Washington State Health Care Authority

Intensive Residential Treatment team program guide

Introduction

Thank you for taking the time to read about a new service delivery model in Washington. Intensive Residential Treatment teams (IRT) are part of Governor Jay Inslee's plan to revamp the state's behavioral health system. The IRTs will provide more support for clients in home and community based care settings.

Purpose of the guide

This is the first version of this guide and there will be issues outside of the scope of this document and as such this document should not be considered as complete. This guide is to assist in the startup and ongoing success of the Intensive Residential Treatment teams (IRT). It is a guide and should be referenced for programmatic decisions when necessary. It is not meant to be a clinical guide and should not be used to make clinical decisions.

Background

Intensive Residential Treatment teams (IRT) are part of Governor Jay Inslee's plan to transition people out of the civil commitment wards in Washington's state hospitals. The concept for IRT teams came from an analysis of the gaps in the state's community resources for individuals being discharged from the state hospital system. The Health Care Authority's (HCA) Division of Behavioral Health and Recovery (DBHR) worked with many state partners including Department of Social and Health Services' (DSHS) Aging and Long-Term Support Administration (ALTSA), the Behavioral Health Administration (BHA) and those in the community. The goal of these meetings was to develop a plan to help people transition out of state hospitals and prevent them from needing re-hospitalization. These meetings produced an analyses that identified the need for more support for people discharging or diverting from state hospitals who did not qualify for ALTSA residential support waiver services. In conjunction with ALTSA, DBHR developed a treatment model that would serve individuals who did not require continued hospitalization, but whose symptoms of mental illness were too acute for independent living, and were residing in ALTSA facilities. The intent of these teams is to wrap care around an individual to support them within their community. HCA submitted the new model to the legislature and four teams were subsequently funded.

Current problem

Many adults who discharge to the community or are diverted from a state hospital are placed in an Adult Family Home (AFH) or Assisted Living Facility (ALF) to meet their basic needs and care for their activities of daily living (ADL). Often these individuals are not getting adequate behavioral health support from community behavioral health providers. AFHs and ALFs are great at caring for people's basic needs. While staff in long-term care facilities are trained to take care a of a person's daily needs, they are not trained to manage or treat the complex behavioral health needs of some of our most vulnerable people. People who are placed in long-term care facilities need robust treatment in order to recover and remain in the community. Currently people are referred to community behavioral health providers who may not be able to provide treatment robust enough for the person to remain successful in their community. This results in people returning to the behavioral health crisis system and back to a state hospitals.

Team's purpose

IRT teams are created to fill the gap of people needing strong behavioral health treatment for people transitioning into are struggling to be successful in an AFH or ALF in their community. Teams provide wraparound discharge and diversion services with 16 hour availability 5 days a week. The team is the primary mental health provider for the person they serve. The team works closely with the facility they live in to help staff support the individuals they serve and to provide direct clinical interventions as is medically necessary. For after hour care the teams make arrangements with local community providers and coordinate with local EDs to ensure a person's needs are met when the team is not available. The team's clinical intervention will be geared to preventing crisis and intervening at crisis onset to significantly diminish the need for after-hours crisis support.

Scope

IRT teams are a voluntary outreach based team that provides wrap around treatment to individuals in ALTSA licensed AFHs and ALFs. They work with individuals who are discharging or diverting from state hospitals. The team will coordinate with natural supports, facility staff, and other formal staff to ensure treatment is successful.

Keys to success

- Team coordination and communication
- Good working relationships with ALTSA and their facilities
- Good relationships with local behavioral health crisis teams and after hour supports
- Recovery focused teams.

Staff roles and descriptions

Core staff

Psychiatric care provider

Requirements

Psychiatric Care Provider need to be licensed to prescribe psychiatric medications in the State of Washington. Be available 24/7 either on call or through a tele-psych arrangement.

Role description

Psychiatric Care Provider will be the person's primary psychiatric medication provider and will ensure they are available for team needs.

Clinician

A clinician is a qualified and licensed professional

Requirements

Must have a Master's degree and be appropriately licensed by DOH and adequately experienced to provide therapeutic services to people with mental health needs.

