

Skilled Nursing Facility/ Acute Care Hospital Work Group

As required by Substitute Senate Bill 5883, Section 213(1)(ii); Chapter 1, Laws of 2017, 3rd Special Session

December 1, 2017

Partnership with the Department of Social and Health Services in convening the work group, dedicating to attend the work group sessions, and assisting in writing the report.



Transforming lives



Skilled Nursing Facility/Acute Care Hospital Work Group

In Appreciation

HCA and DSHS wish to recognize the strong work of the representatives from the organizations who donated their time and contributed to this effort: Adult Family Home Council; Alliance Nursing; Amerigroup Washington Incorporated; Columbia Legal Services; Community Health Plan of Washington; Coordinated Care Corporation; Department of Health; Harborview Medical Center; Home Care Association of Washington; King County Behavioral Health Organization; Leading Age Washington; Long-Term Care Ombuds; Molina Healthcare of Washington; Multicare Health Systems; North Sound Behavioral Health Organization; Providence Health & Services; Spokane County Community Service, Housing, and Community; Symmetry Healthcare Management; The Ensign Group; Thurston-Mason Behavioral Health Organization; UnitedHealthcare Community Plan; University of Washington Medical Center; University of Washington; Northwest Hospital & Medical Center; Washington Health Care Association; and Washington State Hospital Association.

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Executive Summary

The Washington State Health Care Authority (HCA), in coordination with the Department of Social and Health Services (DSHS), is submitting this report to the Legislature as required by Substitute Senate Bill 5883 (SSB 5883), Chapter 1, Laws of 2017, 3rd Special Session, Section 213 (1) (ii):

The authority and the department of social and health services shall convene a work group consisting of representatives of skilled nursing facilities, adult family homes, assisted living facilities, managers of in-home long-term care, hospitals, and managed health care systems. The work group shall identify barriers that may prevent skilled nursing facilities from accepting and admitting clients from acute care hospitals in a timely and appropriate manner. The work group shall consider what additional resources are needed to allow for faster transfers of enrollees, including those with complex needs. By December 1, 2017, the authority shall report the work group's findings to the governor and the appropriate committees of the legislature.

The Skilled Nursing and Acute Care Hospital Work Group convened for three one-day meetings to undertake the task assigned to them. They identified barriers to discharge from a community hospital, proposed solutions to those barriers, identified the resources needed to implement those solutions, and then prioritized the list.

This report acknowledges the variety of reasons why patients may not be timely discharged from the hospital to a skilled nursing facility. One or more of those reasons may be applicable to this subset of hospitalized clients and no one barrier or entity carries the burden of being responsible for the problem.

The proposed solutions and resources recorded in this report represent those put forward during the work group meetings. Not all participants agreed with every solution offered, or the resource identified. While effort was made to gain consensus, in some cases opposing views may not have been voiced. HCA received additional communications from work group members following the work group deliberations and notified all work group participants that additional comments received prior to submission of the report to the Legislature would be published in an appendix to the report (See Appendix C).

While work group deliberations focused on discharge barriers related to Medicaid client hospital admissions, it should be noted that the work group did identify a few barriers and solutions related to individuals with private insurance coverage, including Medicare; individuals who are not insured; or those who have no coverage for long term care, such as undocumented individuals.

Based on an analysis of 2016 Medicaid managed care and fee-for-service hospital admissions for which Medicaid was the primary payer, HCA estimates the magnitude of Medicaid patients in the difficult-to-discharge category is about 0.7 percent of the total inpatient hospital admissions, or about 1,300 admissions per year. It is assumed that the magnitude of the patient admissions of



Medicare clients and private insurance enrollees in the difficult-to-discharge category may vary based on the health of the covered lives and the specific benefit coverage of each payer. HCA has no data to quantify those admissions and associated length of stays paid for by Medicare or private insurance which then requires long term care services covered by DSHS, like SNF placement for non-skilled care.

HCA and DSHS are developing an implementation plan of viable solutions identified through the process. Since the feasibility of a solution was not part of the workgroup process, some proposed solutions require a feasibility analysis to determine the viability of pursuing the solution. However, the work group recognized that with a little effort, time and partnership some of the barriers identified could be mitigated in the short term. One example is developing a best practice discharge planning protocol. A work group has been pulled together to begin working on this deliverable. There are also a variety of solutions that present opportunities for using a process improvement approach and open party-to-party dialogue; these potential improvements could have a significant impact. Consequently, some of these solutions are being developed and future meetings are being scheduled to pursue some of this work. In addition, five Accountable Communities of Health (ACHs) submitted project plans proposals aimed at improving transitional care, which can have a direct impact on this issue. Other barriers will be more challenging, but can be accomplished with a longer timeframe, while others will require additional analysis, funding and/or legislative directives.



Background

About This Report

This report provides information about the work product completed by the Skilled Nursing and Acute Care Hospital Work Group convened under the direction of the Legislature by HCA and DSHS.

The work group convened for three separate one-day meetings to:

- Identify barriers preventing skilled nursing facilities from accepting and admitting clients from acute care hospitals in a timely and appropriate manner;
- Identify solutions that could be implemented to mitigate these barriers; and
- Consider what resources are needed to allow for faster transfer of enrollees, including those with complex needs.

Hospitals provide inpatient acute care for patients in need of immediate, intensive, or emergency services. Most patients successfully transition from the hospital to home or lower level of care settings. However, the increasing number of individuals with complex or challenging needs ready and waiting for discharge to lower level of care settings, a skilled nursing facility (SNF), an adult family home (AFH), an assisted living facility (ALF), or their own home with appropriate supports is concerning for hospitals trying to manage their bed capacity. Difficulties with discharge can affect anyone—Medicaid clients, individuals covered by Medicare, and those covered by private insurance. The end result is the same: Some patients occupy inpatient hospital beds when they no longer need acute care, but wait for placement to a lower level of care. Sometimes a client continues to be an inpatient at the hospital while they wait for a bed in an SNF or alternative community setting after they no longer meet medical necessity for hospital level care. During this time they continue to receive care which may result in moving from needing skilled care to needing non-skilled care. This results in hospital discharge planners navigating two systems and adds complexity and confusion. The use of an inpatient bed for this purpose is a misuse of resources and often does not offer the best care for the client.

With some clients remaining in the hospital longer than medically necessary, hospitals may be placed in the difficult position of:

- Boarding patients who need an inpatient bed in a non-inpatient setting like the emergency room;
- Implementing diversion protocols requiring emergency admissions to seek care at another hospital; and/or
- Rescheduling surgical admissions.



Other Efforts Related to Address Discharge Barriers

Hospital Capacity Work Group

The Department of Health (DOH) is currently convening the Hospital Capacity Work Group to address bed capacity and admission problems that hospitals experienced during last year's flu season, when there were not enough beds available for the number of patients with the flu who required inpatient treatment. This work group identified the top issues contributing to the problem. Interestingly, one of the biggest contributing issues was the inability to successfully discharge a patient to a skilled nursing facility, adult family home, or another lower level of care option due to the complexity of the patient's clinical condition. The type of patients the Hospital Capacity Work Group identified most in this category were those with the same characteristics the Skilled Nursing and Acute Care Hospital work group was convened to address. Optimally, the recommendations and contributions of the Skilled Nursing and Acute Care Hospital work group will have a positive impact on the Hospital Capacity Work Group's efforts.

Difficult to Discharge Client Review Program

To respond to community hospitals' expressed concern about the length of inpatient stays and the inability to discharge some clients when their health conditions indicate they're ready, HCA implemented the "Difficult to Discharge Client" review program at the end of 2015. HCA began this program to provide some oversight to the managed care organizations' (MCOs) processes. Every other week participating hospitals submit a list of clients they have identified as qualified for review. In the beginning, the MCOs were asked to provide written descriptions of case management services provided to assist in the implementation of the discharge plan.

HCA has partnered with the Washington State Hospital Association (WSHA) to promote hospital participation in the program. Originally, only two hospitals were participating in the review program, averaging about 3.4 cases every other week per MCO for a total of 17 for the two hospitals. These two hospitals now average just 1.4 cases every other week. There are six new hospitals regularly participating and the average is about 7 cases per plan, or a total of approximately 35 cases every other week.

While there are weeks that a particular plan or hospital may not have any cases for review, there are circumstances when a case may be submitted for review for several weeks before a discharge plan is actually executed.

To improve program effectiveness, in early 2017, the process was changed to a telephone call review. This program provides HCA's staff the opportunity to work directly with the plans' case management staff and discuss options for these clients. It quickly became apparent that DSHS Home and Community Services staff would add value to the process. DSHS staff now regularly attend these reviews and contribute to the process. When indicated, hospital staff are also invited to participate. Over 143 clients have been discharged under this program since implementing the telephone call review in early 2017. Based on current evaluations, the telephone call approach appears to be more effective than the previous paper review.



This program demonstrates the advantage of a process that utilizes a team approach fostering open communication to develop strategies and options, and define roles and responsibilities for active interventions. Thus, the program supports some of the solutions recommended by the work group.

What Does the Data Tell Us?

Medicaid covers about 1.9 million individuals; 1.7 million are enrolled in managed care. DSHS' Aging and Long Term Support and Developmental Disability Administrations (AL TSA and DDA) serve over 100,000 unique people a year.

Based on analysis of 2016 Medicaid managed care and fee-for-service hospital admissions for which Medicaid was the primary payer, HCA estimates the magnitude of Medicaid patients in the difficult-to-discharge category is about 0.7 per cent of total inpatient hospital admissions.

These difficult-to-discharge clients present unique clinical, economic, and psychosocial placement barriers which differentiate them from the average Medicaid client. While a relatively small segment of the total Medicaid population, their issues and complications can place them in a "high risk group" for MCOs that are financially responsible for their care, for acute care facilities where they may reside long after acute services cease, and especially for skilled nursing facilities where post-acute care is desired but for whom significant risks may result.

In Calendar Year (CY) 2016, approximately 126,849 unique Medicaid clients were admitted to the inpatient setting for a total of 179,306 admissions, including those out-of-state. 136,896 of these admissions were paid by an MCO as the primary payer and 42,410 were paid under the fee-for-service program.

Of the total 179,306 admissions:

- 174,982 resulted in the patient going home, being transferred to another facility for continued inpatient care, leaving against medical advice, or dying; and
- 4,324 or 2.5 percent of the admissions resulted in the client being transferred to a nursing facility or another type of facility for continued care such as an AFH or an ALF. Many of the admissions are for clients who return back to the nursing facility, AFH or ALF from which they came with little to no delay.

In addition, in CY 2016, 21,473 unique individuals were admitted to a nursing facility for services (information based on data from claims paid by HCA for DSHS clients and the MCO encounter data). Approximately 885 of these individuals were covered by a managed care plan which paid for the nursing facility services.



In CY 2016, Medicaid fee-for-service and managed care plans were the primary payer for approximately 17,317 administrative days out of 19,674 administrative days billed.¹ This corresponds to 1,279 inpatient hospital admissions or 0.7 percent of the 179,306 total admissions in CY 2016. Admissions associated with administrative days can be assumed to directly relate to the difficult-to-discharge category because administrative days would not be indicated if discharge was executed when the patient was ready for a lower level of care. HCA and its contracted plans pay \$210.64 each day for administrative days. Thus, it can be deduced that the rate of Medicaid acute hospital admissions which relate to clients falling into the difficult-to-discharge category is about 0.7 percent and probably never rises above 1 percent of Medicaid's total admissions.

Available Lower Level of Care Resources

There are various options available in Washington State to provide lower level of care services: nursing homes, adult family homes, assisted living facilities, swing beds in rural hospitals, in-home care with a paid or unpaid care giver, home health and hospice. As part of their contracts with HCA, MCOs participate in the discharge planning process from the hospital to one of these lower level facilities or the client's private residence. Approximately 85 percent of individuals requiring long-term services and support are serviced outside of a nursing home setting. These options are not a viable solution for every client leaving the inpatient setting. A client's health care needs, preferences and eligibility for these services determine which option is best for the client.

Nursing Homes

Nursing homes provide 24-hour care. Services include: skilled nursing care, personal care, therapy, nutrition management, medication management, organized activities, social services, room, board and laundry. When the client requires 24 -hour skilled nursing care and rehabilitation, Medicare or an MCO covers the cost of care. When the client no longer requires skilled nursing or rehabilitative services but chooses to remain in the facility DSHS covers the cost of custodial care for Medicaid-eligible individuals, currently paying a statewide average of \$214.89 per day; the daily rate is likely to increase to \$215.91 on July 1, 2018. The actual rate paid to a nursing facility may be higher or lower than the statewide average and is based upon their case mix of residents. HCA or the MCO remains responsible for any other health care that may be required, such as durable medical equipment or supplies, pharmacy, and physician visits. The MCO is also responsible for participating in the discharge planning from these facilities to the client's next destination. The MCO or a Behavioral Health Organization (BHO), if applicable, is responsible for providing mental health and substance use disorder services. There are 222 licensed skilled nursing facilities in Washington with a total bed capacity of 21,034, but all these beds are not filled at any given time. The number of Medicaid clients in these facilities averages approximately 9,800. The current statewide occupancy rate for nursing homes is 79.2 percent.

