DEVELOPMENTAL DISABILITIES ADMINISTRATION
Olympia, Washington

TITLE:	RESIDENTIAL HABILIATION CENTER ADMISSIONS	POLICY 17.01.02

Authority:	42 C.F.R. 440	Services: General Provisions
	42 C.F.R 483, Subpart B	Requirement for Long-Term Care Facilities
	42 C.F.R 483, Subpart I	Conditions of Participation for ICF/IID
	Title 71A RCW	Developmental Disabilities
	Chapter 71A.20 RCW	Residential Habilitation Centers
	Chapter 388-97 WAC	Nursing Homes
	Chapter 388-825 WAC	Developmental Disabilities Administration Services Rules
	Chapter 388-835 WAC	ICF/IID Program and Reimbursement
	Chapter 388-837 WAC	Residential Habilitation Center ICF/IID Program
	Chapter 388-829Z WAC	Emergency Transitional Support Services
Reference:	DDA Policy 5.07	Planned Action Notices
	DDA Policy 16.01	Responding to PASRR Program Referrals
	DDA Policy 16.07	Planned Action Notices for PASRR
	DDA Policy 17.02.06	Access to Education for School aged Clients in RHCs
	Engrossed Substitute House Bill 1109, Sec. 203(2)(e)(i)	

BACKGROUND

Residential Habilitation Centers are state-operated facilities certified to provide intermediate care, nursing services, or both to people with intellectual and developmental disabilities. The primary purpose of intermediate care facilities is to provide temporary habilitative services. Nursing facilities provide long-term nursing care, rehabilitative, health care services and planned respite.

Effective July 1, 2012, the Washington State Legislature amended Chapter 71A.20 RCW to prohibit the admission of any person under age sixteen from receiving services at a Residential Habilitation Center. Additionally, no one under age twenty-one may receive ICF/IID or NF services at an RHC unless: “there are no service options available in the community” and “such admission is limited to the provision of short-term respite or crisis stabilization services” (RCW 71A.20.010).

Effective October 19, 2017, the Washington State Legislature amended RCW 71A.20.180 to prohibit new long-term admissions to the Yakima Valley School (YVS) Residential Habilitation Center. YVS shall continue to operate crisis stabilization and respite beds based upon funding.

PURPOSE

This policy establishes eligibility, referral, and admission criteria for DDA-eligible clients requesting admission to a Residential Habilitation Center (RHC) to receive:

- ICF/IID services;
- Emergency Transitional Support Services;
- Nursing Facility (NF) services;
- Planned respite at a NF; or
- Crisis stabilization at Yakima Valley School Nursing Facility.

This policy also establishes procedures for processing a current RHC resident who is requesting: ICF/IID or NF services at a different RHC; or a different service at an RHC (e.g., switching from ICF/IID services to NF services).

ICF/IID services are provided at Fircrest School, Lakeland Village, and Rainier School.
NF services are provided at Fircrest School, Lakeland Village, and Yakima Valley School.[1]
Emergency Transitional Support Services are provided at Rainier School.

SCOPE

This policy applies to all DDA field services, headquarters, and RHC staff working with clients requesting admission to an RHC.

DEFINITIONS

Active treatment as defined in 42 C.F.R. 483.440(a)(1)(2), means a continuous program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services, and related services directed toward:

1. Acquiring the behaviors necessary for the client to function with as much self-determination and independence as possible; and

2. Preventing or slowing the regression or loss of optimal functional status.

[1] YVS can only accept planned respite and crisis stabilization requests.

Active treatment does not include services to maintain generally independent clients who are able to function with little supervision or in the absence of a continuous active treatment program.

Admission means the process by which a client enters the RHC and begins receiving ICF/IID or NF services.

Comprehensive Assessment and Reporting Evaluation or **CARE** is an electronic tool used by DDA staff to assess and manage client services and supports.

Crisis stabilization means a short-term service provided to people with developmental disabilities who are experiencing behaviors that jeopardize the safety and stability of their current living situation that may put them at risk of hospitalization or institutionalization.

