# Chapter 9b: State Hospital Assessments

The purpose of this chapter is to clarify state hospital assessment activities to ensure smooth transition of individuals hospitalized in a psychiatric facility back to their home, community setting or nursing facility. The goal and focus of state hospital assessment activities is to:

* Provide current information to consumers seeking long-term care services.
* Assist patients and their families to locate services of their choice to enable them to make informed choices.
* Engage individuals as soon as they anticipate being discharged from the hospital back to the community to assess long-term care needs and to expedite the authorization of services.
* Develop rapport and collegial relationships with local hospital discharge planners to accomplish this goal.
* Support transitions that increase success, stabilization, and optimal collaboration by working together with Managed Care Organizations (MCO) and Hospital Discharge planners to enable clients to fully access and utilize their medical benefits.
* Work with Forensic Navigators and Forensic Evaluators to support individuals who meet criteria for HCS services under the Civil Transitions Program (5440 bill).

## Ask the Expert

For State Psychiatric Hospitals\Local Psychiatric Facilities- Each region has a State Hospital Discharge & Diversion (SHDD) Transitions Coordinator (TC) and Transition Specialist (TS). Statewide there is a Civil Transitions Program Manager who will assist with Individuals diverting from the state hospitals under the Civil Transitions Program as established by Senate Bill 5440 of 2023.

Region 1 Transition Coordinator: Pamela Young (360)789-4976 or [Pamela.Young@dshs.wa.gov](mailto:Pamela.Young@dshs.wa.gov)

Region 1 Transition Specialist: Jeff Rose (360) 742-2508 or [jeffrey.rose@dshs.wa.gov](mailto:jeffrey.rose@dshs.wa.gov)

Region 2 Transition Coordinator: Sarah Miller (360) 742-1796 or [sarah.miller2@dshs.wa.gov](mailto:sarah.miller2@dshs.wa.gov)

Region 2 Transition Specialist: Lisa Clarke (564) 669-4458 or [lisa.clarke@dshs.wa.gov](mailto:lisa.clarke@dshs.wa.gov)

Region 3 Transition Coordinator: Latia Townsend (360) 999-0470 or [latia.ray@dshs.wa.gov](mailto:latia.ray@dshs.wa.gov)

Region 3 Transition Specialist: Briauna Hill (253) 732-3839 or [Briauna.Hill@dshs.wa.gov](mailto:Briauna.Hill@dshs.wa.gov)

Civil Transitions Program Manager: Andréa Mckinney (360) 867-8247 andrea.mckinney@dshs.wa.gov

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## 

## Background

The mission of the Aging and Long-Term Support Administration (ALTSA) is to transform lives by promoting choice, independence, and safety through innovative services. ALTSA works with Administrative Service Organizations (ASOs), Managed Care Organizations (MCOs), state hospitals and community providers when a state hospital identifies that an individual who is ready for discharge may have an unmet need for assistance with activities of daily living. ALTSA offers a variety of settings in which personal care services can be tailored to meet each individual’s needs, goals and preferences. ALTSA also provides other services designed to support individuals to live in community-based settings, including their own homes or licensed community residential settings. Since 2004, ALTSA has worked to respond to both the functional and behavioral support needs of clients through the progressive building and expansion of specialized, contracted services and long-term care setting choices. Individuals served in ALTSA settings receive mental health services through the state’s ASOs and MCOs. The Trueblood Settlement establishes a plan for providing services to individuals involved in the criminal court system and for providing treatment to people when needed so they are less likely to become involved in the criminal court system. The Civil Transitions Program (CTP) recently developed a process for connecting individuals who have been found not restorable and not competent to stand trial due to an intellectual or developmental disability, dementia, or traumatic brain injury to available wraparound services and supports in community. When a referral is screened in, HCS will offer services to individuals, even those who are not traditionally eligible based on functional and financial criteria.

## Assessing and Discharging Clients from the State Hospital

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| * **State Hospital Discharge definition**: An individual discharging from a state psychiatric hospital into HCS Long-Term Services and Supports (LTSS). * **Diversion definition:** An individual with a 90- or 180-day commitment order for further involuntary treatment who is discharged from a local community psychiatric facility onto HCS LTSS; or an individual who is detained through the Involuntary Treatment Act who is stabilized and discharged into HCS LTSS prior to the need to petition for a 90- or 180-day commitment order. See HCS Role in Supporting a client’s return to a Community Setting. * See HCS Role in Supporting a client’s return to a Community Setting * Commitment orders must be verified and uploaded to DMS by Case Manager; court commitment paperwork, signed by a judge or commissioner, which documents that:   the client is on a 90- or 180-day commitment order for further involuntary treatment, or the client is on a civil commitment detainment under the Involuntary Treatment Act (this includes 120-hour, 14-day, 90-day, 180 day, or Revoked 90/180 LRA.   * For additional services that are available for individuals that meet diversion criteria Case Managers can consider the following program: [GOSH](https://stateofwa-my.sharepoint.com/personal/jeffrey_rose_dshs_wa_gov/Documents/Desktop/GOSH.docx?web=1)      * **State Hospital Assessor:** An HCS staff person who is assigned to assess individuals at the state hospital who have been identified ready for discharge ad may have an unmet need for assistance with activities of daily living. The assessor completes a CARE assessment in collaboration with the state hospital treatment team and ASO/MCO’s to assist with the individual transition planning and integration back into the community.   Chapter 71.05 RCW: [Mental Illness](file:///C:/Users/rosejr/OneDrive%20-%20Washington%20State%20Executive%20Branch%20Agencies/Desktop/RCW%20Mental%20Illness.htm)    **CTP Criteria** – The individual must be found not competent to stand trial and not restorable due to intellectual or developmental disability, dementia, or traumatic brain injury. Individuals who meet the CTP criteria will be assessed for services regardless of functional or financial eligibility criteria.  **Services** - Clients who meet criteria, and have an immediate need for housing, a referral for housing services may be submitted without a CARE assessment or Medicaid application being submitted. Services will only be authorized for 6 months, and the 6-month timeframe will always start on the first day of the service authorization.  **Civil Transition Program Assessor -** An HCS staff person is assigned to assess active or inactive clients in the community or jail. |