¹ An administrative day reimbursement policy unique to Medicaid is used in billing for a clinical situation where the client no longer requires inpatient or observation level of care and could receive appropriate care in a lower level setting if a discharge could be implemented.



Adult Family Homes

Adult Family Homes (AFHs) provide a licensed home-like care setting where staff assume responsibility for the safety and well-being of adult residents. A room, meals, laundry, supervision and varying levels of assistance with care are provided, including assistance with medications and treatments when needed. Some AFHs provide limited skilled nursing care. Medicaid-covered and private pay residents in this setting may also receive delegated nursing services from a provider who has been trained under the Nurse Delegation Program.² Some offer specialized care for people with mental health needs, behavioral support needs, developmental disabilities or dementia. DSHS covers the cost of the personal care services and behavioral support services for those identified to have these needs, as well as the Nurse Delegation services and other waiver services through a daily rate determined by the Comprehensive Assessment Reporting Evaluation (CARE). The CARE is the tool used by DSHS case managers to document a client's functional ability, determine eligibility for long-term care services, and evaluate what and how much assistance a client will receive, and to develop a plan of care. Medicare, HCA or the managed care plan is responsible for any other covered health care services required while the client resides in this setting, such as durable medical equipment or supplies, medications, therapies and physician services. The MCO or a Behavioral Health Organization (BHO), if applicable, is responsible for providing mental health and substance use disorder services. The home can have up to six residents and is licensed by the state.

There are 2,819 licensed AFHs in 34 counties in Washington State. DSHS has 13,599 Medicaid-contracted beds in these AFHs. On May 1, 2017, there were 8,199 DSHS clients residing in AFHs in the state. AFHs rely on private pay, long term care insurance or Medicaid for payment. DSHS has a process for an "exception to rule" (ETR) for a higher rate, if needed for an individual whose needs are different from the majority of clients in the same CARE classification group. The increased rate must be related to a need for assistance with personal care. 4 to 6 percent of AFH rates are approved through this ETR process. Approximately 60 percent of AFH licensed beds are occupied by Medicaid residents.

Assisted Living Facilities

Assisted Living Facilities (ALFs) are facilities in a community setting³ where staff assume responsibility for the health, safety and well-being of adult residents. Housing, meals, laundry, supervision, and varying levels of assistance with care and activities of daily living are provided. Medicaid-covered and private pay residents may also receive nursing services from a caregiver who has been trained under the Nurse Delegation Program. Some provide intermittent skilled nursing care. Some ALFs offer specialized care for people with mental health needs, behavioral support needs, developmental disabilities or dementia. DSHS pays for personal care services, as well as any care and services, including the services provided under the Nurse Delegation Program. HCA or a managed care plan is responsible for any health care services required while the client resides in

² The Nurse Delegation Program is a program that provides training and nursing management to providers who can then perform delegated nursing tasks.

³ The term "community setting" means the facility is in a neighborhood.



this setting, such as durable medical equipment or supplies, physician services, pharmacy and therapies. The MCO or BHO, if applicable, is responsible for providing mental health and substance use disorder services. The home can have seven or more residents and is licensed by the state. There are 541 licensed ALFs in 28 counties in the state. 72 ALFs in 23 counties are designated as a Specialized Dementia Care Program. DSHS has 19,088 Medicaid-contracted beds in these ALFs. ALFs rely on private pay, long term care insurance or Medicaid for payment. Approximately 26 percent of ALF- licensed beds are occupied by Medicaid residents.

Swing Beds

Swing Beds are also a lower level of care option. A swing bed is a designated bed in a rural hospital available to provide either acute care or long-term care nursing services. Under Washington Administrative Code (WAC), a hospital located in a non-standardized metropolitan statistical area as defined by the United States Bureau of Census with a total licensed bed capacity of less than 100 can designate five beds as swing beds. The hospital must be able to meet the minimum Medicare standard of care for rural hospital swing beds. DSHS reimburses \$187.21 per day for room and board when the bed is designated for this purpose. HCA or the MCOs pay for all ancillary services as an outpatient hospital reimbursement; medications and other pharmaceutical services are paid for through the hospital's prescription point of sale system, like any other retail prescription.

Home Health, Hospice, Skilled Nursing, and Adult Day Health

Home Health and Hospice are benefits administered by HCA and the MCOs. Home Health provides coverage for intermittent skilled nursing, a home health aide, physical therapy, occupational therapy, and speech therapy. Unlike Medicare, Medicaid does not require the client to be home bound to be eligible to receive these services. The Hospice benefit is paid on a per diem basis, following the Medicare all-inclusive payment model. The reimbursement rate for hospice services is adjusted from year to year depending on changes to the Medicare rate. However, home health services are paid on a fee-for-service model, or for each defined service rendered. Skilled Nursing and Adult Day Health are available through DSHS. Skilled Nursing is available to individuals who have a need for a skilled task provided by a Registered Nurse or Licensed Practical Nurse and are not eligible for Home Health. Adult Day Health is another alternative to meet the needs of individuals who need skilled nursing, physical therapy, occupational therapy and/or speech therapy. Until this year, the reimbursement rate for the home health benefit had not changed since 2007. Consequently, access to these services dropped off over the last few years. In 2016, the legislature increased the rates for nurses who deliver care under the home health benefit. The impact of that raise, intended to increase access, will be assessed and reported in two legislative reports due to the Legislature on December 29, 2017 and at the end of December 2018.

In-Home Personal Care and Supportive Services

Sixty-five percent of the individuals who rely on Medicaid to provide assistance with long-term services and supports following a hospital stay are served in their own home. Personal care services provided through home care agencies licensed by the Department of Health (DOH) or through individual providers selected, supervised and managed by the person needing services provide assistance with tasks such as bathing, dressing, hygiene, medication reminders, mobility,



and household tasks. Additional services and supports such as private duty nursing, skilled nursing, nurse delegation, personal emergency response systems, home delivered meals, adult day care, and day health are also provided in the private homes of individuals on Medicaid. Approximately 60,000 individuals receive services in their own home.

The Work Group

As directed by the Legislature, a work group consisting of representatives of skilled nursing facilities, managers of in-home long-term care, hospitals, Medicaid's MCOs, the Washington State Hospital Association (WSHA), BHOs, Adult Family Home Council, Leading Age Washington, Washington Health Care Association, Home Care Association of Washington, DSHS's Aging and Long-Term Support Administration (AL TSA) Home and Community Services and Residential Care Services (RCS), HCA's Compliance and Analytics Section, DOH, and a Long Term Care (LTC) Ombudsman. See Appendix A for a complete list of members.

Work Group Process

Approximately 40 people met with a facilitator for three separate one-day meetings to fulfill the assignment of identifying barriers, solutions and required resources to address the problems associated with timely discharge of clients from the hospital setting. On the first day, the 40 attendees were split into six groups to identify the barriers. The group intentionally dispersed representatives from the stakeholder groups to achieve diverse viewpoints at each table.

The barriers were then condensed into a concise list approved by the work group and organized into the following "issue classifications":

- Patient issues;
- Process issues;
- Regulatory issues;
- Rates and financial issues;
- Guardianship issues;
- Insufficient available alternatives (including resources, number of staff and training); and
- Failure to use available alternatives.

At the second meeting, the five groups developed proposed solutions and determined required resources for the barriers identified at the first meeting. At the last meeting, the entire group used a PICK chart approach⁴ to prioritize the final unduplicated list of barriers, correlating solutions and resources needed, into four levels of priority: high yield/low difficulty, high yield/high difficulty, low yield/low difficulty, low yield/high difficulty. The results of these exercises are described in the

⁴ This Lean Six Sigma approach is used to categorize process improvement ideas by how easy or difficult they are to implement, as well as the payoff, high or low, for each idea. The PICK chart defines quadrants for **Possible** (easy, low payoff), **Implement** (easy, high payoff), **Challenge** (hard, high payoff), and **Kill** (hard, low payoff).



next section. Appendix B is the complete matrix of barriers, solutions and resources developed by the work group.

In addition, the work group arranged several presentations and conversations with subject matter experts they identified to fill gaps in their collective knowledge. The presenters, topics, and highlights of these conversations are described below.

- Chase Napier, Acting Deputy Chief Policy Officer with HCA's Policy Division, spoke about the Accountable Communities of Health (ACHs) and their role in the health care delivery model being developed in Washington State under the Medicaid Transformation Demonstration. The ACHs are responsible for *Initiative 1: Transformation through Accountable Communities of Health*. Under this initiative, ACHs work with community partners on regional projects aimed at improving the population health and transforming the way care is provided. The ACHs submit for consideration regional project applications detailing proposed community projects aimed at improving a health care measure. Members of this work group saw an opportunity to work within their region and gather support for their ACH to submit an application that would measure outcomes related to successful discharge planning, such as reduced inpatient days.
- Jon Brumbach, Senior Policy Analyst with HCA's Policy Division spoke to the group about *Initiative 3: Foundational Community Supports*. This initiative focuses on assisting Medicaid clients with complex needs in finding and maintaining stable housing and employment. Work group members thought this program might contribute to mitigating the role homelessness plays in successful discharge planning.
- Peter Graham, Chief of the Office of Rates, DSHS, provided an overview of how DSHS rates are derived for SNF beds.
- Candice Goehring, Director of Residential Care Services (RCS), from AL TSA/DSHS, provided an overview about the role of RCS, and its licensure and oversight responsibilities with SNFs, AFHs, and ALFs. The work group discussed the barriers that licensure and regulatory requirements play in discharge from the hospital setting. The solutions presented later in this report are informed by that conversation as well as Ms. Goehring's willingness to look at options and have further discussion around resolving the barriers related to RCS' role and responsibilities.



Barriers to Hospital Discharges

The six sub-groups were fairly consistent in identifying the primary barriers or challenges for discharging some patients from a community hospital to a skilled nursing facility (SNF), but there are barriers that were not supported by all work group members. The barriers identified by the work group were organized into six “issue classifications”. The description of the barriers by issue classification represent these diverse positions.

Patient Issues

The top issues identified under this classification are clients who are medically and behaviorally complex, meet criteria for placement in an SNF and require specialized services that may not be part of the typical services provided by an SNF or alternative community based setting. Clients falling into this category are those who have one or more of the following clinical or non-clinical situations:

- The number of medically complex patients and the complexity of their problems is increasing. These patients require high or intense skilled nursing care or regularly scheduled treatments such as therapies, dialysis, wound care, methadone and ventilator/tracheostomy care. This group includes bariatric patients who require intense therapy to increase endurance and balance, and recover their independence and ability to perform self-care. Some of these patients also require dietician services and special diets to manage diabetes or promote wound healing, and often need special beds and other equipment to assist staff in the delivery of care. Clients with moderate to severe traumatic brain injury (TBI) are also in this set of patients; their capacity ranges from a persistent vegetative state to a level of disability which adversely affects cognition, sensory processing, communication and behavior, including impulsive behaviors or aggression that may threaten the safety of others.
- Individuals with significant behavioral health conditions may require more staff time and specialized training, including additional staffing to prevent self-harm, harm to others, eloping (walking away) or other behaviors that can put a patient at risk or be disruptive to other patients or families. These patients need appropriate mental health treatment which must be accessed through an MCO or BHO provider, as applicable. Patients with a history or current issues with substance/drug abuse with or without Methadone also fall in this category. These patients can place a facility at risk for illegal activities occurring on the premises which may require authorities to intervene. This group may also include clients with Alzheimer’s or dementia who may require high levels of staff time, additional staffing and staff trained to work with these clients. These clients often have behavior issues or other complexities.
- Individuals with intellectual disabilities that impair intellectual functioning or decision-making and require adaptive behavior treatment plans may also need increased staff time and attention. People with intellectual disabilities need varying levels of supervision and coaching for activities of daily living including personal care. These individuals may need



close supervision to ensure the safety of others or themselves, prevent eloping, and provide assistance in decision-making or executing tasks.

- Although they represent a small group, individuals with aggressive or inappropriate behavior pose staffing model challenges to ensure the safety of the client and other residents. This includes individuals with assaultive or criminal behavior, such as sex offenders and fire starters, as well as individuals with a history of self-harming behavior.
- Homeless clients are in a situation that creates challenges for a successful SNF placement. SNFs cannot discharge without a safe discharge plan into the community. So rather than assume the responsibility of a long term resident with no discharge options, an SNF may refuse admission.
- There are limited options for un-documented/non-citizen patients who are not eligible for Medicaid, but have complex medical care needs and require SNF level of skilled care. There is limited state funding for placement options managed by DSHS's Home and Community Services (HCS). DSHS has authority to serve approximately 40 individuals at any given time. These slots are full and there is only a small amount of turnover in the program. Therefore, these patients may remain in the hospital setting receiving care and waiting for an opening with HCS.
- Patient-focused issues which revolve around family members:
 - A successful discharge can be compromised by a patient's or family member's lack of cooperation or inability to participate in the process. Patients and their families sometimes fail to participate in the placement process or are not able to do so. They may not complete or return required paperwork. Often patients and family members are not aware of how to navigate the long term care system and the available options. Families may believe that solutions exist that are not feasible. This can be disruptive and can delay the discharge process; it can also be traumatic for the client and the family. An example of this might be a patient or family member that will only accept a placement in the patient's home town, despite the availability of viable placements elsewhere.
 - A paid personal care giver may often be the best plan for a successful discharge home when a client needs continued support with personal care and activities of daily living. Clients may select an individual provider. However, this option is not available when a client chooses a caregiver who cannot become qualified for payment under Medicaid. To qualify for payment under state law, caregivers must pass a background check; meet character, competence and suitability criteria; be at least 18 years of age; and not be a "legally responsible adult" (spouse or parent of a child).



