Inpatient Hospital Assessments and Transitions

The purpose of this chapter is to clarify inpatient hospital assessment activities to ensure smooth transitions to home and community-based services. The goal and focus of inpatient hospital assessment and transition activities is to:

- Proactively engage with individuals seeking long-term care (LTC) services to provide up to date information about Medicaid funded long-term care options.
- Assist and educate 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 an inpatient setting.
- Prioritize assessment and expediting authorization of LTC services for individuals once they are referred for services and anticipate transitioning from the hospital to home and community-based services (HCBS).
- Develop rapport and supportive relationships with local inpatient hospital discharge planners and LTC providers in the community.

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Background

An inpatient hospital refers to a licensed healthcare facility that provides 24-hour healthcare for individuals who are admitted. Many inpatient hospital referrals are for individuals new to long-term care (LTC) services and will require a functional and/or financial eligibility determination. Achieving timely transitions to services is essential in reducing the number of days patients spend hospitalized when they no longer meet medical necessity. This chapter applies broadly to assessments completed in inpatient settings like acute care hospitals statewide as well as border hospitals, state hospitals and inpatient psychiatric facilities. Successful transition planning requires robust collaboration and partnership with HCS staff, hospitals, managed care organizations, service providers, and local communities. This collaboration aims to deliver suitable services and community options that respect client preferences and reduce healthcare costs while enhancing individual wellbeing and quality of life. Timely and coordinated assessment and transition planning requires a great deal of data collection, analysis and creative problem solving to ensure systems of care are aligned and responsive to the diverse and complex needs of each individual.

Assessing and Transitioning Clients from Inpatient Hospital Settings

HCS hospital assessments follow policy established in Chapter 3 of the Long-term Care Manual. It is the goal of HCS that all hospital referrals for LTC receive a hospital assessment unless the individual:

- is discharged or the hospital withdrawals a referral prior to an assessment being completed.
- refuses the assessment.

What Conditions Must Be Met for HCS to Conduct an Inpatient Hospital Assessment?

For HCS to conduct and complete an inpatient hospital assessment, the individual must meet the following:

1. Medically stable—the individual is close to baseline functioning and their immediate medical needs, treatments, and therapies have been achieved.
2. The individual, guardian, or legal decision maker is aware of the HCS referral and agrees to an assessment and HCS services. If there are questions on client's capacity, see "Obtain Plan Approval on Plan of Care" outlined in Chapter 3.
3. Psychiatrically stable —the individual 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 72 hours prior assessment and transition.

- Medically Stable individuals for example, are not in ICU, their conditions are predictable and stabilized.
- For individuals on contact precautions like COVID-19, MRSA and other infectious diseases, staff will assess following established universal precautions and safety standards.
- HCS hospital case managers must meet with the individual requesting services, consult with informal decision makers/collateral contacts and review medical records to determine whether the individual has the ability to participate in CARE planning and consent for LTSS.

When is an Individual Not Ready for an Inpatient Hospital Assessment?

1. The individual declines to have an HCS assessment done to explore LTC options they might be eligible for, and this is documented in CARE.
2. Not medically stable-the individual still needs 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 or cannot be replicated in the community.
3. Not psychiatrically stable-the individual continues to require inpatient 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 or cannot be replicated in the community.
4. Combative and/or behaviorally compromised e.g., client who is actively physically assaultive.
5. Being restrained or in seclusion in the last 72 hours, additional details are provided in Restraint Section.

What Assessments Need to Be Prioritized Among Inpatient Hospital Referrals?

At times inpatient hospital staff will notify HCS of the need to prioritize certain referrals. For such cases, the assigned HCS case manager will work with the hospital to determine the order of assessment based on urgency and eligibility.

A referral that is considered a priority may have the following conditions:

1. Medicaid Eligibility: Individuals who are already financially eligible for Medicaid long-term care services
2. Adult Protective Services (APS) Involvement: APS is actively engaged in the case.
3. Hospice: Hospice is involved, and they are requesting HCS to take the lead in finding a community setting.
4. Department of Corrections Referral: the referral originates from DOC who is requesting HCS to take the lead in finding a community setting for a client who is medically complex.
5. Imminent Transition: The individual's planned hospital transition is imminent; it is in a few days not weeks; or
6. Consent: The individual can consent to services or has a legal decision maker to consent to LTC.

What is the Role of HCS When Receiving an Inpatient Hospital Referral?

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) LTC 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 following guidelines in Chapter 3 of the Long-term Care Manual.
3. Assigns the case to the HCS case manager and
4. Performs case transfers when appropriate.

HCS case manager will:

1. Make contact as outlined in Chapter 3 of the Long-term Care Manual.
2. Triage cases to determine the appropriate time for an assessment.
3. Update CARE screens:
   a) **Acute Hospital referrals** will be added to the Acute Hospital Screen in CARE. This screen must be updated throughout their hospital stay, removing barriers to transition as they resolve.
   b) **State Hospital transitions** will be added to the State Hospital/Hospital/E&T Screen in CARE upon transition to a LTC setting.
4. Complete an 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 LTC services to hospital staff, clients, and families.
6. Discuss MAC/TSOA (Chapter 30b) as an option if the client declines HCS Services.
7. Assist with developing multiple potential transition plans into LTC settings concurrently, including finding a provider.
8. Identify, document, and address barriers to transition as early as possible.
   a) For individuals requesting HCS residential settings who have challenging behaviors, you may complete DSHS 10-234a and provide to potential residential providers.
9. Collaborate with hospital staff on transition planning.
10. Coordinate with transitions of care planners at Managed Care Organizations (MCOs).
11. Utilize Fast Track (Chapter 7a) or offer Presumptive Eligibility (PE) (Chapter 30e) for community services, if appropriate.
12. 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:
    a) Referrals for services are made.
    b) Services are authorized.
    c) Service plan is implemented.
    d) Provider service contracts are arranged, if appropriate.
    e) RAC are entered in CARE.
    f) ProviderOne authorization is “error free” and in CARE.

g) The client and provider have signed the service summary and returned it to the relevant HCS staff for review and signature.
h) If Fast Track or PE has been used, the Medicaid application has been submitted with the appropriate documentation to the local financial worker.

Likewise, follow the above procedures outlined from 13 (a) through (g) for transferring client cases to an HCS Residential case manager for clients who will receive services in residential settings.

Acute Hospital: For clients who are discharged into the community before an HCS hospital assessment and/or LTC service plan is in place; the HCS 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 conduct an assessment and/or set up of services for appropriate LTC community options. When these cases are transferred it should be noted that they were transitioned from the hospital before assessment or service planning could be established and that these cases may need to be expedited by the receiving team.

What is the Role of HCS Case Managers in Determining an Individual's Ability to Consent to LTSS?

In addition to consulting with the hospital, the HCS case manager should interact with the individual to determine if they can consent to LTC services or can select a representative to provide consent.
Case managers need to consider if there is an authorized representative (AREP), DPOA, or POA in place, or if other avenues such as guardianship or conservatorship should be considered.

Refer to Chapter 3 for client consent and determining a client's ability to consent to LTSS services. If there are questions on how to proceed, staff with a supervisor.

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 an inpatient 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:
   a) Follow assessment procedures established under Chapter 3 of the Long-term Care Manual.
   b) 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.
   c) Collaborate with hospital staff on discharge planning.
   d) Coordinate with transitions of care planners at MCOs. Chapter 22a
2. 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:
   a) The AAA case manager will immediately staff client's status with HCS supervisor to consider transferring of case to appropriate staff. This should be done promptly to avoid delays.
   b) Create a hospitalization transfer SER with the following information:
      - Hospital name
      - Admission date

- Current hospital social worker
- Barriers to returning home
- Date of staffing with Hospital Supervisor
- Is the client decisional? (If not, who is the guardian/conservator or DPOA)?
- What steps have been taken to maintain or allow the client to return to previous setting?

c) Transfer cases to HCS as soon as it is known that the client will not be returning to in-home services and close all authorizations.

d) HCS case manager will take over the case for all transition planning actions for clients transitioning from inpatient hospitals settings.

3. AAA case managers determine the need to transfer vs. retain hospital referrals for transition, in addition they:
   a) Provide information about LTC services to hospital staff, clients, decision makers, and families.
   b) Assist with developing multiple transition plans into LTC care settings concurrently including finding a provider.
   c) Identify and address barriers to transition as early as possible.
   d) Collaborate with hospital staff on discharge planning.
   e) Coordinate with transitions of care planners at MCOs

❖ If the AAA staff know the client is planning to transition to a skilled nursing facility, keep the case until the client admits then transfer the case immediately to HCS for case to be assigned to the NFCM assigned to that facility.