### Referral Process from a State Hospital or Local Psychiatric Facility

For information regarding the referral process from a hospital setting, refer to [LTC Manual 4: Social Service Intake.](https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/documents/LTCManual/Chapter%204.docx)

### Referral process for CTP clients

* When HCS receives an **active client,** the Civil Transitions Program Manager will email the assigned case manager and supervisor requesting contact be made with the client for a significant change assessment**.** If the client agrees to continue services, the case manager will assess for additional service needs and coordinate with current providers to determine if the client may return to the same residential facility or utilize the same in-home provider. If the client is determined to be financially and functionally eligible, the HCS Case Manager will continue with traditional services. If the client is determined not financially or functionally eligible, the HCS Case Manager will offer services from the Civil Transitions Program conditional service package.
* When HCS receives a referral for an **inactive or new client,** the Civil Transitions Program Manager will send a referral to Regional Intake. The HCS Case Manager will contact the client to offer HCS services. If the client is homeless or at risk for homelessness supportive housing can be offered prior to the CARE assessment being completed. If the client is financially and functionally eligible, the HCS Case manager will continue with traditional services. If the client is found not financially or functionally eligible, the HCS Case Manager will offer services from the conditional service package. The HCS Case Manager will connect with the Forensic Navigator to determine if the individual is eligible for any diversion, supportive housing, or case management programs as a Trueblood class member.

### HCS Response Timeframes

Once a CTP referral has been received by Intake, following the regular intake process, the referral will be entered and assigned to a case manager within **two** working days. The assigned case manager will contact the client to schedule an assessment within **three** working daysfrom the day they receive the assignment in CARE. The case manager will make two attempts to reach the client by phone within three working days of assignment. If unable to reach the client, the case manager will mail a 10-day letter to the client, to the last known address. If there is no response after 10 days, the case will be inactivated. A strong effort will be made to **start** **the** **functional assessment within seven days** from the date of referral. The HCS assessor/case manager must **complete the assessment within 30 days** of the date of receipt of the referral. If the client is at risk of becoming homeless, they may receive Supportive Housing and Transition Services immediately*.*

ALTSA has partnered with the following agencies to assist with the Civil Transitions Program:

1. **Behavioral Health Administration (BHA)** - Forensic Evaluators from BHA conduct an evaluation which results in an Evaluation Report that includes their opinion of competent, if not, are they restorable. The Forensic Evaluators from BHA divert forensically involved criminal defendants out of jail and inpatient treatment settings into community-based treatment settings by connecting individuals to additional supportive services in the community.
2. **Office of Forensic Mental Health Services (OFMHS)** -OFMHS assists with transforming forensic mental health throughout WA by partnering with communities and law enforcement in areas such as mental health resources in jails, competency restoration, diversion programs, and community resources to better support people living with mental illnesses who encounter the criminal court system.
3. **Developmental Disabilities Administration (DDA) -** 5440 referrals are submitted to HCS and DDA, both agencies review the referral information.If IDD is the primary diagnosis DDA will contact the client to offer services.

### Involuntary Treatment Act (ITA): Confirming ITA Status & Case Manager Process

The process identified in this section will need to be repeated at any time a new ITA or LRA is issued. Please refer to Chapter [71.05](https://gcc02.safelinks.protection.outlook.com/?url=http%3A%2F%2Fapp.leg.wa.gov%2FRCW%2Fdefault.aspx%3Fcite%3D71.05&data=05%7C01%7Cashley.beckley%40dshs.wa.gov%7C71b93e45af324d47179f08da22db60dc%7C11d0e217264e400a8ba057dcc127d72d%7C0%7C0%7C637860622859946663%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=L6I92GrHHe7oGZTgHknI2gsrnWgIpyjukOtCabb8V78%3D&reserved=0) RCW for more information regarding the legislative process.

1. **Receive Referral:** When receiving a referral from a Local Psychiatric Facility (LPF) or Acute Care Hospital (ACH), the case manager will ***inquire about the individuals ITA status*** and determine if the client is detained or at the facility voluntarily prior to discharge planning.

1. **Complete or Update CARE Assessment:** Following receipt of referral the case manager will complete a significant change assessment or new CARE assessment to determine financial and functional eligibility.
2. **3. Request Current ITA Documents from LPF or ACH:** The case manager will request documents from the LPF or ACH discharge planner or ITA coordinator. It is important to emphasize that the ITA documents are required to confirm program eligibility before referrals can be made to specialty contract settings.

***Note:* There is an order to the civil commitment process.**

* 1. Clients are usually brought in by a DCR who has authority to put them on a detainment hold for up to 120 hours or 5 days.

**Please look at the paperwork the hospital sends you.**

* + Look for the word “Order” in the paperwork
  + If you don’t see the word “Order”, look for a DCR’s signature
  + Look at the date everything was signed

1. **Send ITA documents to the Regional Point of Contact:**
   * **Region 1:** Jeff Roseat[jeffrey.rose@dshs.wa.gov](mailto:jeffrey.rose@dshs.wa.gov)
   * **Region 2:**  Lisa Clarke at lisa.clarke@dshs.wa.gov
   * **Region 3:** Briauna Hill [at Briauna.Hill@dshs.wa.gov](mailto:Briauna.Hill@dshs.wa.gov)

1. **Upload ITA Documents to Data Management System (DMS):** The case manager will send ITA documents to Barcode.

1. **Update State Hospital Screen:** The case manager will complete the State Hospital Screen in the Client Details section of CARE upon the client’s transition from a LPF or ACH into a community setting (see example below).

### Coordinating with Hospital Discharge Planners

Home and Community Services (HCS) provides case management by working with the client, hospital staff, HCS/AAA/DDA staff, family members/informal supports, the client’s physician/psychiatrist and community providers to assist clients in transitioning to and accessing services in the community. HCS state hospital assessors are stationed at state hospitals & maintain regular communication with the hospital team. HCS staff assessing individuals in local psychiatric facilities should regularly visit each hospital so that HCS presence is complementary to the hospital discharge planning activities and beneficial to clients and discharge planners. HCS should:

1. Clearly define and explain to discharge planner the role HCS/AAA has in assessing Medicaid clients and assisting with the client’s return to the community.