Process Issues

All work group members agreed the discharge planning process and the team approach to care coordination is often compromised.

- Due to variance among systems and staff turnover occurring at all levels, previously defined roles and responsibilities are often forgotten, points of contact are often difficult to identify, and communication protocols are often ineffective. The process suffers from lack of attention, as well as lack of accountability. No single person owns the process; individuals may not be well-versed in what the steps in the process are or how to accomplish them. Consequently, the process may be inefficient.
- With five different Medicaid MCOs, SNFs are often unclear about the specifics of an MCO's SNF benefit, the criteria for coverage decisions, who pays for what, what is being paid for, and who does what. Managing different administrative processes like appeals and contracting can also be burdensome for SNFs. Therefore, they are reluctant to accept contracts with MCOs or accept their clients.
- When patients need rehabilitative or restorative care, Medicare, Medicaid fee-for-service or the MCOs are responsible for payment of services provided in an SNF. When patients are able to discharge from the hospital without the need for rehabilitative or restorative care, but they need long term services and supports provided under Medicaid, DSHS must determine eligibility and, if the individual is eligible, determine the level of care needed. Hospital representatives in the work group identified process issues associated with DSHS determining financial and functional eligibility as a barrier in some cases. Under Medicaid rules, DSHS staff must conduct an assessment of the patient's functional level of care (LOC) to ensure eligibility for placement in a community setting paid for under Medicaid; financial eligibility for a potential SNF patient must also be verified to ensure Medicaid eligibility criteria are met.
- The process to determine eligibility for DSHS managed services and authorization of funds can be lengthy if the patient is new to Medicaid. Finding a willing and able provider can take time and sometimes these processes can be delayed by the patient's slow recovery or clinical condition, preventing timely discharge and potentially compromising access to a vacant bed when it is available.
- Delays in getting authorizations to order specialized equipment and other durable medical equipment results in clients being discharged to facilities without the needed equipment placing the SNFs and other long-term care settings at risk of non-compliance. Durable medical equipment rental vendors may push SNFs to rent equipment prior to approval. If the SNFs try to add the cost to their cost adjustment reports, the costs are disallowed by DSHS because durable medical equipment is considered a separately billable item. Coordination of benefits and establishing the appropriate payer for the service across Medicare, Medicaid medical services, and Medicaid long term services and supports can create delays in getting necessary equipment.



Regulatory Issues

The work group identified several regulatory barriers to SNF placement, some of which have a significant impact on how an SNF decides whether or not to accept a placement. SNFs are often reluctant to take:

- **Caring for the high risk, complex patient**, as described earlier in this report may be viewed by the SNF as placing them at increased risk for a citation from Residential Care Services. An SNF is required to determine if it has qualified and competent staff prior to admitting a client. Considerations include the client's care needs (skilled nursing, rehabilitative care, behavioral health and cognitive care) along with available beds in the SNF with staff qualified and competent to provide the care required. Community partner work group members believe higher risk, complex patients can increase the likelihood the facility will receive a citation for failing to be in full compliance with state and federal licensing as well as statute requirements determined by DSHS's Residential Care Services (RCS) Division, the division responsible for the licensing and oversight of SNFs. Failure to be in compliance with license and certification requirements may mean clients are not receiving care and services which they need as prescribed by their provider and documented in their plan of care. Complaints alleging care concerns, failed practice, abuse, neglect, and exploitation may be reported by the SNF client, their family members, and health and social service providers, as well as the facility's self-reports. All complaint reports require investigation and response within time frames assigned according to the risk of harm to a client. Resulting citations and decreased STAR ratings from CMS can adversely affect the SNF's future placements since these reports are publicly available and published on CMS' website. Citations may also result in fines or enforcement actions, which can be expensive for a facility running on thin margins.
- **Patients who smoke.** Smoking creates a conflict between the patient's rights under regulation and regulations that prohibit the patient from smoking inside the facility; it may also adversely impact available staffing. Washington state law prohibits smoking inside health care facilities. However, if an SNF allows smoking on its campus, then a client has the right to have access to the smoking area. The requirement that the patient leave his or her room and go outside to smoke may be a workload concern since a staff member would need to escort a client outside and, if necessary, stay with the client while he or she smokes. SNFs may also be concerned about protecting their staff from second-hand smoke exposure.
- **Patients who are combative, at risk for walking away or need assistive devices for safety.** Although the safety and rights of clients and staff is always a concern, measures that some would consider a safety requirement violate federal and state regulations and may limit placement options. Federal and state regulations prohibit use of restraints. In addition to this being a violation of client rights, Federal law also prohibits the use of secure locked doors to prevent elopement. An SNF is required to complete a comprehensive assessment to determine required safety devices for clients, including fall and injury risks, adaptive equipment and level of staff supervision of clients at risk of elopement, falls, or other injuries.



- **Homeless clients.** These clients face greater challenges to transition back to the community. Federal and state regulations require the SNF to provide a safe discharge. However, there are sometimes limited resources available, especially in rural areas, to support placement in another community setting.

Rates and Financial Issues

SNFs give significant weight to the reimbursement rate when making a decision about accepting an admission. There are a couple of issues here:

- When the care required at the SNF is classified as skilled or rehabilitative, the MCO or Medicare is responsible for payment for these services.
 - With the exception of one MCO, the managed care contracts with SNFs do not include a reimbursement rate that is relative to the required level of care like Medicare does. MCO contract rates generally do not provide sufficient financial incentives to the SNF to compensate for the significant "outside the norm" costs and possible regulatory risks.
 - Therapies, medications, durable medical supplies and equipment that are a covered Medicaid benefit and are required to treat medically complex clients do not appear to be reasonably accounted for in the managed care reimbursement rate. SNFs cannot absorb these costs so they decline to admit clients who need, or may need, these services.
- When the care required at an SNF is not skilled or rehabilitative, DSHS is responsible for the payment of the SNF stay.
 - Nursing home rates are facility-specific, meaning each facility receives an individual daily rate based on the facility's Medicaid Average Case Mix Index. Some work group members do not believe the case mix gives sufficient weight to behavior issues that may require a higher staffing model to manage.
 - Coverage for therapies, medications, durable medical supplies and equipment in this situation is not always clear, though for individuals enrolled with managed care plans, these expenses are supposed to be covered by the MCO. SNFs sometimes deny admission because of their inability to cover expected costs for these items.
- When there are difficulties discharging SNF patients to a lower level of care, such as adult family homes. DSHS is responsible for payment of lower levels of care such as AFHs. If the person's private residence is not a reasonable discharge destination from the SNF and an AFH is not a viable discharge option, the SNF may not be willing to admit the client to the SNF setting.



- Work group members believe that sometimes the DSHS rate is the barrier to placement in one of these types of settings. Community partners on the work group believe requesting an Exception to Rule from DSHS—to allow for a higher payment rate for a community placement associated with the care of complex patients—is difficult and time-consuming.
- HCA’s policy allows HCA or a hospital to declare days that no longer meet inpatient criteria as payable under a reduced rate of \$210.64 per day (the administrative day rate) while the client waits for discharge to the next level of care. Additionally, medications can be paid for through the hospital’s point of sale pharmacy system. While HCA pays for administrative days until the client is discharged, hospitals report the contracted MCOs may not authorize payment for these days after the client has improved to the point where they would no longer meet SNF placement criteria and may be qualified as custodial. The administrative day rate is the same or less than the SNF daily rate. Community participants on the work group see this as creating an adverse incentive to the MCOs’ active engagement in successful, timely discharge planning.
- Community participants on the work group believe SNF residents with complex health care needs call for an integrated health care delivery model. However, it is difficult to access the varied funding sources associated with the services delivered in an integrated care model due to multiple billing requirements for each source.
- The work group identified other financial and rate barriers to SNF placement that are not specific to Medicaid-covered individuals.
 - Since SNF and other long-term care services are not a benefit available to all Washington citizens and there is no funding source to cover these admissions outside of Medicaid, Medicare, and private pay, these patients have longer hospital stays because they cannot be discharged to a lower level of care at an SNF.
 - An SNF is not a covered benefit in the essential benefit package under private insurances contracted through the Health Benefit Exchange and there is no publicly sponsored coverage for SNF care for individuals whose income is above Medicaid's qualifying level.

Guardianship Issues

Some patients seeking SNF or other long-term care placement have health and mental health conditions that affect their ability to make informed decisions for themselves and may require a guardian or other decision-making supports. Establishing a guardianship takes time to prepare and submit the paperwork and for the court to appoint a guardian ad litem to conduct an investigation and report back to the court. The guardian ad litem must obtain documentation from the patient’s physician or psychologist and report their findings to the court. Then a hearing is held to establish a permanent guardian, if indicated. This process can be further complicated by trying to find a guardian who will accept high-risk, high-need individuals or by a patient’s inability to pay for a guardian.



- At a minimum, this process takes about 60 days. During this time, the patient cannot be released to a lower level of care. A guardian ad litem cannot make decisions for the patient or consent to a placement. In addition, HIPAA regulations do not allow communications with the family when the patient lacks decision-making competency and cannot sign HIPAA-required releases.
- Although Medicaid does allow some limited reimbursement for guardians out of a long-term care client's income, this does not cover many of the initial establishment costs and legal fees. For many low-income Medicaid enrollees who do not have sufficient income to pay guardian fees, it is difficult to find a guardian and the Office of Public Guardianship has insufficient resources to meet the demand for services.
- Clients in an institutional setting can receive post-eligibility treatment income (PETI). However, relying on a client's ability to pay guardian fees using a deduction from the PETI process can create a disincentive for guardians to move clients out of an institutional setting. This is because the PETI may not apply and a deduction cannot be allowed when the client moves to a home setting.

Insufficient Available Alternatives (Resource, Staffing, and Training)

The work group identified the lack of available care alternatives for some complex clients as being a barrier to discharge from a community hospital.

Resource Issues

- There are insufficient resources in some rural communities to complete successful discharge planning for all patients who are residents of these communities.
- There are no gero-psych units in many areas of the state.
- There are few SNFs available that offer specialized services to address the needs of complex clients.
- There are not enough resources to ensure access for Medicaid clients who need memory care for conditions like Alzheimer's or dementia, given the increase in the prevalence of dementia in Washington State.
- There is no resource that provides a description of each SNF's scope of services.
- There is a lack of sufficient managed care contracted options for SNF, Home Health, Hospice, or private duty nursing (PDN).
- There is a lack of adult family homes available in some communities that are willing to serve complex clients that do not need nursing home care.
- There are delays in some areas of the state to access trained and certified in-home care providers.



- Workforce issues: The population is changing, people are younger and sicker, and more people require assistance.
- Developmental Disability Administration (DDA) has limited crisis placement options available. Many patients do not have skilled-care needs, but are sometimes placed in the hospital for as long as 6-9 months with the hospital being paid \$210.64 per day. This precludes the bed from being used for a client who requires inpatient care.

Staffing Issues

The shortage of qualified licensed and non-licensed staff is becoming an acute problem in many communities and is affecting provision of support services at all levels, and may be contributing to an increase in hospitalizations and readmissions:

- Staffing levels in some SNFs are insufficient to deliver the level of care required. SNF nursing salaries are not competitive enough to attract nurses from hospitals to this care setting. There is a regulatory requirement for 24/7 RN staffing in an SNF and a minimum of 3.4 hours of direct care per resident day is required. SNFs have mixed success with recruiting and retaining nurses, risking non-compliance and poor patient outcomes if they cannot maintain the appropriate staffing ratios.
- Complex managed Medicaid clients may present issues which require special staffing above that generally provided by nursing facilities that care for a more typical geriatric population. The introduction of residents with complex medical and psychological needs may require the SNF to have additional staff on hand to protect these clients and other facility residents.
- There is a shortage of qualified medical staff at all levels, including RN's, MD's, NP's, and PA's to serve the public in community settings.
- The nursing shortage also compromises the ability for home health, hospice, and private duty agencies to meet the demand for post-hospitalization services which results in extended stays while resources are being recruited.

Training Needs/Education and Information Issues:

Training needs and the need for policy and procedure education for various partners engaged with the process is another barrier.

- SNF staff may be unprepared for the level of skilled nursing required for complex medical and behavioral/mental health cases, or the unexpected issues that can develop with challenging clients.
- Limited training is available to prepare staff for challenging clients.
- SNF billing staff have had difficulties keeping up with the varied billing requirements of the five Medicaid MCOs. Facilities report having trouble obtaining payment after repeated billing attempts due to requests for approvals and supporting documentation which may

have been repeatedly submitted. This problem may result from a combination of MCO practices and nursing home staff members' lack of knowledge about the process. The result, however, is a disincentive for the nursing home to risk admitting a patient if they believe it will be difficult to receive payment.

