/or assisting with residential responsibilities. These staff assist clients to select, obtain, and maintain safe, decent, affordable housing and maintain a link to other essential services provided within the community. The objective of supported housing is to help obtain and maintain an independent living situation. Supported Housing is a specific program model in which a consumer lives in a house, apartment or similar setting, alone or with others, and has considerable responsibility for residential maintenance but receives periodic visits from mental health staff or family for the purpose of monitoring and/or assisting with residential responsibilities, criteria identified for supported housing programs include: housing choice, functional separation of housing from service provision, affordability, integration (with persons who do not have mental illness), right to tenure, service choice, service individualization and service availability.
26	Therapeutic Foster Care: Children are placed with foster parents who are trained to work with children with special needs. Usually, each foster home takes one child at a time, and caseloads of supervisors in agencies overseeing the program remain small. In addition, therapeutic foster parents are given a higher stipend than to traditional foster parents, and they receive extensive pre-service training and in-service supervision and support. Frequent contact between case managers or care coordinators and the treatment family is expected, and additional resources and traditional mental health services may be provided as needed."

Business Rules:

Required for substance use disorder and mental health clients who are enrolled in a special program.

A client can be enrolled in more than one program at a time.

Field Format:

Length: 3

Type: CHAR

Data Element History:

<p>Service Episode</p>	<p>EPISODE RECORD KEY</p>	<p>Return to Table of Contents</p>	<p>Effective Date: 04/01/2016</p>
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Definition:

Indicates the unique identifier of a service episode record. Created by the BHO. Must be unique within the BHO.

Code Values:

N/A

Business Rules:

Required for substance use disorder and mental health clients who are authorized for and who receive services.

Field Format:

Length: 15

Type: CHAR

Data Element History:

SERVICE EPISODE MODALITY	Return to Table of Contents	Effective Date: 04/01/2016
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Definition:

Indicates the mode treatment to be provided to the client, if not receiving mental health inpatient services.

Code Values:

Code	Definition
1	Substance Use Disorder - Outpatient
2	Substance Use Disorder – Intensive Outpatient
3	Substance Use Disorder - Inpatient
4	Substance Use Disorder – Intensive Inpatient
5	Substance Use Disorder – Long Term Residential
6	Substance Use Disorder – Recovery House
7	Substance Use Disorder – Withdrawal Management (aka Detox)
8	Substance Use Disorder - Opiate Substitution
9	Mental Health - Outpatient

Business Rules:

Required for all substance use disorder clients and any mental health clients not receiving inpatient services.

Field Format:

Length: 2

Type: CHAR

Data Element History:

SERVICE EPISODE START DATE	Return to Table of Contents	Effective Date: 04/01/2016
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Definition:

Indicates the date that a particular treatment modality, as constituted by a particular set of services provided to a particular client that the contracting BHO is authorized to pay for, starts..

Code Values:

N/A

Business Rules:

Required for substance use disorder and mental health clients who are authorized for services by a BHO and who receive services.

Field Format:

Length: 8

Type: DATE (CCYYMMDD)

Data Element History:

SERVICE EPISODE END DATE	Return to Table of Contents	Effective Date: 04/01/2016
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Definition:

Indicates the date that particular treatment modality,, as constituted by a particular set of services provided to a particular client that the contracting BHO is authorized to pay for, end.

Code Values:

N/A

Business Rules:

Required for substance use disorder and mental health clients who are authorized for services by a BHO and who receive services.

Field Format:

Length: 8

Type: DATE (CCYYMMDD)

Data Element History:

DISCHARGE REASON	Return to Table of Contents	Effective Date: 04/01/2016
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Definition:

Indicates the primary reason the client is being discharged from treatment.

“Lost Contact” are outpatient clients who did not get back to the provider and are not able to be contacted.

“Left against advice, including dropout” is a termination of treatment initiated by the client, without the provider’s concurrence.

“Terminated by facility” is a termination of treatment services that is initiated by the provider in response to a client’s continued violation of the agency’s established rules or in response to a client’s inability to continue participating in treatment (i.e. medical reasons, transfer of job, etc.).

Code Values:

Code	Definition
1	Treatment Completed
2	Left against advice, including dropout
3	Terminated by facility
4	Transferred to another SA treatment or Mental Health program
5	Incarcerated
6	Death by Suicide
7	Death NOT by Suicide
8	Other
9	Lost Contact
97	Unknown

Business Rules:

Required for all substance use disorder and mental health clients when an end date is reported in the Service Episode transaction.

Field Format:

Length: 2

Type: CHAR

Data Element History:

SERVICE REFERRAL SOURCE	Return to Table of Contents	Effective Date: 04/01/2016
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Definition:

Indicates the client's primary referral source to treatment.

Code Values:

Code	Definition
1	Self / Family
2	Substance Use Disorder Provider
3	Mental Health Provider
4	Other Healthcare Provider
5	Self Help Group
6	School
7	Employer
8	Court / Criminal Justice
9	Other Community Referral
97	Unknown

Business Rules:

Required for all mental health and substance use disorder clients

Chose the primary referral source

Field Format:

Length: 2

Type: CHAR

Data Element History:

Substance Use	AGE AT FIRST USE	Return to Table of Contents	Effective Date: 04/01/2016
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Definition:

Indicates the age at which the client first used the specific substance.