2. At a minimum, the following information shall be provided to the hospital discharge planner:

• Name, telephone, and fax number of the local office

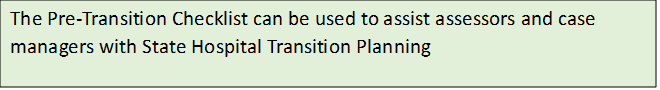
• Name, telephone number, and work schedule of assigned staff and back-up staff

• Name and telephone number of HCS/AAA staff supervisor and Regional Administrator/Director

• Referral (intake) procedures, including procedures for back-up staff

3. To ensure that there are no delays in discharge, case management staff should:

• Encourage hospital discharge planners to refer individuals to HCS for and assessment as soon as it becomes apparent that community-based services are needed and consented for (i.e. before admission if the need for long-term care services is known, upon admission or during the first day of admission) and provide information regarding a patient’s discharge status.



• Respond to referrals by the end of the next working day, or within the time frame the hospital needs, to ensure timely coordination of transition planning.

### Early Engagement

*Purpose:* To streamline eligibility determination and transition planning activities for patients. Early engagement efforts with the client and healthcare / hospital staff and patients aids in identifying, connecting, and authorizing appropriate community-based services and resources. Early engagement supports the Person-Centered model in transition planning.

Home and Community Services (HCS) staff (State Hospital Headquarters, Regional State Hospital Supervisor, or Program Manager Staff) will collaborate with healthcare / hospital staff to identify those patients who may request or benefit from Long-Term Services and Supports. Case Managers can support this partnership by developing an understanding of hospital referral and discharge polices to enhance early engagement with patients. HCS staff should consider the following factors: financial eligibility, clinical stability (a conversation with healthcare / hospital staff should take place where risk factors as well as medical complexities are documented in the CARE assessment), and the client’s preference in care settings. As with all transition planning and case management activities, the HCS assessor will discuss the variety of long-term services and supports the Department can offer in different care settings with the client.

For medically complex discharges, and for all Triggered Nursing Referrals Case Managers can consider the following programs:

* [Nursing Services](https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/documents/LTCManual/Chapter%2024.doc) (for all Nursing Triggered Referrals)
* [Adult Day Health](https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/documents/LTCManual/Chapter%2012.docx)
* [Registered Nurse Delegation](https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/documents/LTCManual/Chapter%2013.doc)
* [Private Duty Nursing](https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/documents/LTCManual/Chapter%2025.docx)

### HCS Role in Supporting a Client’s Return to a Community Setting

HCS is responsible for completing assessments of referred Medicaid applicants who have indicated an interest in receiving home and community-based services.

Assessments are conducted at: Acute care or general hospitals, evaluation and treatment centers; (E&T, single certification beds, specialty care, and local community psychiatric facility) and State Hospitals.

1. Prior to hospital discharge, Home and Community Staff will:
2. Complete a full [CARE Assessment,](https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/documents/LTCManual/Chapter%203.docx) discussing care needs, and present appropriate service options to the client and/or the family.

Utilize [FAST TRACK](https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/documents/LTCManual/Chapter%207a.docx)  financial eligibility for community services, if necessary. If FAST TRACK has been used, the HCS Staff will ensure that a Medicaid application has been submitted with the necessary documentation to the local financial worker.

1. Authorize Services as outlined in the CARE Assessment
2. Follow Policy and Procedure when transferring the client case for ongoing case management.

### Discharge Planning to a Community Setting (HCS/AAA Responsibilities)

For information regarding HCS/AAA case management responsibilities and Case Transfer Guidelines for Institutional (Hospital, Nursing Facility, or ICF-MR) Settingsrefer to[LTC Manual Chapter5.](https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/documents/LTCManual/Chapter%205.docx)

* For individuals discharging or diverting from a State Hospital who wish to live independently, see[LTC Manual, Chapter 5b](https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/documents/LTCManual/Chapter%205b.docx) for more information on***Governor’s Opportunity for Supportive Housing (GOSH) Services*** and other Supportive Housing resources.

For information regarding HCS case management responsibilities for 1115 LTSS Presumptive Eligibility procedures for patients deferring or discharging from a Community Psychiatric Hospital or Acute Care Hospital or who have deferred or discharged from a Community Psychiatric Hospital or Acute Care Hospital within the last 30 days, and will or have returned to an in home setting refer to Chapter 30e

[Chapter 30e](https://stateofwa-my.sharepoint.com/personal/jeffrey_rose_dshs_wa_gov/Documents/Desktop/Chapter%2030e.docx?web=1)

### Hospital Admissions and Subsequent Transitions to a Nursing Facility:

Hospitals may discharge patients to a nursing facility without prior authorization from HCS. This includes discharges from the emergency rooms or other situations where the client is not officially admitted (e.g. observation stay). For more information on how transitions from hospitals to the nursing facility are done see [LTC Manual Chapter 9a](https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/documents/LTCManual/Chapter%209a.docx).

For Admissions into a Nursing Facility using Expanded Behavior Supports-see [Chapter 10: NFCM and Relocation](https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/documents/LTCManual/Chapter%2010.docx).

### Discharges to the Transitional Care Units/Rehab Centers

For more information on discharges to transitional care units/rehab centers see [LTC Manual Chapter 9a](https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/documents/LTCManual/Chapter%209a.docx).

## Assessment Data and reporting

### State Hospital Discharge and Diversion State Hospital Report

One measurement of Home and Community Services work relates specifically to actively assisting ALTSA clients relocate from state hospitals to home and community-based settings. The data to track the relocation of clients is now in CARE. With this data, the report will identify clients transitioning from state hospitals or local psychiatric hospitals to the community. The legislature will be following the progress of this program. ALTSA will provide pertinent data to the legislature. The State Hospital Report can be found in ADSA Reporting. Regional Administrators, Deputy Regional Administrators, Field Service Administrators, SHDD Program Managers, and SHDD Supervisors have access to this report. CTP clients will also be tracked in CARE under the State Hospital Screen. Discharge date and discharge status will be entered by the HCS case manager, this screen will be completed despite the eligibility outcome. CTP Conditional Services are available for 6 months, a financial and functional eligibility will be completed within the first 90 days. For those at risk for homelessness, housing services will be reviewed at six months with the ability to re-authorize for up to two years. Clients receiving conditional services will be case managed by HCS and not transferred to AAA. The CTP Program Manager will send a referral to Regional Intake. Once assigned, the HCS Case Manager will contact the client to review HCS services and offer CARE assessment. Financial eligibility is concurrently determined if the client submits a Medicaid application.