- Hospital staff are not clear on the Pre-Admission Screening and Resident review (PASSR) process when working with DDA and mental health clients.
- There is a lack of knowledge among hospital staff about DSHS' Home and Community Services and its policies and procedures.
- There is lack of knowledge about the Long Term Care (LTC) provider's role in working with a client and the client's rights following hospital discharge or transfers.

Failure to Use Available Alternatives

The work group also recognized failure or inability to use available alternative care options as barriers to discharge from the community hospital setting. For example:

- The BHO is not always recognized as an available resource that can provide behavioral health services to clients with behavioral health conditions in a variety of settings.
- The DSHS' benefit for respite care cannot always be arranged quickly when the client lives in rural areas of the state.
- There are challenges in identifying alternative care settings for SNF placement, such as adult family homes, assisted living facilities, or a patient's home with home health.
- Agency budgets create silos. Funds cannot be combined to reimburse the provider for a range of medically necessary services when those services are payable under different agencies' budgets. There is no current structure for combining funds through one payer, except for the integrated managed care model where behavioral health and physical health benefits are paid for by one payer. This solution is not workable because there is no blended funding stream from DSHS for services under that agency's various subsections: Developmental Disabilities Administration, Aging and Long- Term Support Administration, and Children's Administration.
- Practitioners are unclear about payer coverage policies and benefits regarding palliative care: when to use it; how it fits with home health; how to bill, etc. Therefore this is not used as an alternative care option to SNF placement.



Barriers, Solutions, and Required Resources

The work group recommended solutions and required resources for each barrier and then prioritized each barrier and its related solution and required resource(s). Some barriers are not experienced statewide and other barriers were not seen as significant by all work group members. Therefore, those that received only one or two votes during the prioritization process were removed from the matrix.

In turn, not all participants agreed with every solution offered, or the resource identified. While effort was made to gain consensus, in some cases opposing views may not have been voiced. The solutions and resources recorded represent those put forward during the work group meetings.

Certain solutions may only require an investment of time and staff resources. Some may eventually result in requests for legislation changes or funding. The matrix in Appendix B represents the work group's prioritized, recommended solutions and required resources for all barriers identified as significant.

The work group recognizes that some solutions will not be feasible, but believes the high yield solutions identified as having a low to medium investment should be readily pursued.

High Yield/Low Investment Solutions

Barriers	Solutions
SNF-contracted rate with MCOs does not include costs for therapies, medications, durable medical equipment (DME) required by complex patients. <i>(Issue classification: Rates and Financial)</i>	<ul style="list-style-type: none"> Consider other reimbursement options: MCOs pay separately for medications, therapies, and DME; <i>OR</i> all MCOs pay tiered rates that include medications, DME, and therapy costs. HCA provide tools and education to SNFs on the available benefits and when SNFs can bill separately for different services. MCOs provide clear guidance to facilities on which services are included in the rate and which are not.
SNF rate with fee-for-service (FFS) does not include money for therapies required by complex patients; nor does the case mix rate methodology give sufficient weight to a small number of individuals in the facility that may have a higher need. <i>(Issue classification: Rates and Financial)</i>	<ul style="list-style-type: none"> Review rate structure to determine if therapies are reimbursed at appropriate level. Consider reimbursing therapies separately through adult therapies benefit. Review rate structure to determine if it is possible to pay outside the case-mix system for individuals with extraordinary needs. HCA provide tools and education to SNFs on the available benefits and when SNFs can bill separately for different services. Provide clear guidance to facilities on which services are included in the rate and which are not.
There is often a lack of clarity regarding the different MCOs' coverage criteria and process for billing covered services resulting in claims denials and billing office	<ul style="list-style-type: none"> HCA provide more information regarding billable services.



frustration. <i>(Issue classification: Process)</i>	
Delays in getting authorizations to order specialized equipment and other DME. <i>(Issue classification: Process)</i>	<ul style="list-style-type: none"> • Need more DME providers and better process to coordinate benefits across Medicare, Medicaid medical and Medicaid long term services and supports: <ul style="list-style-type: none"> ○ ProviderOne delays in payment should be reviewed—current system is payment-focused and not patient-focused. ○ Streamline the whole process (LEAN). ○ Create an accelerated approval process for urgent DME supplies.
SNFs won't accept MCO covered client because MCO contract rate is too low to cover cost of care for a complex patient. <i>(Issue classification: Rates and Financial)</i>	<ul style="list-style-type: none"> • Request MCOs consider reimbursing SNFs based on patients' acuity levels/plan of care (intensity of service); <ul style="list-style-type: none"> ○ Negotiating financial incentives in contracts with SNFs. ○ Re-evaluating current SNF rates model (such as Medicare methodology).
MCOs using the Administrative Day Rate (ADR) in a community hospital setting in lieu of the more costly per diem for an SNF bed for complex clients. <i>(Issue classification: Rates and Financial)</i>	<ul style="list-style-type: none"> • Ensure ADR is being applied appropriately by MCOs. Clarify the criteria for who is qualified, who pays it, and when criteria is not met. • Increase the ADR. • Incorporate a pay for performance methodology into the MCO contracts e.g., reduced inpatient days or number of administrative days paid.
Guardianship process delays and challenges. <i>(Issue classification: Guardianship)</i>	<ul style="list-style-type: none"> • Look at opportunities within process.
Level Of Care (LOC)-functional assessment process and delay issues. <i>(Issue classification: Process)</i>	<ul style="list-style-type: none"> • Look at opportunities within process.



High Yield/Medium Investment Solutions

Barriers	Solutions
<p>SNF concern about licensing/surveys/Star ratings at SNFs, AFHs and ALFs prohibiting admission. <i>(Issue classification: Regulatory)</i></p>	<ul style="list-style-type: none"> • Look at regulatory challenges with RCS/DOH. DOH regulates licensed/registered personnel within the facilities and RCS has oversight over the facilities through state and federal regulation. • Look at ways in which RCS can provide more of a consultative, interactive process. • Improve communication and coordination between HCS and RCS regarding placement of difficult clients. HCS will consult with RCS even prior to authorizing services for the patient. • Re-establish the role of Quality Improvement Coordinators)/Quality Assurance Nurse at RCS. • Recreate A teams. • Improve provider education regarding roles. • Reinstate regular provider meetings between RCS and providers. • Report complex behavioral clients separately from Star Rating. • Create a specialty community team to work with transitions regarding this patient population: RN, MSW, Community Health provider, DSHS, Provider, and MCO Case Manager.
<p>Concerns that the rates generated by the DSHS's CARE tool are too low for clients in lower classification groups. <i>(Issue classification: Rates and Financial)</i></p>	<ul style="list-style-type: none"> • DSHS's rates need to account for complexities around behavior, IV drug use, mental health, and aggression.
<p>Requesting and obtaining exceptional rates through an Exception to Rule (ETR) for AFH placements is difficult and time consuming. <i>(Issue classification: Rates and Financial)</i></p>	<ul style="list-style-type: none"> • DSHS's CARE/Level of Care functional assessment needs to be a separate section to account for 5 percent of the population using 50 percent of the resources.
<p>Lack of standardized discharge planning process. <i>(Issue classification: Process)</i></p>	<ul style="list-style-type: none"> • A consistent, streamlined MCO/hospital discharge planning protocol with defined roles and responsibilities of participants. • Look at process with the intent to identify ideal point in time to establish earlier communications. • Standardized education regarding <i>all</i> post-acute care services (Long Term Acute Care (LTAC), SNFs, Home Health, Outpatient, Behavioral Health, Home Care.
<p>Lack of alternative care settings for complex patients in lieu of SNF placement, such as adult family home or other models. <i>(Issue classification: Insufficient Available Alternatives)</i></p>	<ul style="list-style-type: none"> • More providers and options to serve individuals outside of hospital settings. • Encourage entrepreneurs to open residences that include an interdisciplinary model to meet the needs of more complex clients by funding start-up costs. • Clarify swing bed policy.



Conclusion and Next Steps

There are barriers to discharging some patients with complex needs to SNF or community settings. There are also opportunities to resolve those barriers, such as implementing best practices, and collaboration toward mutual goals. The applicable solutions to these barriers can be grouped in terms of short and long term objectives, and whether legislation and additional funding is required. Because the solutions to the barriers lend themselves to a constructive grouping, improvement efforts need not wait for a legislative directive to do so.

HCA, MCOs and participating hospitals will continue the “difficult to discharge” review program, inviting interested hospitals to join the program and providing oversight to those cases referred.

There is a genuine, sincere interest in making improvements, primarily because everyone concurs there is a problem. The members of the work group and the organizations they represent are committed to working on these issues to improve the current situation and remove as many barriers as possible to improve timely discharge rates.

HCA and DSHS are developing an implementation plan of viable solutions identified through the process. Since the feasibility of a solution was not part of the workgroup process, some proposed solutions require a feasibility analysis to determine the viability of pursuing the solution.

There are a variety of solutions that present themselves as opportunities using a process improvement approach and some open party-to-party dialogue, which could have significant impact. The work group recognized that with a little effort, time and partnership some of the barriers identified could be mitigated in the short term. One example is developing a best practice discharge planning protocol. A work group has been pulled together to begin working on this deliverable. There are also a variety of solutions that present opportunities for using a process improvement approach and open party-to-party dialogue; these potential improvements could have a significant impact. Consequently, some of these solutions are being developed and future meetings are being scheduled to pursue some of this work. In addition, five Accountable Communities of Health (ACHs) submitted project plans proposals aimed at improving transitional care, which can have a direct impact on this issue.

Some proposed solutions are clearly longer term objectives that will take some creative deliberation and legislation to support a significant change in the current structure and business processes. Examples include blending all funds to pay for SNF services as one payer or developing a high risk pool funded from multiple sources to cover excessive SNF costs or gaps in coverage.

HCA received additional communications from work group members following the work group deliberations and notified all work group participants that additional comments received prior to submission of the report to the Legislature would be published in an appendix to the report. (See Appendix C).



Appendix A: Work Group Members

Name	Representing
John Ficker	Adult Family Home Council
Eric Bailey	Alliance Nursing
Heather Navarre	Alliance Nursing
Kathy Archer	Amerigroup Washington Incorporated
Lani Spencer	Amerigroup Washington Incorporated
Ali Bilow	Columbia Legal Services
LuAnn Chen, M.D.	Community Health Plan of Washington
Mary Jo Briggs	Community Health Plan of Washington
Callie Macleod	Coordinated Care Corporation
Leona Parker	Coordinated Care Corporation
Bart Eggen	Department of Health, Community Health Systems
Anita Canonica	DSHS/Aging and Long-Term Support Administration/Home and Community Services
Cathy Kinnaman	DSHS /Aging and Long-Term Support Administration/Home and Community Services
Debbie Blackner	DSHS /Aging and Long-Term Support Administration/Home and Community Services
Jennifer Ferguson	DSHS /Aging and Long-Term Support Administration/Home and Community Services
Kelli Emans	DSHS /Aging and Long-Term Support Administration/Home and Community Services
Kristin Byrne	DSHS /Aging and Long-Term Support Administration/Home and Community Services
Sonya Sanders	DSHS /Aging and Long-Term Support Administration/Home and Community Services
Tara Fairfield	DSHS /Aging and Long-Term Support Administration/Home and Community Services
William Reeves	DSHS /Aging and Long-Term Support Administration/Home and Community Services
Charles Demler	DSHS /Aging and Long-Term Support Administration/Residential Care Services
Debra Hoeman	DSHS /Behavioral Health Administration/Mental Health
Lauren Bertagna	DSHS /Developmental Disabilities Administration
Elise Chayet	Harborview Medical Center
Norma Cole	Harborview Medical Center
Chase Napier	Health Care Authority/Healthier WA
Jon Brumbach	Health Care Authority/Healthier WA
DeeAnn Smith	HCA/Medicaid Program Operations and Integrity



Name	Representing
Gail Kreiger	HCA /Medicaid Program Operations and Integrity
Teresa Cooper	HCA /Medicaid Program Operations and Integrity
Leslie Emerick	Home Care Association of Washington WA State Hospice and Palliative Care Organization
Barbara Vannatter	King County Behavioral Health Organization
Diane Swanberg	King County Behavioral Health Organization
Laura Hoffman	LeadingAge Washington
LeighBeth Merrick	LeadingAge Washington
Patricia Hunter	Long-Term Care Ombuds
Christi Sahlin	Molina Healthcare of Washington, Incorporated
Darla Hall	Molina Healthcare of Washington, Incorporated
Karen Mandella	Molina Healthcare of Washington, Incorporated
Juliann Trumm	Multicare Health Systems
Betsy Kruse	North Sound Behavioral Health Organization
Kristen Jacobson	Providence Health & Services
Kristen Federici	Providence Health & Services
Justin Johnson	Spokane County Community Service, Housing, and Community
James "Scott" Hale	Symmetry Healthcare Management
Ben Flinders	The Ensign Group
Adelina Dana	Thurston-Mason Behavioral Health Organization
Cindy Spain	UnitedHealthcare Community Plan
Tashau Asefaw	UnitedHealthcare Community Plan
Louise Simpson	UW Medical Center
Brian Giddens	UW Medical Center
Matt Lund	UW Medicine
Karen Miles	UW Northwest Hospital & Medical Center
Lauri St. Ours	Washington Health Care Association
Claudia Sanders	Washington State Hospital Association
Zosia Stanley	Washington State Hospital Association