Role description

Will provide psychotherapeutic interventions including individual therapy, group therapy, and other modalities as appropriate. Will work to coordinate resources for the team and those they serve.

Nurse

Requirements

At least one nurse must be a Registered Nurse (RN). A RN is a professional licensed by DOH as an RN and able to distribute psychiatric medicines per prescriber order. The other nurse must be at least licensed by DOH as a Licensed Practical Nurse (LPN) and must follow all practice requirements and guidelines for their license type.

Role description

Nurses will provide an array of medication and wellness support. This includes psych-education related to medication and wellness. Assist in assuring medications are filled and ready for pickup or delivery to the facility depending on arrangements.

Certified Peer Counselor (CPC)

Requirements

Must be recognized by the authority as a peer counselor as defined in WAC 182-538D-0200.

Role description

Peers work with the person on recovery oriented problem solving. Peers will use their own experiences and their unique ability to problem solve from an empathetic perspective to help those they serve progress in their recovery. They will work to help build skills and progress community integration.

Required position

Mental Health Provider (MHP)

Requirements

MHPs are any mental health professional who meets the criteria under WAC 246-341-200. It is required that 1 MHP be on each team. All mental health services will need to be provided under the supervision of an MHP. This role can be fulfilled by a clinician, nurse, or PCP. Link to requirements: https://apps.leg.wa.gov/wac/default.aspx?cite=246-341-0200

Role description

The MHP(s) for the IRT team are required to complete all intakes into services and sign completed recovery plans. MHPs provide oversight for other team members and must validate that services provided are working towards the goals of the recovery plan.

Optional Staff

Program manager

Requirements

Must be a licensed mental health provider as either a Licensed Independent Social Worker (LICSW), Licensed Mental Health Counselor (LMHC), Licensed Marriage and Family Therapist (LMFT), or any other DOH independent licensed mental health professional. This person can be a member of a team or be overseeing the program and not involved in service delivery.

Role description

Provides oversight of the facility and manages personal decisions. They are responsible for maintaining program integrity and ensuring staff are supported.

Program support person

Requirements

Must be able to work in a healthcare environment. Recommended they have experience with reception and insurance information.

Role description

They will assist in scheduling and coordinating the functions of the facility. They can help with researching information and coordinating paperwork in the facility.

Staffing pattern

Shift	Recommended minimum staff per shift	Notes
Day (7:00 to 14:30)	1 Clinician, 1 Peer, 1 Nurse	Prescriber should set regular hours for the team and be available for consults as needed.
Swing (14:00 to 22:30)	1 Clinician, 1 Peer, 1 Nurse	

Night (22:00 to 7:30)	None	Need to have good coordination with after hour crisis network.

Regular hours

It is important the team create a regular schedule and keep it consistent. The schedule of when the team is available to meet with an individual and who on the team is available for contact should be shared with those they serve, facility staff, and community partners. There should be information on who to contact during regular hours and afterhours to support those the team serves. These hours should be respected as much as possible to allow the team to keep routines of self-care. Team members should not be expected to work outside of their shift as much as possible to reduce burnout.

Service modality

Admission and intakes

Admission criteria

IRT teams will work with individuals who meet Medical Necessity (MN) for Rehabilitation Services as defined in the Washington State Medicaid State plan for services, meet MCO Utilization Management (UM) standards, and clinical criteria. These terms are defined below:

Medical Necessity

Medical Necessity (MN) for IRT is met when the person meets the definition from WAC 246-341-0200.

> ""Medical necessity" or "medically necessary" is a term for describing a required service that is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions in the recipient that endanger life, or cause suffering or pain, or result in illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the person requesting service. Course of treatment may include mere observation or, where appropriate, no treatment at all."[1]

Utilization Management

Utilization Management (UM) is defined as "evaluating & determining coverage for and appropriateness of medical & behavioral health care services, as well as providing needed assistance to providers and patients, in cooperation with other parties, to ensure appropriate use of resources." UM in this context includes reviewing a person who is receiving IRT services to ensure the person still receives the least intensive mental health services necessary. This is a function completed solely by the MCOs but should be done with IRT and HCS input to ensure continuity of care when a person needs to transition to a different level of care.