### State Hospital Discharge and Diversion Outcomes Tracking

Outcome tracking is used to track outcomes and identify overdue outcomes. The Data Collection and Reporting resources assigned to the project identify project performance measurements, criteria and targets. The Governor, the legislature and agency executives are closely monitoring the investment in the state’s behavioral health system. Analyzing outcomes can be used to improve services and supports and identify possible gaps in services and supports. The outcomes will be used to provide recommendations to legislature on best practices related to admission, transition from long-term involuntary inpatient treatment systems, and the stability and transitions to community based behavioral health services.

Outcomes are tracked at 30 days, 6 months and 12 months after an individual’s transition. Case Managers receive ticklers in CARE at 30 days, 6 months and 12 months to update outcomes. When an individual discharges from a State Hospital onto HCS services or is diverted from a Local Psychiatric Facility (LPF) onto HCS services, stability of the individual at the setting should be determined. This is done by the Case Manager contacting the Provider via phone or in-person and checking in on how things are going with the individual. Document the conversation in an SER and update the Outcome on the State Hospital screen. Ticklers for Outcomes are received in the CARE tool at 30 days, 6 months, and 12 months. Trainings on how to complete Outcomes are available to staff. You can contact the expert for your region for more information. Targeted Case Management should be a consideration by the HCS and/or AAA Case Manager. For a safe and sustainable plan of care see [LTC Manual Chapter 3](https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/documents/LTCManual/Chapter%203.docx).

Outcomes should be updated on the Outcome tab on the State Hospital screen: 30 days after discharge or diversion, 6 months after discharge or diversion (2nd Post Discharge) and 12 months after discharge or diversion (3rd Post Discharge.) Outcomes should also be updated if there is a major change, including if the individual stops receiving HCS Services, returns to the State Hospital, or passes away.

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| Outcomes | When to Use |
| Deceased | A client passes away |
| Returned to State Hospital | A client is admitted to a State Hospital |
| No Longer HCS | A client stops receiving HCS service – no longer wants services, moves out of state, whereabouts unknown |
| Detained in Community | A client is admitted to an E&T or hospital psych ward/bed for a behavioral health issue, or goes to jail |
| Stable in Setting/Interventions | A client is stable in their current HCS setting |
| Unstable in Setting/Interventions in Progress | A client is unstable in their current HCS setting |
| Changed HCS Settings | A client moves from one HCS setting to another HCS setting – for example moves from an AFH to an ALF |
| Hospital, Acute Care | A client is admitted to a hospital for a medical (non-behavioral health) issue |

## Management of Complex Hospital Client Transitions

### Discharge Barrier Consult

*The creation of Discharge Barrier Consult:* Home and Community Services (HCS) and Behavioral Health Administration (BHA) determined there was a need for a cross systems staffing approach to transitioning individuals with complex needs from the state hospitals on to HCS long-term services and supports with the individual’s multi-disciplinary team.

*The purpose and scope of the Discharge Barrier Consult:* The purpose of the Discharge Barrier Consult is to collaborate and determine appropriate statewide resources and supports for individuals transitioning from the state hospitals with an end goal of identifying barriers and risk and developing a comprehensive transition plan. The individual’s case is reviewed for barriers, needs, and risks. In addition to the aforementioned, the availability of resources in the community are discussed.

*The decision-making body at the Discharge Barrier Consult:* The attendees of the consultation may consist of representatives from the individual’s multidisciplinary transition team. The team may include but is not limited to representatives from the Managed Care Organizations, Health Care Authority, Behavioral Health Administration HQ, the State Hospitals, and Aging and Long-term Support Administration. The Meeting is prompted by the HCS staff to include but not limited to the SHDD Assessor, SHDD Supervisor or Program Manager via email to the Transition Coordinator. The meeting is a standing meeting scheduled for every other Thursday of the month. The attendees staff cases, review barriers to transition, and work towards solutions.

There are no criteria used to determine which HCS settings are approved or disapproved for individuals: The objective of the Discharge Barrier Consult is to develop a comprehensive plan with the intent of the individual transitioning with HCS services. No decisions are made concerning approval or disapproval of HCS services for qualified individuals.

### Escalation Path and Process

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| **Who/ Where to Escalate** | **What is involved and what needs to be done** |
| Who to escalate? | Clients that face barriers to services related to a history of, **but not limited to**:   * Arson/fire setting behavior * Murder history * Rape history or any sexual aggression towards others * Significant assaults * Significant suicidal ideation or self-harm behavior   \*DSHS form***10-234a*** must be completed. |
| Escalation within Regional HCS | * Send e-mail with the client’s name and reason for staffing to your supervisor, Program Manager, and Transition Coordinator. * A **Discharge Barrier Consult** may be warranted. To request a consultation, ask your regional SHDD Transition Coordinator or Program Manager for instructions to submit a request. * A **jail-based restoration staffing** may be warranted. To request a staffing send an email with the client’s name and reason for staffing to your supervisor and the Civil Transitions Program Manager. To request a consultation, ask your regional SHDD Transition Coordinator or Program Manager for instructions to submit a request. |
| Escalation within ALTSA Headquarters (HQ) | While many issues can address at the regional level by a supervisor, or Program Manager, it is necessary on occasion to escalate an issue to Headquarters. Issues are escalated if they cannot be resolved at the lowest level.   * The Supervisor or Program Manager may also bring the issue directly to the specific work team, e.g. Supervisor, Case Manager, 5440 Program Manager, Forensic Navigator, Forensic Evaluator, for resolution if the issue can’t be effectively addressed. In this case, if the issue is not resolved to the Supervisor or Program Manager’s satisfaction or if there are issues beyond the Supervisor’s control, the Supervisor or Program Manager will escalate the matter to the Regional Field Service Administrator or Deputy Regional Administrator and SHDD Administrator. If the SHDD Administrator cannot resolve the issue, then the issue will be escalated exclusively to the DSHS ALTSA Community Transition Office Chief.   + The DSHS ALTSA CLASS Office Chief, DSHS ALTSA HCS Director, and Governance will be the final level of escalation.   + Identified issues may need escalation beyond HCS to Health Care Authority leadership, contact HCA Nursing Consultant, Public Health.   + The State Hospital Discharge and Diversion Administrator, Regional Administrator, Deputy Regional Administrator, and Field Service Administrator, is responsible to elevate risks and issues to DSHS ALTSA HCS Executive Leadership and prepare documentation needed to present to them for decision. |