What is the Role of Residential Case Managers in Transitioning Clients Back to Residential Settings?

Residential Care Case Managers (RCCM) are responsible for case managing clients returning to their residential setting following an inpatient hospital stay. It is important to remember to end personal care services timely when notified a client has been admitted into the hospital.

1. For inpatient 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:
   a) Follow bed hold policy outlined in Chapter 8.
   b) Follow established protocol for assessing and updating CARE assessments to reflect any changes to the client's care plan as outlined in Chapter 3 of the Long-term Care Manual.
   c) Continue to case manage the clients who were on CFC/COPES/New Freedom/ prior to hospitalization and provide reassessments/service plan changes.
   d) The RCCM will authorize the service plan prior to transition.
   e) Collaborate with hospital staff on transition planning.
   f) Coordinate with transitions of care planners at MCOs. Chapter 22a

2. When clients are not expected to return to their previous residential setting, the residential unit will:
    a) Staff the case with the receiving HCS supervisor, to discuss transferring of case. This should be done promptly to avoid delays.
    b) Close all authorizations and notify providers of services ending.
    c) Create SER documenting notification to providers of services ending.
    d) 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 previous residential setting.
        - Date of staffing with Hospital Supervisor
        - Is the client decisional? (If not, who is the guardian/conservator or DPOA)?
        - What steps have been taken to maintain or allow the client to return to the previous setting?

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

When an NFCM is unclear whether the client will return to the nursing facility, retain case management of the client for 30-days, or until the client transitions to another nursing facility. Upon admission into another nursing facility, the NFCM will transfer the case to the assigned NFCM of that center.
If the client is not going to be returning to a Nursing Facility, or has been hospitalized over 30 days NFCMs will:

1. Immediately staff the case with the receiving HCS supervisor,
2. Create a hospitalization transfer SER with the following information
    - Hospital Name
    - Admission date
    - Current hospital social worker
    - Barriers to returning to SNF setting.
    - Date of staffing with Hospital Supervisor
    - Is the client decisional? (If not, who is the guardian/conservator or DPOA)?
    - What steps have been taken to maintain or allow the client to return to the previous setting?
3. Transfer the case to an HCS supervisor for case assignment.

> ❖ If the RCCM staff know the client is planning to transition to a skilled nursing facility, keep the case until the client admits then transfer the case immediately to HCS for case to be assigned to the NFCM assigned to that facility.

What is the Role of Hospital Discharge Planners When Transitioning Clients to a Community Setting?

Hospital discharge planners are responsible for sending LTC financial applications to determine Medicaid eligibility for individuals as soon as it has been identified that they will need these services as part of their discharge plan. An HCS referral will need to be submitted when the individual is near ready to discharge to determine their functional eligibility for Medicaid LTC services. Hospitals may reference the HCS Referral Guide to determine when an individual is appropriate to refer to HCS.

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 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 and referral form and financial application with valid applicant's location and contact information.
4. Pursue guardianship or conservatorship if client lacks 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 information, and access to pertinent information affecting transitioning 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.
    - Refer to Chapter 22a for additional information on how to coordinate with MCOs.

Acute Care Hospital Only

- If an acute care hospital is unable to identify a proposed guardian or conservator for court nomination, the hospital may submit a referral to the HCS Guardianship Program Manager for an eligibility determination for the Guardianship and Conservatorship Assistance Program (GCAP). See section below titled Guardianship and Conservatorship Assistance Program (GCAP) for information on GCAP referral process.
- For updates on any GCAP referrals or active case status, refer to the Guardianship/Conservatorship screen in CARE.

How is Coordination with Hospital Discharge Planners Done?

HCS unit supervisors or designated staff will maintain regular contact with each hospital and conduct in-service training when appropriate to disseminate updated information about LTC 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:
   a) Clearly define and explain to discharge planners the role HCS/AAA has in assessing new clients and clients returning to the community.
   b) Discuss all Medicaid long-term care services including MAC/TSOA referrals with hospital discharge staff for transition planning.
   c) Develop a written hospital transition coordination plan between the local hospital(s) and HCS 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.
   d) 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:
   a) HCS intake and referral form and procedures (see appendix II)
   b) LTC application and procedures.
   c) Policies for LTC assessment outlined in this chapter.
   d) A request for data needed from hospitals by HCS hospital case managers (see information under assessment data and reporting section of this chapter).
   e) Provide hospital staff with information on roles and HCS process for transitioning individuals out of hospitals and share the following link where a brief training can be accessed. Hospital Staff Training: Partnering with Home and Community Services (HCS)

To avoid delays with transitioning individuals:

- Hospital staff, or the patients, will need to submit an application if the individual does not already receive Medicaid benefits.
  - For applicants under the age of 65 who do not have Medicare coverage they can apply with Health Care Authority online at: Washington Healthplanfinder.
  - For applicants over the age of 65, or younger but receive Medicare benefits, they can apply online with DSHS online at: Washington Connection.
  - When submitting application to DSHS, Hospital staff will follow additional instructions documented in appendix III to Expedite Acute Care Hospital Applications.
- Hospital staff, patients or family must submit the HCS Intake and Referral form.

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 transition 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 transition planning to help ensure coordinated efforts. They are responsible for the following activities to assist in transition 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 transition 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 services.
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 Enrollee and family caregivers and support network in assessing needs.

- Medicare Advantage and Dual-eligible Special Needs Plans (D-SNP) also have a requirement to participate and implement transition care activities. Refer to Chapter 22a for information about MCO contacts or visit the Cross System Care Coordination webpage.

Who Else May Be Involved in Inpatient Hospital Transition Activities?

1. Developmental Disabilities Administration case manager and/or DDA Nursing Care Consultant:
   a) Triage referrals and determine functional eligibility by assessing the client's care needs.
   b) Assist with developing transition plans into long-term care settings.
   c) Provide information about long-term care services and support to hospital staff, clients, and families.
   d) Coordinate with hospital staff for transition planning.
   e) Collaborate with HCS case manager when needed to assist with developing client's 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 providers etc.
4. Public Benefit Specialists—Determine client's Medicaid financial eligibility.
5. Guardian/Conservator or sometimes Court Visitor: Participates in transition planning and decision making.
6. State Hospital Treatment Team- clinical team at state hospitals responsible for transition planning.

- Coordination and/or transfer of client services between DDA and HCS may occur for several reasons. Follow instruction in Chapter 7h 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 LTC services.

How are ETR Requests for Eligible Inpatient 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 three business days of receipt by the Headquarters ETR Committee.

- Follow the detailed ETR process outlined in Chapter 3 of the Long-term Care Manual for personal care and other ETR types.
- Additional information on ETRs can be found on the ETR Personal Care

What are Some Examples of Frequent Barriers to Inpatient 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. An assessment will be completed and wait for consent from client or client's legal representative for plan approval, unless otherwise noted in court orders.
2. Client refusing to receive HCS services.
3. Lack of family or social supports to assist with the application process
4. Use of restraints or seclusion
5. Lack of readily available specialized community resources for individuals who have medical and behavioral complexities.
6. Financial eligibility: Client is unable to provide the required financial verification documents necessary to make financial eligibility determination.
7. Client's medical and psychological condition is not conducive for having an assessment.
8. Lack of adequate documentation.
9. Intermuscular (IM) medication that are "pro re nata" (PRN) or scheduled daily that cannot be replicated in a community setting.

- If Case Managers are needing assistance with transitions resources, refer to the Transition Academy.
- Case Manager can also utilize the Pre-Discharge Checklist, DSHS 20-331.

What is HCS Guidance About Use of Restraint in Inpatient Hospital Settings?

The Centers for Medicare and Medicaid (CMS) have 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 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.

A-(0160) A drug or medication is considered a chemical restraint when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition.

Use of restraints in a 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, consider the requirements outlined below when restraints are used. The section titled **Hospital Federal Regulations** includes further guidance that supports and expands on 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 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 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 should staff with your supervisor to determine if a Department of Health report should be made.