Appendix B: Barriers, Solutions and Resources/Actions

Top Priorities with High Yield/Low Investment

Barriers	Solutions	Resources / Actions
<p>SNF-contracted rate with MCOs does not include costs for therapies, medications, durable medical equipment (DME) required by complex patients. <i>(Rates and Financial)</i></p>	<ul style="list-style-type: none"> • Consider other reimbursement options: MCOs pay separately for medications, therapies and DME; <i>OR</i> all MCOs pay tiered rates that include medications, DME & therapy costs. • HCA provide tools and education to SNFs on the available benefits and when SNFs can bill separately for different services. • MCOs provide clear guidance to facilities on which services are included in the rate and which are not. 	<ul style="list-style-type: none"> • HCA investigate feasibility of options for using various benefits; work with MCOs and SNFs regarding contract provisions. • Report back to work group.
<p>SNF rate with fee-for-service (FFS) does not include money for therapies required by complex patients; nor does the case mix rate methodology give sufficient weight to a small number of individuals in the facility that may have a higher need. <i>(Rates and Financial)</i></p>	<ul style="list-style-type: none"> • Review rate structure to determine if therapies are reimbursed at appropriate level. • Consider reimbursing therapies separately through adult therapies benefit. • Review rate structure to determine if it is possible to pay outside the case-mix system for individuals with extraordinary needs. • HCA provide tools and education to SNFs on the available benefits and when SNFs can bill separately for different services. Provide clear guidance to facilities on which services are included in the rate and which are not. 	<ul style="list-style-type: none"> • HCA and DSHS investigate assumptions around SNF rate and feasibility of using current benefits structure. • Report back to work group.



<p>There is often a lack of clarity regarding the different MCOs' coverage criteria and process for billing covered services resulting in claims denials and billing office frustration. <i>(Process)</i></p>	<ul style="list-style-type: none"> • HCA provide more information regarding billable services. 	<ul style="list-style-type: none"> • DSHS and HCA include billable services information in SNF provider guide. • Report back to work group.
<p>Delays in getting authorizations to order specialized equipment and other DME. <i>(Process)</i></p>	<ul style="list-style-type: none"> • Need more DME providers and better process to coordinate benefits across Medicare, Medicaid medical and Medicaid long term services and supports: • ProviderOne delays in payment should be reviewed—current system is payment-focused and not patient-focused. • Streamline the whole process (LEAN). • Create an accelerated approval process for urgent DME supplies. 	<ul style="list-style-type: none"> • HCA and DSHS to review authorization process and timeliness. • HCA and /DSHS to ensure billers are preparing claims to support timely payment. • HCA and DSHS work with work group, MCOs and FFS staff on developing best practice for DME authorization procedures. • Report back to work group.
<p>SNFs won't accept MCO covered client because MCO contract rate is too low to cover cost of care for a complex patient. <i>(Rates and Financial)</i></p>	<ul style="list-style-type: none"> • Request MCOs consider reimbursing SNFs based on patients' acuity levels/plan of care (intensity of service); <ul style="list-style-type: none"> ○ Negotiating financial incentives in contracts with SNFs. ○ Re-evaluating current SNF rates model (such as Medicare methodology). 	<ul style="list-style-type: none"> • Work group conduct root cause analysis. • HCA, MCOs, and SNF provider groups review contracting formats with goal of establishing best practice template for group and single case agreement arrangements which encourage discharge to SNF. • HCA create incentives for MCOs to pay SNFs in a more creative model than Medicaid FFS. • HCA consider including pay for performance measures in MCO contracts, such as increased SNF placements and/or reduced hospital administrative paid days. • Report back to work group.



<p>MCOs using the Administrative Day Rate (ADR) in a community hospital setting in lieu of the more costly per diem for an SNF bed for complex clients. <i>(Rates and Financial)</i></p>	<ul style="list-style-type: none"> • Ensure ADR is being applied appropriately by MCOs. Clarify the criteria for who is qualified, who pays it, and when criteria is not met. • Increase the ADR. • Incorporate a pay for performance methodology into the MCO contracts e.g., reduced inpatient days or number of administrative days paid. 	<ul style="list-style-type: none"> • HCA review the MCOs concurrent review policies and application of general discharge screens when determining appropriateness of ADR rate in lieu of inpatient rate. • HCA revise contracts to ensure plans are using general discharge screens in concurrent review process. • HCA review Inpatient Provider Guide is clear as to how to bill, when to bill, and who to bill. • HCA consider revising MCO contracts to include an SNF related pay for performance option to contracts. • HCA investigate feasibility of increasing ADR. • Report back to work group.
<p>Guardianship process delays and challenges. <i>(Guardianship)</i></p>	<ul style="list-style-type: none"> • Look at opportunities within process. 	<ul style="list-style-type: none"> • DSHS and work group develop a best practice.
<p>Level Of Care (LOC)-functional assessment process and delay issues. <i>(Process)</i></p>	<ul style="list-style-type: none"> • Look at opportunities within process. 	<p>DSHS and work group develop a best practice.</p>



Top Priorities with High Yield/Medium Investment

Barriers	Solutions	Resources / Actions
<p>SNF concern about licensing/surveys/Star ratings at SNFs, AFHs and ALFs prohibiting admission. <i>(Regulatory)</i></p>	<ul style="list-style-type: none"> • Look at regulatory challenges with RCS/DOH. DOH regulates licensed/registered personnel within the facilities and RCS has oversight over the facilities through state and federal regulation. • Look at ways in which RCS can provide more of a consultative, interactive process. • Improve communication and coordination between HCS and RCS regarding placement of difficult clients. HCS will consult with RCS even prior to authorizing services for the patient. • Re-establish the role of Quality Improvement Coordinators)/Quality Assurance Nurse at RCS. • Recreate A teams. • Improve provider education regarding roles. • Reinstate regular provider meetings between RCS and providers. • Report complex behavioral clients separately from Star Rating. • Create a specialty community team to work with transitions regarding this patient population: RN, MSW, Community Health provider, DSHS, Provider, and MCO Case Manager. 	<ul style="list-style-type: none"> • DSHS conduct regulatory review. Develop recommendations, if indicated. • DSHS reallocate some current RCS staff to SNF, AFH, and ALF support; determine if additional staff are required. • DSHS/RCS develop educational materials. • HCA, DSHS and work group investigate creating specialty community teams for case discussion and discharge planning (A-Team approach). • HCA, DSHS and work group incorporate processes, along with roles and responsibilities definitions, into best practices discharge planning protocol. • RCS Investigate feasibility of reporting complex behavior clients separately from STAR rating. • Report back to work group.



<p>Concerns that the rates generated by the DSHS's CARE tool are too low for clients in lower classification groups. <i>(Rates and Financial)</i></p>	<ul style="list-style-type: none"> • DSHS's rates need to account for complexities around behavior, IV drug use, mental health, and aggression. 	<p>Work in progress:</p> <ul style="list-style-type: none"> • DSHS developed a rate methodology for AFHs for the 2017-2019 Collective Bargaining Agreement (CBA) that generates higher rates in the lower classification groups. The rate methodology is only partially funded. Based on legislative direction, DSHS is working with stakeholders to develop a new rate methodology for ALFs. DSHS anticipates that this methodology will also generate higher rates in the lower classification groups if and when it is funded. • Report back to work group.
<p>Requesting and obtaining exceptional rates through an Exception to Rule (ETR) for AFH placements is difficult and time consuming. <i>(Rates and Financial)</i></p>	<ul style="list-style-type: none"> • DSHS's CARE/Level of Care functional assessment needs to be a separate section to account for 5 percent of the population using 50 percent of the resources. 	<p>Work in Progress:</p> <ul style="list-style-type: none"> • See rate methodology work in item above. As of July 1, 2017 AFHs may submit ETRs to the DSHS directly if a request was denied by the department's social worker. • Report back to work group.
<p>Lack of standardized discharge planning process. <i>(Process)</i></p>	<ul style="list-style-type: none"> • A consistent, streamlined MCO/hospital discharge planning protocol with defined roles and responsibilities of participants. • Look at process with the intent to identify ideal point in time to establish earlier communications. • Standardized education regarding <i>all</i> post-acute care services (Long Term Acute Care (LTAC), SNFs, Home Health, Outpatient, Behavioral Health, Home Care). 	<ul style="list-style-type: none"> • HCA will continue its "difficult to discharge clients" review program. • HCA review impacting WACs, RCWs, Code of Federal Regulations (CFR) and existing processes. • HCA, DSHS and work group members develop a best practice for discharge planning, defining roles and responsibilities to be implemented for all hospitals and all MCOs.



		<ul style="list-style-type: none"> • HCA, DSHS and work group Incorporate into best practice for discharge planning developed above. • HCA investigate opportunity for DOH to provide educational class(es). • HCA and DSHS revise SNF provider guide to provide clarity on policy, define terms, and clarify services eligible for separate payment to meet SNFs’ needs.
<p>Lack of alternative care settings for complex patients in lieu of SNF placement, such as adult family home or other models. <i>(Insufficient Available Alternatives)</i></p>	<ul style="list-style-type: none"> • More providers and options to serve individuals outside of hospital settings. • Encourage entrepreneurs to open residences that include an interdisciplinary model to meet the needs of more complex clients by funding start-up costs. • Clarify swing bed policy. 	<ul style="list-style-type: none"> • DSHS to continue engagement outreach to providers interested in opening new AFHs and other community settings. • HCA to ensure MCO case managers and hospital discharge planners are aware of swing bed option. • Report back to work group.



Top Priorities with High Yield/Hard Investment

Barriers	Solutions	Resources / Actions
<p>Patients with challenging situations: assaultive, fire starters, walk away, substance/drug abuse with or without Methadone, sex offenders, sleep disorder, self-harm, behavioral health, personality disorder, criminal history, homeless, dementia and Alzheimer's, intellectual disability and Traumatic Brain Injury (TBI). <i>(Patient Issues)</i></p>	<ul style="list-style-type: none"> • Develop more specialized post-acute facilities, including memory care units. • Expand Enhanced Service Facility (ESF) model as some facilities with Expanded Community Services (ECS) contracts cannot take some of these clients. • Develop providers with Mental Health Training and provide incentives for providers to accept behavioral health clients. • Educate payers about available options; they do not know all the options available and think SNFs are the only choice for patients discharging from hospitals. • Look at regulatory challenges with RCS/DOH, such as smoking. Provide increased support and training for DSHS staff working with hard-to-place clients. • Share information on available programs and funding to support these patients. • Peer-to-peer outreach regarding behavioral health. <p>Increase options for medical respite/IV drug use, e.g., Edward Thomas House. Provide more supportive settings in high density cases.</p> <p>Use sitters and counselors for clients with behavioral health and substance use disorder (SUD) conditions in SNFs.</p>	<ul style="list-style-type: none"> • DSHS develop resources for discharge planners and payers: what's available, how do I find it, who do I contact? • DSHS investigate feasibility of developing new specialized post-acute resources; request funding through decision package, if indicated. • Work group incorporate process-associated issues, including a protocol that addresses specific measures to take when placing the challenging client, into best practice in discharge planning protocols identified above. • HCA and DSHS conduct regulatory review. Develop recommendations, if indicated. • Report back to work group.



	<ul style="list-style-type: none"> • Substitute Suboxone for methadone. Start behavioral health services at hospital prior to discharge. Develop a challenging client protocol that will include the specific measures to take when placing the challenging client who has unique needs and who may require different steps or resources to secure a viable placement. 	
<p>Lack of community resources as a viable discharge setting: SNFs are reluctant to take clients for whom there is no definitive discharge plan to the next level of care. <i>(Insufficient Available Alternatives)</i></p>	<ul style="list-style-type: none"> • Develop more specialized units and post-acute facilities. Expand Enhanced Service Facility (ESF) model as some facilities with Expanded Community Services (ECS) contracts cannot take some of these clients. Look at building a supported living model for HCS clients/cluster care (A system of home care for clients that allows the needs of many clients who live in proximity to be met by a team of workers). • Supportive housing initiative under the Medicaid Transformation Demonstration Project. 	<ul style="list-style-type: none"> • DSHS investigate feasibility of developing new specialized post- acute resources, request funding through decision package, as indicated. • Legislation would be required for capital funding to build facilities with less restrictive requirements (such as 40 year commitment). • Legislation would be required for funding for rental subsidies to get/retain housing. • Report back to work group.
<p>Medically complex patients: wound care, vent, dialysis, bariatric, medical co-morbidity, etc. <i>(Patient Issues)</i></p>	<ul style="list-style-type: none"> • Develop more specialized facilities. • Build supported living model for HCS clients/cluster care. 	<ul style="list-style-type: none"> • DSHS and HCA investigate feasibility of establishing specialized units in SNFs that receive enhanced funding. • DSHS and HCA formalize current bariatric program in other areas of the state. • DSHS and HCS investigate feasibility of piloting a model for supported living. • Report back to work group.



<p>BHOs or Integrated MCOs are often not involved early enough. <i>(Process)</i></p>	<ul style="list-style-type: none"> • Get behavioral health representatives at the table early. • Need to look at blending funding streams from different agencies; currently the options are too narrow (AFHs specializing in behavioral health patients may not take medically complex cases and vice versa). • Improve communication across state agencies. • Develop more AFHs with ECS contracts. • Create shared ownership and responsibility—develop a new model for doing business. • Create a high-risk pool of difficult to discharge patients that are “staffed” by a multi-disciplinary team responsible for the development and implementation of a discharge planning. 	<ul style="list-style-type: none"> • HCA, DSHS and work group incorporate participants, communications and maximizing use of available benefits into Best Practice discharge planning protocol. • DSHS to continue engagement outreach to providers interested in opening new AFHs and other community settings. • HCA, DSHS and work group develop an inter-agency staffing model or review board for high risk patients and make joint decisions about placement, risks, rates and funding sources. • Report back to work group.
<p>Difficulty in finding guardians who will accept high risk needs patients. <i>(Guardianship)</i></p>	<ul style="list-style-type: none"> • Expand who can be a guardian or look at less restrictive options; supported decision-making. Fund additional slots with the Office of the Public Guardian. 	<p>Work in progress:</p> <ul style="list-style-type: none"> • WINGS taskforce is currently analyzing options (Legislative report) • Will wait for recommendations from WINGS taskforce report. Guardianship is out of scope of DSHS and HCA.
<p>Too many financial silos (individual agency budgets) prevents construction of a viable, one payer approach to reimbursement for high risk/high care patients. <i>(Rates and Financial)</i></p>	<ul style="list-style-type: none"> • Create a high risk pool funded by contributions from multiple administrations to cover costs for these high risk/high care patients. 	<ul style="list-style-type: none"> • Legislation required to mandate development of high risk pool, source of contributions, and entity responsible for disbursements. • Legislation to allocate funds for a qualified contractor to do a study on the concept of a high risk pool and address



		these questions: How many people are in it and what are their average Medicaid costs? How could it be funded? What do our clients look like? (Do a deeper data dive.) What mechanism could we use to share the risk? Create a definition of “high risk”.
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Top Priorities with Low Yield/Low Investment

Barriers	Solutions	Resources
Hospitals are not clear about PASSR process when working with DDA patients. <i>(Insufficient Available Alternatives)</i>	<ul style="list-style-type: none"> • Develop clear guidelines for working with patients with development disabilities and mental health needs and the requirements of PASSR. 	<ul style="list-style-type: none"> • DDA and Behavior Health Administration (BHA) assess need for training and provide additional training to hospitals who need additional training. Determine how to meet training needs driven by staff turnover. • Report back to work group.
Patient and/or family is non-cooperative, or unable to participate in the process. <i>(Patient Issues)</i>	<ul style="list-style-type: none"> • Create a consistent communication tool for patients and their families about what to expect when accepting services and payment for Medicaid services. • Ensure social services at SNFs are available to assist client and family members with paperwork and navigating the process. 	<ul style="list-style-type: none"> • HCA and DSHS develop written information for patients to meet this need.



Top Priorities with Low Yield/Medium Investment

Barriers	Solutions	Resources
Lack of knowledge of HCS work and process. <i>(Insufficient Available Alternatives)</i>	<ul style="list-style-type: none"> • Clear guidelines for working with HCS patients. 	<ul style="list-style-type: none"> • DSHS disseminate education materials for hospitals, SNFs and MCOs. • Report back to work group.
Unclear payer coverage policy and benefits regarding palliative care: when to use it, how it fits with home health, how to bill etc. <i>(Failure to Use Available Alternatives)</i>	<ul style="list-style-type: none"> • Collaborate with DOH and determine application of Medicaid benefit under new DOH palliative care program. • Clarify in HCA Provider Guides. 	<ul style="list-style-type: none"> • HCA staff work with DOH and develop provider guide information to educate providers about options for reimbursement under Medicaid benefits. • Report back to work group.

Top Priorities with Low Yield/Hard Investment

Barriers	Solutions	Resources
Rates in long term care are too low and inadequate for some clients with higher care needs. <i>(Rates and Financial)</i>	<ul style="list-style-type: none"> • Continue to explore value based payment (VBP) models in long term care. 	<ul style="list-style-type: none"> • DSHS investigate feasibility of using value based purchasing in their reimbursement models for long term care. • Report back to work group.
Workforce challenges. <i>(Insufficient Available Alternatives)</i>	<ul style="list-style-type: none"> • Incentivize people to accept these positions. Look at opportunities in the pre-Medicaid delivery model under the Medicaid Transformation Demonstration Project. 	<ul style="list-style-type: none"> • HCA and DSHS include long term care workers in workforce development efforts. • Report back to work group.
Client is homeless, has criminal history or bad credit which creates inability to access affordable housing options, prohibiting discharge home with in-home care. <i>(Patient Issues)</i>	<ul style="list-style-type: none"> • Use supportive housing model under Medicaid Transformation Demonstration Project to access housing. • Do not require criminal history check for housing. 	<ul style="list-style-type: none"> • HCA build connections to supportive housing model. • DSHS Investigate opportunity to change criminal history policy. • Report back to work group.



Appendix C: Work Group Organization Comments

After the Work Group development and review of the draft report, the Health Care Authority received a request from a work group organization to include additional comments and edits. The authority notified all work group organizations and invited additional comment. The authority received a number of comments which have been compiled in this appendix. The format of the comments have been edited for consistency and the references to page numbers have been updated to reflect the pagination in the report as submitted to the Legislature. However, the content of the comments appear as received by HCA. In addition, HCA has added editorial notes to indicate edits incorporated into the final report submitted to the Legislature.



Community Health Plan of Washington / Community Health Network of Washington

See CHPW comments attached. These are not necessary to include in the addendum, but wanted to make sure our thoughts were captured.

On page 3 and page 24:

The work group recognized that with a little effort, time and partnership some of the barriers identified could be mitigated in the short term. One example is developing a best practice discharge planning protocol.

Comment: *We would want any best practice protocol to not be duplicative of work being done in other settings and take into account any overlap with ACH work.*

On page 12, second bullet:

- Individuals with significant behavioral health conditions may require more staff time and specialized training, including additional staffing to prevent self-harm, harm to others, eloping (walking away) or other behaviors that can put a patient at risk or be disruptive to other patients or families. These patients need appropriate mental health treatment which must be provided by an MCO or BHO, as applicable.

Comment: *Clarification is needed that MCOs don't provide services, they reimburse providers for care that they render.*

Editorial Note - This sentence was altered in the final report to read as follows:

These patients need appropriate mental health treatment which must be accessed through an MCO or BHO provider, as applicable.

On page 13, first bullet:



- Although they represent a small group, individuals with aggressive or inappropriate behavior pose staffing model challenges to ensure the safety of the client and other residents. This includes individuals with assaultive behavior or a criminal history, including sex offenders and fire starters, as well as individuals with a history of self-harming behavior.

Comment: *Simply having a criminal history = hard to place. This is inappropriate promotion of stigma/bias and doesn't belong in a state agency report.*

Editorial Note - This sentence was altered in the final report to read as follows:

This includes individuals with assaultive or criminal behavior, such as sex offenders and fire starters, as well as individuals with a history of self-harming behavior.

On page 14, second bullet:

- With five different Medicaid MCOs, SNFs are often unclear about the specifics of an MCO's SNF benefit, the criteria for coverage decisions, who pays for what, what is being paid for, and who does what. **Comment:** *This entire sentence should be clear since it pertains to MCOs, we might suggest better language.* Managing different administrative processes like appeals and contracting can also be burdensome for SNFs. Therefore, they are reluctant to accept contracts with MCOs or accept their clients.

On page 14, fourth bullet:

- The eligibility determination can be lengthy if the patient is new to Medicaid. Finding a willing and able provider can take time and sometimes these processes can be delayed by the patient's slow recovery or clinical condition, preventing timely discharge and potentially compromising access to a vacant bed when it is available.

Comment: *This doesn't make sense – eligibility for Medicaid itself or eligibility for waiver services or for something else? This bullet lumps several disparate issues in one – (1) eligibility for Medicaid (2) finding a provider (3) patient's recovery time and the impact on discharge – it's not clear what barrier is being identified. Eligibility for transition to SNF?*

Editorial Note - This sentence was altered in the final report to read as follows:

The process to determine eligibility for DSHS managed services and authorization of funds can be lengthy if the patient is new to Medicaid.

- Delays in getting authorizations to order specialized equipment and other durable medical equipment results in clients being discharged to facilities without the needed equipment placing the SNFs and other long-term care settings at risk of non-



compliance. Durable medical equipment rental vendors may push SNFs to rent equipment prior to approval. If the SNFs try to add the cost to their cost adjustment reports, the costs are disallowed by DSHS because durable medical equipment is considered a separately billable item. Coordination of benefits across Medicare, Medicaid medical services, and Medicaid long term services and supports can create delays in getting necessary equipment. **Comment on last sentence:** *Why? No explanation given so this is incomplete.*

Editorial Note – The last sentence was altered in the final report to read as follows:

Coordination of benefits and establishing the appropriate payer for the services across Medicare, Medicaid medical services, and Medicaid long term services and supports can create delays in getting necessary equipment.

On page 15:

Regulatory Issues **Comment:** *Is there a citation to the regulations discussed?*

The work group identified several regulatory barriers to SNF placement, some of which have a significant impact on how an SNF decides whether or not to accept a placement. SNFs are often reluctant to take:

- **High risk, complex patients**, as described earlier in this report. An SNF is required to determine if it has qualified and competent staff prior to admitting a client. Considerations include the client’s care needs (skilled nursing, rehabilitative care, behavioral health and cognitive care) along with available beds in the SNF with staff qualified and competent to provide the care required. **Comment:** *These are two separate issues. Below is a separate issue that is not regulatory.* Community partner work group members believe higher risk, complex patients can increase the likelihood the facility will receive a citation for failing to be in full compliance with state and federal licensing as well as statute requirements determined by DSHS’s Residential Care Services (RCS) Division, the division responsible for the licensing and oversight of SNFs. Failure to be in compliance with license and certification requirements may mean clients are not receiving care and services which they need as prescribed by their provider and documented in their plan of care. Complaints alleging care concerns, failed practice, abuse, neglect, and exploitation may be reported by the SNF client, their family members, and health and social service providers, as well as the facility’s self-reports. All complaint reports require investigation and response within time frames assigned according to the risk of harm to a client. Resulting citations and decreased STAR ratings from CMS can adversely affect the SNF’s future placements since these reports are publicly available and published on CMS’ website. Citations may also result in fines or enforcement actions, which can be expensive for a facility running on thin margins. **Comment:** *This is not a regulatory issue – it is a concern about high risk patients and complaints – it fits better under “patient issues” section. What is described here is that SNFs are afraid of complaints.*



Editorial Note – The first sentence was altered in the final report to read as follows:

- **Caring for the high risk, complex patient**, as described earlier in this report may be viewed by the SNF as placing them at increased risk for a citation from Residential Care Services.



Coordinated Care

Thank you for providing us with a draft report and the opportunity to provide feedback before HCA finalizes this report. We appreciate the opportunity to partner with you and others to identify barriers and solutions to address the challenges. Thank you again for convening the workgroup last summer and the subsequent meetings this fall, and we look forward to ongoing work in this area.

On page 11

- Chase Napier, Acting Deputy Chief Policy Officer with HCA's Policy Division, spoke about the Accountable Communities of Health (ACHs) and their role in the health care delivery model being developed in Washington State under the Medicaid Transformation Demonstration. The ACHs are responsible for *Initiative 1: Transformation through Accountable Communities of Health*. Under this initiative, ACHs work with community partners on regional projects aimed at improving the population health and transforming the way care is provided. The ACHs submit for consideration regional project applications detailing proposed community projects aimed at improving a health care measure. Members of this work group saw an opportunity to work within their region and gather support for their ACH to submit an application that would measure outcomes related to successful discharge planning, such as reduced inpatient days.

Comments: *Please consider coordination with the Medicaid Transformation Demonstration Initiative One pay-for-reporting and pay-for-performance metrics when identifying potential measures and/or incentives to include in the Medicaid Managed Care Organization (MCO) contracts. All of the MCOs are engaged in Demonstration activities with the nine Accountable Communities of Health across the state, and there may be unique opportunities, specifically with the Transitions of Care and Diversion Intervention Projects, under Initiative One that align with recommendations included in this Report.*

- **ADDITIONAL SOLUTION:** *We should leverage federal dollars through the Medicaid Demonstration (1115 waiver) to develop pilots that can help address some of the barriers identified related to hospital discharge and SNF placement. ACHs are able to*



develop transitions and diversion pilots under Initiative 1 of the Demonstration. HCA should be encouraging all stakeholders (WSHA, SNFs, and MCOs) to work collaboratively statewide in all of the ACH regions in this area.