## Transition Resources

### Community Transition Services (CTS)

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| **Community Transition Services (CTS):** CTS is money used to purchase one-time, set-up expenses necessary to help relocate clients discharging from a CMS approved institutional setting to a less restrictive setting (see [WAC 388-106-0270](http://apps.leg.wa.gov/WAC/default.aspx?cite=388-106-0270)) | |
| **Who is eligible for CTS?** | HCS/AAA clients who are receiving Medicaid long-term services who:   * Are discharging from an institution for mental disease (IMD), nursing facility, or intermediate care facility for individuals with intellectual disabilities (ICF-ID) to a home and community-based setting; and * Will be receiving Community First Choice (CFC) or Residential Support Waiver (RSW) services upon discharge   CTS funds **must** be considered before you use CTSS or WA RDs state funds. |
| **What is covered under Community Transition Services** [**SA297**](https://intra.dda.dshs.wa.gov/ddd/P1ServiceCodes/documents/Service%20Codes/SA297_Community_Transition_or_Sustainability__Services_Federal_Match.docx)**?**  **CTS: Goods** [**SA296**](https://intra.dda.dshs.wa.gov/ddd/P1ServiceCodes/documents/Service%20Codes/SA296_Community_Transition_or_Sustainability__Items_Federal_Match.docx)**?**  HCS Only: You may utilize Kroger for purchasing Goods. | Services may include:   * First month’s rent, security deposits, safety deposits * Utility set-up fees or deposits * Health and safety assurances, such as pest eradication, allergen control, or non-recurring cleaning fees prior to occupancy * Moving fees * Community Choice Guiding (when leaving a Nursing Facility or State Hospital. Use [SA263](https://intra.dda.dshs.wa.gov/ddd/P1ServiceCodes/documents/Service%20Codes/SA263_Community_Choice_Guide.docx) for CCG Services). If authorized pretransition, WA RDs would be appropriate funding source. * This service includes the training of participants and caregivers, in the maintenance or upkeep of equipment purchased only under the service and does not duplicate training provided under other waiver services.   Goods may include:   * Furniture, essential furnishings, and basic items essential for basic living outside the institution * The provision of goods that increase independence or substitute for human assistance to the extent that expenditures would have been made for the human assistances, such as purchasing a microwave.   CTS cannot be used to authorize environmental modifications. If a client transitioning from a congregate setting needs an environmental modification completed prior to discharge, that service must be accessed via COPES or CTSS depending on eligibility. |
| **What is not covered under CTS?** | * Federal rules require that services do not include recreational or diversional items such as television, cable, or DVD players. * CTS does not pay for items or services paid for by Medicaid or other programs and resources. * Community Transition Services may not be used to furnish or set up living arrangements that are owned or leased by an AFH, ARC, EARC, ESF or AL facility.   For eligible clients, the CTSS can be used in combination with CTS for items/services not covered under CTS. |
| **How much can I spend?** | The amount that can be used for CTS is $2,500  **Note:**  CTSS ETRs are Local, CTS ETRs require a HQ approval. |
| **Do I need to use a contracted provider?** | If the DSHS payment system will pay directly for a service or item, a contract is required for all CTS providers.   * Check to see if the provider has an existing contract for the service or goods that will be provided * If there is not an existing contract, pursue the appropriate contract before services can be authorized. Providers must meet all other obligations associated with the contracting process such as background checks, Medicaid Provider Disclosure Statement and insurance requirements, when applicable. * For one-time payment for deposits or set up fees, the Special Considerations contract can be used. * NOTE:   1. A contract is not required if another payment mechanism is utilized. Options include:      1. Using a PCard (state issued credit card available to HCS staff); or      2. Authorizing a contracted provider to pay for deposits and set-up fees directly and be reimbursed.         1. Compensation to the contracted provider for issuing payment does not count towards the CTS $2,500 limit. |
| **How do I authorize CTS?** | 1. Perform a CARE assessment to determine/document the need and plan of care for the CTS. CTS needs are often captured in the Treatment table as “Other” and/or in the Environment Screen (CARE Desktop) or Client Safety (Environment field in CARE Web). 2. The Sustainability Goals screen in CARE may be used as part of transition planning and as a communication tool with contracted providers. 3. Move the assessment to *Current*. The CTS provider may be used as the paid provider. 4. Document the extent of services provided and the cost in the SER; for NF discharges use Contact Code “NFCM.” 5. Assign the applicable CFC RAC and authorize the items or services using the appropriate code(s). The total cannot exceed $850 without a HQ approved ETR. For RSW clients, add RAC 3056 “RSW-CFC ancillary services.” 6. Submit a [Social Services Packet Cover Sheet (DSHS Form 02-615)](http://forms.dshs.wa.lcl/formDetails.aspx?ID=13767) to DMS with all invoices, receipts, etc. Include verification that the client received the goods or services. 7. Send the client a Planned Action Notice reflecting CTS. |
| **When do I authorize this service?** | This is solely for one-time payments to help a client establish a residence (no ongoing services/items). Only if the client has needs beyond what is covered under CTS can CTSS also be used. CTS funds can be accessed up to 30 days after discharge if the item/service is needed for a successful discharge and no other resource is available.  When Community Transition Services are furnished to individuals returning to the community from an institutional setting, the service is not considered complete and may not be billed until the participant leaves the institution and is enrolled in the CFC or RSW program.  You may use CTS each time the eligible client is discharged from a Nursing Facility or State Hospital.  Additional information can be found in [CFC Chapter 7b](https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/documents/LTCManual/Chapter%207b.docx). |
| **Bathroom Equipment** | If it appears a client may meet HCA’s exceptional criteria for necessary bathroom equipment, the DME vendor must request an ETR from HCA for the item(s).  When it is apparent to the case manager that a client needing bathroom equipment does not meet HCA’s exceptional criteria, an ETR request must be submitted to HCS HQ following all procedures outlined in the [Social Service Authorization Manual](https://intra.dda.dshs.wa.gov/ddd/P1ServiceCodes/documents/SSAM/Social_Services_Authorization_Manual.htm). |
| **Are ETRs allowed for CTS?** | All CTS funds that exceed $2500 must have an ETR approval from the Community First Choice (CFC) Program Manager. Send CFC ETR requests by choosing “Pending HQ Approval” in processing status and Victoria Nuesca as the “Worker”.  Send a notification email to [NuescVL@dshs.wa.gov](mailto:NuescVL@dshs.wa.gov?subject=CTS%20ETR) with CTS ETR in the subject line. |