Managing and Transferring Inpatient Referrals

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 withdrawal the HCS referral due to client not being near ready for discharge (pending guardianship except when pending through GCAP services, not medically or psychiatrically stable, etc.), the CM will take the following actions:

1. SER mutual decision for withdrawal of referral
2. Enter outcome in the CARE hospital screen
   - **Acute Hospital** will select withdrawal
   - **State Hospital** will select inactive
3. Refer to Chapter 27 on when a PAN is required.
4. Send a 14-443 to financial stating "the LTC request was withdrawn, please redetermine for non-LTC medical. CARE is being inactivated." Financial will determine Medicaid eligibility and if client qualifies, the case will be sent to the CSO.
   - Omit the 14-443 for MAGI
5. Inactivate the case in CARE.
6. As soon as a new HCS referral is received, verify with financial status of eligibility, and create a new entry in the acute care or state 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**.
- ❖ If an individual is pending appointment of a contracted guardian or conservator through GCAP services, the referral is not to be withdrawn due to pending guardianship.

When Would a Hospital Referral for Transition Be Inactivated?

Some individuals who are referred to access LTC services 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 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 Nursing Care Consultant (NCC) or 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 (except in the case of Acute Hospital GCAP eligible clients) the client has not made any progress towards transition planning:
    a) Conduct a staffing with the unit supervisor to review the status of the case including what has been done, and
    b) May inactivate the client in CARE using the "No Current Discharge Plan" code.
    c) 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 case manager will inactivate the case immediately.

❖ Cases resulting in the termination of GCAP services for reasons including but not limited to; a client leaving hospital against medical advice, identification of less restrictive guardian/conservator, or no identified contracted guardian/conservator identified may be inactivated in CARE by the assigned HCS case manager using the "No Current Discharge Plan" code after Guardian/Conservator screen is finalized by GCAP staff.

How are Transitions from Inpatient Hospitals to a Nursing Facility Done?

1. Hospitals may discharge patients to a nursing facility without prior authorization from HCS (refer to Chapter 10 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 of the Long-term Care manual for details.)

❖ If a client needs Expanded Behavior Supports (EBS) to support a transition to a SNF, refer to Chapter 10 for process on how to make a referral.

How are Transitions from Inpatient Hospitals to Transitional Care Units/In-Patient Rehab and 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) Hospital, HCS considers that transition a hospital discharge and are no longer considered inpatient.

When the transition to IPR is located within a hospital, this is not considered a hospital discharge.

1. Conduct a CARE assessment for clients who have applied for LTC services and are ready to transition to community settings.
2. If the client is transitioned to the transitional care setting prior to assessment, conduct the assessment at the transitional care setting.

- ❖ When a client transfers from an acute hospital to LTAC, this is considered a transition. The discharge outcome on the acute hospital screen for this client is "Other medical facility."
- ❖ When a client is referred from LTAC 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 Inpatient 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 a 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 is 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 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 LTACs:

1. When the individual has submitted a LTC application for financial eligibility and is pending Medicaid and;
2. The individual has been referred to HCS for a functional assessment for LTC services by a border acute care hospital or LTAC, and;
3. When the individual is a Washington resident and is planning to return to the state;
4. Follow procedures established in Chapter 3 of the Long-term Care Manual for CARE assessments.

What is the Process for Submitting Non-Grant Medical Assistance (NGMA)

MAGI-based clients are not part of the Aged, Blind, Disabled population and therefore if waivered services are needed a NGMA will need to be complete to determine eligibility. Please see Chapter 7h for a detailed process of how to complete a NGMA. Case managers should consider the location of the client they are working with and follow outlined processes below.

Acute Hospital: Social Service Specialist may submit Hospital Certification of Potentially Disabling Condition (HCA form 19-0054) along with NGMA packet to move forward with transition planning. This document allows the PBS to approve waiver eligibility for 90 days while Department of Disability Determination Services (DDDS) completes a full review. Send the following to Financial Policy Analyst (FPA)

- Client Name
- ACES ID
- DDS Office submitted to:
- Facility Name:
- Date 19-0054 submitted:
- Date NGMA sent:
- Reason for request to expediate NGMA:

State Hospital/Residential Treatment Facilities/Local Psychiatric Facilities: Complete and submit the NGMA packet. In addition, an email to the Financial Policy Analyst (FPA) and the SHDD Public Benefits Coordinator (PBC) with the following information in order to request DDDS to expedite the NGMA application.

- Client Name
- ACES ID
- DDS Office submitted to:
- Facility Name
- Date NGMA sent:
- Reason for request to expediate NGMA:

What is the Role of Case Managers When Assessing a Client with a Known Legal History?

Documentation of criminal offenses:
Investigating or determining whether a client has a record of criminal justice system involvement is not necessary to determine whether a client is eligible for services but may be relevant to care planning and service delivery.

Case managers should use the following guidelines for documenting disclosed criminal behavior and offenses as part of a CARE assessment. It may be necessary to ask clarifying questions to the individual you are assessing to better understand the nature of a charge or conviction that is disclosed or known.

The CARE assessment is not intended to be a complete record of criminal activity or legal involvement; documentation should be relevant to care planning.

Why is legal history included?
The purpose of including any information about the client's potential, or actual criminal history, is so that a provider is aware of the client's needs and able to evaluate whether they want to take on the duty to care for the client and can meet their obligation to protect other clients. It is not about providing the provider with a detailed criminal history of each potential client

Limitations on sharing criminal history information from a law enforcement agency:
If you have criminal history information from a law enforcement agency it may include convictions as well as pending charges and dispositions other than convictions. For these records you can include and disclose to providers information about convictions and pending charges without restriction. For other arrests and dispositions of charges included in the criminal history report, only certain information can be disclosed.

Charges that meet special criteria and should be documented:

1. If an incident occurred within the last 12 months and the person is still being processed by the criminal justice system (i.e. is on parole)
    a) The charges:
        - Resulted in an acquittal for not guilty by reason of insanity (NGRI);
        - Resulted in a dismissal for incompetency under 10.77 RCW (civil conversion)

How and where to document convictions/pending charges/charges that meet special criteria:

1. The case manager should include documentation in the safety screen under the legal comments section so that it is visible to a provider.
2. If known the CM should indicate:
    a) the date of the crime
    b) the nature of the crime the individual was convicted of
    c) indication of who the crime was committed against.

How to document criminal behavior and history disclosed by the client/family/notes or other:
If the information you have is reported by another source, such as a provider, a family member, or the client themselves, the case manager is not responsible to confirm this information and can include the information in the CARE assessment.

If you are unsure if the information is true or not, don't document information as fact, rather indicate in CARE that the information has been reported by client/family/notes or other.

If you are documenting any legal history add the following in the comment field of the legal section:
Any criminal history information about the client included in the assessment details is for information only. The department has not conducted a comprehensive background check, nor has it independently verified information reported to it by third parties, including the client. Therefore, any information about the client's criminal history included in the assessment details may be incomplete or inaccurate.

What is the Involuntary Treatment Act (ITA)?

Individuals experiencing a behavioral health crisis may present as a risk to themselves or others or be unable to care for their basic need of health and safety. The involuntary Treatment Act (ITA) provides the statutory framework for civil investigations, evaluations, detention, and civil commitments of individuals experiencing a mental disorder or a substance use disorder whose symptoms are so acute that the individual may need to be treated on an involuntary basis. For additional information pertaining to the ITA process reference HCA Involuntary Treatment Act or Acute Behavioral Health and ITA.

What Additional Steps to Take When Transitioning an Individual on an ITA (Civil Commitment)?

1. Request ITA Documents from Local Psychiatric Facility (LPF) or Hospital:
    a) Court orders are official legal documents that confirm a client is under involuntary treatment pursuant to a civil commitment. Orders issued under an ITA must clearly specify the type and duration of detainment, which may include 120-hours, 14-days, 90-days, 180 days, or if they have a revocation of an LRA.
    b) If a client was detained under the ITA process, but has switched to voluntary status, HCS will still need to obtain a copy of the ITA documents.
    c) ITA documents must be signed by a judge or court commissioner.
2. Request any relevant Behavioral Support Plans or Risk Management Plans.
3. Upload Documents to Data Management System (DMS): The case manager will send ITA petition, court orders, and any relevant LRA documentation to Barcode via email.

The process identified in this section will need to be repeated at any time a new ITA or Less Restrictive Alternative (LRA) is issued. Please refer to Chapter 71.05 RCW for more information regarding the legislative process.

What is the Role of HCS Case Manages when Receiving a Referral from the Office of Public Defense?

HCS intake may receive a referral from OPD requesting a CARE assessment be completed for individuals residing at Eastern State Hospital and Western State Hospital. OPD will be representing the client in court and will bring forward potential setting options the client may be eligible for upon discharge. Home and Community Services has an obligation to complete a CARE assessment when requested by OPD.

If a referral is received, the Case Manager will:

1. Notify the State Hospital treatment team of the referral received from OPD and schedule the assessment.
    a) If the treatment team is in support of transition, state hospital initiates next steps for discharge.
    b) If the treatment team is not in support of the transition, the treatment team will present this at court. HCS performs the CARE assessment and continues transition planning.

Instruction for OPD Assessment Disclaimer

Since referrals from OPD may not be supported by the treatment team or may not indicate the client is ready to transition to the community. If the treatment team does not agree or the client is not on the active discharge list, follow the process below to print special instructions on the CARE assessment:
CARE plan Main screen:

1. Select **Eastern State Hospital or Western State Hospital** for "Client location at time of assessment". For clients residing at Maple Lane Campus, **please select Western State Hospital** from the drop-down box. This will ensure the OPD disclaimer language populates to the assessment.
2. Selecting this from the location drop down, then populates the question:
   a) Print OPD referral disclaimer on the Assessment details?
   b) **Select:** "Yes" to display the following disclaimer to print on the Assessment Details:
      "The attached assessment is not an endorsement or recommendation by the Department of Social and Health Services that the person is ready or appropriate for discharge from an inpatient setting. DSHS uses the CARE tool to assess a person's current ability to perform "activities of daily living" which include bathing, bed mobility, dressing, eating, locomotion, medication management, toileting, transferring, and person hygiene. The assessment is not performed by psychiatric professionals, nor is it a substitute for clinical or legal determinations under chapters 71.05 and 10.77 RCW of a persons readiness for discharge from an inpatient setting, a persons readiness for a less restrictive alternative or conditional release, or whether a person poses a safety risk to the public or themselves. Instead, it is a point in time evaluation of functional eligibility for DSHS services as required by the Medicaid program."

While assessment is pending:

1. Notify OPD that a CARE assessment has been completed and relay the results of the functional eligibility assessment. Inquire about the following:
   a) is OPD requesting that referrals be sent to providers, OR
   b) is the request for functional eligibility determination only?
2. If a request is made for referrals to be sent, send referrals.
3. Continue working with the treatment team and MCO through cross-system meetings to determine next steps and what services may be available to the client.
4. If the court determines that discharge will occur, a new assessment may be appropriate. Follow Chapter 3 guidance on when a new assessment is warranted, once the state hospital has completed all required transition steps.

What Is Intensive Residential Treatment (IRT) and What is the Referral Process?

Intensive residential treatment (IRT) is a Medicaid Behavioral Health service for individuals discharging or diverting from state hospitals or long-term hospitalizations into residential settings. IRT teams are the primary mental health provider who provide intensive mental health care to individuals in residential settings to support their transition to a lower level of care. IRT is not available in all Counties. For additional information reference the Heath Care Authority (HCA) Intensive residential treatment (IRT) teams.

For clients wanting to transition to Passages, in Spokane County:

- Send referrals to Lisa Taylor-Tussey ltaylortussey@passagesfs.org, include the MCO liaison

For clients wanting to transition to Emerald City in Pierce, Spokane and King Counties:

- Send referrals to Emerald City IRT- irt@emeraldcity.health, include MCO liaison

Special Considerations for State Hospital and other BHHA Facility Transitions

Transitions from Behavioral Health Habilitation Administration (BHHA) facilities including both Eastern and Western State Hospitals as well as the state hospital- Residential Treatment Facilities (RTF), Olympic Heritage Behavioral Health and Maple Lane. Case Managers will follow all inpatient assessment and transition process and policy.

What Additional Documentation Should I Receive to Assess a Client?

As of 2/15/2026, BHHA facilities will be responsible for completing and submitting the **HCS Form 20-340: Individualized Community Transition Planning Summary Form (ICTPS)** in advance of an assessment being conducted.

1. The ICTPS form must be completed for every new HCS referral and provide the HCS case manager with pages 1 & 2 of the form.
2. HCS case manager will initiate the Behavior Snapshot section of the ICTPS and will collaborate in person when possible with the facility to complete the document to accurately capture recent and historical behaviors.
    a) This may involve coordinating with other members of the patient's treatment team to provide relevant behavioral information on the form and incorporated into the CARE Assessment.
    b) The HCS case manager can request the availability of inpatient staff to complete the Behavior Snapshot section together directly following the in-person assessment.
3. Upon Completion the ICTPS should be scanned into DMS for retention. For more information see What Information Is Needed by HCS Hospital Case Managers to Conduct an Assessment?

What is a Public Benefits Coordinator?

The Public Benefit Coordinator (PBC) is available to provide the following pre-and/or post transition assistance for an individual transitioning from a state hospital:

- Coordination with the financial department
- Coordination with the Division of Disability Determination Services (DDS) for disability determinations needed (through the NGMA referral process) to access HCS waiver services
- Assistance with any necessary or available payee options
- Public benefit related matters such as accessing Medicaid or Social Security benefits

Determination for Aged, Blind, Disabled Cash Assistance

For clients residing at Western State Hospital (WSH), Eastern State Hospital (ESH), State Hospital-Residential Treatment Facility (SH-RTF) or who have diverted from the state hospital require a

determination for Aged, Blind, or Disabled (ABD) cash assistance, the assigned HCS Public Benefits Specialist (PBS) will reach out to the assigned ICMS Social Service Specialist (SSS) by 14-084/DID referral.

Refer to SH/SH-RTF ICMS Case Management for SHDD Referrals to determine the appropriate ICMS worker (CSO SSS or HCS PBC) to contact for ABD determinations.

If the client is approved for ABD cash after they discharge, they will be appointed an SSI facilitator within DSHS who will help them meet their ABD cash requirements to file for SSI.

Supplemental Security Income (SSI) Facilitation

SSI facilitation is not needed while clients reside at WSH, ESH, or SH-RTF because clients do not qualify for SSI while in residence.

- SSI facilitation will be provided by the local CSD SSI Facilitator if the client discharges without HCS services.
- SSI facilitation will be provided by the SHDD Public Benefits Coordinator (SHDD PBC) or an HCS SSI facilitator (Region 2 only) if the client discharges with HCS services.

If an ABD cash recipient discharges with HCS services, the SHDD PBC or assigned HCS SSI facilitator will contact the client to discuss their ABD cash requirements, discuss their options on how to file for SSI, and pursue a signed Interim Assistance Reimbursement Agreement (IARA) (if needed). A signed IARA will be needed along with a client's SSI application packet so the state can recoup funds from a client's SSI retroactive payments for any ABD cash benefits issued during the SSI application process.

The SHDD PBC or assigned SSI facilitator will track the client's SSI claim progress in ICMS and provide ongoing assistance to the client's SSI/SSDI application, which may include any follow-up on approval, appeal, or denial of their SSI claim. The SHDD PBC will continue to provide SSI facilitation while a client remains active on ABD cash or until a final determination has been made on their SSI application.

ESH Clients Only

- ESH clients placed on discharge planning go through the ESH pre-release program with the SSA office where the ESH Financial Recovery Enforcement Officer (FREO) assists clients with applying for SSI/SSDI benefits prior to discharge from ESH.
- When an ESH client discharges with HCS services, the SHDD PBC will review SSA crossmatches (such as SOLQ, BENDEX, or SDX) and coordinate with ESH FREO staff to determine if SSI/SSDI applications have been submitted prior to discharge. The SHDD PBC will provide ongoing SSI facilitation after discharge and obtain the signed IARA from the client (if needed).

State Funded Long-Term Care for Non-Citizens

If the SHDD Public Benefit Specialist (PBS) identifies an individual who is either diverting or transitioning

from the state hospital needs a Non-Citizen Long Term Care (NC-LTC) slot, a referral should be made to SHDD Public Benefits Coordinator (SHDD PBC). The SHDD PBC will make referrals to HCLA HQ to place individuals on the NC-LTC waitlist or to allocate the individual a slot.

Washington Civil Discharge Settlement

Per the Washington Civil Discharge Settlement Agreement, "The goal of the Settlement Agreement is to avoid costly and time-consuming litigation on behalf of individuals who are or will be civilly committed at Western or Eastern State Hospital." The parties to the settlement agreement are Disability Rights of Washington (DRW), the Health Care Authority (HCA), and the Department of Social and Health Services (DSHS). As a result of the settlement, there are specific metrics that must be met when planning for a transition to a home and community-based setting.

What is a Forensic Patient?

A forensic patient is a person who is receiving mental health treatment within the legal system because they are involved in a criminal case.

Not Guilty by Reason of Insanity (NGRI)

A defendant is found not guilty by reason of insanity and acquitted of the charge(s) against them when the court determines the person was not able to tell right from wrong due to their mental state at the time of the offense. These types of forensic patients typically experienced severe symptoms of mental illness at the time of the offense, which gravely impaired their capacity to perceive reality or think clearly. For additional information see BHHA NGRI

State Hospital – Residential Treatment Facilities (SH-RTFs)

These facilities were created as a part of the state's Behavioral Health transformation investment in community-based mental health. State Hospital Residential Treatment Facilities (SH-RTFs) promote person-centered psychiatric care for those individuals who are civilly detained on 90 and 180 day holds. They are managed by the Behavioral Health and Habilitation Administration for individuals transitioning from the State Hospitals for competency restoration. These facilities permit patients to receive care in smaller facilities allowing them to receive treatment in their communities closer to home, their families, and their support systems.

Assessment Data & Reporting

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

1. Information needed from hospitals.
    a) Submit a complete financial application prior to the date of the assessment or at the time of sending an intake referral form.
        i. For applicants under the age of 65 who do not have Medicare coverage they can apply with Health Care Authority online at: Washington Healthplanfinder.
        ii. For applicants over the age of 65, or younger but receive Medicare benefits, they can apply online with DSHS online at: Washington Connection.

iii. When submitting application to DSHS, Hospital staff will follow additional instructions documented in appendix III to Expedite Acute Care Hospital Applications.

b) 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:
   i. Demographic /face sheet
   ii. Progress notes from physicians, nursing, physical therapy (PT), occupational therapy (OT), speech and other therapies
   iii. Admission notes on client's health, physical and psychiatric conditions
   iv. List of current diagnoses
   v. History & Physical (H&P)
   vi. Current wound care notes including treatments.
   vii. Care Plan and/or Behavior Support Plan (BSP) and/or Treatment plan when applicable
   viii. Last 7-day medication administration records (MAR)
   ix. Behaviors and interventions (i.e., client wanders and needs to be redirected, yelling, and screaming, assaultive behaviors)
   x. Known sexual offender status, or related legal issues
   xi. Social work/ discharge planning notes including date of medical clearance for discharge.
   xii. Guardianship/ DPOA copy (if applicable)
   xiii. Current Durable Medical Equipment (DME) used by client for the assessment (hospital staff to coordinate any future need for DME post discharge)
   xiv. Any information critical to a successful transition plan.

c) HCS has established agreements with several acute care hospitals to access Electronic Health Records (EHR). If needing access to EHR system contact your Regional Acute Hospital Program Manager.

2. Notice of change of client condition
   a) 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.
3. Considerations for patients in restraints
   a) To speed up transitions into LTC services, 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 consecutive days prior to assessment and any transition.

Use of Electronic Health Records (EHR)

HCS maintains read-only access agreements with hospital systems permitting the review of electronic health records solely for care coordination and transition planning.

Appropriate use of EHR:

Staff should not be printing, saving, or sending documents from the electronic health record. The only exceptions are:

1. If you have consent from a client, it may be appropriate to print the following documents:
    a. POA, guardianship or other legal documents.
    b. Medical documentation for NGMA applications.
    c. Involuntary Treatment Act (ITA) - civil commitment orders and Least Restrictive Alternative (LRA) order or the Conditional release (CR) agreement.
2. If you have printed any of the above documents, send them to DMS.

- For acute hospital assessors who do not have access to the EHR system (or new staff), medical records need to be requested directly from the hospital. Records should be shredded after work is complete.

What is the Transition Discharge and Planning System (TDPS)?

The Transition and Discharge Planning System (TDPS) is one of the primary systems utilized by the Behavioral Health and Habilitation Administration (BHHA) and Home and Community Services (HCS) to support assessment, transition planning, and discharge coordination for individuals who may require HCS long-term services and supports following discharge from a BHHA facility. TDPS is an electronic health record (EHR) system that contains protected health information (PHI) and other confidential client information. The same standards, safeguards, and procedures that apply to other HCS electronic health record systems apply when accessing and documenting in TDPS.

As part of HCS's responsibilities, staff are required to document early engagement activities, complete required assessments, and update transition planning information within established timeframes. HCS is also responsible for maintaining accurate and timely documentation within the **HCLA (ALTSA) Activities** tab to support coordination of services and compliance with HCS policy and practice expectations.

TDPS was implemented as part of the state's response to the Civil Discharge Settlement Agreement and continues to serve as a shared system supporting discharge planning across multiple divisions. Specific TDPS tabs require ongoing updates by HCS Social Service Specialists (SSSs) and Public Benefit Specialists (PBSs) throughout the assessment, eligibility, and discharge planning process. Timely and accurate documentation in TDPS supports effective coordination with BHHA and other partners to facilitate safe, appropriate, and timely transitions to community-based long-term services and supports. For more information and TDPS instructions, please see: The Transition Discharge Planning System

What Information Must Be Reported and Tracked For Hospital Referrals?

The **Acute Care Hospital** CARE Web Screen outlines required information that needs to be reported about acute care hospital referrals and transition activities.

1. HCS hospital case managers or designated staff at regional offices will follow instructions outlined in the CARE Web Help Screen for Acute Care Hospital to document client barriers, transition plan, and document updates on client progress to transition out of acute care hospitals.
2. 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 **State Hospital/Hospital/Evaluation and Treatment (E&T)** CARE Web Screen outlines required information that tracks referrals and outcomes for clients transitioning from state hospitals and local psychiatric facilities, regardless of their Involuntary Treatment Act (ITA) status.

1. HCS case managers or designated staff at regional office will follow instructions outlined in the CARE Help screen to document the discharge status and delay reason, referral submitted and if the client meets criteria.
2. Case Manager will need to document post transition evaluations in the outcome section for 30 days, 6 months and 12 months.

- Case Manager input and data tracking provides information 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 Inpatient Hospital Settings?

For HCS, length of stay refers to the period of time a client continues to stay in the hospital from the date of HCS referral to the time client transitions.

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

This process outlines strategies to be utilized 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 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 60 days from the date of referral to HCS, additional contact requirements will be followed:
    a) Face-to-face contact at the hospital every other month and documented in a SER. Document in 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.

b) Document contact conversations weekly that occur with the family, collaterals, and hospital staff.
c) The HCS 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 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:
   a) Conduct case staffing with local office supervisor on a weekly basis.
   b) Send at least weekly updates to hospitals for coordination purposes per local policies and procedures.
   c) Increase communication efforts with hospital discharge planners, community partners, and community choice guides to help assist with transition efforts.
   d) 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.

- 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.
- Utilize the Specialized Settings referral form in Appendix VI.
- Utilize the Transition Academy for additional resources.

How is A Complex Client Case Escalated?

The following table outlines when and how complex cases will be escalated for Individuals across all inpatient settings. There are various staff resources available to assist with complex staffing, for details and who to contact please refer to Appendix VII

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 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 their 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

Who/ when to Escalate	What is involved and what needs to be done
	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 a 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 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 HCLA Headquarters (HQ) if there continue to be barriers. ○ Use the case staffing referral form (appendix V) to document cases referred to HQ.
Clients at 90+ 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 HCLA Headquarters (HQ).

Acute hospital: Guardianship and Conservatorship Assistance Program (GCAP)

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

What is the Guardianship and Conservatorship Assistance Program (GCAP)

Some individuals referred to HCS for long-term care services deal with multi-faceted barriers including the lack of a decision maker for consent to services making the assessment and transition more complicated and time intensive. To reduce some of the pressure on an already strained healthcare system, DSHS, in partnership with acute care hospitals, implemented a guardianship pilot project in July 2022 aimed at targeting this small sub-group of individuals for assistance with identifying Certified Public Guardians and/or Conservators for the purposes of accessing access LTC services which would allow for client transitions from Acute Care Hospitals.

Effective September 1, 2024, given the successful outcomes, DSHS has transitioned the guardianship pilot project to a program. The program is called the HCS Guardianship and Conservatorship Assistance Program (GCAP).