Clinical Criteria

Clinical criteria means the guidelines used to assess whether or not an individual qualifies to be served by an IRT team. These guidelines are meant to be used to define the scope of the team's scope of service to an individual. Final decision on fit is a clinical decision that will be made by the IRT team. If a person no longer meets the criteria IRT teams should use clinical discretion to decide whether to continue to serve the individual. The clinical criteria for IRT teams to serve an individual are:

The individual being referred to services must meet **all** of the following criteria:

1. Diagnosed with a DSM 5 (or its successor) mental disorder which with the appropriate clinical interventions can be reasonably assumed to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions in the recipient;
2. Receiving services in a DSHS/ALTSA/HCS residential facility;
3. Presenting with symptoms of their mental disorder which without this level of intervention, could put their continued success in the community at-risk;

[1] https://app.leg.wa.gov/wac/default.aspx?cite=246-341-0200

The individual being referred to services must also meet **one** of the following criteria at intake:

1. Diversion: A diversion means an individual who resides in their community presenting with symptoms that puts the individual at risk for a higher level of care without the intervention of an IRT team. Examples of diversion are below:
    - At risk for involuntary treatment; or
    - psychiatric hospitalization; or
    - at risk of losing their living arrangement in their community; or
    - is currently held in an emergency department or hospital awaiting placement in an inpatient facility; or
    - Is currently held in an emergency room with no placement available due to presenting symptoms or level of need; or
    - In a community diversion, stabilization, or triage facility that is unable to find placement due to level of acuity or need; or
    - Will be released from a jail or prison and will need support to stay in their community.

2. Discharge: An individual admitted to a psychiatric inpatient facility, ready for discharge from the facility, with a discharge plan that includes placement in an ALTSA facility, but the symptoms of their current mental illness jeopardizes or poses an obstacle for admission to and/or continued success in an ALTSA facility.

Referral process

Possible referrals for services will be initiated by the MCO staff (including hospital liaisons), HCS staff, or local providers. If the initial source of the referral is not the MCO for the person then they will need to contact the plan's liaisons. If they do not know who they are they should staff with HCA program managers or HCS hospital diversion teams to identify a contact. All referrals should be staffed by the MCO and HCS to ensure the person is within the UM needs of the plan and there will be placement within the IRT team service area.

For persons who will be on a Less-Restrictive Alternative (LRA) or Conditional Release (CR) the MCO should ensure all conditions for these orders can be met with IRT teams and make arrangements for the person if they require other treatments or have certain requirements the teams cannot monitor.

ALTSA Home and Community Services (HCS) staff will transmit the referral packet including all relevant documents. HCS staff will do an assessment called a Comprehensive Assessment Reporting Evaluation (CARES)[2] which is used to determine the person being referred is appropriate for either an AFH or ALF. They will complete their referral to the team typically before they have found placement for the individual.

If a person is being placed on a Residential Support Waiver (RSW) program HCS will need to ensure there is no duplication with IRT services prior to placement. This should include an agreement on what the SBS provider and IRT team will provide to ensure there is no overlap. MCOs should be consulted during this process. If the person who is discharging will be on a LRA or CR these services should be clearly laid out in the court order and all parties understand their role.

Once the team has accepted the referral the team needs to make contact with the person being referred to assess if they understand the team and their services, and to ensure the person agrees to work with them. They should relay the person's decision to the MCO and HCS staff and make plans to stay engaged with the person prior to discharge to build rapport. If the person does not have active Medicaid during the planning period, these services should be billed as Rehabilitation Case Management.

If the team is unable to serve the person being referred they need to respond back in writing to the MCO and HCS staff referring the person with the reasons they cannot accept the person. If there are technical issues in the referral that are preventing the team from accepting the referral MCOs and HCS staff will be given time to correct these if possible i.e. the person is looking to be placed outside of the geographic location of the IRT teams. If the referral can be corrected the MCO and HCS should work to solve these problems and resubmit the referral.