Code Values:

Code	Definition
0	Client born with a substance use disorder resulting from in-utero exposure
1-98	Age At First Use, in years
99	Not applicable

Business Rules:

Only reported for substance use disorder clients.

Reported if a substance is selected.

Must be less than or equal to client's age when reported.

Reported at admission, discharge and updated every 90 days.

Field Format:

Length: 2

Type: CHAR

Data Element History:

DATE LAST USED	Return to Table of Contents	Effective Date: 04/01/2016
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Definition:

Indicates the date that client last used a specific substance.

Code Values:

N/A

Business Rules:

Only reported for Substance Use Disorder clients.

Reported at admission, discharge and updated every 90 days.

Required if any substance other than "No substance abuse" is reported.

Must be less than or equal to the date on which it is reported.

Date last used must be greater than the client's Birthdate or Age of First Use.

Field Format:

Length: 8

Type: DATE (CCYYMMDD)

Data Element History:

FREQUENCY OF USE	Return to Table of Contents	Effective Date: 04/01/2016
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Definition:

Indicates the frequency that the client used a specific substance in the last 30 days.

Code Values:

Code	Definition
1	No Use In The Past Month
2	1-3 Times In Past Month
3	4-12 Times In Past Month
4	13 Times In Past Month
5	Daily
6	Not Applicable

Business Rules:

Only reported for Substance Use Disorder clients.

Required if any substance other than "No substance abuse" is reported.

Reported at admission, discharge and updated every 90 days.

Field Format:

Length: 2

Type: CHAR

Data Element History:

METHOD	Return to Table of Contents	Effective Date: 04/01/2016
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Definition:

Indicates the most common method the client uses to administer a specific substance.

Code Values:

Code	Definition
1	Inhalation
2	Injection
3	Oral
4	Other
5	Smoking

Business Rules:

Only reported for substance use disorder clients.

Reported if a substance is selected.

Reported at admission, discharge and updated every 90 days.

Field Format:

Length: 2

Type: CHAR

Data Element History:

PEAK USE	Return to Table of Contents	Effective Date: 4/1/2016
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Definition:

Indicates the highest monthly use pattern in the twelve months preceding admission.

Code Values:

Code	Definition
1	No Use
2	1-3 Times In A Month
3	4-12 Times In A Month
4	13 or More Times In A Month
5	Daily
6	Not Applicable

Business Rules:

Only required for substance use disorder clients.

Reported at admission.

Field Format:

Length: 2

Type: CHAR

Data Element History:

SUBSTANCE	Return to Table of Contents	Effective Date: 04/01/2016
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Definition:

Indicates the specific substance(s), or substance category(s), the client is being seen for.

Code Values:

Code	Definition
1	None
2	Alcohol
3	Cocaine/Crack
4	Marijuana/Hashish
5	Heroin
6	Other Opiates And Synthetics
7	PCP-phencyclidine
8	Other Hallucinogens
9	Methamphetamine
10	Other Amphetamines
11	Other Stimulants
12	Benzodiazepine
13	Other non-Benzodiazepine Tranquilizers
14	Barbiturates
15	Other Non-Barbiturate Sedatives or Hypnotics
16	Inhalants
17	Over-The-Counter
18	Oxycodone
19	Hydromorphone
20	MDMA (ecstasy, Molly, etc)
21	Other

Business Rules:

Required field for all clients receiving Substance Use Disorder services.

Reported at admission, discharge, and updated every 90 days.

A Substance (except for No Substance Abuse) cannot be selected more than once.

The same substance(s) must be included in the report at admission, every 90 days, and at discharge. The purpose of this is to detect how frequency and method of use change for the 3 substances between admission and discharge.

Field Format:

Length: 2

Type: CHAR

Data Element History:

IDENTIFIERS	CLIENT ID	Return to Table of Contents	Effective Date: 04/01/2016
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Definition:

A string of characters, in combination with a service entity (BHO, treatment provider, etc.) uniquely identifies a client within the system overseen by the service entity.

Code Values:

N/A

Business Rules:

Required for all clients.

Within a given service entity, the Client ID must be unique to an individual.

Field Format:

Length: 20

Type: CHAR

Data Element History:

BHO ID	Return to Table of Contents	Effective Date: 04/01/2016
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Definition:

The Unique identifier assigned to each BHO by ProviderOne. It is the same identifier used for sending 837 encounters to ProviderOne.

Code Values:

N/A

Business Rules:

N/A

Field Format:

Length: 20

Type: CHAR

Data Element History:

PROVIDER NPI	Return to Table of Contents	Effective Date: 04/01/2016
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Definition:

Indicates the entities National Provider Identifier (NPI) as obtained through federal registration via ProviderOne.

Code Values:

N/A

Business Rules:

N/A

Field Format:

Length: 10

Type: CHAR

Data Element History: