# Chapter 9a: Hospital Assessments

### Purpose

The purpose of this chapter is to clarify hospital assessment activities to ensure smooth transitions of those residing in a hospital to in-home, community residential settings, or to nursing home facilities. The goal and focus of hospital assessment activities is to:

* Proactively engage with individuals seeking long-term care services.
* Provide up to date information about Medicaid funded long term care options to hospital staff and individuals seeking these services.
* Assist hospital patients and their families in making informed decisions regarding home and community service options.
* Assist hospitals in working with Medicaid eligible patients to access long-term services and supports (LTSS) to avoid staying in the hospitals when they no longer need acute care services.
* Prioritize the assessment of long-term care eligibility for individuals as soon as they are referred for services and anticipate transitioning from the hospital to a less restrictive setting.
* Expedite the authorization of long-term services and supports.
* Develop rapport and supportive relationships with local hospital discharge planners and long-term service and support providers in the community.

# Ask the Expert

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# Background

Many acute care hospital patients who are referred to the Department’s Home and Community Services (HCS) division are new to long-term care services and will require a functional and/or financial eligibility determination. Ensuring timely transitions to services is essential in reducing the number of days patients spend in acute care settings when they no longer meet medical necessity. Aging and Long-Term Support Administration must coordinate transitions with border acute hospitals and more than 50 acute care hospitals statewide. Successful transition planning involves strong collaboration and partnership with regional staff, hospitals, managed care organizations, providers, and communities, to provide appropriate services and community options that honor patient choice and reduce medical costs while increasing individual wellbeing, and quality of life. Completing hospital assessments and coordinating transitions planning involves a great deal of data collection, analysis and creative problem solving for systems of care to be better aligned and responsive to unique individual needs.

# Assessing and Transitioning Clients from the Hospital

HCS hospital assessments for individuals eligible for Medicaid MUST follow policy established in [Chapter 3](https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/documents/LTCManual/Chapter%203.docx) of the Long-term Care Manual. It is the goal of HCS that all hospital referrals for LTSS receive a hospital assessment unless a) the individual is discharged or the hospital withdrawals a referral prior to an assessment being completed or 2) the individual refuses the assessment. In addition, the patient MUST meet conditions for conducting an HCS assessment in the hospital outlined in this chapter.

### What Conditions Must Be Met for HCS to Conduct a Hospital Assessment?

## For HCS to conduct and complete a hospital assessment, the individual in an in-patient setting must meet the following:

1. Medically stable—the individual at this point is close to baseline functioning and their immediate medical needs, treatments, and therapies have been achieved.
2. Individual, guardian, or legal decision maker is aware of the referral to HCS and agrees to be assessed. If the client lacks decision making capacity, they should still be assessed to determine program eligibility, but cannot be transitioned until a decision maker is in place. Please refer to [Chapter 3](https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/documents/LTCManual/Chapter%203.docx) for performing a CARE assessment.
3. Psychiatrically stable —the individual at this point is close to baseline functioning and their immediate psychiatric needs, treatments, and therapies have been achieved, evidenced by no use of physical or chemical restraints in the past 3 days prior assessment and transition.

* Medically Stable individuals for example, are not in ICU, their conditions are predictable and stabilized.
* If the client does not have capacity to make their own decisions, and no authorized representative is in place, a legal decision maker designated as a Durable Power of Attorney (DPOA), Power of Attorney (POA), or guardian will have to be established before the client can be transitioned out of the hospital.
* HCS hospital case managers MUST consult with informal decision makers/collateral contacts and medical records to determine whether the client lacks capacity to make their own decisions for LTC services and develop a plan of care if the client is unable to make their needs known. The case will stay pending until a guardian or a legal decision maker is in place.

### When is an Individual Not Ready for a Hospital Assessment?

1. When the individual declines to have an HCS hospital assessment done to explore LTSS options they might be eligible for, and this is documented in CARE.
2. Not medically stable—the individual still needs acute care medical intervention and is not back to baseline functioning or no new baseline has been identified; immediate medical needs, treatments, and therapies are not yet in place.
3. Not psychiatrically stable---the individual continues to require in-patient psychiatric services and are not back to baseline functioning or no new baseline has been established; immediate needs, treatments and therapies are not yet in place.
4. Combative and/or behaviorally compromised e.g., client who is all out assaultive,
5. Client is being chemically or physically restrained.
6. Individuals on frequent use of intermuscular medications (IM) that cannot be replicated in a community setting. E.g., the individual is given psychotropic IM medication that is ordered as needed or PRN for behavioral management.

* If an individual is being held in isolation, they **must** be medically/psychiatrically stable, and predictable for an assessment to occur.
* For individuals on contact precautions like COVID-19, MRSA and other infectious diseases, staff will assess them following established universal precautions and safety standards.
* In addition, for individuals who are in physical restraints or being held in isolation rooms, consult medical records, hospital staff, and informal decision makers/ collateral contacts before considering CARE assessment completion. Discuss with hospital staff on measures and approaches being taken to wean an individual off these restraints which will allow HCS to pursue transition options for less restrictive settings.
* For clients on frequent use of IM, when a case manager is in doubt, they should consult with a Nursing Care Consultant (NCC) or Hospital Transition Support Unit RN in your region to review the situation.

### What Assessments Need to Be Prioritized Among Hospital Referrals?

Sometimes hospital staff will notify HCS of the need to prioritize certain referrals. For such cases, the assigned HCS hospital case manager will work with the hospital to determine the order of assessment.

A hospital referral that is considered a priority over other hospital referrals may have the following conditions:

1. Individuals who are already financially eligible for Medicaid long-term care services
2. APS is involved.
3. Hospice is involved and they are requesting HCS to take the lead in finding a community setting.
4. Department of Correction referral requesting HCS to take lead in finding a community setting for a client who is medically complex.
5. Individual’s planned hospital discharge is imminent; it is in a few days not weeks; and
6. The individual can consent to services or has a representative to consent to services.

### What is the Role of HCS in Transitioning Clients to a Community Setting?

### HCS is responsible for initiating functional assessments and financial eligibility determination of referred Medicaid applicants who have indicated a preference for community-based (home or residential) LTSS services.

### The HCS intake unit:

1. Receives and conducts an initial screening of the referral and/or long-term care service application (request for long-term care services).
2. Enters applicant in CARE within one working day following guidelines in [Chapter 3](https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/documents/LTCManual/Chapter%203.docx) of the Long-term Care Manual.
3. Assigns the case to the HCS hospital case manager, and
4. Performs case transfers when appropriate.
5. For clients new to long-term care services, and those who will not return to their previous community setting within 30 days of being hospitalized; these referrals will be assigned to the HCS hospital unit.

The HCS hospital case manager will:

1. Make contact with the client within two working days of receipt of referral as outlined in [Chapter 3](https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/documents/LTCManual/Chapter%203.docx) of the Long-term Care Manual.
2. Triage cases to determine the appropriate time for an assessment.
3. Update the Acute Hospital Screen in CARE Web to start tracking the referral and keep the client record up to date. Barriers should be removed when they are resolved.
4. Complete a full initial, initial/reapply or significant change assessment in CARE to determine care needs, and present appropriate service options to the client, family, and/or decision maker or guardian, and authorize personal care services within 30 days from the date of receipt of the referral.
5. Provide information about long-term care services and supports to hospital staff, patients, and families.
6. Discuss MAC/TSOA as option if the client declines HCS Services
7. Assist with developing multiple potential transition plans into LTC care settings concurrently, including finding a provider.
8. Identify, document, and address barriers to transition as early as possible.
9. Collaborate with hospital staff on discharge planning.
10. Coordinate with transitions of care planners at Managed Care Organizations (MCOs).
11. Submit Non-Grant Medical Assistance (NGMA) applications for those who will benefit from Waiver services and do not meet the Aged/Blind/Disabled criteria to access Waiver services.
12. Utilize FAST TRACK for community services, if appropriate
13. Submit transfer requests to HCS intake unit or direct supervisor for clients who will be receiving long-term care services in their homes for ongoing AAA case management as soon as the:

* Referrals for services are made.
* Services are authorized.
* Service plan is implemented.
* Provider service contracts are arranged, if appropriate
* RAC are entered in CARE.
* ProviderOne authorization is “error free” and in CARE,
* The client and provider have signed the service summary and returned it to the relevant HCS staff for review and signature.
* If FAST TRACK has been used, the Medicaid application has been submitted with the appropriate documentation to the local financial worker.

1. Likewise, follow above procedures outlined from 1(i) through (xi) for transferring client cases to an HCS Residential case manager for clients who will receive services in residential settings.
2. For hospital clients who are discharged from Acute care hospitals before an HCS hospital assessment and/or LTC service plan is in place; the HCS hospital case manager or supervisor will submit a transfer request for the individual to be followed up by the HCS in-home unit, or HCS residential unit to expedite assessment and/or set up of services for appropriate LTC community options. When these cases are transferred it should be noted that they were discharged from the hospital before assessment or service planning could be established and that these cases need to be expedited by the receiving team.
3. For hospital clients who were receiving long-term care services in residential settings (AFH, AL, or ESF) prior to hospitalization and are expected to return to this setting upon discharge, unless the case was assigned to the HCS hospital case manager:
   1. The HCS residential case manager will conduct a significant change assessment when warranted based on the last assessment done on this client in CARE.

* Follow established protocol for assessing and updating CARE assessments to reflect any changes to the client’s care plan as outlined in [Chapter 3](https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/documents/LTCManual/Chapter%203.docx) of the Long-term Care Manual.
* If an initial assessment was completed upon admission to the hospital, unless there are changes in client’s functional abilities, a new assessment may not be required following a referral to HCS.
* A care plan needs to meet client’s needs at the time of transition.
* The residential case manager will authorize the service plan prior to transition.
* Provide information about long-term care services and supports to hospital staff, clients, and families.
* Assist with developing multiple transition plans at the same time into LTC care settings concurrently including finding a provider.
* Identify and address barriers to transition as early as possible.
* Collaborate with hospital staff on discharge planning.
* Coordinate with transitions of care planners at MCOs.
  1. Discuss options for MAC/TSOA if client declines HCS services.
  2. When clients are not expected to return to their previous residential setting, the residential unit will staff the case with the hospital unit, create a hospitalization transfer SER with the following information, and transfer the case to an HCS hospital case manager.
* Hospital Name
* Admission date
* Current hospital social worker
* Barriers to returning to residential setting.
* If the client cannot return to their previous residential setting, the residential case manager will transfer the case immediately to an HCS hospital case manager.
* If the HCS residential manager knows the client is planning to transition to a skilled nursing facility, or that an assessment is not needed prior to nursing facility admission; transfer the case immediately to the NFCM assigned to that facility once the client has been admitted to the facility.

### What is the Role of HCS Case Managers in Determining Decision Making Capacity?

### Until a Court determines that an individual lacks decision-making capacity, the individual still retains their civil right to make their own decisions. It is important for the client to participate in person-centered planning and to honor their choice of representative. Since HCS is not a health care provider, it must follow Medicaid law when looking for client consent to provide Medicaid long-term care services. As such, a healthcare directive or healthcare power of attorney is generally not sufficient for obtaining consent for HCS LTSS services outside of a medical setting unless it contains an additional provisional clause specifying authority to consent to services.

### The case manager should interact with the individual to determine if the individual can consent to HCS services or can select a representative to provide consent. In addition to consulting with the hospital on the individual’s capacity, the case manager should see if the individuals can answer simple questions and understands the services being offered. Ideally, a client designates their representative in writing well in advance of needing a representative, sometimes verbal designation is sufficient if it is well documented. If there are questions about how to proceed, case managers should staff with a supervisor and determine if escalation to HQ/AAG is appropriate. In situations where an individual is severely incapacitated and does not have the ability to choose a representative, a guardianship or conservatorship may be the only available option to ensure client choice and consent for HCS services.

When a Medicaid client lacks capacity to make their own decisions concerning their long-term care needs and no authorized representative, DPOA, or POA is in place, unless the individual has a relative or friend who is willing to pursue guardianship; the acute care hospital or another party would need to pursue guardianship or conservatorship for the individual to transition into a long-term care setting. In a small subset of clients who do not have an identified person willing to serve as a guardian or legal decision maker, resources may be available through HCS Guardianship Pilot project. Please consult your supervisor or Regional Guardianship Case Manager.

A Court Visitor (formally known as Guardian Ad litem- GAL) is an investigator for the court and they are responsible for vetting a proposed guardian and completing an investigative report to the court outlining recommendations as to the need and scope of a guardianship and who an appropriate person would be to serve as guardian in the case. In some incidents a Court Visitor or other court appointed decision maker may participate in transition planning in a case where the court has specifically ordered them to do so. Review the court order carefully to establish what the Court Visitor has been authorized to do.

* At times, a client can still legally execute a DPOA using residual capacity even when medical records have documented the client as non-decisional for medical informed consent purposes. This is because there are different legal thresholds for execution of DPOA verses informed consent for medical procedures.
* Healthcare partners should be encouraged to assist clients in executing healthcare DPOAs with a provisional clause to allow for the consent to LTSS. Below is an example of such a provisional clause:
  + *Agent has authority to apply for LTSS benefits and /or to consent to and coordinate LTSS on behalf of principle*.
* DPOA or POA can be executed after the guardianship process has been initiated. It is a preferred less restrictive alternative arrangement to guardianship. Guardianship should be sought as a last resort option as it is the most restrictive in nature and removes a client’s civil rights under court order, unless if the court intervenes to dismiss the guardianship case and orders the client capable of making their own decisions.

For more assistance about client consent including questions on client decision-making capacity, refer to the complex case and escalation pathway [Appendix VII](#_Appendix_VII_Complex).

### What is the Role of AAA in Transitioning Clients Back to their Own Home?

AAAs are responsible for case managing clients returning to in-home services following a hospital stay.

1. For clients who were receiving in-home services prior to hospitalization, who are expected to return to this setting upon discharge, the AAA and their case management subcontractors will:
2. Follow assessment procedures established under [Chapter 3](https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/documents/LTCManual/Chapter%203.docx) of the Long-term Care Manual.
3. Continue to case manage the clients who were on CFC/COPES/New Freedom/MAC/TSOA long-term care services prior to hospitalization and provide reassessments/service plan changes around the time of discharge.
4. Be responsible for conducting a significant change assessment when appropriate.
5. For clients who were receiving in-home services prior to hospitalization and will not return to in-home services within 30 days of being hospitalized:
6. The AAA case manager will immediately staff client’s status with HCS/ Hospital supervisor to consider transferring of case to appropriate staff. This should be done promptly to avoid delays.
7. Create a hospitalization transfer SER with the following information:
   * Hospital name
   * Admission date
   * Current hospital social worker
   * Barriers to returning home
8. Transfer cases to HCS hospital case managers as soon as it is known that the client will not be returning to in-home services and close all authorizations.
9. HCS hospital case manager will take over the case for all transition planning actions for clients transitioning from acute care hospitals.
10. AAA case managers determine the need to transfer vs. retain hospital referrals for transition, in addition:
11. Provide information about long-term care services and supports to hospital staff, clients, and families.
12. Assist with developing multiple transition plans into LTC care settings concurrently including finding a provider.
13. Identify and address barriers to transition as early as possible.
14. Collaborate with hospital staff on discharge planning.
15. Coordinate with transitions of care planners at MCOs.

* If the client cannot return to in-home services after the case has been staffed, the AAA case manager will close out authorizations and immediately transfer the case to an HCS hospital case manager.
* If the AAA staff know the client is planning to transition to a skilled nursing facility, or that an assessment is not needed prior to nursing facility admission; transfer the case immediately to the NFCM assigned to that facility once the client has been admitted to the facility.

### What is the Role of Nursing Facility Case Management in Transitioning Clients Back to Skilled Nursing Facilities?

For cases managed by NFCM; when the client is not expected to return to their previous NF setting, the NF case manager will:

1. Immediately staff the case with the hospital unit,
2. Create a hospitalization transfer SER with the following information, and
   1. Hospital Name
   2. Admission date
   3. Current hospital social worker
   4. Barriers to returning to SNF setting.
3. Transfer the case to an HCS hospital case manager.

* If the client cannot return to their previous NF setting, the NF case manager will transfer the case immediately to an HCS hospital case manager.

### What is the Role of Hospital Discharge Planners in Discharging Clients to a Community Setting?

Hospital discharge planners are responsible for sending HCS client referrals for LTC service assessment and Medicaid eligibility determination as soon as it is determined that the individual being hospitalized will need these services as part of the discharge plan.

In addition to implementing the hospital’s coordination plan with the local office, discharge planners will:

1. Identify and communicate early on, barriers to discharging each individual that is being referred for LTC services.
2. Prior to making a HCS referral, determine if the client is willing to accept long-term care services.
3. Submit a completed intake/referral form and financial application with valid applicant’s location and contact information.
4. Pursue guardianship if client no longer has the ability to consent to LTC services on their own and did not consent to authorizing a representative.
5. Work with client’s family or authorized representative to create discharge plan, which may include setting up medical and mental health aftercare appointments and secure medical equipment for the client to use after discharge.
6. Provide status updates, clinical info, and access to pertinent info effecting d/c planning.
7. Assist with locating long term care community options.
8. Coordinate with AAA and DSHS staff concerning referrals for long-term care services and schedule assessments.
9. Coordinate individual transitions with MCOs for services and supports.

### How is Coordination with Hospital Discharge Planners Done?

HCS hospital unit supervisors or designated staff will maintain regular contact with each hospital and conduct in-service training when appropriate to disseminate updated information about long-term care services. This will also ensure that HCS’ presence is complementary to hospital discharge planning activities. The goal of HCS is to nurture a positive working relationship with individuals and entities pertinent to the discharge planning process to ensure effective coordination and client outcomes. Barriers to transition individuals need to be identified and addressed early in the transition plan process. HCS designated staff will:

1. Communicate:
2. Clearly define and explain to discharge planner the role HCS/AAA has in assessing new clients and clients returning to the community.
3. Discuss all Medicaid long-term care services including MAC/TSOA referrals with hospital discharge staff for discharge planning.
4. Develop a written hospital transition coordination plan between the local hospital(s) and Home and Community Services office to ensure these processes and activities are understood. At a minimum, the following information shall be provided to the hospital discharge planner:

* Contact information for the local office.
* Contact information for specific staff including back-up staff assigned to the hospital (if available).
* Escalation contacts for the regions or designee outlined in appendix I.
* Procedures for case staffing individual cases that may require multi-system resources and support to transition.

1. Encourage hospital discharge planners to refer individuals appropriately as soon as it becomes apparent that community-based services are needed.
2. Provide the following forms and documents:
   1. HCS referral (intake) form and procedures (see appendix II)
   2. [LTC application](https://www.washingtonconnection.org/home/) and procedures
   3. Policies for LTC assessment outlined in this chapter.
   4. A request for data needed from hospitals by HCS hospital case managers (see information under assessment data and reporting section of this chapter).
   5. Provide hospital staff with information on roles and HCS process for transitioning individuals out of acute care hospitals and share the following link where a brief training can be accessed. <https://360.articulate.com/review/content/a3c57916-38cb-482e-8b32-4c5d182aa801/review>

To AVOID delays with discharging individuals:

* Hospital staff, patients or family must submit the HCS Intake and Referral form, and long-term care services application. The application is available online at: <https://www.washingtonconnection.org/home/>
* Hospital staff will follow additional instructions documented in appendix III to Expedite Acute Care Hospital Applications.
* Identify and address barriers for transitioning individuals early in the process and use the escalation path if there are concerns about HCS process or timeliness which includes escalating individual cases to HCS supervisors.

### What is the Role of Medicaid Managed Care Organizations in Transitioning Clients to a Community Setting?

Managed Care Organizations (MCOs) are responsible for transitional care services which require them to work with appropriate staff at any hospital to implement safe, comprehensive discharge plan(s) that assures continued access for medically necessary covered services which will support the client’s recovery and prevent readmission.

MCOs also have a responsibility to work with HCS to coordinate services and assist in discharge planning to help ensure coordinated efforts (also see [MB H20-029](https://fortress.wa.gov/dshs/adsaapps/Professional/MB/HCSMB2021/H21-044%20Revision%20to%20Long-Term%20Care%20(LTC)%20Manual%20Chapter%2022.docx)). They are responsible for the following activities to assist in discharge planning:

1. Arranging for DME approval and delivery
2. Assigning a PCP for the client to see post discharge.
3. Assisting in finding community transition settings
4. Negotiating contracts with SNFs and paying for SNF stays that meet rehabilitative or skilled criteria.
5. A written discharge plan, including scheduled follow-up appointments, provided to the Enrollee and all treating providers; Formal or informal caregivers shall be included in this process when requested by the Enrollee.
6. Ensuring timely access to follow-up care post discharge and to identify and re-engage Enrollees who do not receive post discharge care.

MCOs have the following responsibilities after discharge:

1. Organizing post-discharge services, such as rehabilitative or skilled home care services, after-treatment services, and occupational and physical therapy service
2. Telephonic reinforcement of the discharge plan and problem-solving two (2) to three (3) business days following discharge
3. For Enrollees at high risk of re-hospitalization, the MCO ensures the Enrollee has an in-person assessment by the Enrollee’s PCP or Care Coordinator for post-discharge support within seven (7) calendar days of hospital discharge.  The assessment must include follow-up of discharge instructions, assessment of environmental safety issues, medication reconciliation, an assessment of support network adequacy and services, and linkage to appropriate referrals;
4. Scheduling outpatient Behavioral Health and/or primary care visits within seven (7) calendar days of discharge and/or physical or mental health home health care services delivered within seven (7) calendar days of discharge.
5. Follow-up to ensure the Enrollee saw his/her provider; and
6. Planning that actively includes the patient and family caregivers and support network in assessing needs.

* Medicare Advantage and dual eligible special needs plans also have a requirement to participate and implement transition care activities. Refer to [MB H20-029](https://fortress.wa.gov/dshs/adsaapps/Professional/MB/HCSMB2021/H21-044%20Revision%20to%20Long-Term%20Care%20(LTC)%20Manual%20Chapter%2022.docx) for information about MCO contacts or on the HCS intranet site located here: [Medicaid & Medicare Managed Care Coordination Contacts](https://intra.altsa.dshs.wa.gov/hcs/documents/Medicaid%20and%20Medicare%20Managed%20Care%20Coordination%20Contact%20Lists.xlsx).

### Who Else May Be Involved in Acute Care Hospital Transition Activities?

1. DDA case manager and/or DDA Nursing Care Consultant:
   * Triage referrals and determine functional eligibility by assessing the client’s care needs.
   * Assist with developing transition plan into long-term care settings.
   * Provide information about long-term care services and supports to hospital staff, clients, and families.
   * Coordinate with hospital staff on discharge.
   * Collaborates with HCS case manager when needed to assist with developing client care plan.
2. DDA PASRR Team—for Pre-Admission Screening Residential Referral eligibility determination.
3. Other service providers authorized by HCS e.g., community choice guides, supportive housing provider etc.
4. Public Eligibility Specialists—Determine client’s Medicaid financial eligibility.

1. Guardian or sometimes Court Visitor: Participates in transition planning and decision making.

* Coordination and/or transfer of client services between DDA and HCS may occur for several reasons. Follow instruction in [Chapter 7h](https://manuals.dshs.wa.gov/altsa/aging-and-long-term-support-administration-long-term-care-manual) of the long-term care manual appendix I for details.
* If the client needs services only provided through DDA (such as SOLA or Supportive Living) consult with DDA regional management prior to determining eligibility for LTSS.

### How are ETR Requests for Eligible Acute Care Hospital Clients Processed?

Personal Care Exception to Rule (ETR):

1. ETRs are reviewed and decided based upon individualized needs for assistance with personal care and how those needs differ from many clients in the same classification group.
2. ETR requests should include how additional funds requested through the ETR will be used by the provider to meet the client’s individual personal care needs.
3. ETRs can be denied at the local level if the CM/SSS does not think the client’s needs differ from the majority. If the request is denied locally, the client will receive documentation of this decision which includes contact information for the client to request a HQ ETR Review.
4. Personal Care ETRs will be processed within seventy-two hours (72) of receipt by the Headquarters ETR Committee.

Follow the detailed ETR process outlined in [Chapter 3](https://manuals.dshs.wa.gov/altsa/aging-and-long-term-support-administration-long-term-care-manual) of the Long-term Care Manual. This chapter also addresses other types of ETR.

### What are Some Examples of Frequent Barriers to Acute Care Hospital Client Assessment or Transition Planning?

1. Pending Guardianship: This occurs when hospital staff indicate the client does not have capacity to make their own decisions and yet the same client has not been deemed incompetent by court of law. The assessment will be completed and wait for consent from client’s legal representative.
2. Client refusing to receive HCS services.
3. Lack of family or social supports

### Physical and chemical restraints

### Lack of readily available specialized community resources for individuals who are bariatric, need dialysis, among other medical and behavioral complexities.

### Financial eligibility: Client is unable to provide required documents over a period, information that is needed for financial verification necessary to make financial eligibility determination.

### Client’s medical and psychological condition is not conducive for having an assessment.

### Lack of appropriate space to conduct assessments privately.

### Lack of adequate documentation.

1. Intermuscular (IM) medication that are “pro re nata” (PRN) or scheduled daily.

**What is HCS Guidance About Use of Restraint in Acute Care Hospital Settings?**

In 2007, the Centers for Medicare and Medicaid (CMS) published federal rules to uphold patient’s rights when it came to the use of restraints or seclusion in hospital settings.

A-(0159) A restraint is— (A) Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely.

Clarification of federal hospital regulations about appropriate use of restraints and the role of HCS/AAA staff as mandatory reporters was published via [MB H24-005 Addressing Use of Restraint](https://fortress.wa.gov/dshs/adsaapps/Professional/MB/HCSMB2024/h24-005%20use%20of%20restraints.docx). Details of this guidance is outlined below.

|  |
| --- |
| **Use of Restraints in an acute care hospital Setting:**  Restraints are allowable in this setting; it must be for the shortest duration possible. Patients in Acute hospital settings have the right to be free from physical and mental abuse, restraints, and seclusion. Restraints may only be used to ensure immediate physical safety of the patient, staff, and others.  Additionally, please understand the following requirements when restraints are used. Please note that the section labeled Hospital Federal Regulations has additional information to support these requirements:   * Cannot be used for routine fall prevention (A-0154). * May only be used when less restrictive interventions are ineffective (A-0164). * Each order for restraints must be for no more than 4 hours up to a 24-hour period before a new order is needed(A-0171). * Restraints must be discontinued at the earliest possible time regardless of the order (A-0174). * Must be ordered only by an attending physician or licensed practitioner that is responsible for the patients care (A-0168). * Cannot be a standing or PRN (as needed) order (A-0169). * A licensed physician responsible for the patient’s care must:   + See a patient face to face within 1 hour after the initiation of the restraint (A-0178).   + Assess the patient following the use of restraints (A-0172).   + Assess the patient within 1 hour to identify the immediate situation, reaction of the patient, behavioral condition, and the identify the need to terminate the restraint or seclusion (A-0179).   ***Reminder: HCS/AAA cannot assess, or transition clients being restrained, Long Term Care settings cannot restrain clients.***  **Examples of Interventions that are Not Considered Restraints in an Acute Care Hospital setting:**  Please note, these examples are from CMS regulations and can be found [here](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_a_hospitals.pdf) under A-0161.   * **Orthopedically prescribed devices**. * **Surgical dressings** or **bandages**. * **Protective helmets**. * A **mechanical support** such as a neck, head, or back braces. * A medically necessary **positioning or securing device** used to maintain the position, limit mobility, or temporarily immobilize the patient during medical, dental, diagnostic, or surgical procedures is not considered a restraint. * Use of an **IV arm board** to stabilize an IV line is generally not considered a restraint.   + However, if the arm board is tied down (or otherwise attached to the bed), or the entire limb is immobilized such that the patient cannot access his or her body, the use of the arm board would be considered a restraint. * Many types of **hand mitts**.   + However, the following can be considered a restraint:     - Pinning or otherwise attaching those same mitts to bedding or using a wrist restraint in conjunction with the hand mitts.     - If the mitts are applied so tightly that the patient's hand or fingers are immobilized.     - If the mitts are so bulky that the patient's ability to use their hands is significantly reduced * **Recovery from anesthesia** that occurs when the patient is in a critical care or post anesthesia care unit is considered part of the surgical procedure; therefore, medically necessary restraint use in this setting would not need to meet the requirements of the regulation.   + However, if the intervention is maintained when the patient is transferred to another unit or recovers from the effects of the anesthesia (whichever occurs first), a restraint order would be necessary, and the requirements of standard (e) would apply. * Other methods that involve the **physical holding** of a patient for the **purpose of conducting routine physical examinations or tests**. * Siderails to **protect** the patient **from falling out of bed**. * To permit the patient to **participate in activities without the risk of physical harm** (this does not include a physical escort).   Hospitals have a responsibility to use the least restrictive alternative. As a mandatory reporter, if you are concerned that a patient is being improperly restrained you must report it to the Department of health. |

### When Would HCS Accept a Hospital Withdrawal of a Client Referred for LTC Services?

If the hospital and the client (if able to communicate their choice at the time) agree to allow HCS to withdrawal the referral due to client not being near ready for discharge (pending guardianship, not medically stable, etc.), the CM may will take the following actions:

1. SER mutual decision for withdrawal of referral
2. Enter outcome (withdrawal) and date in Acute hospital screen.
3. Do not send a PAN to the client; instead, the Case manager may send a courtesy letter explaining who to contact to get transition planning started again one the client has a decision maker.
4. Send a 14-443 to financial stating “the LTC request was withdrawn, please redetermine for non-LTC medical. CARE record is being inactivated.”
   * Omit the 14-443 for MAGI clients.
5. Inactivate CARE record. Financial will determine Medicaid eligibility and if client qualifies, the case will be sent to the CSO.
6. As soon as a new HCS referral is received, verify with financial status of eligibility, and create a new record in the acute care hospital screen with a new referral date.

* Every referral must have a distinct referral date, even if the client was previously withdrawn and is re-referred for services. Enter the record in the acute hospital screen with a **new referral date**.
* A PAN is not required for clients for whom the hospital requests to withdrawal the referral.

### When Would a Hospital Referral for Transition Be Inactivated?

Some individuals who are referred to access LTSS may not have a transition plan in place due to reasons such as not being financially eligible for services, not being medically stable, psychiatrically stable, or guardianship is not in process, and/or among other barriers that may be identified through case staffing.

The HCS hospital case manager will;

1. Offer ongoing support to the client, family and /or representative by addressing concerns regarding care in community-based settings.
2. For medically complex individuals, consult with the HCS Community Nurse Consultant (CNC), AAA Registered Nurse case manager.
3. Offer other services such as Adult Day Health, Skilled Nursing, RN Delegation or Private Duty Nursing
4. Continue to support all efforts towards reducing or eliminating barriers to a less restrictive setting.
5. If after 4 months there is no decision maker established for purposes of providing consent to HCS services or the client has not made any progress towards transition planning:
   1. Conduct a staffing with the unit supervisor to review the status of the case including what has been done, and
   2. May inactivate the client in CARE using the “No Current Discharge Plan” code.
   3. Advise the hospital when it would be appropriate to re-refer the individual.
6. For a client who refuses HCS services, does not apply, has been determined not to be financially eligible, HCS has lost contact, or client has been determined not to be a good fit for HCS services through the challenging/complex case protocol, the HCS hospital case manager will inactivate the case immediately, and update the acute hospital screen.

### How are Transitions from Acute Care Hospitals to a Nursing Facility Done?

1. Hospitals may discharge patients to a nursing facility without prior authorization from HCS (refer to [Chapter 10](https://intra.altsa.dshs.wa.gov/docufind/LTCManual/) of the Long-term Care Manual for NFCM relocation.)
2. Hospital staff will facilitate the nursing facility admission from the hospital.
3. The hospital discharge planner or nursing facility must still notify the HCS hospital case manager of pending admissions to SNFs to appropriately transfer cases to NFCMs.
4. HCS staff will not have to complete initial CARE assessments for individuals (Medicaid and non-Medicaid) who have been identified as meeting the Pre-Admission Screening & Resident Review (PASRR) criteria prior to discharge from the hospital (refer to [Chapter 10](https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/documents/LTCManual/Chapter%2010.docx) of the Long-term Care manual for details.)

### How are Transitions from Acute Care Hospitals to Transitional Care Units/In-Patient Rehab Long Term Acute Care Centers (LTAC) Done?

When an individual transitions to In-patient Rehabilitation (IPR) outside a hospital or to a Long-term acute care (LTAC), HCS considers that transition a hospital discharge. When the transition to IPR is located within a hospital, this is not considered a hospital discharge.

## Conduct a CARE assessment for clients who have applied for LTC services and are ready to transition to community settings.

1. If the client is transitioned to the transitional care setting prior to assessment, conduct the assessment at the transitional care setting.
2. Individuals in transitional care beds outside a hospital are no longer considered inpatient.

* When a client transfers from an acute hospital to LTAC, this is considered a transition. The discharge outcome for this client is “Other medical facility.”
* When a client is referred from LTAC e.g., Vibra Health Care to HCS for LTC services, do not add the referral to the Acute care hospital CARE screen.

### How are Transfers outside the Region for Clients in Acute Care Hospitals Done?

When a client is transferring to a different region while still in the hospital, the following should be done:

1. Conduct a case staffing with supervisor to confirm need for transfer.
2. HCS hospital supervisor in charge of a transferring case must transfer the case in CARE and Barcode to the intake unit of the client’s destination region while the case is still open, OR
3. The supervisor at the region making the transfer may request intake at the destination region to assign the case or contact the intake supervisor to facilitate the transfer.
4. When the intended location to transition the client is outside the local HCS office, notify the receiving office and staff the case before final arrangements to transition the case are in place.
5. When a hospital discharge is imminent and a CARE assessment has been conducted, the HCS hospital case manager may keep the case and put services in place before making the transfer.

### How are Hospital Assessments for Clients Referred by Acute Care Hospitals or LTAC With HCS Agreements, Near Washington State Borders Done?

## HCS Hospital case managers are responsible for assessing out of state Washington residents in border acute care hospitals or LTAC:

## When the individual has submitted a LTC application for financial eligibility and is pending Medicaid and;

## The individual has been referred to HCS for a functional assessment for LTC services by a border acute care hospital or LTAC, and;

## When the individual is a Washington resident and is planning to return to the state;

## Follow procedures established in [Chapter 3](https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/documents/LTCManual/Chapter%203.docx) of the Long-term Care Manual for CARE assessments.

# Assessment Data & Reporting

### What Information Is Needed by HCS Hospital Case Managers to Conduct An Assessment?

1. Information needed from hospitals.
   * Submit a Complete financial application prior to the date of the assessment or at the time of sending an intake referral form.
     1. PAPER: Hospitals, or clients residing in hospitals, will submit [18-005](https://www.hca.wa.gov/assets/free-or-low-cost/18-005.pdf)  application with an Acute Care Hospital coversheet (refer to Appendix III, Expedite Acute Hospital Applications including coversheet).
     2. WaConn: Complete an application online at: <https://www.washingtonconnection.org/home/>. When completing the application, the client/hospital representative are advised to indicate the name of the hospital on the address line and in the additional comment section of the application, state that the client currently resides in a hospital.
   * Client specific information needed from the hospital: To determine functional eligibility, establish the level of care, and develop a service plan for community providers, hospitals are requested to fax, email, or print and make available at the nurses’ station the following information for the HCS hospital case manager on the date of the assessment. This information is not on the Medicaid application and having it promptly assures timely completion of assessment:
2. Demographic /face sheet
3. Progress notes from physicians, nursing, physical therapy (PT), occupational therapy (OT), speech and other therapies
4. Admission notes on client’s health, physical and psychiatric conditions
5. List of current diagnoses
6. History & Physical (H&P)
7. Provide Involuntary Treatment Act (ITA) paperwork (if applicable). Also refer to the state hospital assessment [Chapter 9b](https://manuals.dshs.wa.gov/altsa/aging-and-long-term-support-administration-long-term-care-manual) for details.
8. Current wound care notes including treatments.
9. Care Plan and/or Behavior Support Plan (BSP) and/or Treatment plan when applicable
10. Last 7-day medication administration records (MAR)
11. Behaviors and interventions (i.e., client wanders and needs to be redirected, yelling, and screaming, assaultive behaviors)
12. Social work/ discharge planning notes including date of medical clearance for discharge.
13. Guardianship/ DPOA copy (if applicable)
14. Current Durable Medical Equipment (DME) used by client for the assessment (hospital staff to coordinate any future need for DME post discharge)
15. Any information critical to a successful transition plan.
    * HCS has established agreements with several acute care hospitals to access Electronic Health Records (EHR). Follow the [HCS Electronic Health Records Access Process](https://teamshare.dshs.wa.gov/sites/hcs/ACHT/ACHSP/Resources/Electronic%20Health%20Records%20Contract%20Docs%20(NEW)/Electronic%20Health%20Record%20Access%20process%20document%20Revision%2010.27.2021.pdf?Web=1) located on the Acute Care Hospital SharePoint site, to gain necessary access to EHR hospital systems.
16. Notice of change of client condition

When there is a change in the client’s condition or the client transitions prior to the assessment, the hospital staff must notify the HCS hospital case manager immediately to appropriately utilize the assessment time slots.

1. Considerations for patients in restraints

To speed up transitions into LTSS, hospitals are requested to transition individuals from restraints prior to assessment and maintain the individual without restraints for prospective providers. The current HCS policy is for clients to be free of physical and chemical restraint for 3 days prior to assessment and any transition.

### What Information Must Be Reported And Tracked For Hospital Referrals?

Ensuring timely access to LTC services for individuals referred by acute care hospitals is one of the key components of how ALTSA transforms lives. The ability to track hospital referrals statewide using standardized data allows ALTSA to record and tell a story of HCS transitions out of acute care hospitals and barriers to transition.

1. The Acute Care Hospital CARE Web Screen outlines required information that needs to be reported about acute care hospital referrals and transition activities.
2. HCS hospital case managers or designated staff at regional offices will follow instructions outlined in the [CARE Web Help Screen](https://careweb.dshs.wa.gov/help/output/default.html#t=Client%2FClient_Details%2FAcute_Hospital.htm) for Acute Care Hospital to document client barriers, transition plan, and document updates on client progress to transition out of acute care hospitals.
3. To access the acute care hospital screen HCS hospital case managers (assessors) /staff must be granted access depending on the need for use. Access is granted by designated regional staff.

The statewide reporting system for acute care hospital referrals allows HCS to track clients referred to HCS to transition out of the hospital in a coordinated way. It provides data on a statewide level that is used to respond to leadership, legislative, and constituent inquiries and identify potential policy and appropriation requests to address gaps.

# Management of Complex Hospital Client Transitions

### What is Length of Stay (LOS) in Acute Hospital Settings?

For HCS, Length of stay in acute care hospitals refers to the period a hospital patient continues to stay in the hospital from the date a hospital referral is made to HCS for that individual to access long-term care services.

### What Additional Transition Strategies Should Be Applied to Complex Client Referrals?

This process outlines strategies to be utilized when dealing with hospital clients whose transition to community settings is hindered by significant barriers making it more likely for the individual to remain in the hospital more than 30 days past the date of referral to HCS. For such individuals:

1. The initial CARE assessment will be completed within a week (7 days) from the date of referral or from the date the client is stable and predictable.
2. When no community option is available for a client after 2 months (60 days) from the date of referral to HCS, additional contact requirements will be followed:
   * 1. Face to face contact at the hospital every other month and documented in a SER. Document a SER if the client has had any care plan changes or document if care plan remains the same, what transition efforts are being made etc.
     2. Document contact conversations weekly that occur with the family, collaterals, and hospital staff.
     3. The HCS hospital case manager will review the medical records and determine if the initial assessment no longer meets the client’s care needs and follow assessment and care planning policy outlined in [Chapter 3](https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/documents/LTCManual/Chapter%203.docx) of the Long-term Care Manual.
3. Complex case coordination and case staffing requirements for clients who are still hospitalized 30 days or more past referral:
   * 1. Conduct case staffing with local office supervisor on a weekly basis.
     2. Appointed staff at each regional HCS office will document and make necessary updates in the hospital database once a week and/or when transition to community settings occurs.
     3. Send at least weekly updates to local hospitals for coordination purposes per local policies and procedures.
     4. Increase communication efforts with hospital discharge planners, community partners, and community choice guides to help assist with transition efforts.
     5. Follow case staffing and escalation procedures established by the local office, Region, and HQ as outlined in this chapter to provide additional support and resources for transition options.
     6. Refer clients to specialized settings such as Community Support & Stability providers (CSS), Specialized Dementia Care Program (SDCP), Transitional Care Center of Seattle (TCCS) among others using a single referral form for Specialized settings—see appendix VI.

* Utilize the HCS Screening Tool in Appendix IV to escalate cases
* Utilize Case Staffing Referral Template Appendix V to document and submit case staffing requests.

### How is A Complex Client Case Escalated?

The following table outlines when and how complex cases will be escalated for Individuals in acute care hospital. Escalation of complex cases that are currently in a State Hospital, [Chapter 9b.docx (live.com)](https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.dshs.wa.gov%2Fsites%2Fdefault%2Ffiles%2FALTSA%2Fhcs%2Fdocuments%2FLTCManual%2FChapter%25209b.docx&wdOrigin=BROWSELINK). There are various staff resources available to assist with complex staffing, for details and who to contact please refer to [Appendix VII](#_Appendix_VII_Complex)

| **Who/ when to Escalate** | **What is involved and what needs to be done** |
| --- | --- |
| Escalation from HCS to Hospitals | * Each hospital identifies how it would like issues to be escalated when they are not able to be resolved at the discharge planning level. * HCS will be provided with discharge planning /case manager lead contacts or other designees for each hospital. * When there are difficulties in utilizing the identified escalation path, the HCS local office/regional designee will contact the Acute Hospital Program Manager in HCS. |
| Escalation within HCS | * Follow local office and regional escalation procedures with designated staff. At a minimum, follow the escalation steps outlined below.   + Supervisor will use escalation Screening Tool (see appendix IV) when staffing with the CM to determine if an individual’s case needs to be escalated to further support a transition plan. This tool can be used at any point in the case management process, early use is recommended).   + If client screens in via the escalation screening tool:     - staff with cross system partners     - Refer client to regional escalation staffing or directly to HQ if determined appropriate. |
| Escalation with Cross System Partners | * If client screens as complex, follow regional protocol and HQ guidance to staff cases with MCO, BH-ASO, DSNP or other relevant partners to create a transition team. * Coordinate with the Managed Care Systems Consultants (MCSC) for your region as necessary to ensure appropriate escalation |
| Clients at 30 days from date of referral | * These cases should be staffed with a supervisor. * Complex cases must be staffed with cross system partners |
| Clients at 60 days from date of referral | * These cases should be staffed at regional level by designated staff.   + Case staffing must be documented to include options explored and outcomes.   + From the regional level, cases may be escalated to ALTSA Headquarters (HQ) if there continue to be barriers.   + Use the case staffing referral form (appendix V) to document cases referred to HQ. |
| Clients at 100 + days from date of referral or after regional/ cross system partner staffing | * These cases will be staffed at HQ in collaboration with designated regional managers. In addition, HQ will staff:   + Special referrals from regions and hospitals   + Cases brought to the attention of the administration from external interest groups. * If all recommendations have been explored and there is continuous communication with cross system partners but without a clear path to transition, such cases may be restaffed at ALTSA Headquarters (HQ). |

# References & Program Resources

### Related WACs, RCWs & Federal Regulations

[WAC 388-106-0015](https://app.leg.wa.gov/wac/default.aspx?cite=388-106-0015)What long-term care services does the department provide?

[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 and assistance to hospital patients in need of long-term care.

[RCW 74.34.020](https://apps.leg.wa.gov/RCW/default.aspx?cite=74.34.020) Definitions

Code of Federal Regulations 482.13 (e): Condition of participation: Patient’s rights—Restraint or seclusion [Code of Federal Regulations](https://www.govinfo.gov/content/pkg/CFR-2017-title42-vol5/xml/CFR-2017-title42-vol5-part482.xml#seqnum482.13)

Centers for Medicare and Medicaid (CMS) State Operations Manual [SOM Appendix A (cms.gov)](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_a_hospitals.pdf)

### Transition Resources

| **PROGRAM/SERVICE** | **BRIEF DESCRIPTION** |
| --- | --- |
| Behavioral Health Personal Care (BHPC) | Acute care hospital client referrals who meet the criteria for (BHPC), are handled in the same manner as all other BHPC requests. Please follow instructions in [Chapter 22a](https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/documents/LTCManual/Chapter%2022a.docx). |
| Behavioral Support Services | Services are available to in patient clients under WA Roads. Client training is available through COPES and should be accessed through that program for all COPES eligible individuals. Individuals who are not eligible for COPES should receive this service through WA Roads. See [Behavior Support Services H2019](http://intra.dda.dshs.wa.gov/ddd/P1ServiceCodes/documents/Service%20Codes/H2019_Behavior_Support___Individual.docx) |
| HCS Complex Cases & MCO Coordination contacts list | HCS HQ contacts list for assistance on Complex Case Staffing provided by the SHDD team and MCSCs. Refer to [Appendix VII](#_Appendix_VII_Complex) of this chapter. |
| Housing Maintenance Allowance (HMA) | The HMA is income, up to 100% of the Federal Poverty Level, that the client can keep maintaining his/her residence during a NF or institutional stay. [WAC 182-513-1380](https://app.leg.wa.gov/wac/default.aspx?cite=182-513-1380). For program detail see [Chapter 10](https://manuals.dshs.wa.gov/altsa/aging-and-long-term-support-administration-long-term-care-manual) of the Long-term care Manual |
| 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 may complete [DSHS 10-234a](https://www.dshs.wa.gov/office-of-the-secretary/forms?field_number_value=10-234a&title=) to include in the residential provider referral packet. |
| State Funded Community Transition or Sustainability Services (CTSS or WA Roads) | CTSS are non-recurring setup items or services necessary to assist individuals establish, resume, or stabilize a home or community-based setting. [WAC 388-106-0950](https://app.leg.wa.gov/wac/default.aspx?cite=388-106-0950), [WAC 388-106-0955,](https://app.leg.wa.gov/wac/default.aspx?cite=388-106-0955) [WAC 388-106-0960](https://app.leg.wa.gov/wac/default.aspx?cite=388-106-0960). Refer to [Chapter 5](https://manuals.dshs.wa.gov/altsa/aging-and-long-term-support-administration-long-term-care-manual) of the Long-term Care Manual for details. |
| Discharge Options-Desk Aid for Citizens vs. Non-citizens | This is a desk tool used by Aging and Long Term Supports Administration (ALTSA) field staff that has all the medical coverage groups/programs in Washington and what Home and Community Service can be authorized under that medical program if functionally eligible. |
| Diversion Services | An individual who is detained through the Involuntary Treatment Act who is stabilized and has long-term care needs, qualifies for diversion services. Refer to [MB H19-042](https://fortress.wa.gov/dshs/adsaapps/Professional/MB/HCSMB2019/h19-042%20state%20hospital%20discharge%20and%20diversion%20(shdd)%20capturing%20diversions%20in%20care%20effective%20july%201,%202019.docx). |
| Specialized Behavior Support Services in Residential Settings | This is a compiled list of specialized behavior support services available in residential settings. These services are available to eligible LTC individuals with personal care and complex behavioral needs related to a mental health, neurocognitive or dementia diagnosis. The settings are not intended to replace the need for behavioral health treatment or supports accessed through the behavioral health care system. |
| Supportive Housing | Service that supports individuals with complex needs secure community-based, affordable housing of their choice along with individualized support to assist the person with stabilization and self-identified goals. For ALTSA recipients, this service is available in two ways: Foundational Community Supports (FCS), or the Governor’s Opportunity for Supportive Housing (GOSH). Refer to [Chapter 5b](https://manuals.dshs.wa.gov/altsa/aging-and-long-term-support-administration-long-term-care-manual) of the Long-term Care Manual for details. |
| The Medicaid & Long-term care services for Adults Brochure | [22-619.pdf (wa.gov)](https://www.dshs.wa.gov/sites/default/files/publications/documents/22-619.pdf). This brochure is distributed to individuals interested in services. In addition, HCS hospital Supervisors and Case Managers coordinate with their local Area Agency on Aging who maintain a list of contracted service providers. |
| Transition Care Center of Seattle (TCCS) | A specialized Nursing Facility serving complex population of dually eligible (Medicaid-Medicare) beneficiaries transitioning out of acute care hospitals. Refer to **Admission Process Flow** and the **Specialized Referral Form** attached below for details. |