CRM means the field services DDA case resource manager, social worker, or social service specialist.

Discharge means the permanent movement of a client to another facility or setting not under the jurisdiction of an RHC Governing Body.

Discharge goal means a habilitation goal identified by a client's interdisciplinary team that, when achieved, suggests the client is ready to live in a more independent setting.

Emergency Transitional Supports means a short-term service provided to people with developmental disabilities who are currently, or at risk of becoming, hospitalized without medical need and do not have an immediate, safe discharge option.

Habilitation means services intended to help a client acquire, retain, or improve upon the self-help, socialization, and adaptive skills necessary to reside successfully in a community-based setting.

Individual habilitation plan or **IHP** means a comprehensive plan developed by the client's interdisciplinary team that includes a detailed description of the client's needs, supports, and preferences to aid in the client's transition to a less-restrictive environment.

Interdisciplinary team or **IDT** means a group of people who collaborate to develop the individual habilitation plan under DDA Policy 17.06.03, *Interdisciplinary Team*, or develop the individual plan of care under DDA Policy 17.06.04, *Interdisciplinary Team: Nursing Facility*.

Intermediate care facility for individuals with intellectual disabilities or **ICF/IID** means a Medicaid-certified facility operating under Title XIX of the Social Security Act in 42 C.F.R. 440.150 to furnish health or rehabilitation services.

Legal representative means a parent of a client if the client is under age 18 and parental rights have not been terminated or relinquished, a court-appointed guardian if a decision is within the scope of the guardianship order, or any other person authorized by law to act for the client.

Necessary supplemental accommodation representative or **NSA** means a person who receives copies of DDA planned action notices and other department correspondence to help a client understand the documents and exercise the client's rights. The NSA representative is identified by a client when the client does not have a legal guardian and the client is requesting or receiving DDA services.

Nursing facility or **NF** means a nursing facility regulated by 42 C.F.R. 483, subpart B, 42 C.F.R., subpart C, and Chapter 388-97 WAC.

Preadmission screening and resident review or **PASRR** means a federally mandated program that requires a client be assessed for nursing facility level of care before admission to a Medicaid-certified nursing facility.

PASRR assessor means a regionally designated CRM who completes the PASRR process.

Planned respite means a scheduled break in caregiving to families and primary caregivers of clients.

Residential Habilitation Center or **RHC** means a state-operated facility under RCW 71A.20.020 certified to provide ICF/IID or nursing facility services.

Serious mental illness (SMI) contractor means the mental health professional contracted by the Health Care Authority who completes the process for clients who may have a mental health diagnosis.

Transition means the process by which a client moves from an RHC into the community.

Treating professional means a person who specializes in the discipline within their scope of practice.

POLICY

A. ICF/IID services are temporary. DDA staff must discuss the client's discharge goal during the admission process. The IDT will develop targets based on the client's needs to meet the discharge goal. Permanent or long-term admission at an ICF/IID is not available. For ICF/IID services, federal guidance establishes criteria for when a client can be discharged from the facility for good cause, absent an emergency, and provide reasonable time for the client to prepare for such discharge. The RHC must monitor and document by

treating professional assessments, progress notes and IDT discussions if a client has met the following discharge criteria:

1. The RHC cannot meet the client's needs;

2. The client no longer requires an active treatment program;

3. The client chooses to reside elsewhere; or

4. The RHC determines that another level of service or living situation would be more beneficial to the client.

B. Before admission to an RHC, the client's CRM must present the options to receive community-based services.

C. A request for ICF/IID or NF services at an RHC requires prior approval (see Procedures Section (A)).

D. Admission is temporary:

1. Admission to an RHC to receive ICF/IID services is limited to 180 consecutive days.

2. Admission to an RHC nursing facility to receive planned respite is limited to 30 days in a calendar year, not to exceed 30 consecutive days across two calendar years.