[2] https://www.dshs.wa.gov/altsa/home-and-community-services/comprehensive-assessment-reporting-evaluation-care

If there is any issues with referrals any of the referring parties and the team can request to staff the case with any of the referring parties and HCA to work through any barriers.

Referral process flow chart

See Appendix A

Intake

The MHPs on the team are responsible for completing a comprehensive intake assessment into services that establishes medical necessity (defined below) for the services, treatment goals, and the services that will be delivered. Teams should attempt to get any signed Release of Information (ROI) for any treatment coordination that will be need in the intake. If the team is unable to get these ROIs at time of intake they should attempt to complete them in the initial recovery planning. The intake needs to establish treatment goals and the services that will support the person to those goals. These services need to be reflected in the recovery plan.

Recovery orientation: Prevent re-traumatization by making the intake through enough the person does not have to repeat their story to every member of the team, but is not invasive to the point a person is re-traumatizing themselves.

Treatment goals and services that will be provided will be used to assess ongoing Utilization Management needs for service utilization. The intake must be completed prior to the delivery of any other services. It is recommended to have the shift that completes the comprehensive assessment to ensure those who are not there review the intake thoroughly. A medical screening and medication evaluation should be completed by the prescriber as soon as they are able. This should be added to comprehensive intake after completion. For the purpose of clarity and understanding for all involved in the IRT teams intake process: Medical Necessity, User Management, and Clinical Criteria are defined below as follows. These definitions are only for IRT teams and should not be considered universal for all Medicaid services.

Recovery and crisis planning

Recovery planning

Recovery planning for the IRT teams is a little different than other outpatient recovery planning. Recovery plans, often called care plans or services plans, need to be updated regularly per regulation. MHPs need to update the recovery plan but can include any of the members of the team the person wishes to include. Separate sections for the nurses and peers services can be called out in separate sections. It is best if the team can recovery plan together but a person's preference will determine who they choose to recovery plan with. Different members from each shift may recovery plan at different times on the same recovery plan to make sure their goals and interventions are captured. Clinicians, peers, and nurses can complete their part of all of the recovery plan but it must be signed off by the MHP prior to any services being provided under it. ROIs should be reviewed during recovery planning to ensure they are up to date and still clinically necessary to ensure the person's privacy is being kept.

Important note: Recovery plans need to keep the golden thread from intake and address needs that have not been addressed. Recovery plans can be used for the purpose of UM by MCOs to ensure the person is still benefiting from services. All documentation for services needs to be congruent with the recovery plan.

Recovery orientation: Do not just make the recovery plan about the services a team provides, but include actionable steps for the person and their supports to work towards recovery.

Crisis planning

Crisis planning is an important step for working with people who are working to advance in their recovery. Crisis planning is the chance to be proactive with individual's who may experience periods of distress. It is a chance to work collaboratively with all involved to ensure the plan brings together everyone's perspectives and voices. It is most important to make this a plan that has action steps for the person being served and their facility staff with a clear list of do's and don'ts to help the person in crisis. This can include a list of relevant trauma information that can help inform responders in which decisions to make. Crisis plans should be updated along with recovery plans. Crisis plans should also be updated regularly after a crisis occurs. Crisis plans should be shared with facility staff, HCS, and the crisis system in their region. If a person accesses a specific crisis resource that resource can be engaged for crisis planning.

Important note: Crisis plans should be shared with all crisis providers in the region, but can only be done with a signed ROI to do so. Teams should engage the person on the reasons for sharing a crisis plan and how it will help a person if they ever go into crisis get the best outcome. Crisis plans can be shared as a whole or if the person prefers it

in part with community partners. Crisis plans can be developed by the teams or can be part of a systems wide crisis plan.

Recovery orientation: Crisis plans can be developed into a WRAP plan and can include things the person could do daily to help keep themselves well. This approach helps the person take ownership of their mental health and wellbeing.

Least Restrictive Alternatives and Conditional Releases

For some who are enrolled in IRT services they will be on a Least Restrictive Alternative (LRA) or Conditional Release (CR). These are special court ordered treatment that have specific conditions a person agrees to in order to be discharged from a commitment. LRAs and CRs require monitoring by an outpatient mental health provider. These reporting requirements should be completed by the IRT team as they are the person's primary mental health provider. Teams will need to work with their local courts and/or their local BH-ASO on the requirements for reporting on the LRA or CR.