GCAP is a state-funded program with limited slot availability for clients meeting specific criteria. GCAP is designed to assist Acute Care Hospitals (ACH) in the identification of proposed guardians and/or conservators for a small subset of eligible and presumed eligible clients needing a decision maker to access LTC services. GCAP is designed as a collaborative process wherein DSHS HCS works in tandem with acute care hospitals to assist with the identification of proposed guardians and/or conservators while the hospital remains the petitioning party to a motion filed with the court under RCW 11.130. Only in limited situations does HCS serve as the petitioning party in such cases.

Additional information pertaining to GCAP may be found in Chapter 388-106-2100 WAC and on the Inpatient Hospital Assessments and Transitions stakeholder site: GCAP Information and Resources

Services that GCAP Provides

GCAP provides professional guardianship and/or conservatorship services to eligible clients for the purposes of establishing a legal decision-maker required to facilitate care transitions for eligible clients no longer able to consent to their own care. GCAP offers limited financial support to certified contracted professional guardians (CPG) and conservators as a way of removing barriers for Medicaid clients accessing professional decision-making services to support their long-term care needs. To support such work, service rates were mirrored from service rates for similar services offered through the Office of Public Guardians, to incentivize professional guardians and conservators to accept legal appointments for Medicaid recipient cases that would have otherwise posed financial obstacles in accessing decision-making services.

1. Each GCAP case receives:
    a. A monthly guardianship and/or conservatorship service fee at the following denominations as calculated from the date of court appointment:
        i. Months 1-3 at a monthly rate of $710.00

ii. Months 4-12 at monthly rate of $440.00
iii. Months 13+ (Tier 2 clients only) at a monthly rate of $235.00 or allowable Medicaid rate.

b. A one-time case establishment fee in the amount of $1,500.00
   i. This fee is a one-time fee, per GCAP case, paid to contractor to assist in the offset of legal filing fees and court costs which were identified as causing significant financial barriers to professional guardians and conservators willing to accept appointment of Medicaid cases.

2. Each GCAP case filed and appointed in King County receives:
   a. A one-time King County Filing Stipend in the amount of $2,500.00
      i. This fee is a one-time fee, per GCAP case, paid to contractor to assist in the offset of legal filing fees and court costs which were identified as disproportionately higher in King County causing significant financial barriers to professional guardians and conservators willing to accept appointment of Medicaid cases in said county.
3. Each GCAP case that is terminated after contractor court appointment prior to the identified term completion date receives:
   a. A one-time case closure fee in the amount of $300.00
      i. This fee is a one-time fee, per GCAP case, paid to contractor to assist in the offset of legal filing fees and court costs associated with final notices or court reports required to close an established guardianship or conservatorship legal case under RCW 11.130.
      ii. This fee is not authorized for services completing the designated tier term.
4. Each new GCAP contractor receives:
   a. A one-time only, operational expense stipend in the amount of $4,000.00
      i. This fee is paid upon the court appointment of a new contractor's first GCAP case following the execution of their initial DSHS GCAP contract.
         - This fee is not paid upon court appointment of first GCAP case following contract renewal or extension.
      ii. This fee is paid to assist new contractors with offsetting the financial burden of operational expenses imposed on small businesses to meet initial contracting requirements, such as insurance requirements.
         - The contractor is responsible for maintaining ongoing compliance with contractor requirements after this one-time fee is issued.

What is a GCAP Program Slot, Tier Term, or Tier Designation

As outlined in WAC 388-106-2105, a GCAP program slot means a GCAP program vacancy based on timeframe of needed resources as designated by either a "Tier 1" and "Tier 2" designation when the following definitions are applied:

1. **Tier 1:** A program slot with a maximum service benefit of up to 12 months duration from the time of court appointment of a contractor.
2. **Tier 2:** A program slot with continuous service benefits for individuals not required to pay participation towards their cost of care based on financial thresholds per WAC 182-513-1315(1)-(3) or individuals who are not United States citizens.

A tier term is the corresponding amount of time a client will receive benefits based on the designated tier approved.

Who are GCAP Contractors

GCAP contractor eligibility criteria are outlined in WAC 388-106-2110 .

What are the client eligibility criteria for GCAP

GCAP eligibility criteria are outlined in chapter 388-106-2110 WAC. To be initially determined eligible for GCAP services, an individual must:

1. Meet LTC services Medicaid functional eligibility requirements in chapter 388-106 WAC and financial eligibility requirements in WAC 182-513-1315(1)-(3) or be determined provisionally approved;
2. Not have financial resources to pay for guardianship services, fees, or costs from their estate;
3. Have a qualifying neuro-cognitive diagnosis as defined in WAC 388-106-2105;
4. At the time of referral and acceptance into the program, be occupying an acute care hospital bed, and not be in a restricted sub-group, including but not limited to:
    a. Occupancy in a bed readiness program bed
    b. Occupancy in a skilled nursing facility bed
    c. Occupancy in inpatient rehabilitation bed
    d. Occupancy in an inpatient mental health bed
    e. Occupancy in an emergency department bed
    f. Occupancy in a long-term acute care hospital (LTACH) bed
    g. Occupancy in an acute care hospital bed under observation status
    h. Occupancy in an acute care hospital bed under a single bed certification pursuant to chapter 71.05 RCW
5. At the time of referral and acceptance into the program, no longer require an inpatient level of care at an acute care hospital;
6. Likely require the appointment of a guardian and/or conservator to be able to access and maintain long-term services and supports; and
7. Not have a professional or lay guardian or conservator willing to accept nomination.

To remain eligible for GCAP services for the duration of the designated term, an individual must:

1. Remain functionally and financially eligible for DSHS LTC benefits; and
2. Receive a DSHS LTC service.

How to make a GCAP referral

When it is determined that a client no longer has the ability to consent to LTC services and did not consent to authorizing a representative, a guardianship and/or conservatorship may be needed to support the client's transition and ongoing care. A hospital, directly or through assistance of an assigned case manager or public benefits specialist, may refer such a client for consideration for GCAP services by following the practice outlined in WAC 388-106-2115 and 388-106-2120.

1. If the hospital is unable to identify a proposed guardian or conservator for court nomination, the hospital may submit a referral for GCAP services to the Guardianship Program Manager (GPFM) for eligibility determination. The hospital must:

a. Submit and complete the ListServ process to meet their due diligence in attempts to identify a less restrictive guardian or conservator willing to serve the client.
b. Submit the GCAP Referral Form which may be found on the Inpatient Hospital Assessments and Transitions Stakeholder website: GCAP Information and Resources.
c. Submit all supplemental documentation and/or clinical packet as requested
d. Submit LTC application on behalf of client if one has not previously been submitted
    i. The Guardianship Program Manager will provide eligibility determination within 3 business days from the date referral form and complete packet are received or completion date of statewide ListServ process, whichever occurs later.
    ii. The Guardianship Program Manager will send a Notice of Department Decision (NDD) regarding program eligibility determination to the client and hospital referent.
        - NDD 27-254: Notice of Department Decision- Approved
        - NDD 27-255: Notice of Department Decision- Denied

2. If a client is determined to be eligible for GCAP services, the case will be:
    a. Assigned to the Case Manager per regional process and
    b. The Guardianship Program Manager and/or GCAP SHPC will be listed on the overview screen in CARE to provide oversight of legal case progression and ongoing liaison services to contracted guardians and conservators for the duration of a client's GCAP tier term.:
        i. Confirm hospital petitioner status.
            a. When hospitals serve as petitioning party to the UGA motion, the hospital discharge planner collaborates with their legal counsel to execute petition, declaration statements, and legal pleading for filing with the court. Hospital discharge planner must supply contact information of hospital legal counsel to the Guardianship Program Manager for ongoing GCAP coordination.
            b. When hospitals are unable to serve as petitioning party to the UGA motion, the hospital discharge planner must request for Petition Exemption ETR from the Guardianship Program Manager.
                - Petitioner Exemption ETRs will be processed within seventy-two hours (72) of receipt by the Guardianship Program Manager.
                - If approved for Petitioner Exemption ETR, HCS will serve as petitioning party through the Office of the Attorney General (OAG) and the acute care hospital discharge planner will be required to submit a supplemental declaration of support for HCS petition.
        ii. Schedule client visits with identified proposed contractor(s).
            a. Visits may occur in person, telephonically, or electronically based on client needs and contractor preference.
        iii. Assist court visitor with obtaining required clinical documentation, including a Medical Report from a hospital provider.

3. If a client is appointed a guardian and/or conservator through GCAP services, the hospital acknowledges:
    a. That transition may not occur until such time that DSHS receives copies of both orders appointing guardian and/or conservator and letters of office.