   Note: The discharge day is not considered in the total number of days a client accesses planned respite. Admission to an RHC greater than 30 consecutive days may affect a client's financial benefits under the Social Security Administration and could incur participation costs.

E. A person is eligible to receive ICF/IID services if:

1. DDA-eligible under Chapter 388-823 WAC;
2. Eligible for Medicaid under Title 182 WAC; and
3. Likely to benefit from and willing to participate in active treatment.

F. A person is eligible to receive NF services if:

1. DDA-eligible under Chapter 388-823 WAC;

2. Eligible for Medicaid under Title 182 WAC; and

3. Assessed to meet PASRR eligibility criteria. Before admission to a nursing facility, a PASRR assessor must complete the PASRR determinations and provide a copy of the determinations and planned action notice (PAN).

G. A person is eligible to receive emergency transitional support services if the person meets requirements under WAC 388-829Z-015.

H. RHC ELIGIBILITY

A client is eligible for admission to an RHC if the client:

1. Is eligible for ICF/IID or NF or emergency transitional services under Policy Section (E) or (F) or (G);

2. Does not require inpatient treatment related to a behavioral health care need, where such treatment is available through the Medicaid State Plan and prescribed by the client's treating professional;

3. Is not incarcerated in jail or prison for a crime or detained under Chapter 71.05 RCW or Chapter 71.09 RCW and any pending civil commitment proceedings have been dismissed; and

4. Under RCW 71A.20.010:

   a. A client under age 16 must not be admitted to an RHC.

   b. For a client aged 16 through 20, a client may be admitted to an RHC only if there are no service options available in the community to appropriately meet the client's needs.

PROCEDURES

A. REFERRAL FOR ADMISSION TO AN RHC

1. Before submitting a request for admission for services provided by an RHC, the CRM must discuss Medicaid State Plan benefits and community-based services with the client and legal representative and explain the difference between ICF/IID and NF (see RHC ICF/IID brochure, RHC FAQ, and RHC Fact Sheets).

2. If the client and the client's legal representative request ICF/IID services, the CRM must document the following in the clients CARE record:

a. Information has been provided regarding applicable community-based services, including but not limited to Home and Community-Based stabilization services;

b. Discussion of the temporary nature of ICF/IID services[2]. Inform the client and their legal representative that:

i. Discharge planning begins during the admission process;

ii. Once the client meets discharge criteria, the assigned regional field office will work with the client and the client's legal representative to identify services in the community;

iii. Active treatment eligibility must continue to be met after admission as required under 42 C.F.R. 483.440; and

iv. The client's legal representative, if the client has one, has an obligation to:

A) Participate in care planning discussions; and
B) Respond promptly to the RHC when consent is needed.

3. If a client is not admitted to an RHC and the client or the client's legal representative requests NF services, the CRM must work with the client to contact their primary care physician to explore community options to meet their needs.

4. A CRM may submit planned respite requests up to 180 days before the requested start date. The request must identify:

a. The specific date of a client's arrival and

b. The date they will leave and return to their primary residence.

5. If the client and the client's legal representative request services in an RHC the CRM must:

a. Follow DDA Policy 4.01, *One Referral;* and

[2] *Rethinking Intellectual and Developmental Disability Policy to Empower Clients, Develop Providers, and Improve Services*. https://app.leg.wa.gov/ReportsToTheLegislature/Home/GetPDF?fileName=Ruckelshaus%20Workgroup%202019%20DD-RHC%20Report%20to%20Legislature_d4838af6-7bf7-45f5-8416-f67a242b4f37.pdf

b. Complete and submit to their supervisor a prior approval in CARE with the category "Overnight Respite, Stabilization, and RHC Admission" for the following service types:

i. RHC planned respite; or

ii. RHC admission that indicates the type of service requested (ICF/IID, emergency transitional support services, crisis stabilization, or NF services).