Teamwork

This multidisciplinary team of six will serve a range of needs, recognizing that each person they serve will have different needs that are better supported by some members rather than others. Teams will need to keep each other informed of their location, who they met and if there is any relevant information for each other. Coordination and communication are important for the team to work. Teams will need to develop their own approach to these problems. Shifts should develop shared calendars if they don't outreach all together so they know where each member is in case of emergency. Shift change should involve case daily case staffing as relevant. If one team member is providing a service to an individual served by the team that affects what another person is doing they should staff what they are doing to prevent issues from arising.

Teams should create formal tracking systems for those they serve including a board with all their names with pertinent information, current status, and recovery plan due dates, and other important information for anyone on the team to use. These tools should be digital so team members can access and update them from the field.

Daily log

A digital and remotely shareable notebook, cardex, or spreadsheet form which the team maintains on a daily basis to provide a roster of the individuals the team serves, brief documentation of any treatment or service contacts which have occurred within the past 24 hours, and a concise behavioral description of those served by the team with a clinical status and any additional needs.

Daily team meeting

A daily staff meeting held during shift change between the two shifts to briefly review the service contacts which occurred within the past 24 hours and the status of all the individuals the team serves. Teams should review the service contacts which are scheduled to be completed during the current day and revise as needed. Plan for emergency and crisis situations as needed. The daily log and the daily staff assignment schedule are used during the meeting to facilitate completion of these tasks.

Daily staff assignment schedule

A written, daily timetable summarizing all individual treatment and service contacts to be divided and shared by staff working on that day. The daily staff assignment schedule is developed from a central file of all weekly individual schedules.

Weekly care coordination meeting

A weekly meeting with the entire team including the prescriber to discuss the week's activities and their current status. In this meeting the team should plan out the next week's activities. In this meeting any recovery plan reviews should be scheduled and assigned. The team should also review documentation for completeness and ensure all paperwork is up to date for these reviews.

Weekly individual schedule

A written schedule of the specific interventions or service contacts (i.e., by whom, when, for what duration, and where) which fulfill the goals and objectives in a given individual's person-centered treatment plan. The team shall

maintain an up-to-date weekly individual schedule for each person they serve per the person-centered treatment plan.

Service recording

Individual team members are responsible for documenting appropriate services provided. Teams who are providing a service together as a team need to ensure the service is properly documented. Teams should designate the person to document the service. This should be the primary person for service delivery

External coordination

All external coordination that requires sharing a personally identifiable information (PHI) will need a signed Release of Information (ROI) from the person being served prior to any communication. ROIs for known services and collaterals should be collected at intake.

Natural supports

Teams should attempt to include natural supports in treatment as much as clinically possible. Teams with the permission of the person being served and signed ROIs should engage natural supports in the person's care. Always let the person being served have control over the information shared and supporters engaged in their treatment. Natural supports are more meaningful for a person receiving services and it should be valued as part of the person's recovery. Natural supports may not always be clinically appropriate for all aspects of care. Screen natural supports to ensure they are healthy and helpful for the specific interventions they will be involved in. Use good clinical judgement to make sure they do not inadvertently cause harm. Tailor interventions that will include natural supports to ensure the natural support is receiving the following as part of the intervention:

- Psycho-education on the person's diagnosis, symptoms, and how the intervention helps
- Education on the intervention and their role.
- Breaking down stigma
- Reinforcing recovery

Community coordination

Coordinating with a person's community includes all activities that help a person integrate into their communities. As an example this can include helping them learn the bus system by arranging trainings.

Medical and medical service coordination

Teams should coordinate with medical service providers especially primary medical providers (PMP). PCPs and nurses should reach out the medical providers to learn more about any of the co-occurring medical conditions that affect a person's mental health. All team member should be aware of these co-occurring disorders and how to support the person and help them navigate.