# 

# Glossary

|  |  |
| --- | --- |
| **Word** | **Definition** |
|  |  |
| Complex client escalation process | Established process that requires multi-systems supports in the community to establish and sustain transitions to community settings. Such cases present significant medical, psychiatric and/ or criminal concerns that inhibit transitions to community settings. |
| Community settings | Long-term care service options where clients can reside such as the client’s home, Adult Family Home, Assisted living facilities among others. |
| Conservatorship | A person appointed by the court to make decisions with respect to the property or financial affairs of an individual, adult or minor, subject to conservatorship. |
| Discharge plan | A care plan developed for a client indicating where the client will transition to including the type of support/ services the client will need. This plan is created by the client, family, hospital discharge planner, and HCS or AAA staff. The client may seek to transition in different Long-term care service options including nursing homes. |
| Diversion from acute care hospital | An individual who is detained through the Involuntary Treatment Act who is stabilized and transitioned into home and community long-term care settings prior to the need to petition for a 90 or 180 day commitment order (see [MB H19-042](https://fortress.wa.gov/dshs/adsaapps/Professional/MB/HCSMB2019/h19-042%20state%20hospital%20discharge%20and%20diversion%20(shdd)%20capturing%20diversions%20in%20care%20effective%20july%201,%202019.docx)). |
| Hospital assessment | A CARE assessment to determine functional eligibility for long-term care services in community-based settings. |
| Hospital discharge planners | Designated staff who work with the client to create and implement a discharge plan. Discharge functions are usually carried out by social workers and Registered Nurses in hospitals. Managed care organizations and other insurance carriers including Medicare participate in transition care play and important role. |
| Inpatient Rehabilitation (IPR) | Inpatient hospitalized for purposes of rehabilitation. When an individual transitions to IPR outside a hospital or Long-term acute care (LTAC), HCS considers that transition a hospital discharge. |
| Guardian | A person appointed by the court to make decisions with respect to the personal affairs, support, care, health, and welfare of the adult subject to guardianship to the extent necessitated by the adult's limitations. |
| Length of Stay | For HCS, Length of stay in acute care hospitals refers to the period from the date a hospital patient is referred to access long-term care services through the duration of their hospitalization. |
| Medical necessity | A determination by the attending hospital physician that the patient needs to remain in the hospital to receive medical care. A client who meets this definition is admitted under private health insurance, Medicare, or Medicaid. |
| Medically stable or predictable | The patient at this point does not need acute care medical intervention, is close to baseline functioning and their immediate needs, treatments, and therapies have been achieved. In most cases stage the client can transition to community settings. |
| Priority Cases | Cases that the hospital request to handle as priority upon referral and meet the priority criteria, outlined in this chapter. For such cases HCS staff are required to contact the client within 2 days and conduct an assessment within 7 days if conditions for conducting an assessment are met. |
|  |  |
| Psychiatrically stable | The patient has been determined by a psychiatric provider usually a psychiatrist or psychiatric nurse in a hospital of psychiatric inpatient facility to on longer need in-patient hospitalization. The individual at this point is close to baseline functioning and their immediate medical psychiatric needs, treatments, and therapies have been achieved, evidenced by no use of physical or chemical restraints in the past 3 days prior to discharge. |
| Referral | Any request for service that is accompanied by a Medicaid application, or for a client with current Medicaid eligibility. A referral from and acute hospital generates an HCS intake. |
| Swing Bed | A hospital bed that can be utilized as a skilled nurse facility bed. This is considered a discharge from an acute hospital and is transferred to an NFCM worker. |

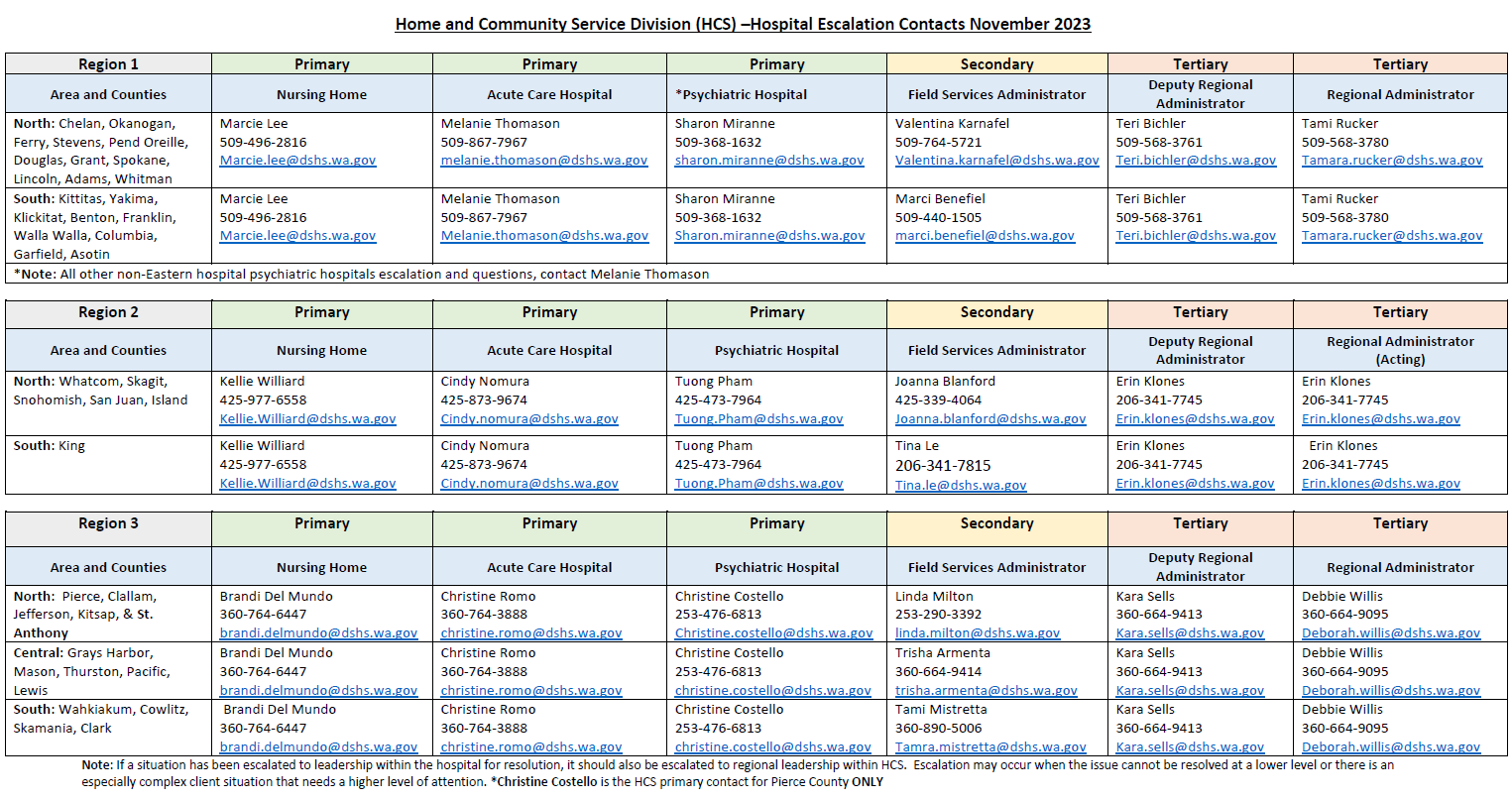
# 

# Revision History

|  |  |  |  |
| --- | --- | --- | --- |
| **Date** | **Made By** | **Change(s)** | **MB #** |
| 5/12/2020 | Grace Kiboneka | Version incorporates draft MB review comments from the field and subsequent responses for policy |  |
| April, 2021 | Grace Kiboneka | Version: - Incorporates clarifying language and technical corrections to several sections in the chapter and adds a new section concerning the role of HCS hospital case manager in confirming decision making capacity. Added a link where hospital staff can be referred to access a brief training on HCS process for transitioning clients out of hospitals. |  |
| Dec, 2021 & Jan, 2022 | Grace Kiboneka | Added new language under role of CM in determining capacity. Removed requirement for updating notes weekly in acute care screen. Reduced waiting period from 6 to 4 month for a case to be inactivated.  Added new language for Hospital withdrawal of a referral, updated section about escalation of complex cases, Appendix IV, V, escalation of complex cases |  |
| May /2022 | Grace Kiboneka | Updated HCS Regional escalation contact chat. Appendix 1 |  |
| October/2022 | Grace Kiboneka | This version includes the following major modifications to:   * the role of Case managers in determining decision making capacity * Coordination with hospital discharge planners * Hospital withdrawals of client referred to HCS * Escalation of a complex client case * Escalation to the HCS Region Escalation Contact Chart |  |
| August 2023 | Grace Kiboneka | This version has no new policy. It clarifies policy for:   * Individuals in isolation rooms, and one on precaution * Updates table for cross systems complex case contacts, managed care coordination and adds SHDD a new resource—Transition Specialists * Added SHDD and CBHC contact list as an attachment in the Resource table. * Provides a compiled list of Specialized Behavior Support Services for Residential settings. * Updated referral form for SDCP and TCCS services. |  |
| March 2024 | Grace Kiboneka | * Added detailed policy guidance on Restraint. * Clarified language for clients using IM frequently. * Updated Complex Staff resources. * Updated HCS escalation contact list. * Created appendix VII for escalation pathway resources and removed previous escalation contact matrix from the main body of the chapter and corresponding program information. |  |

# Appendices

### Appendix I HCS Region Escalation Contact Chart



### Appendix II [DSHS Intake and Referral Form 10-570.pdf](https://www.dshs.wa.gov/sites/default/files/forms/pdf/10-570.pdf).