On page 12

Patient Issues

The top issues identified under this classification are clients who are medically and behaviorally complex, meet criteria for placement in a SNF and require specialized services that may not be part of the typical services provided by a SNF or alternative community based setting. Clients falling into this category are those who have one or more of the following clinical or non-clinical situations:

- The number of medically complex patients and the complexity of their problems is increasing. These patients require high or intense skilled nursing care or regularly scheduled treatments such as therapies, dialysis, wound care, methadone and ventilator/tracheostomy care. This group includes bariatric patients who require intense therapy to increase endurance and balance, and recover their independence and ability to perform self-care. Some of these patients also require dietician services and special diets to manage diabetes or promote wound healing, and often need special beds and other equipment to assist staff in the delivery of care. Clients with moderate to severe traumatic brain injury (TBI) are also in this set of patients; their capacity ranges from a persistent vegetative state to a level of disability which adversely affects cognition, sensory processing, communication and behavior, including impulsive behaviors or aggression that may threaten the safety of others. **Comment:** *These patients with complex conditions includes those patients/members requiring isolation (eg MRSA, VRE). Ability and/or desire of SNFs to accommodate members with such infections can be very limited.*

On page 15

- **Patients who smoke.** Smoking creates a conflict between the patient's rights under regulation and regulations that prohibit the patient from smoking inside the facility; it may also adversely impact available staffing. Washington state law prohibits smoking inside health care facilities. However, if an SNF allows smoking on its campus, then a client has the right to have access to the smoking area. The requirement that the patient leave his or her room and go outside to smoke may be a workload concern since a staff member would need to escort a client outside and, if necessary, stay with the client while he or she smokes. SNFs may also be concerned about protecting their staff from second-hand smoke exposure.



Comment: Another barrier to SNF placement moving forward may be those patients using cannabis for medical purposes. In our experience, most SNFs do not have clear policies on this because of fears around Federal laws. Not sure this is a current barrier, but could become one given Washington's new marijuana laws.

On page 18

- **IDENTIFIED BARRIER:** There is a lack of sufficient managed care contracted options for SNF, Home Health, Hospice, or private duty nursing (PDN).

Comments:

- *Despite an adequate network, the challenges of discharging complex patients to SNFs still remain. The biggest barrier to SNF discharge is not a lack of contracted facilities, but rather the ability or willingness of facilities that will accept these complex patients. For example, no one will take our IV drug-abusing members. There is limited capacity for dialysis and bariatric beds and no TBI facilities.*
- *Even our participating providers (those we have contracts with) do not always accept our members in a timely manner.*
- *Increasing contracting requirements does not solve the root cause – we need to address why facilities cannot accept these complex patients.*
- *These patient barriers and regulatory barriers are identified in the report, and we believe these challenges are the biggest contributors to this problem. The solutions in this report should attempt to address these challenges, as they will have the biggest impact.*
- **ADDITIONAL BARRIER:** *One of the major barriers we have experienced is that SNFs will not take members on Methadone, but will take Suboxone. This challenge may be assumed in the “complex patients” but want to call out this specifically.*
- **ADDITIONAL BARRIER:** *Patients with complex conditions include those patients/members requiring isolation (e.g. MRSA, VRE). Ability and/or desire of SNFs to accommodate members with such infections can be very limited. This may be assumed in the “patient issues” section of barriers, but wanted to note this particular challenge.*
- **ADDITIONAL BARRIER:** *Another barrier to SNF placement moving forward may be those patients using cannabis for medical purposes. In our experience, most SNFs do not have clear policies on this because of fears around Federal laws. Not sure this is a current barrier, but could become one given Washington's new marijuana laws.*



On page 21

- PROPOSED SOLUTION: MCOs pay separately for medications, therapies and DME; OR all MCOs pay tiered rates that include medications, DME & therapy costs.

Comment: *We believe having tiered rates inclusive of widely varying costs is likely going to increase costs in an unfavorable and less controllable way than separate reimbursement, so would advocate for the first option of this proposed solution.*

On page 22

- PROPOSED SOLUTION: Increasing the administrative day rate (ADR) commensurate with SNF care.

Comments:

- *This is not a solution to this particular problem. MCOs are incentivized to move our members out of hospitals as remaining inpatients presents great risk for nosocomial infections, falls, deconditioning etc. The barriers identified (patients with complex needs) have nothing whatsoever to do with “perverse financial incentives” to keep members inpatient instead of moving them to a SNF. Prioritizing this over other measures will do zero to solve the outlined problem.*
- *Concerned about using the administrative day rate for members who do not meet SNF criteria, especially in light of the suggestion that these rates should be equal. There is a reason there is a difference in rates – one assumes a higher level of acuity and increased needs.*

On page 27

SNF-contracted rate with MCOs does not include costs for therapies, medications, durable medical equipment	Consider other reimbursement options: MCOs pay separately for medications, therapies and DME; OR all MCOs pay tiered rates that	HCA investigate feasibility of options for using various benefits; work with MCOs and SNFs regarding contract provisions.
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Skilled Nursing Facility/Acute Care Hospital Report
December 1, 2017



<p>(DME) required by complex patients.</p> <p><i>(Rates and Financial)</i></p> <p>Comment: <i>This barrier still confuses us slightly, but seems to be an issue with other payers who do not tier payments, intensity of therapy or therapy in combination with medical needs is reimbursed at higher rates and DME is separately reimbursed.</i></p>	<p>include medications, DME & therapy costs.</p> <p>Comment: <i>We believe having tiered rates inclusive of widely varying costs is likely going to increase costs in an unfavorable and less controllable way than separate reimbursement, so would advocate for the first option of this proposed solution.</i></p> <p>HCA provide tools and education to SNFs on the available benefits and when SNFs can bill separately for different services.</p> <p>MCOs provide clear guidance to facilities on which services are included in the rate and which are not.</p>	<p>Report back to work group.</p>
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On page 33

<p>Patients with challenging situations: assaultive, fire starters, walk away, substance/drug abuse with or without Methadone, sex</p>	<p>Develop more specialized post-acute facilities, including memory care units.</p> <p>Expand Enhanced Service Facility (ESF) model as some facilities</p>	<p>DSHS develop resources for discharge planners and payers: what's available, how do I find it, who do I contact?</p>
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Skilled Nursing Facility/Acute Care Hospital Report
December 1, 2017



<p>offenders, sleep disorder, self-harm, behavioral health, personality disorder, criminal history, homeless, dementia and Alzheimer's, intellectual disability and Traumatic Brain Injury (TBI).</p> <p><i>(Patient Issues)</i></p>	<p>with Expanded Community Services (ECS) contracts cannot take some of these clients.</p> <p>Develop providers with Mental Health Training and provide incentives for providers to accept behavioral health clients.</p> <p>Educate payers about available options; they do not know all the options available and think SNFs are the only choice for patients discharging from hospitals.</p>	<p>DSHS investigate feasibility of developing new specialized post- acute resources; request funding through decision package, if indicated.</p> <p><i>Comment:</i> <i>Coordinated Care STRONGLY supports this proposed solution.</i></p> <p>Work group incorporate process-associated issues, including a protocol that addresses specific measures to take when placing the challenging client, into best practice in discharge planning protocols identified above.</p> <p>HCA and DSHS conduct regulatory review. Develop recommendations, if indicated.</p> <p>Report back to work group.</p>
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On page 34

<p>Medically complex patients: wound care, vent, dialysis, bariatric, medical co-morbidity, etc.</p> <p><i>(Patient Issues)</i></p>	<p>Develop more specialized facilities.</p> <p>Build supported living model for HCS clients/cluster care</p>	<p>DSHS and HCA investigate feasibility of establishing specialized units in SNFs that receive enhanced funding.</p> <p>DSHS and HCA formalize current bariatric program in other areas of the state.</p> <p>DSHS and HCS investigate feasibility of piloting a model for supported living.</p> <p><i>Comment:</i> <i>Coordinated Care supports these changes.</i></p> <p>Report back to work group.</p>
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Molina Healthcare of Washington

Thanks for the chance to review and provide input. Molina is resubmitting an earlier comment, see below and attached. While we respect if you decide not to include it, we feel it is important so we are resending. Thanks for your consideration.

On page 19

Training Needs/Education and Information Issues:

Training needs and the need for policy and procedure education for various partners engaged with the process is another barrier.

Comment:

- *SNF staff may be unprepared for the level of skilled nursing required for complex medical and behavioral/mental health cases, or the unexpected issues that can develop with challenging clients. **Editorial Note – this edit was adopted in the final report.***



Washington State Hospital Association

Thank you for the opportunity to provide additional comments on this HCA/DSHS report. On behalf of our 106 member hospitals, please find WSHA's comments below:

- **Difficulty discharging patients from acute care hospitals is an urgent and significant issue.** WSHA encourages HCA, DSHS, and the legislature to appreciate the urgency facing patients, families, and hospitals when a patient is not appropriately placed in a post-acute care setting. While it is easier to merely “admire the problem” of difficult to discharge patients, more must be done and HCA has the opportunity to take a proactive role. It is in the best interest of Washington State’s health system to reduce the number of patients remaining in hospitals when they do not need acute inpatient care. Other community settings are more appropriate for patients in the long term and hospitals are a limited resource that is the most expensive setting in health care. The use of an inpatient bed for patients who no longer need acute care is a misuse of resources and often does not offer the best care for the patient.
- **Substantial legislative and funding improvements are necessary to effect long term improvements.** The problem of difficult to discharge patients requires changes that are high investment and heavy lift, in addition to the lower investment solutions called out in the report. More difficult and time/resource intensive solutions are necessary. Some of the most important barriers to difficult to discharge patients will require significant legislation and funding increases. While the issue is clearly complex, systemic, long term improvements require significant efforts.
- **Difficulty placing patients in post-acute settings is specifically a problem for Medicaid patients and those who are uninsured.** The executive summary notes “While work group deliberations focused on discharge barriers related to Medicaid client hospital admissions, it should be noted that most of the barriers and solutions identified by the work group are not payer-specific and apply equally to patient admissions of Medicare clients and private insurance enrollees. However, the work group did identify a few barriers and solutions that are not specific to Medicaid-covered individuals.” First, we assume the “not” in the last sentence is a typo. Second, the notion that the difficult to discharge patient issue is not payer specific does not coincide with the concerns expressed by hospitals. The most significant challenges in finding post-acute placement for patients needing skilled nursing or non-skilled long term care is for Medicaid patients (both those covered by MCOs and those accessing separate long-term care benefit through Home and Community Services) or those who are uninsured. While there are challenges for privately insured and Medicare patients, these occur much less frequently.
- **The problem of difficult to discharge patients includes both SNF placement *and* long-term care/non-skilled nursing settings.** While the legislative directive specifically notes SNFs it is important to emphasize that both skilled and non-skilled settings impact this problem. Further, both hospitals and SNFs transfer patients to other long term care settings.



- **The number of impacted patients should be more clearly quantified, including MCO, Home and Community Services, and uninsured patients.** While the executive summary notes that .7 percent of all Medicaid admissions are part of the difficult to discharge category, this needs to be translated into real numbers. Given the number provided in the “What Does the Data Tell Us?” section, .7 percent appears to be about 1,300 patients, but it would be helpful to have that number specifically included in the executive summary. It should be noted that this number does not reflect those patients who have Medicare as a primary payer, but qualify for Medicaid’s non-skilled services through Home and Community Services. It is also important to note that uninsured patients are also within the difficult to discharge category, including patients who are undocumented or otherwise do not qualify for Medicaid.
- **Administrative day rate information should be expanded to include observations that the \$210.64 falls well short of the daily cost for an inpatient bed.** Further, work group participants, including WSHA, noted that data available from HCA does not appear to accurately reflect the number of patients on administrative day rate at any given time.
- **WSHA appreciates the work HCA and DSHS have put into this issue and the report.** Thank you for the important work and effort to complete this report. WSHA looks forward to continued work to improve post-acute care placement for patients in Washington State.



Home Care Association of Washington

Thank you for your work on this document. Here are a few comments compiled from our members.

Executive Summary:

- Add "not" to final sentence on page 5, i.e., "not specific."
Editorial Note – verbiage changed in final report.
- Recommend: Add total cost in actual dollar amount to strengthen the impact

Available Lower Level of Care Resources (On page 7)

- Consider utilizing different terminology, such as alternate level of care as many times the level of care is not lower, just lower cost.

Home Health, Hospice, Skilled Nursing and Adult Day Health (On page 9)

- Consider adding Social work as discipline that Home health provides, although Medicaid does not cover.

The Work Group (On page 10)

- Please correct Washington Home Health Association to the correct title: Home Care Association of Washington. ***Editorial Note – reference corrected in final report.***

Process Issues (On page 14)

- Significant work on process has been done by Qualis and WSHA toolkit. This should be referenced as resources.