### **Community Transition or Sustainability Services (CTSS***)*

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| [**Community Transition or Sustainability Services (CTSS)**](https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/documents/Community%20Transition%20and%20Sustainability%20Services%20CTSS.docx)**:**  CTSS are state funded non-recurring setup items or services necessary to assist individuals establish, resume or stabilize a home or community-based setting. [WAC 388-106-0950](http://apps.leg.wa.gov/WAC/default.aspx?cite=388-106-0950); [388-106-0955](http://apps.leg.wa.gov/WAC/default.aspx?cite=388-106-0955); [388-106-0960](https://apps.leg.wa.gov/WAC/default.aspx?cite=388-106-0960). | |
| **Who is eligible for CTSS?** | You are eligible for community transition or stabilization services if you:   1. Meet eligibility criteria to receive long-term services and supports from home and community services. 2. Are transitioning from a hospital, nursing facility, licensed assisted living facility, enhanced services facility, or adult family home to your own home, or are living in the community and need stabilization services to remain there; and 3. Do not have other programs, services, or resources to assist you with these costs; and 4. Have needs beyond what is covered under the Community Transition Services (under CFC or RSW); or 5. Are not eligible for Community Transition Services (under CFC or RSW). |
| **What is covered under CTSS?**  **CTSS Goods** [**SA290**](https://intra.dda.dshs.wa.gov/ddd/P1ServiceCodes/documents/Service%20Codes/SA290_Community_Transition_or_Sustainability_Services__Items.docx)  **CTSS Services** [**SA291**](file:///C:\Users\becklan\Downloads\SA291_Community_Transition_or_Sustainability__services%20(3).docx) | CTSS may include, but are not limited to:   1. Security deposits that are required to lease an apartment or home, including first month's rent. 2. Activities to assess need, arrange for, and procure necessary household furnishings. 3. Setup fees or deposits for utilities, including telephone, electricity, heating, water, and garbage. 4. Services necessary for your health and safety such as pest eradication and nonrecurring extreme cleaning. |
| **What is not covered under CTSS?** | CTSS does not pay for items or services paid for by other state programs or Community Transition Services. CTSS does not include recreational or diversional items such as television, cable, or DVD players. |
| **When do I need a provider contract?** | If the DSHS payment system will pay directly for a service or item, a contract is required for all CTSS providers.   * Check to see if the provider has an existing contract for the service or goods that will be provided. * If there is not an existing contract, pursue the appropriate contract before authorizing services. Providers must also meet all other obligations associated with the contracting process such as background checks, Medicaid Provider Disclosure Statement, and insurance requirements, when applicable. * For one-time only payment for deposits or set up fees, the Special Considerations contract can be used. * NOTE:   1. A contract is not required if another payment mechanism is utilized. Options include:      1. Using a PCard (state issued credit card); or      2. Authorizing a contracted individual transition services provider to pay for deposits and set-up fees directly and be reimbursed.         1. Compensation to the contracted provider for issuing payment does not count towards the CTSS $$2,500 limit. |
| **How do I authorize CTSS?** | You must:   1. Perform a CARE assessment to determine/document the need and plan of care for the CTSS. CTSS needs are captured in the Treatment screen in CARE as “other” with a comment indicating the nature of the service in the comment box. Assign the “Other” Treatment to the paid provider in the Care Plan Screen. 2. If the client will not be discharging with long-term care services, document the client need and reason for the allowance in the SER. 3. The Sustainability Goals screen in the Client Details section of CARE may be used as part of transition planning and as a communication tool with contracted providers. 4. Complete the [Housing Modification Property Release Statement (DSHS Form 27-147)](https://www.dshs.wa.gov/sites/default/files/forms/word/27-147.docx) for all environmental modification authorizations if the client has a rental agreement or does not own the residence. 5. Document all costs in the SER under Contact Code “Admin.” 6. Authorize services and/or items using the appropriate code(s). The total cannot exceed $2,500 without local ETR. 7. Submit a [Social Services Packet Cover Sheet (DSHS Form 02-615)](http://forms.dshs.wa.lcl/formDetails.aspx?ID=13767) to DMS with all invoices, receipts, housing modification property release statement, etc. Include verification that the client received the goods or services. 8. Send the client a Planned Action Notice for any CTSS.   **Note:** The HCS social worker must coordinate and authorize CTSS for all DDA clients. |
| **When do I authorize this service?** | This is solely for one-time payments to help a client establish, resume or stabilize a residence (no ongoing services/items). CTSS funds can be accessed up to 30 days after discharge if the item/service is needed for a successful discharge and no other resource is available.  You may use the CTSS each time the eligible client transitions from an institution **or** for each occurrence of instability that threatens the loss of the client’s continued living in the community. |
| **Bathroom Equipment** | If it appears a client may meet HCA’s exceptional criteria for necessary bathroom equipment, the DME vendor must request and ETR from HCA for the item(s).  When it is apparent to the case manager that a client needing bathroom equipment does not meet HCA’s exceptional criteria, an ETR request must be submitted to HCS HQ following all procedures outlined in the [Social Service Authorization Manual.](https://intra.dda.dshs.wa.gov/ddd/P1ServiceCodes/documents/Service%20Codes/SA291_Community_Transition_or_Sustainability__services.docx) |
| **Are ETRs allowed for the CTSS?** | Yes, all CTSS requests that exceed $850 must have a local office ETR approval. |

