What is Home and Community Services doing to help address the current capacity issues in acute care hospitals?

Home and Community Services (HCS) is implementing a statewide emergency plan around the need to surge activities at acute care hospitals to determine eligibility, service plan and find viable community alternatives.

A. HCS surge plan in place starting Wednesday, March 18

We will begin implementing our 90 day surge plan on Wednesday 3/18/2020 with the following goals:

- Shorten timeframe from intake to assessment and do the extensive work necessary to find transitional settings for patients
- Implement new resources, using appropriated budget dollars allocated specifically to acute care hospital surge, for our most challenging clients in acute care settings for the longest length of time
- Transition people in need of LTC services out of hospitals as quickly as possible due to COVID-19

B. HCS is expanding capacity under the surge plan

- **Replacing in-person requirements with telephone and technology options:** To ensure the health and safety of clients and staff during the COVID-19 state of emergency, the in-person requirement for assessing and care planning may be waived and substituted with telephonic or other technology as appropriate.
- **Adding additional staff resources:** Through use of overtime, reassignment of staff where feasible and utilizing trained AAA staff to assist HCS where needed. HCS regions have put overtime plans in place and are enhancing communication strategies with the AAA for this work.
- **Adding additional funding to support hospital discharges**: These resources are ONLY available to individuals currently located in an acute care hospital inpatient bed. HCS staff are being provided information and guidance on these new resources and evaluating the individuals they are currently working with in the hospital that may be able to transition through utilization of these additional resources. It is important that these resources be utilized where they are most needed based upon the needs of the individual patients.
    - 40 additional non-citizen long-term care transitions. We have begun work to transition all known non-citizen clients who are currently in inpatient beds at acute care hospitals.
        - If you have an individual who meets criteria for this program and is in an inpatient bed please email Natalie.lehl@dshs.wa.gov
        - Use subject line: NC LTC – inpatient bed – hospital name
    - $60 add on to contracted facilities who have Specialized Dementia Care contracts and available beds (to support up to 65 transitions)
    - Contracted Specialized Behavioral Health beds (to support up to 65 transitions)
    - Add-on for SNFs who accept challenging clients from acute hospitals. We are working closely with HCA around expectations for MCOs related to acute hospital transitions to skilled nursing facilities.

To enable Home and Community Services to do this work most effectively they need support from the hospitals.

What is the process for HCS Hospital Case Managers to conduct a telephonic assessment?

A. Information needed from hospitals

- **Submit a Complete financial application:**
    - **PAPER:** Hospitals, or clients residing in hospitals, will submit 18-005 applications with an Acute Care Hospital coversheet (attached).
    - **WaConn:**
      Complete an application online at Washington Connection. 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.

- **Client specific information is needed in order to determine functional eligibility, establish the level of care and develop a service plan for community providers.** Hospital staff can assist by providing accurate and up to date information on the following items on or before the date of assessment. Having this information will help assure timely completion of assessments which reflect client needs. This information is not on the Medicaid application so providing it to the HCS case manager is helpful:
    - Demographic/face sheet
    - Progress notes from nursing, physical therapy, occupational therapy, speech and other therapies
    - Admission notes on clients health, physical and psychiatric conditions
    - List of current diagnosis
    - Current wound care notes including treatments
    - Care plan
    - Last 7 day medication administration records
    - Behaviors and interventions (i.e. client wanders needs to be redirected, yelling and screaming, assaultive behaviors) and the frequency of those behaviors in the last 7 days, whether they are easily altered, triggers if known and interventions.
    - Social work/discharge planning notes including date of Medical clearance for discharge
    - Guardianship/DPOA copy (if applicable)
    - Current Durable Medical Equipment (DME) used by client for the assessment
    - Any information critical to a successful discharge plan

- Due to HCS conducting telephonic assessments during this emergency, the hospital should be prepared to fax or secure email the following information to help expedite the process. The HCS social worker can provide this information as requested by the hospital.

B. Notice of change of client condition

When there is a change in the client's condition that impacts the ability of the client to discharge or the client discharges prior to the assessment, the hospital staff must notify the HCS hospital case manager as soon as possible in order for HCS to quickly reprioritize and effectively leverage available resources.

C. Considerations for patients in restraints

It is very difficult to find community options if restraints of any kind are being used with a patient. To speed up discharge, it would be helpful for the hospital to transition the patient from restraints prior to assessment and maintain the individual without restraints for prospective providers

What additional information/assistance is needed due to the current COVID-19 emergency?

A. **Respiratory notes:** Make respiratory notes available for assessment so we can include in documentation.

B. **Testing and communication with providers:** Have a plan in place and be willing to conduct COVID-19 testing or have clinical staff willing to communicate with potential providers.

How do we escalate cases?

A. **HCS**: The Washington State Hospital Association will provide HCS with discharge planning/case manager lead contacts or other designees for each hospital. Each hospital will identify how it would like issues to be escalated when they are not able to be resolved at the discharge planning level. If there are difficulties in utilizing the identified escalation path, HCS will contact the Acute Hospital Program Manager in HCS.

B. **Hospitals**: if you need to escalate a case please escalate to the regional office so they can assign a resource or follow up. Attached is the escalation contacts for each region.