Regulatory Issues (On page 15)

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- Recommend noting that mixing patients with significant/challenging behavioral health problems into a group of short-term rehab residents can cause short term residents to move out early.

Pre-Admission Screening and Resident Review (PASSR) process (On page 20)

- A PASSR must be completed on **every** referral from hospital to SNF.



LeadingAge Washington

Thank you for a copy of the final report. We appreciate the work that was put into this report, and the opportunity to work with the Health Care Authority on the barriers. I would also like to thank you for the opportunity to meet with you, Scott Hale and Lauri St. Ours from WHCA. I believe the action plan we set up at that meeting re; the MCO workgroup will be a great starting point for further work. At this time, LeadingAge Washington does not have any further comments to add to the addendum document. We look forward to working with you and the MCO workgroup.

Washington Health Care Association

WHCA will not be providing and additional comments. We think the report fairly presents the issues and needs and potential solutions.

Washington State Hospice and Palliative Care Organization

Leslie Emerick - please add the WA State Hospice and Palliative Care org to the list of folks I represent. Thanks! . ***Editorial Note – reference in Appendix A updated.***



Seattle Region 2, Developmental Disabilities Administration Washington State Department of Social and Health Services

The report looks great. Thanks for the opportunity!

Washington State Long-Term Care Ombudsman Program

Thank you for the opportunity to provide input into this report. Although it appears that the overall admission and discharges from Washington State hospitals are handled well with a smaller number of individuals remaining in hospitals longer than needed, this is an important issue for all stakeholders but in particular the vulnerable adult who is technically “homeless” and dependent on the healthcare and state systems for protection and care.

The Washington Long-Term Care Ombuds was invited to attend two of three meetings convened by the Health Care Authority. During these two meetings the LTC Ombuds was the only consumer representative advocating for the rights of “patients” who are deemed “difficult to place”. It is our experience that most case managers, health and long-term care staff, physicians and those who provide direct care, have the best interests of the residents at center of mind. They do their best to advocate for patients. However, systems are not people. Our systems are rigid and sometimes counter the exact good that professionals are attempting on behalf of the individual patient. From what was heard during the workgroup meetings, it appears that DSHS, hospitals, MCOs and providers are looking for ways to “flex” the system to better respond to the needs of individuals.

The “fourth” discussion convened by DSHS at the Shoreline Conference Center was helpful as it brought those who are working in the field together to communicate about what they saw as the real issues and offer possible solutions. It is clear that stakeholders do not know about the vast resources, services and benefits available through each of Washington’s systems (Medicaid, behavioral health, long-term care). They also do not know about the federal and state Long-Term Care Residents Rights (RCW 70.129) laws and perhaps other

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consumer protection laws that apply to beneficiaries. It is apparent that information and education is needed and desired by workers across systems to include MCO's, hospital administrators and social workers, long-term care providers, case managers and the behavioral health system. Opportunities to bring policymakers, government, clinicians, consumers (or consumer advocates) and providers together to communicate is key to effecting change in this issue of "difficult to place" patients.

I believe the voice of the consumer, in particular the long-term care resident or potential long-term care resident perspective, and their family caregivers are sorely missing from this report, and overall from the workgroup meeting discussions. Missing from the report is the examination of the legal responsibilities and assurances the state (and their contractors) must fulfill as a participant in federal programs, i.e. Medicaid and the waivers to Medicaid. The comments to the report stated below are to provide an additional perspective and experience from the LTC Ombudsman Program which advocates on behalf of LTC residents (www.waombudsman.org). Vulnerable adults who are subject to our complex system of health and long-term care, and subjects of a complicated matrix of payers and insurers that impact their lives are finding themselves lost and confused at times. They do not understand their health and long-term care benefits or their legal rights. Many of these individuals are passive consumers who do not have the skill sets, sophistication or knowledge in what is happening behind the scenes in hospitals, long-term care facilities, MCOs and insurers.

Lastly, it is our experience as ombudsmen, when there is no local long-term care bed available, the individual remains in the hospital waiting for a bed. We have worked on several cases at the LTCOP where a resident has lived for months in a hospital bed, and at times physically restrained. Living in a hospital for days, weeks or months beyond need, is not only not an acceptable solution for the hospital and payers, but it is not a suitable living situation for vulnerable adults. Studies show that elders lose muscle strength and independence the longer they are in a hospital. Their risk for falling increases, and they have a higher risk for becoming disoriented and confused. Interruptions in sleep cycles while in the hospital impact negatively on an elder's overall health. The longer an individual is in a hospital, the greater their risk for serious infections. Most individuals don't want to stay in the hospital any longer than they must to get better. A hospital is not a home, and not necessarily the best therapeutic setting for an individual. We absolutely must find better ways to support the long-term care system to accept "difficult to place" individuals. This calls for a much more thorough analysis than the scope and parameters permitted during this workgroup process, and allowed in this report.



Comments by section by the State Long-Term Care Ombudsman Program

PATIENT ISSUES, pages 12, bullet point 2:

Individuals with significant behavioral health conditions may require more staff time and specialized training, including additional staffing to prevent self-harm, harm to others, eloping (walking away) or other behaviors that can put a patient at risk or be disruptive to other patients or families. These patients need appropriate mental health treatment which must be provided by an MCO or BHO, as applicable. Patients with a history or current issues with substance/drug abuse with or without Methadone also fall in this category. These patients can place a facility at risk for illegal activities occurring on the premises which may require authorities to intervene. This group may also include clients with Alzheimer's or dementia who may require high levels of staff time, additional staffing and staff trained to work with these clients. These clients often have behavior issues or other complexities.

Comment: The report's description above is limited in describing the needs of vulnerable adults who have dementia or Alzheimer's disease and the impact of it on our health and long-term care system. Some studies have found that more than half of nursing home residents have some kind of dementing illness such as Alzheimer's disease. Individuals with Alzheimer's or dementia are three times more likely to be hospitalized. They are also more likely to spend their last living years living in a long-term care facility rather than in their private home. This is not a small group of individuals but a large cohort who frequently use hospitals.

The issues of "behavioral challenges" will only increase given the increasing aged population and increased aging being a risk factor for dementia. The Centers for Medicare and Medicaid, consumer organizations, DSHS, hospitals and provider organizations have invested heavily on training to meet the needs of people with dementia. Proper staffing levels, environments and tools are needed to support people who have dementia in acute and long-term care settings.



LTCOP recommends in addition to this report, reviewing the work of the **BREE Collaborative** and the Washington State Dementia Action Coalition (DAC) plans and recommendations to address dementia and Alzheimer's disease. The State Legislature recently convened the DAC work group to study the impacts of dementia and Alzheimer's on our state, communities and families. Additionally, the Alzheimer's Association (www.alz.org) and other dementia/Alzheimer's type organizations are excellent resources providing guidance about family caregiving issues, clinical approaches, workforce training, and public policy.

Bottom of Page 13:

- *Patient-focused issues which revolve around family members:*
 - *A successful discharge can be compromised by a patient's or family member's lack of cooperation or inability to participate in the process. Patients and their families sometimes fail to participate in the placement process or are not able to do so. They may not complete or return required paperwork. Often patients and family members are not aware of how to navigate the long term care system and the available options. Families may believe that solutions exist that are not feasible. This can be disruptive and can delay the discharge process; it can also be traumatic for the client and the family. An example of this might be a patient or family member that will only accept a placement in the patient's home town, despite the availability of viable placements elsewhere.*
 - *A paid personal care giver may often be the best plan for a successful discharge home when a client needs continued support with personal care and activities of daily living. Clients may select an individual provider. However, this option is not available when a client chooses a caregiver who cannot become qualified for payment under Medicaid. To qualify for payment under state law, caregivers must pass a background check; meet character, competence and suitability criteria; be at least 18 years of age; and not be a "legally responsible adult" (spouse or parent of a child).*

Comments: It is the LTC Ombudsman Program's experience that most family members are not an issue but rather assets to vulnerable adults. Family members and family caregivers are often times the sole advocate for the rights of their loved one, and should have a voice during the discharge planning process, especially if the patient has significant impairments to their cognition or unable to express their wishes. A solution we heard during the meetings is to involve the family member (if the patient so desires or cannot speak for



themselves) as early as possible. The potential long-term care resident has a right to choose where he/she wants to receive care and live. Individuals in this category will need support well after discharge from the hospital. It is in their best interest to have access to family and friends, and our state should do everything possible to help maintain these important relationships.

Regulatory Issues, page 15:

Comments: Regulatory issues are enforced by the Centers for Medicare and Medicaid and /or by Washington State Department of Health and Social Services. This section of the report requires a more thorough discussion than what was discussed during the three meetings, to include data from state and federal enforcement records, consumer perspective and regulator input.

Multiple studies have shown that the use of physical restraints is harmful to vulnerable adults. The use of physical restraints in long-term care facilities is prohibited, except under specific circumstances as described in federal law. Additionally, this law has been in place since the federal OBRA law of 1991. Health and long-term care providers should all be well versed in understanding this decades old law and rules, and accustomed to it.

The overuse of chemical restraints is a quality initiative by the Centers for Medicaid and Medicare over the last five years, and it may be currently at the “front of mind” for providers. This law is also decades old, but in reality it is more strictly enforced over the last few years because of this initiative.

The CMS initiative aims to reduce the misuse of anti-psychotics and it has had a positive impact on the lives and health of elderly demented adults in our state, who were on these drugs unnecessarily. There is a serious disconnect between what is legal in hospital-based care, which is meant for short stays, and what is legal in long-term facility based care. Using these powerful sedating drugs increases the risk of serious long-term adverse effects on elderly patients. Hospitals have doctors and RNS available 24 hours a day, seven



days a week to monitor the use of these drugs and use of physical restraints. But nursing homes, adult family homes and assisted living facilities do not have these types of professionals in their environment, seeing residents 24/7.

The need for a more deliberate discussion regarding the issue of federal and state laws and regulations was not possible during this workgroup timeframe. The LTCOP has a different perspective and does not believe this is a barrier to placement. It is a concern by providers, but in most cases should not be a barrier.

Rates and Financial Issues, pages 16-17:

Comments: The Washington Long-term Care Ombuds concurs that low rates appears to be an issue for some long-term care providers in all settings. It is the LTCOP's experience that a low reimbursement rate has been problematic and expressed by providers and by consumers. Low rates can impact consumer choice and access. Care needs that are behavioral, related to serious mental illness, dementia, Alzheimer's disease, head injuries and other neurological processes may not be fairly recognized or weighted through care assessments and payments methodologies, across the various systems. DSHS (Home and Community Services) has recognized in the past that cognitive impairments should be recognized through the CARE tool. Other benefits administrators (MCOs) should consider following their lead in weighing cognitive impairments in their plans. Dementia care may not require 24/7 RN care, but a person with dementia, may require 24/7 vigilant monitoring and guidance by lower level staff.

The issue of workforce shortage in long-term care settings cannot be understated. Washington's long-term care workforce issue is in dire need of a coordinated, statewide response and a long-term plan to address the shortages. Several entities have tried to act on this issue, but individually actions are still not enough to address the impending crisis. Our state's turnover rates for some positions in nursing homes ranks as one of the highest in the nation. Lack of staffing has a real negative impact on quality of care and can lead to abuse and neglect of the disabled and vulnerable elderly. We need more qualified people to work in long-term care facilities: Certified Nursing Assistants who do the daily hands on care, RNs who assess medical care needs and delegate/supervise, therapists to provide rehabilitative services, and geriatric psychiatrists, doctors and ARNPS who provide medical care and treatments. With the aging of the Skilled Nursing Facility/Acute Care Hospital Report
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boomers, and the lack of younger people going into these fields, we need to look beyond our past remedies to something more aggressive in workforce recruitment and with long-range sustainability.

Guardianships, Pages 17-18:

Comments: When a person has no one to help make decisions regarding medical care and living arrangements that person is truly alone and vulnerable. Having a person's legal rights removed through court of law is serious business with life-changing impacts.

- We concur that there are individuals who could greatly benefit from having an appointed guardianship. In addition to the report's plan or recommendations, the LTCOP supports adequate funding of the State (Adult Protective Services) to pursue guardianship on behalf of those who have no one and cannot express their wants or wishes.
- The LTCOP supports expansion of the Office of Public Guardianship case load and services provided to expand alternatives to guardianships.
- In addition, LTCOP would like clear development of regulations regarding who is responsible (what entity) to initiate guardianship proceedings for a vulnerable adult.
- The LTC Ombudsman Program encourages the use of supportive decision making as a less expensive, invasive and productive approach instead of guardianship, when possible. The Office of Public Guardianship, the WINGS, and DSHS have looked into implementing supported decision making in the long-term care/Medicaid population and can share their analysis and recommendations.
- It is important to note that a durable power-of-attorney and guardianship is not a guarantee that a "difficult to place" individual will be more likely to be placed in a long-term care facility.

The lack of time available for this workgroup process prohibited the gathering and analysis of data relevant to decision making capacity, and guardianship issues. It is not clear, as it relates to this report, the numbers of people who need a guardian or legal decision maker and are not able to move out of the hospital. We would like to see the data and further analysis.