Intellectual/developmental disability services

If a person is enrolled with the Developmental Disability Administration (DDA). Teams will need to coordinate with the DDA's case manager and any supports put in place to help a person with their disabilities. Teams need to take care to not conflict with treatment recommendations or procedures to ensure the person is getting the most from their support. If there is not DDA case manager or contact then HCA will help facilitate contacts and ensure there is no duplication.

Substance Use Disorder treatment

If a person enrolled in IRT teams services is also receiving treatment for a co-occurring substance use disorder (SUD). Teams will need to coordinate with the SUD treatment provider in a holistic fashion to ensure the person is successful in all their treatment goals. PCPs and nurses should coordinate with the provider with regard to any medications prescribed. Clinicians and peers should coordinate with similar provider types from the SUD provider to make sure the team stays consistent with care.

Afterhours coordination

Some of those the team serves will need to have regular contact with someone outside of the team's regular hours. Teams should work with regular partners to provide afterhours support for those they serve and the facilities they work with. Agreements should be in place to allow the sharing of information with these partners. Crisis plans should be shared

Facility coordination

Teams will need to coordinate with facilities and their staff. This should include at least weekly check-ins with staff about their observation of the individual residing their and hear any concerns. Teams can also provide education about the individual's presentation and support the facility in better working the individual served by the team.

Residential Support Waiver (RSW) provider

If a person is enrolled with a residential support waiver (RSW) behavioral support provider, teams will need to coordinate with the provider to ensure there is no duplication of services between the IRT team and RSW provider. Teams need to coordinate with the RSW provider to ensure the provider is able to support the facility and its staff. The IRT team should be the primary medication prescriber but, if the person is already receiving medication through the RSW provider then the team will need to coordinate with that provider and the team should not prescribe any psychiatric medications to that individual.

Criminal court coordination

If a person is connected to the criminal local court system the team must ensure they are coordinating with any case manager, parole, probation, or other professional appointed by the court to monitor a court order for all matters related to any mental health requirements the person must comply with. If the person does not sign any ROIs or refuses to let the IRT team be involved then this decision needs to be documented in the clinical record.

Discharge planning

There is no required timeframe to discharge a person from the IRT teams. Teams serve as the primary mental health providers and can continue to work with the individual as long as they meet medical necessity and clinical criteria. Completing treatment should be the goal and discharge planning should be part of this goal. Discharge planning should mirror the recovery plan's goals and all discharge paperwork should reflect steps towards achieving these goals. Most discharges from an IRT team occur when the person being served and the team agree discharge is warranted and proper coordination and planning have taken place to ensure the person is successful after services from the team cease. Some other discharges can occur when IRT teams determine services cannot be provided or the person no longer needs the level of care. Proper coordination and documentation of this coordination needs to occur prior to all discharges.

Important note: The person's housing may be affected by any discharge. It is important to coordinate with the facility and HCS staff prior to any discharge to mitigate this chance. MCOs should be made aware of any impacts to their member's housing prior to any decision related to discharge.

Treatment completed

If a person completes their treatment goals and has been stable for a period of time the team should engage the person in discharge planning. If a person is hesitant then the team should use clinical judgement on how to proceed with discharge planning. When the person agrees to discharge from a team the team will work to find adequate and clinically appropriate after care in the community. Teams should take into account medications the person is being prescribed and ensure there is a prescriber capable and willing to provide these medications prior to the team discharging the individual. Teams should work with MCOs to ensure there is adequate follow up care and they are notified of the discharge.

Recovery orientation: This is the ultimate goal of all IRT services. Helping people graduate from this level of care by accomplishing their treatment goals. It is highly recommended this be a celebration for the person in recognition of all the hard work put in by the team and the person. A graduation ceremony would be a good idea.

Treatment no long necessary

If a person is enrolled in services with an IRT team but the IRT team determines they are no longer benefiting from services the IRT team can engage the person is discharge planning. This can occur because either the person has completed all goals and is stable and refuses to discharge from IRT services or services are ineffective or services are inappropriate. To complete this type of discharge the team should meet with the individual and attempt to engage them in discharge planning. Teams should also coordinate the facility, HCS staff, and the MCO and discuss their concerns. The team should attempt to coordinate care after IRT services end. If the person refuses this should be documented and best attempts to set up after care should be made.