### Appendix III Expedited Acute Hospital Application chart and coversheet

This process should be used for **Long-Term Service and Supports applications only**

**Region 1**

***Pend Oreille, Stevens, Ferry Okanagan, Chelan, Douglas, Grant, Lincoln, Spokane, Adams, Whitman, Klickitat, Kittitas, Yakima, Benton, Franklin, Walla Walla, Columbia, Garfield and Asotin Counties***

Submit 18-005 applications with an Acute Care Hospital coversheet (see below), or apply online at [Washington Connection](https://www.washingtonconnection.org/home/).

Hospitals contact Social Services intake (by calling intake at 509-568-3767 or 1-866-323-9409, or faxing the Intake and Referral form to 509-568-3772, etc.).

**Region 2**

***King,* Snohomish, Whatcom, Skagit, Island, and San Juan Counties**

**Paper:**

Hospitals, or clients residing in hospitals, will submit 18-005 applications with an Acute Care Hospital coversheet (see below).

**WaConn:**

Complete an application online at [Washington Connection](https://www.washingtonconnection.org/home/). When completing the application, the client/hospital representative should indicate the name of the hospital on the address line, and state that the client currently resides in a hospital in the additional comments section of the application.

**Region 3**

**Pierce, Kitsap, Thurston, Mason, Lewis, Grays Harbor, Pacific, Cowlitz, Clark, Clallam, Jefferson, Skamania and Wahkiakum Counties**

**Paper:**

Hospitals, or clients residing in hospitals, will submit 18-005 applications with an Acute Care Hospital coversheet (see below).

**WaConn:**

Complete an application online at [Washington Connection](https://www.washingtonconnection.org/home/). When completing the application, the client/hospital representative should indicate the name of the hospital on the address line, and state that the client currently resides in a hospital in the additional comments section of the application.

**Hospital Application Referral Coversheet.**

ATTENTION

IU staff.

This is an

Acute Care Hospital Application **for LTSS**

and contains

\_\_\_\_\_ pages.

### Appendix IV HCS Screening Tool: A Guide for Escalation

Revised November 2021

All cases that meet criteria should be escalated for a regional case staffing via the email icon on your desktop.

Screening Criteria for Escalation:

* **Unstable in current setting or does not have a reasonable transition plan confirmed AND**
* At least one of the criteria in section **A** **AND**
* At least one item from **B**

**A)** Mark all the Complex Client Criteria that apply:

|  |  |
| --- | --- |
| Medically complex at D/C:  Wound Care;  Dialysis,  Vent/Trach  Other | Serious and Persistent Mental Illness (SPMI)(Major Depression, Bipolar Disorders, Schizophrenia and Borderline Personality Disorder) |
| Bariatric | Substance Use Disorder (SUD) – history or current |
| Traumatic Brain Injury (TBI) | Alzheimer’s/dementia with behaviors |
| Criminal history: (sex offender, assaultive, arson, murder, etc.) | Aggressive or inappropriate behaviors: (Current or past assaultive behaviors, etc.) |
| Homeless or cannot return to previous setting | Family or client disagree with plan/complex family dynamics |

1. Mark all that apply:

|  |  |
| --- | --- |
| **Medical Related** | **Behavioral Health Related** |
| Current pressure ulcer requiring ulcer care | Wandering with elopement risk |
| Unstable diabetic on insulin | Uncooperative during care |
| Requires weight-bearing or physical assistance from 2 or more people | Refuses care or placements |
| Fall risk due to balance issues | Has a behavioral plan in place |
| Pronounced cognitive impairments that impact impulsivity and judgement | Unable to follow a behavioral plan |
| Requires awake staff overnight due to frequency of care needs at night (repositioning program, toileting, wound care or other treatments, etc.) | Mental Health issues (especially personality disorders); in denial or receiving MH treatment |
| Requires suctioning (with trach) | Suicidal ideation or actions |
| Long-term central line in place; on TPN, IV antibiotics | Self-harming behaviors |
| Ostomy/colostomy care/wound care | Inappropriate sexualized behaviors towards others or public displays |
|  | Up at night and requires intervention (disruptive/unsafe) |
|  | Inappropriate toileting (outside of the toilet, on floors, etc.) |
|  | Smokes; will not stop or wear patch |
|  | Reported they will continue to use substances when D/C |

|  |  |
| --- | --- |
| **Medical &/or Behavioral Related** | **Other Items** |
| Requires cuing or prompting to complete tasks | Non-decisional – no informal decision maker or formal DPOA, POA, or guardian in place |
| Requires 1:1 supervision | Cultural or language preferences |
| Requires supervision for safety when going outside of home or facility | Power wheelchair indoors |
| Requires accompaniment to doctor or MH appointments, treatment centers (dialysis, methadone), or other health related appointments | Complex DME or environment modifications |
| Unaware of own safety |  |
| Refuses to take medications or other prescribed treatments |  |
| Requires secure setting (limited egress) |  |
| Requires an individual room for some specific reason |  |

### Appendix V Acute Hospital/ Complex Regional/HQ Case Staffing Referral Template

Unless your regional leadership recommends the case to be brought to the Headquarters Case Staffing, start with the regional complex staffing. Once all recommendations from the regional staffing have been completed and there is still no clear path to a transition, alert your regional contact to bring the case to HQ for staffing. Please update the regional staffing form with any new information and send to your regional lead requesting a staffing with HQ.



### Appendix VI Specialized Settings Referral Template

### Use this form when referring individuals to the Specialized Dementia Care Program (SDCP) or Transition Care Centers of Seattle (TCCS) paying close attention to eligibility criteria and instructions outlined on the form.

### 

### Appendix VII Complex Case Staffing Escalation Pathway

The staff resources and detailed information outlined below is intended to provide support to regional staff with relevant program resources when handling complex cases.

* [Complex Case Staffing: About](#Complexabout)
* [How to make a referral to the Regional Complex case staffing](#_How_to_make)
* [How to make a referral to the Headquarters Complex Case Staffing](#_How_to_make_1)
* [Client Consent, Capacity, and Decision-Making](#_Who_is_the_1)
* [How do I request assistance on a capacity or consent related concern from the Guardianship Program Manager or Guardianship Case Managers?](#_How_do_I)
* [Where do I send Guardianship Pilot Project Case referrals or questions?](#_Where_do_I)
* [Managed Care Organization (MCO) and Dual Eligible Special Needs Plan (DSNP) escalation support: Including BHPC and CBHS/1915(i)](#_Who_are_the)
* [My client is detained under an ITA with complex barriers](#_My_client_is)
* [Who do I contact for specialty contract referrals questions and escalations?](#_My_client_is)
* [Resources and Trainings](#_Who_to_reach)
* [Complex Discharge Pilot](#_What_is_the)

**Complex Case staffing**

Complex case staffing is a collaborative venue where subject matter experts come together to problem-solve and generate ideas to address challenging situations. It serves as a platform for interdisciplinary teams to discuss barriers, explore various perspectives, and develop innovative strategies to propel the case forward effectively. The process involves active engagement, shared expertise, and a focus on achieving positive outcomes for the client.

There are regional and headquarters pathways available for complex cases. These venues are open to all HCS and AAA teams and occurs virtually.

**How to determine which venue to staff my case?**

Staff should start at the Regional Complex Case Staffing unless your regional leadership recommends the case to be brought to the Headquarters Case Staffing.

**How to make a referral to the Regional Complex Case Staffing**

Each region has their own process for staffing complex cases. Please contact your regions MCSC for information on how to refer your case to be staffed and/or escalated.

|  |  |  |
| --- | --- | --- |
| Region 1 | Sarah Rogala, Managed Care Systems Consultant (MCSC) | [sarah.rogala2@dshs.wa.gov](mailto:sarah.rogala2@dshs.wa.gov) |
| Region 2 | Laura Botero, Managed Care Systems Consultant (MCSC) | [laura.botero@dshs.wa.gov](mailto:laura.botero@dshs.wa.gov) |
| Region 3 | Genevieve Boyle, Managed Care Systems Consultant (MCSC)  **OR**  SHPC HELPDESK | [genevieve.boyle@dshs.wa.gov](mailto:genevieve.boyle@dshs.wa.gov)  **OR**  [R3hcs.hrswshpchlpdsk@dshs.wa.gov](mailto:R3hcs.hrswshpchlpdsk@dshs.wa.gov) |

**What are the next steps after I send an email to my regional MCSC?**

The MCSC will respond to your inquiry within 2 business days and partner with you on the staffing date and time.

**How to make a referral to the Headquarters (HQ) Complex Case Staffing**

|  |  |  |
| --- | --- | --- |
| 1) Staff with your supervisor | 2) Fill out the *Complex Case Regional & HQ Case Staffing Referral\** | 3) Email form to the Complex Case Staffing Specialist, Erika Gustafson [erika.gustafson@dshs.wa.gov](mailto:erika.gustafson@dshs.wa.gov) |

\* You can find the referral form in Appendix V of [LTC Chapter 9a](https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/documents/LTCManual/Chapter%209a.docx)

**What to expect when referring to the Headquarters Complex Case Staffing?**

Referral will be added to the next HQ staffing date unless a different staffing date is requested. Staffing's occur weekly Fridays. The Complex Case Staffing specialist, the program manager or supervisor will send the assigned SSS3 an invite to the HQ Complex Case staffing which is held via teams. Each case manager, supervisor, or Program Manager will have 3 to 5 minutes to present client's case and barriers. After completion of the case staffing, the Complex Case Staffing Specialist (CCSS) will email recommendations to the Program Manager and Supervisor for next steps, SER note staffing, and follow up with hospital on collaboration and notification of case escalation. The CCSS will then track client's case until barriers have been resolved.

|  |
| --- |
| **Client Consent, Capacity, and Decision-Making** |

**Who is the Guardianship Program Team and what do they do?**

The Guardianship Program team is composed of a Guardianship Program Manager (GPM) and regional Guardianship Case Managers (GCM). GPM serves as the subject matter expert related to the processes involved with the Uniform Guardianship, Conservatorship, & Other Supportive Arrangements Act (UGA) under RCW 11.130 and the Uniform Power of Attorney Act under RCW 11.125. The GPM and regional GCMs coordinate with regional and HQ staff on cases involving clients with decisional capacity, consent, and decision-maker related concerns impacting the client’s ability to access or maintain long-term care services and supports.