### Assistive Technology (AT)

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| **Assistive Technology (AT):** These services should be considered for those clients who are eligible for assistive technology through [RSW](https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/documents/LTCManual/Chapter%207f.docx) (known as CFC Ancillary Services) or [CFC (see chapters for additional information)](https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/documents/LTCManual/Chapter%207b.docx). Assistive Technologymay be used to purchase adaptive/assistive items and devices. Assistive technology is designed to:   1. Increase a person’s functional independence &/or substitute for caregiver assistance with an ADL, IADL or health related task. 2. Maximize a person’s health and safety. 3. Increase the likelihood that adults in institutional settings will transition to their own homes and communities.   Please see [Chapter 7b: Community First Choice](https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/documents/LTCManual/Chapter%207b.docx) from the LTC Manual for more information on CFC Ancillary services that are offered to CFC and RSW recipients. |

### Roads to Community Living (RCL)

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| Roads to Community Living is an additional package of services created from the lessons learned and cost savings seen through the first year of the RCL project. In 2009, Washington State legislature approved this additional funding to relocate adults from institutions. WA Roads services are available to assist with transition planning for clients who are not eligible through RCL and also as a resource for challenging or complex cases involving individuals who are currently living in the community, but who are at risk of losing their community setting.    See the Roads to community Living Chapter 29 [Chapter 5a](https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/documents/LTCManual/Chapter%205a.docx) in the LTC Manual for more information regarding eligibility and services offered. |

### Washington Roads

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| Washington Roads is an additional package of services created from the lessons learned and cost savings seen through the first year of the RCL project. In 2009, Washington State legislature approved this additional funding to relocate adults from institutions. WA Roads services are available to assist with transition planning for clients who are not eligible through RCL and also as a resource for challenging or complex cases involving individuals who are currently living in the community, but who are at risk of losing their community setting.  See the WA Roads [Chapter 5a](https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/documents/LTCManual/Chapter%205a.docx) in the LTC Manual for more information regarding eligibility and services offered. |

### Civil Transitions Program

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| **Who is eligible for CTP?** | Individual is referred to ALTSA from BHA starting December 1, 2023;  Individual is found not competent to stand trial and not restorable due to intellectual or development disability, dementia, or traumatic brain injury and your competency is not restorable  \*Individuals meeting criteria may have an assigned Forensic Navigator through BHA, who is responsible to help the individual receive wraparound support. The HCS Case Manager will coordinate with this individual when assessing for services. |
| **Who can provide services?** | \*Individual providers (IP’s) who provide services to clients in their own home.  \*Home care agencies that provide services to clients in their own home. \*Home care agencies must be licensed under RCW chapter 70.127.  \*Providers who are contracted with the department to provide goods and services.  \*Durable medical equipment vendors and adult day providers that have a core provider agreement with Health Care Authority.  \*Supportive Housing providers as defined in WAC 388-106-1715.  Housing services: For individuals with an immediate need for housing, a referral for housing services may be submitted without a CARE assessment or Medicaid application being submitted. For more information see chapter 5b Housing Resources for ALTSA clients. |
| **Duration of Services?** | Regardless of whether a client is only functionally eligible, only financially eligible, or neither, services will only be authorized for 6 months. The 6-month timeframe will start on the first day of the service authorization.  Exception:For those at risk of homelessness, housing services will be reviewed at six months with the ability to re-authorize for up to two years |
| **CTP Resources** |  |

## State Funded Long-Term Care for Non-Citizens

If the Public Benefit Specialist (PBS) or Social and Health Program Specialist (SHPC) 2 assigned to the case identifies that an individual who is either diverting or transitioning from the state hospital is in need of a Long-Term Care Non-Citizens (LTC NC) slot, a referral should be made to SHDD Public Benefit Coordinator. The Public Benefit Coordinator will make referrals to ALTSA HQ to place individuals on the LTC NC waitlist or to allocate the individual a slot. Individuals enrolled in the LTC NC program can receive personal care services in their own home or residential setting. See the HCBS Waiver LTC Chapter 7a eligibility section for financial eligibility criteria.

[Medicaid manual link](https://www.hca.wa.gov/free-or-low-cost-health-care/i-help-others-apply-and-access-apple-health/apple-health-medicaid-manual-wac-index)

## Expedited Non-Grant Medical Assistance (NGMA)

Once the PBS or SHPC 2 identifies an individual will require a NGMA for waiver services, they will send an email to the Public Benefit Coordinator to request an expedited decision with the Disability Determination Services (DDS) for any individual who is diverting or transitioning from the state hospital, receiving treatment at a State Hospital-Residential Treatment Facility (SH-RTF) or who was recently transferred under court ordered civil commitment status from the state hospitals. The Public Benefit Coordinator will coordinator via email with a dedicated team at DDS and will coordinate efforts related to the process including, but not limited to, gathering additional medical evidence, coordinating directly with adjudicators and providing emailed NGMA decisions from DDS directly to the assigned PBS, SHPC 2 and/or the client’s Barcode Electronic Client Record (ECR). The Public Benefits Coordinator will review the NGMAs each month and provide averaging data and referral information to the regional partners. The Public Benefit Coordinator will also provide additional data upon request from regional or Headquarters leadership.

The NGMA process should occur concurrently with social services. All social services referrals, including, but not limited to, referrals for CSS or RSW services, should proceed while an expedited NGMA is pending a decision with DDS. A NGMA is required when an individual transitions with waiver services to the community, but transition planning efforts should not be paused while waiting for the NGMA decision.

The PBS and SHPC 2s will complete NGMA referrals for all individuals identified as not having a previous disability decision on file either in the Barcode ECR or by Social Security regardless of their functional eligibility. However, an expedited referral to the Public Benefit Coordinator is only needed when the individual will require waiver services upon their transition to the community.