When is a GCAP record created

Effective September 1, 2024, all GCAP referrals will generate a GCAP record in CARE Web.

1. GCAP records can only be created by a member of Guardianship Management security group.
2. GCAP records are view only for HCS staff with CARE Web access.

When and how are GCAP records finalized

A GCAP record is finalized when either of the following occur:

1. A GCAP referral is received and eligibility determination results in denial; or
2. GCAP services are terminated.
    a. The most common reasons for GCAP service termination include but are not limited to a client leaving hospital against medical advice prior to appointment of a GCAP Contractor, identification of a less restrictive guardian/conservator, no identified GCAP Contractor, client death, completion of GCAP service term, client no longer eligible for LTC services, alternative funding identified, etc.
    b. When GCAP services are terminated:
        i. the GCAP record is finalized in the CARE Web screen after noting the termination reason in the GCAP notes section;
        ii. the case may be inactivated in CARE using the "No Current Discharge Plan" code or be reassigned as applicable;
        iii. A Notice of Department Decision (NDD) regarding program termination is sent to the client, hospital referent, and GCAP contractor for all termination reasons other than termination for client death or completion of original GCAP tier term.
            - NDD 27-256: Notice of Department Decision- Regarding Termination of Services

❖ A GCAP record remains "active" or "open" for the duration of the client's designated GCAP service term, regardless of the client's residence.

How are Medicaid LTC applications processed for GCAP clients

Financial eligibility determination for GCAP approved cases are processed by the same procedures outlined in Chapter 7a with the following exceptions:

1. If an individual is pending appointment of a contracted guardian or conservator through GCAP services, the referral is not to be withdrawn due to pending guardianship.
2. GCAP cases are eligible to remain open or in pending status under 'good cause justification' for up to 120 calendar days from the date of court appointment to ensure guardian/conservator receives necessary court documents sufficient to marshal pre-existing

client accounts and access financial documentation required for financial eligibility determination.

What are the responsibilities of the Guardianship Program Manager and GCAP SHPC

For GCAP Cases:

- Processes referrals, petitioner exemption requests, and issues corresponding Notice of Department Decisions (NDDs).
- Creates and manages the Guardianship/Conservatorship Screen in CARE Web to reflect legal case status updates pertaining to a petition filed under RCW 11.130
- Manages GCAP RAC and Authorizations

RAC	SERVICE CODE	MODIFIERS
3315- GCAP	**SA111**	• **UA**: Months 1-3 at monthly rate of $710 • **UB**: Months 4-12 at monthly rate of $440 • **UC**: Months 13+ (Tier 2 clients only) at monthly rate of $235 or allowable Medicaid rate. • **U1**: Operational Expense Stipend $4,000 • **U2**: King County Filing Stipend $2,500 • **U3**: Case Establishment Fee $1,500 • **U4**: Case Closure Fee $300

- Coordinates with Public Benefits Specialist
- Communicate with legal teams and the Administrative Offices of the Courts (AOC)
- Monitors cases for the duration of specified GCAP term
- Serves as liaison for GCAP contractors
- Manage and monitor GCAP Contracts

Additional Decision Maker Resource Tools

HCLA How to Identify a Guardian	This is a resource tool designed to outline the process of identifying a person to serve as guardian and/or conservator for individuals who no longer have capacity to consent to services and have no legal decision-maker identified. A person must be identified for nomination as proposed guardian and/or conservator in order to file a legal motion with the court. This resource tool also serves to explain the process of identifying a proposed nominee utilizing alternative programs such as GCAP and Office of Public Guardians (OPG) as both are distinct and separate programs with their own eligibility criteria and governing laws.
Power of Attorney vs Uniform Guardianship Act	This is a resource tool designed to overview available court processes to explore identification of an alternative decision maker for individuals who no longer have capacity to consent to services themselves. This resource tool explains the differences between the Power of Attorney Act and the Uniform Guardianship, Conservatorship, and Other Protective Arrangements acts and the legal remedies that can be provided under each motion type.
Document Review Checklist for Alternative Decision Maker Authority	This is a resource tool designed to provide HCS staff with a checklist to evaluate a potentially identified alternative decision maker's legal authority to consent to LTSS on behalf of a client.
HCLA Training Page	This is a resource training designed to provide HCLA staff with instructions on how to use the *Document Review Checklist for Alternative Decision Maker Authority* form.

Appendix I: HCS Hospital and Nursing Facility Escalation Contacts

Appendix II: DSHS Intake and Referral Form 10-570

Available on the Acute Care Hospitals webpage

Appendix III: Expedited Acute Hospital Application Coversheet

Available on the Acute Care Hospitals webpage

Appendix IV: HCS Screening Tool: A Guide for Escalation

All cases that meet criteria outlined in the HCS Screening Tool: A Guide For Escalation should be escalated for a regional case staffing. See instructions on How to make a referral to the Regional Complex Case Staffing.

Appendix V: 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.
Complex Case Staffing 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
- How to make a referral to the Regional Complex case staffing
- How to make a referral to the Headquarters Complex Case Staffing?
- How do I request assistance on a capacity or consent related concerns?
- Where do I send Guardianship and Conservatorship Assistance Program (GCAP) case referrals or questions?
- Managed Care Organization (MCO) and Dual Eligible Special Needs Plan (DSNP) escalation support: Including BHWS and CBHS/1915(i)
- Resources and Trainings

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 region's MCSC for information on how to refer your case to be staffed and/or escalated.

Region 1	Megan McCue, Complex Case Staffing Specialist	megan.mccue@dshs.wa.gov
Region 2	Laura Botero, Managed Care Systems Consultant (MCSC)	r2ccs@dshs.wa.gov
Region 3	Social Services SHPC Helpdesk	altsar3shpchelpdesk@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, Megan McCue Megan.McCue@dshs.wa.gov

* You can find the referral form Complex Case Staffing Form

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

Referrals 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.

How do I request assistance on a capacity or consent related concerns?

The case manager should submit a request for escalation when any legal decision-making document(s) initially reviewed and determined to be insufficient should be staffed with supervisor ***and*** escalated to Headquarters for final review ***prior to*** communicating any decision. Headquarters staff will review, provide final determination, and assist with communication to involved parties. For escalation requests involving document reviews for alternative legal decision maker authority, the case manager should complete the *Document Review Checklist for Alternative Decision Maker Authority* form before submitting a request for assistance. For additional instructions on completing the form, refer to Chapter 3 or the Additional Decision Maker Resource Tools and/or the HCLA Training Page at end of Chapter 9.

1) **For Hospital and/or GCAP cases involving document reviews**, send an email to the escalation pathway inbox at: HCSDecisionMakerEscalationPathway@dshs.wa.gov
    a) When submitting a request, attach copies of ***both*** the completed *Document Review Checklist for Alternative Decision Maker Authority* form ***and*** the document(s) in question and provide the following information: Client first and last name
    b) Client ACES ID
    c) Region
    d) Current Location of Client
    e) Concern or Explanation of Inquiry Request
2) Allow up to 5 business day response time. **For All Other cases, refer to Chapter 3 Getting Plan Approval.**

Where do I send Guardianship and Conservatorship Assistance Program (GCAP) referrals or questions?

Referral form and GCAP specific information may be found at: GCAP Information and Resources. Regions may send their inquiries directly to the GCAP Team shared inbox at: GCAP@dshs.wa.gov

What are the next steps after I send an email?

For escalation pathway emails, HQ staff will respond to your inquiry within 5 business days and partner with you on recommendations, document review outcomes, and any next steps depending on the escalation request type. For GCAP 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 BHWS, IBSS 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 Behavior Health Wraparound and Supports (BHWS), Intensive Behavioral Supportive Supervision (IBSS) 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?

- MCO and/or DSNP care coordination
- BHWS
- IBSS
- CBHS/1915i escalation or support

Send an email to your regional MCSC with your inquiry, client's name and Provider One number.

Region 1	Jennifer Torres- Salas	MCSCsupport@dshs.wa.gov
Region 2	Laura Botero	
Region 3	Genevieve Boyle	

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.

RESOURCE AND TRAININGS

Chapter 7f: Residential Support Waiver (RSW)

Chapter 24: Nursing Services & Triggered Referrals

Chapter 22a: Apple Health Managed Care and Apple Health Medicare Connect (D-SNP)

Chapter 22d: Community Behavioral Health Supports (CBHS)

Community Behavioral Health Support (CBHS) Services: 1915i SharePoint

Chapter 29: Roads to Community Living (RCL)

Transition Academy: SharePoint site for case manager transition resources

Who to reach out for additional training or questions?