Utilization Management note: MCOs as part of their UM procedures may not authorize further IRT services for their member. If this occurs IRT teams will need to develop a discharge plan and ensure there is coordination of care after services with IRT are discontinued.

Mutual agreement to end services

If a person feels services are not working for them and the team agrees then the team will work to find the person follow up care. If the person declines this assistance then this should be documented in the discharge paperwork. MCOs, HCS, and facility staff need to be notified of this decision and discharge planning should be completed before the discharge occurs.

Special discharges

The following discharges are a special type of discharge for a person who the team cannot provide services to due to lack of engagement or inability to serve the individual. For all of these discharges proper documentation of the reason for discharge and attempts to prevent the discharge or engage the client need to be documented. MCOs should be contacted prior to discharge. HCS and facility staff may be contacted after discharge for cases where the discharge must happen before contact can be made.

Loss of contact

Loss of contact occurs if a person being served by an IRT team is unable to be located or refuses to work with the IRT team for more than 30 days. Teams will need to adequately attempt to locate and engage the person using HCS staff, facility staff, and any contacts with ROI on file. If teams are unable to engage the person then teams will need to engage HCS case managers and facilities about the possibility of discharging the individual. MCOs need to be notified prior to any discharge of the team's inability to locate or engage the client and plans to discharge.

Hospitalization

If a person is being served by an IRT team needs inpatient care then the IRT team should coordinate with the facility staff where the person will be receiving inpatient care. If the hospitalization is less than 30 days teams should continue to work with the person while they are inpatient to help motivate them to discharge successfully. If the person will need longer in a hospital setting then teams will use clinical discretion to determine whether or not to keep a person open on their team. If the person loses their Medicaid while in the hospital teams will need to ensure it is turned on again when the person discharges back to the team.

Recovery orientation: Use the time a person is in the hospital to help them not only recover from a crisis but work to help normalize hospitalization and keeping their focus on recovery even if services need to be terminated for the person.

Incarceration

If a person is being served by an IRT team becomes incarcerated teams will need to coordinate with the jail mental health system to ensure the person receives ongoing care while incarcerated. Clinical judgement should be used to determine if the person should remain open with the team.

Important note: If a person is incarcerated for more than 48 hours they will lose their Medicaid which means the MCO will no longer be involved in the persons care. Teams will use their judgement on whether to keep the individual open with them while they are incarcerated. Teams will need to ensure the individual reapplies for Medicaid upon release if they stay with the team.

Billing and Service Reporting

All teams will need to record service encounters following the appropriate HCA billing guide and BHDS reporting standards. Teams will submit all service and billing to the MCOs they are contracted. Teams need to ensure their service reporting and billing follow the guidelines set by each MCO they are contracted with.

Example billing codes and service descriptions

Below is an example of some of the services that can be provided by IRT teams. IRT teams can provide any service in the mental health billing guide[3] that an individual team member is credentialed and qualified for and is appropriate to achieving the recovery plan goals.

Services are encountered using the modifier UD to track services that are encountered by the teams. Services can be isolated by drilling down with the place of service codes POS 33 or POS 14. The exact service encounter reporting and

[3] https://hca.wa.gov/billers-providers-partners/prior-authorization-claims-and-billing/provider-billing-guides-and-fee-schedules

billing methods will be set up with the MCOs the teams are contracted with. In the Behavioral Health Data System (BHDS) system use program ID# 44 when reporting services.

Billing Code	Modifier	Service Description	Service Interval	Provider Type Only
H2027	UD	Psycho-Education	15 minute intervals	
H0038	UD	Peer Support	15 minute intervals	CPC
H0034	UD	Medication Training	15 minute intervals	
T1001	UD	Nursing Assessment/Eval.	1 per encounter	RN
H0031	UD	Mental Health Intake Assessment	15 minute intervals	MHP
H2014	UD	Skills training	15 minute intervals	
H2015	UD	Community support	15 minute intervals	
90853	UD	Group Therapy	15 minute intervals	
H2011	UD	Crisis Intervention Services	15 minute intervals	

Appendix A – Referral Process Flow Chart