## Hospital Transition Support Unit

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| **Hospital Transition Support Unit: The** formulation of the HTSU Head Quarters (HQ) and regional teams were established in response to delays in state hospital transitions. ALTSA received additional funding to address the state hospital transition and diversion needs for individuals who have been determined financially and functionally eligible for Long Term Service Supports through increased staffing and service supports. | |
| **Behavioral Support Consultation/Training Request** | Each region has an assigned HTSU Behavior Support Trainer to offer a variety of supports for providers offering services to individuals who have transitioned from State Hospitals. HTSU Behavior Supports include:   * In-person or webinar instructor led trainings * Behavior support consultation and home-visits * State Hospital transition support     See HTSU Provider Training Catalog [HTSU Training 2024.pdf](file:///C:/Users/rosejr/AppData/Local/Temp/1/OneNote/16.0/Exported/%7B1133C22B-02E4-43AB-BDB0-42D49D003517%7D/NT/1/HTSU%20Training%202024.pdf) for detailed training and consultation services.  To request Behavior Support Consultation and/or Training, complete and follow the instructions listed on [DSHS 15-557](http://forms.dshs.wa.lcl/formDetails.aspx?ID=50402). Completed referral forms are to be sent to the SHDD Referral inbox: [SHDDRef@dshs.wa.gov](mailto:SHDDRef@dshs.wa.gov). |
| **State Hospital & Local Psychiatric Facility Transition Planning** | The Pre-Discharge Checklist is a tool to assist HCS hospital assessors in discharge planning and service delivery for individuals who are hospitalized in a state hospital or local psychiatric facility and transitioning into long-term care services in a community-based setting. [DSHS 20-331](http://forms.dshs.wa.lcl/formDetails.aspx?ID=52514) is optional, assessor sends to DMS if completed as cold mail or file only. |
| **Individuals with Complex Behaviors** | For individuals with challenging behaviors (i.e., assaultive, property destruction, self-injurious, challenging sexualized behaviors, history of arson, and/or history or criminal activity), the assigned case manager or assessor will complete [DSHS 10-234a](http://forms.dshs.wa.lcl/formDetails.aspx?ID=42377) to include in the residential provider referral packet. |
| **Public Benefits Coordination** | The HTSU Public Benefit Coordinator is available to provide the following pre and/or post transition assistance for an individual transitioning from a state hospital:   * Establishment of a payee * All social security related matters * Coordination with the financial department * Assistance with immigration document acquisition and/or naturalization * Any other public benefit related matters   For public benefits supports contact: TBD |

## IRT Process

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| **State Hospital IRT referrals** | Client can be functionally or financially eligible for MPC, CFC, CFC+Copes or RSW. Clients must be transitioning from a state hospital to an AFH or ALF (clients transitioning to GOSH and In-home settings are not eligible for IRT services). HCS assessor will:   * Send referrals via email to the IRT provider in your region and include the MCO liaison. * Work with the Transition Coordinator to help coordinate in-hospital or virtual visits for the IRT team to interview clients at ESH/WSH. * Coordinate with the local MCO liaison for approval and post discharge care coordination for clients receiving RSW services and IRT supports. |
| **Diversion IRT referrals** | Client can be functionally or financially eligible for MPC, CFC, CFC+Copes or RSW. Individuals must meet diversion criteria to be eligible for IRT services and transitioning into to an AFH or ALF in Spokane County (clients transitioning to GOSH and In-home settings are not eligible for IRT) Diversion criteria, client must be under an involuntary psychiatric civil commitment (72 hr., 14-day, 90-day, 180-day) at a local psychiatric facility. HCS assessor will:   * Send the referral with ITA civil commitment paperwork to the Transition Specialist. Once the client’s status as a diversion is verified, HCS regional case manager can send a valid referral to the IRT provider in your region and include MCO liaison. * Help facilitate in-person or virtual interview with client at local psychiatric facility as needed. |

## Rules and Policy

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| [RCW 70.41.310](https://app.leg.wa.gov/RCW/default.aspx?cite=70.41.310) | Long-term care -- Program information to be provided to hospitals -- Information on options to be provided to patients. |
| [RCW 74.39A.040](https://app.leg.wa.gov/RCW/default.aspx?cite=74.39A.040) | Department assessment of Medicaid eligible individuals – Requirements. |
| [WAC 388-106-0355](https://apps.leg.wa.gov/WAC/default.aspx?cite=388-106-0355) | Eligibility requirements for nursing facility level of care. |
| [MB 00-45](http://intra.altsa.dshs.wa.gov/docufind/mb/HCS/archives/MB2000/Revised%20August%2010%20MB.doc) | Hospital Assessments. |

## Resources

### HCS Behavior Support Consultation and/or Training Request



### Individuals with Complex Behavior



**Pre-discharge Checklist**



### Support for Complex Cases



### Trueblood Overview



PBS FINANCIAL/SOCIAL SERVICE COMMUNICATION REFERENCE GUIDE



## Revision History

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| **Date** | **Made By** | **Change(s)** | **MB #** |
| 2/2/2024 | Lateisha  de lay | * **AdD NEW CIVIL TRANSITIONS PROGRAM INFORMATION** |  |
| 1/25/2020  4/28/2020  1/19/2021  5/3/2021  10/22/2021  1/19/2022  5/5/2022  7/31/2022  10/27/2022  5/2023 | Lateisha De Lay  Ashley Beckley  Ashley Beckley  Ashley Beckley  Ashley Beckley  Ashley Beckley  Ashley Beckley  Ashley Beckley  Ashley Beckley  Ashley Beckley | * Included Information related to Strategic Measures and State Hospital Report. * Added Hospital Admissions and Discharge Planning: From a Community Setting (HCS/AAA Responsibilities). * Added SHDD Resource section. * Added hyperlinks to referenced chapters. * Added State Hospital Assessor definition. * Added chart to instruct which Outcome drop-down to use. * Updated Fast Track link. * Updated Region 2 Transition Coordinator contact details. * Added Region 2 Transition Coordinator- Bret Anderson * Updated SHDD Training Catalog Hyperlink and document attachment. * Updated Region 3 Transition Coordinator name and contact details. * Updated hyperlinks throughout the chapter and added SHDD webpage link to state hospital resource section. * Added Public Benefits Coordination to the State Hospital & Diversion resources table. * Added link to the SHDD Website. * Updates to the escalation process. * Added Involuntary Treatment Act (ITA): Confirming ITA Status & Case Manager Process * Added Roads to Community Living information * Updated contact information in State Funded Long-Term Care for Non-Citizens section. * Added Escalation Process for complex cases. * Added Civil Commitment Process & removed CARE screenshot image. * Added *Support for Complex Cases* document to resource section. * Update to Transition Coordinator contact information and added Transition Specialist contact details. |  |