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

Inpatient Hospital Assessments and Transition Policy	Jody Gasseling Erika Gustafson	Jody.Gasseling@dshs.wa.gov Erika.Gustafson@dshs.wa.gov
Community Behavioral Health Supports (CBHS)	Managed Care System Consultant (MCSC)	MCSCsupport@dshs.wa.gov
Uniform Guardianship Act DPOA, Consent, Capacity and Decision Making	Sarah Tremblay Joshua Glasgow	GCAP@dshs.wa.gov
Roads to Community Living (RCL)	Jody Gasseling	DSHSALTSARCLReferrals@dshs.wa.gov

Appendix VIII: 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.
Conservator	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.
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 planning and play an 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.
Involuntary Treatment Act (ITA)	A court ordered mental health or substance use disorder treatment that is a civil legal process.
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 medical intervention, is close to baseline functioning and their immediate needs, treatments, and therapies have been achieved. In most cases, the client can transition to a community setting.
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.
Provisional Approval	The process of allowing clients a conditional approval for accessing the State-Funded Guardianship and Conservatorship Assistance Program under Medicaid Long-Term Services and Supports (LTSS), without having to wait for the full functional and financial Medicaid eligibility determination.
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 no 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	A referral is any request for service that is accompanied by a Medicaid application or for a client with current Medicaid eligibility. A referral generates an intake. HCS is expected to assist individuals who may need assistance in completing an application.

Special Agent	The person appointed by the court for temporary authority over a specific purpose or task pursuant to RCW 11.130.375 or RCW 11.130.635. The special agent differs from court visitor, who acts as the court investigator. Special Agents are granted specific authority that are time limited, typically 60 days or up to 120 days maximum.
State Hospital Discharge	An individual discharging from a state psychiatric hospital onto HCS LTC services.
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.
Transition plan	A care plan developed for a client indicating where the client will transition to include 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.

REFERENCES & PROGRAM RESOURCES

Related WACs, RCWs & Federal Regulations

WAC 388-106-0015	What long-term care services does the department provide?
RCW 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	Department assessment of and assistance to hospital patients in need of long-term care.
RCW 74.34.020	Definitions

Code of Federal Regulations 482.13 (e): Condition of participation: Patient's rights—Restraint or seclusion Code of Federal Regulations.

Centers for Medicare and Medicaid (CMS) State Operations Manual SOM Appendix A.

Transition Resources

Adult Medicaid Behavioral Health Treatment Services	This document is intended to be used to help identify the services available for someone with behavioral health challenges. The term "behavioral health" refers to mental health, substance use, or co-occurring mental health and substance use disorders. Adult Medicaid Behavioral Health Treatment Services
Behavioral Health Wrap Around Support, previously Behavioral Health Personal Care	Beginning July 1st, 2024, a Managed Care Organization (MCO) will only fund the following Behavioral Health Wraparound Support (BHWS) formerly, Behavioral Health Personal Care (BHPC) for additional personal care hours reflected in an increase beyond the CARE generated hours. To review eligibility, see LTC Chapter 22a.
Community Behavioral Health Support (CBHS) Services/1951i	**Supportive Supervision and Oversight (WAC 182-561-0400)**. Supportive Supervision and Oversight is direct monitoring, redirection, and cueing of the client to prevent at risk behavior that may result in harm to the client or to others. These interventions are not related to the provision of personal care.
Behavioral Support Services	Services are available to inpatient 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. S
State Funded Guardianship and Conservatorship Assistance Program (GCAP)	For hospitalized individuals determined to not have decisional capacity and who lack a legal decision maker necessary to access LTSS**.** The program contracts with certified professional guardians and conservators statewide to accept court appointment for these challenging cases in order to facilitate transitions of these individuals out of acute care hospitals. WAC 388-106-2100. Refer to Appendix VIII of this chapter.
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 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. For program detail see Chapter 10 of the Long-term care Manual
Individuals with Complex Behaviors	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 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, WAC 388-106-0955, WAC 388-106-0960. Refer to Chapter 5a of the Long-term Care Manual for details.
Discharge Options-Desk Aid for Citizens vs. Non-citizens	This is a desk tool used by Home and Community Living Administration (HCLA) 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. Discharge Options Desk Aid Citizens vs. Non Citizens
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. HCS Specialized Behavioral Support Services
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 -HCLA recipients, this service is available in two ways: Foundational Community Supports (FCS), or the Governor's Opportunity for Supportive Housing (GOSH). Refer to Chapter 6a of the Long-term Care Manual for details.
The Medicaid & Long-term care services for Adults Brochure	22-619 Medicaid and LTSS for Adults: 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 populations 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. Transitional Care Center of Seattle
Workflow	Workflow was created to assist case managers with understanding workflow processes from referral to transition. Acute Hospital and Local Psych WorkflowState Hospital Referral Workflow

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 I	
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.	
October 2024	Jody Gasseling and Erika Gustafson	• Updated chapter title to reflect transition work • Updated contact information for chapter owners • Removed BHPC language and added CHBS, BHWS, IBSS (1915i) • Fixed grammatical errors • Updated Referral and Admission Process form for TCCS. • Updated Specialized Setting Referral Template • Updated Appendix I HCS Escalation Regional Contact Chart • Added section on Electronic Health Records • Created appendix VIII for Guardianship and Conservatorship Assistance Program (GCAP) policy	
March 2025	Jody Gasseling and Erika Gustafson	• Move and create new section for RCCM to Hospital Transfers • Updated Appendix I HCS Region Escalation Contact Chart • Additional Decision Maker Resource Tools • Edited, When Would A Hospital Referral for Transition be Inactivated? • Added: legal issues, to What Info Is Needed by HCS Hospital Case Managers to Conduct an Assessment • Edited: What Conditions Must Be Met for HCS to Conduct a Hospital Assessment • Updated escalation pathway contacts and emails • Added additional SER documentation when transferring Residential, NFCM, and In Home cases • Linked Transition Academy under "What are some examples of frequent barriers to acute care hospital clients assessments or transition planning" as well as "what additional transition strategies should be applied to complex client referrals".	
July 2025	Erika Gustafson and Jody Gasseling	• Change ALTSA to HCLA • Change DDA to DDCS • Removal of regional guardianship case manager duties • Moved Consent, Decision making and Capacity to Chapter 3 • Removal of Complex Transition Pilot • Updated escalation pathway • Revised: What Are the Responsibilities of the Guardianship Program Manager • Added "Document Review Check List for Alternative Decision-Making Authority" under Additional Decision Maker Resource Tools	

October 2025	Jody Gasseling, Erika Gustafson, Latia Townsend	• Alignment of acute hospital and state hospital policy • Added LaTia Townsend as SHDD Point of Contact • Clarified when a client is not ready for a hospital assessment. • Added Special Considerations for State Hospital Transitions • Added ITA definition and case manager responsibilities • Added IRT referral process • Added Pre-Discharge Checklist • Added case manager responsibilities for RSO clients • 6358 State Hospital Discharge Review for SHDD clients	
April 2026	Jody Gasseling Erika Gustafson Sarah Tremblay	• Added: What is the Role of Case Managers When Assessing a Client with a Known Legal History? • Simplified language in section "When is an individual not ready for an Inpatient Assessment?" • Alignment clarified language in EHR policy • Updated GCAP Escalation path • Updated new links to forms, added form 20-340 with CM instructions • Added definition of inpatient hospital • Added NGMA process for SH and AH • Removed RSO guidance and sent to Chapter 3 • Added definition to "HCS Guidance about use of restraints" • Added TDPS, Early Engagement, OPD, Forensic patients, Early engagement and NGRI • Linked to Chapter 3 on "What is the Role of HCS When Receiving an Inpatient Hospital Referral"	
July 2026	Jody Gasseling Erika Gustafson Sarah Tremblay	• Updated Titles to Inpatient Policy Systems Change Manager • Added Joshua Glasgow as a Chapter owner • ALTSAAcuteHospitalGuardianshipCaseStaffing@dshs.wa.gov inbox to HCSDecisionMakerEscalationPathway@dshs.wa.gov • Added GCAP@dshs.wa.gov inbox for all GCAP referrals • Moved TDPS under EHR section • Added Chapter 24 under Resources and Trainings • Updated existing links • Removed appendix VI: specialized setting referral template	