The Guardianship Program team members are:

|  |  |
| --- | --- |
| *Guardianship Program Manager (GMP)* | *Sarah Tremblay* |
| *Region 1 Guardianship Case Manager (GCM)* | *Amy Depaolo* |
| *Region 2 Guardianship Case Manager (GCM)* | *Kendra Kruse* |
| *Region 2 Guardianship Case Manager (GCM)* | Angelique Johnson |
| *Region 3 Guardianship Case Manager (GCM)* | *Heather Chappell* |

**How do I request assistance on a capacity or consent related concern from the Guardianship Program Team?**

|  |  |  |
| --- | --- | --- |
| * Document(s) Review. | * Staffing with the Office of the Attorney General (OAG) or Headquarters Guardianship team | * For any other capacity or consent related concern or question |
| **Send an email** to the ALTSA Escalation Pathway, which is monitored Monday - Friday: [ALTSAAcuteHospitalGuardianshipCaseStaffing@dshs.wa.gov](mailto:ALTSAAcuteHospitalGuardianshipCaseStaffing@dshs.wa.gov) | | |

**Where do I send Guardianship Pilot Project Case referrals or questions?**

|  |
| --- |
| Guardianship Pilot Project Case referrals or questions (general or case specific) |
| All regions may send their inquiries directly to (GPM) Sarah Tremblay [Sarah.Tremblay@dshs.wa.gov](mailto:Sarah.Tremblay@dshs.wa.gov) |

**What are the next steps after I send an email?**

For escalation pathway emails, the GCM will respond to your inquiry within 2 business days and partner with you on recommendations, document review outcomes, and any next steps depending on the escalation request type. For pilot case referrals or questions, the GPM will respond to your inquiry or referral within 2 business days and update referral status and eligibility determination in a SER note.

**Managed Care Organization (MCO) and Dual Eligible Special Needs Plan (DSNP) escalation support: Including BHPC and CBHS/1915(i)**

**Who are the Managed Care Systems Consultants (MCSC) and what do they do?**

MCSCs are part of the HQ integration team, and each region has a MCSC assigned to assist with connecting staff to the Managed Care Organizations (MCOs) and Dual- Special Needs Plans (D-SNP). They play a key role in the coordination of Behavioral Health Person Care (BHPC) and Community Behavioral Health Support (CBHS/1915i) escalation requests and assist on complex cases in the regions and with our AAA partners.

**How do I request support for**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| * MCO and/or DSNP care coordination | | | * BHPC Escalation or support | | * CBHC/1915i escalation or support |
| **Send an email** to your regional MCSC with your **inquiry**, **client’s name** and **Provider One number**. | | | | | |
| Region 1 | Sarah Rogala | | [sarah.rogala2@dshs.wa.gov](mailto:sarah.rogala2@dshs.wa.gov) | |
| Region 2 | Laura Botero | | [laura.botero@dshs.wa.gov](mailto:laura.botero@dshs.wa.gov) | |
| Region 3 | Genevieve Boyle | | [genevieve.boyle@dshs.wa.gov](mailto:genevieve.boyle@dshs.wa.gov) | |

**What are the next steps after I send an email?**

The MCSC will respond to your inquiry within 2 business days and partner with you on next steps depending on the escalation request.

**State Hospital Discharge and Diversion (SHDD) Team**

**Who is the State Hospital Discharge and Diversion Team?**

The HQ State Hospital Discharge and Diversion (SHDD) Teams is composed of Transition Coordinators (TC) and a Transition Specialists (TS). Transition Coordinators (TC) support transitions from State Hospitals and Transition Specialists (TS) support diversion work from community psychiatric and acute care hospitals for clients who are involuntarily detained under the Involuntary Treatment Act (ITA). Each region has a **TC** and **TS** assigned to partner with staff. They provide clinical consultation, offer training to support timely, quality and support a safe, person-centered transitions to client’s preferred setting. In addition, they coordinate with the regional teams and the judicial system on all show cause hearings. They also serve as the primary point of contact for specialty contracted facilities (CSS, ESF, SDCP+) referrals and escalations.

**My client is in the State Hospital. How do I request support for:**

|  |  |  |  |
| --- | --- | --- | --- |
| * Transition Planning for complex barriers | * Risk Assessment Review | * Specialty contract facilities (CSS, ESF and SDCP+) referrals and escalations | * IRT Referral assistance |

**Send an email** to your regional **TC** with your **inquiry**, **client’s name and ACES ID**

|  |  |  |
| --- | --- | --- |
| Region 1 | Pamela Young, Transition Coordinators | [pamela.young@dshs.wa.gov](mailto:pamela.young@dshs.wa.gov) |
| Region 2 | Sarah Miller, Transition Coordinators | [sarah.miller2@dshs.wa.gov](mailto:sarah.miller2@dshs.wa.gov) |
| Region 3 | LaTia Townsend, Transition Coordinators | [latia.townsend@dshs.wa.gov](mailto:latia.townsend@dshs.wa.gov) |

**My client is in a Community Psychiatric setting or Acute Care Hospitals setting. How do I request support for**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| * Transition Planning for complex barriers. | | * Show Cause Hearing Questions/Support | * ITA document Review | | * Specialty contract facilities (CSS, ESF and SDCP+) referrals and escalations |
| **Send an email** to your regional **TS** with the **client’s name, ACES ID and your inquiry.** | | | | | |
| Region 1 | Jeff Rose, Transition Specialist | | | [jeffrey.rose@dshs.wa.gov](mailto:jeffrey.rose@dshs.wa.gov) | |
| Region 2 | Lisa Clarke, Transition Specialist | | | [lisa.clarke@dshs.wa.gov](mailto:lisa.clarke@dshs.wa.gov) | |
| Region 3 | Briauna Hill, Transition Specialist | | | [briauna.hill@dshs.wa.gov](mailto:briauna.hill@dshs.wa.gov) | |

**What are the next steps after I send an email?**

The TS will respond to your inquiry within 2 business days and partner with you on next steps depending on the escalation request.

**Complex Discharge Pilot**

**What is the Complex Discharge Pilot?**

The Complex Discharge Pilot will be implemented in Spring of 2024 with the goal of decreasing length of stay, reduce admissions and strengthen care coordination between all parties working with these complex individuals.

This pilot will be specific to 5 hospital sites across the state who will have dedicated hospital staff to provide enhanced care management (ECM) to individuals identified by the hospitals as being medically stable but have barriers to discharge. These individuals, referred to as pilot participants, will be eligible for ECM services for 180 days to work through the barriers that prevent them from living within a community setting of their choice.

Pilot participants will be case managed by identified NFCM for the duration of their enrollment in the pilot.

**Have questions about the Complex Discharge Pilot?**

Jody Gasseling- Acute Hospital Change Manager [Jody.Gasseling@dshs.wa.gov](mailto:Jody.Gasseling@dshs.wa.gov)

Amanda Speck- RCL Enrollment Specialist [Amanda.Speck@dshs.wa.gov](mailto:Amanda.Speck@dshs.wa.gov)

**Resources and Trainings**

[Chapter 7f:](https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/documents/LTCManual/Chapter%207f.docx) Residential Support Waiver

[Chapter 9a:](https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/documents/LTCManual/Chapter%209a.docx) Acute Care Hospital Assessments

[Chapter 9b:](https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/documents/LTCManual/Chapter%209b.docx) State Hospital Assessment

[Chapter 22a](file:///C:\Users\Kibongs\AppData\Local\Microsoft\Windows\INetCache\Content.Outlook\25X7Q6UC\Chapter%2022a): Apple Health Managed Care and Apple Health Medicare Connect (D-SNP)

1915i SharePoint: [Medicaid 1915i Waiver - Home (sharepoint.com)](https://stateofwa.sharepoint.com/sites/DSHS-ALT-HCS-Medicaid-Community-Behavioral-Health-Supports-1915i/SitePages/LearningTeamHome.aspx?OR=Teams-HL&CT=1661882806587&clickparams=eyJBcHBOYW1lIjoiVGVhbXMtRGVza3RvcCIsIkFwcFZlcnNpb24iOiIyNy8yMjA3MzEwMTAwNSIsIkhhc0ZlZGVyYXRlZFVzZXIiOmZhbHNlfQ==)

**Who to reach out for additional training or questions?**

The Integration Team is here to support regional staff. If you are interested in additional trainings, please reach out to the main contact person listed below.

|  |  |  |
| --- | --- | --- |
| Complex Discharge Pilot | Jody Gasseling | [Jody.Gasseling@dshs.wa.gov](mailto:Jody.Gasseling@dshs.wa.gov) |
| Acute Hospital Assessments and Transition Policy | Grace Kiboneka  Jody Gasseling | [Grace.Kiboneka@dshs.wa.gov](mailto:Grace.Kiboneka@dshs.wa.gov)  [Jody.Gasseling@dshs.wa.gov](mailto:Jody.Gasseling@dshs.wa.gov) |
| 1915i | Sarah Rogala  Geneviene Boyle  Laura Botero | [Sarah.Rogala2@dshs.wa.gov](mailto:Sarah.Rogala2@dshs.wa.gov)  [genevieve.boyle@dshs.wa.gov](mailto:genevieve.boyle@dshs.wa.gov)  [laura.botero@dshs.wa.gov](mailto:laura.botero@dshs.wa.gov) |
| Uniform Guardianship Act  DPOA, Consent, Capacity and Decision Making | Sarah Tremblay or regional Guardianship Case Managers | [Sarah.Tremblay@dshs.wa.gov](mailto:Sarah.Tremblay@dshs.wa.gov) |