6. The CRM must include information in the prior approval as follows.

a. In the "Request Description" tab:

i. The RHCs from which the client consents to receive services; and
ii. The client's age if the client is aged 16 through 20.

b. In the "Justification for Request" tab:

i. Any significant events that occurred that led to the request; and
ii. The client's plan for discharge, including:

A) The setting type and provider the client will discharge to, if known; and

B) The client's discharge goals.

c. In the "Alternatives Explored" tab:

i. A list of alternatives explored and a description of why each alternative was not appropriate, available, or effective; and

ii. A statement, if applicable, that the client or the client's legal representative is unwilling to consent to a DDA Home and Community-Based Services waiver, Roads to Community Living, or State Plan services in a community setting.

7. After reviewing the prior approval, the CRM supervisor must submit the prior approval to regional management for review.

8. After receiving the prior approval, the regional administrator or designee must:

a. Review the prior approval;
b. Include applicable comments about the request; and
c. Submit the request in CARE to the DDA HQ RHC Admissions Committee.

9. The RHC Program Manager must:

a. Confirm a complete referral packet and prior approval were received;

b. Review all requests with the RHC Admissions Committee, except for planned respite requests, to determine which RHC should receive the referral;

c. Send the referral packet to an applicable RHC coordinator or designee for consideration; and

d. Include the RHC Director in planned respite requests to the RHC, if the request is for seven consecutive days or longer.

B. ADMISSION DECISIONS

1. For all admission requests, the RHC must:

a. Review referral documentation, including relevant client history;

b. Conduct a preliminary evaluation in-person or virtually using current functional assessments of the client's developmental, behavioral, social, health, and nutritional status;

c. Ensure the client's needs can be safely met by the RHC;

d. Verify federal funding, vacancy, and sufficient staffing are available to meet the client's support needs;

e. Ensure the RHC Medical Director or designee reviews the referral and provides input on the decision;

f. Consult with the RHC Director if the client's support needs require enhanced or additional staffing; and

g. No more than five business days after completing the preliminary evaluation, communicate the admission decision to the RHC Program Manager.

2. To determine if a client meets admission criteria for ICF/IID services, the RHC must determine if the client is willing to participate in active treatment.

3. To determine if a client meets admission criteria for NF the RHC must verify the client meets nursing facility level of care under WAC 388-106-0355.

4. The RHC Program Manager must:

   a. Notify the CRM, regional management, designated facility staff, and PASRR staff as applicable of the RHC decision;

   b. Process the prior approval in CARE.

5. The DDA CRM must:

   a. Notify the client and legal representative of the admissions decision;
   b. Complete the planned action notice; and
   c. For approvals:

      i. Communicate with the client, family, or legal representative regarding the information and documents that will be required before admission as outlined in DSHS 15-592, *RHC Admission Checklist;*

      ii. Assist the RHC admission coordinator to obtain required documents outlined in the admission checklist;

      iii. Review DSHS 10-424, *Voluntary Participation Statement*, with the client, the client's family, and the client's legal representative;

      iv. Notify the Long-Term Care and Specialty Unit using Barcode 15-345 of the client's admission date to the RHC, and for planned respite, the discharge date; and

      v. Update the client's person-centered service plan according to the instructions provided by the RHC Program Manager.

C. PRE-ADMISSION

1. If the RHC has determined they can support the client, the RHC must schedule and facilitate a pre-admission meeting and include: the client; the client's family or legal representative; and professionals or support staff from disciplines and service areas needed to meet the client's identified support needs. For NF services, notify regional PASRR staff.

2. The pre-admission meeting must:

   a. Determine the need for an environmental evaluation, such as an assessment for structural modifications, durable medical equipment, accessibility needs, etc.;

   b. Discuss the client's identified medical needs, including any future scheduled appointments with community providers;

   c. Determine school coordination (if applicable) as required by DDA Policy 17.02.06, *Access to Education for School-Aged Clients in RHCs*;

   d. If admitting for ICF/IID services, inform the client and legal representative of the requirement for continued ICF/IID eligibility once the client is admitted; and

   e. Determine the client's admission date.

3. The RHC employee coordinating the admission must communicate the admission date to the RHC Program Manager.

4. Before a client is admitted for NF services:

   a. The referring regional PASRR assessor must complete the PASRR Level 1 assessment and determination as required by DDA 16.01, *Responding to Preadmission Screening and Resident Review Program Referrals;*

   b. The NF must ensure that the PASRR Level 1 is accurate and a referral has been made to the Serious Mental Illness (SMI) contractor for clients with positive indicators that will be admitted for more than 30 days.

   c. A notice of determination from the SMI contractors must be received by the NF prior to admissions expected to last more than 30 days.

d. Send the planned action notice as required by DDA 16.07, *Planned Action Notices for PASRR*; and

e. PASRR Level 2 assessments must be completed for all NF admissions lasting more than 30 days. If the admission is anticipated to exceed 30 days, the PASRR assessor must complete the PASRR Level 2 assessment before the 31st day of services.

D. ADMISSION TO AN RHC

On or before the client's date of admission for ICF/IID or NF services, the RHC must:

1. Complete DSHS 15-592;

2. Orient the client and the client's family or legal representative to the client's new living unit;

3. Update CARE and the electronic health record with admission information;

4. Establish a communication framework with the client's family or legal representative and field services case management staff;

5. Ensure a comprehensive admission evaluation is completed in accordance with the client's healthcare needs as required by DDA Policy 9.06, *Health Services: Residential Habilitation Centers*; and

6. Establish meeting dates and timelines for comprehensive assessments and development of the IHP or individual plan of care.

E. POST-ADMISSION

1. For a client whose services will exceed 30 consecutive days, before the 30th consecutive day:

   a. The CRM must:

      i. Update the client's person-centered service plan, as needed (e.g., terminate service authorizations or waivers); and

      ii. Send planned action notices as applicable.

b. The RHC must:

i. If the client is receiving ICF/IID services, develop an IHP per 42 C.F.R 483.440 (c) and outline the discharge goals;

ii. If the client is receiving NF services, ensure the PASRR level 2 is complete and develop a care plan that includes PASRR recommendations;

iii. Notify the Long-Term Care and Specialty Unit using Barcode 15-345; and

iv. Notify the Social Security Administration of admission to the RHC.

2. For a client receiving ICF/IID services, no more than 60 days from admission, the IDT (which includes the client's case manager, and if applicable the client's managed care organization), must convene to review whether the client meets discharge criteria.

a. If the client meets discharge criteria, the discharge process will begin.

i. The RHC must:

A) Document the evidence of an assessment that evaluated the pros and cons of the discharge and rationale for the final decision; and

B) Provide information on Roads to Community Living, complete and begin the enrollment process.

ii. The assigned regional field office must:

A) Complete the RCL enrollment process when applicable; and
B) Work with the client to identify community-based services.

b. If the IDT determines the client does not meet discharge criteria:

i. The IDT must make any necessary changes to the client's IHP, continue treatment, and schedule a subsequent review in the next 120 days.

ii. The RHC must apply to be the client's representative payee, unless the family or legal representative request to continue as payee.

iii. The CRM must move the DDA assessment to history.

c. For a client admitted to an RHC for ICF/IID services whose length of admission is approaching 180 days:

i. The IDT must continue to assess the client's discharge goals and determine if discharge criteria has been met.

ii. The CRM must:

A) Consult with regional management and the client's IDT to determine barriers to community-based services; and

B) Request an exception to policy every 180 days if the IDT determines the client still meets ICF/IID eligibility criteria.

EXCEPTIONS

Any exception to this policy must have the prior written approval of the Deputy Assistant Secretary.

SUPERSESSION

DDA Policy 17.01.02, *RHC Admissions for Intermediate Care and Nursing Facility Services* Issued January 19, 2023

DDA Policy 17.01.03, *Planned Respite Provided by a Nursing Facility at an RHC* Issued April 15, 2023

Approved: _____ Date: August 1, 2024

Deputy Assistant Secretary
Developmental Disabilities Administration