Barriers to Hospital Discharge: Patients with Needs for LTSS

Senate Health and Long-Term Care Committee

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Transforming Lives

Washington State
Department of Social
& Health Services
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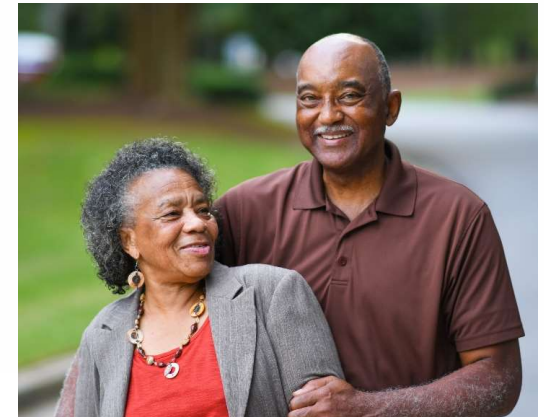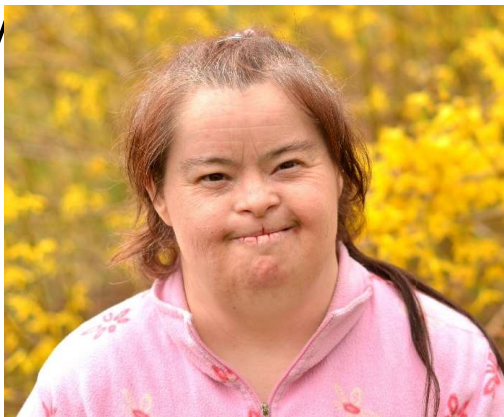Washington State Department of Social and Health Services

Who We Serve

ALTSA serves many clients of different ages with different needs:

- Older adults
- Adults with a functional disability
- Families
- Caregivers

Medicaid LTSS
Monthly Caseload: 68,500

How Do Clients Qualify for Services?
A client must be functionally and financially eligible

Functional Need
- Activities of Daily Living (ADL): eating, bathing, toileting, etc.
- Instrumental ADLs: shopping, laundry, meal prep, etc.
- "CARE assessment"
- "Nursing Facility Level of Care" or State Plan

Limited Income
- State Plan = 100% of SSI
- Waiver = 300% of SSI (*in most cases*)
- "Client Participation"
- "Personal Needs Allowance"

Limited Assets
- < $2,000 for individual
- < $55,000 if married
- "Spend Down"
- "Estate Recovery"

# Barriers to Discharge is Not Just a Medicaid Problem

- Difficulties in discharge can affect anyone.

- Medicaid patients in the difficult-to-discharge category equal **about 0.7% of the total inpatient hospital admissions.**

Statewide population who "No Longer Meet Medical Necessity"

Data gathered between July 1 and October 30, 2019

1 Individual was Not Financially Eligible

1 Individual Refused ALTSA Services

Still Awaiting Discharge: 173 out of 430 (40%)

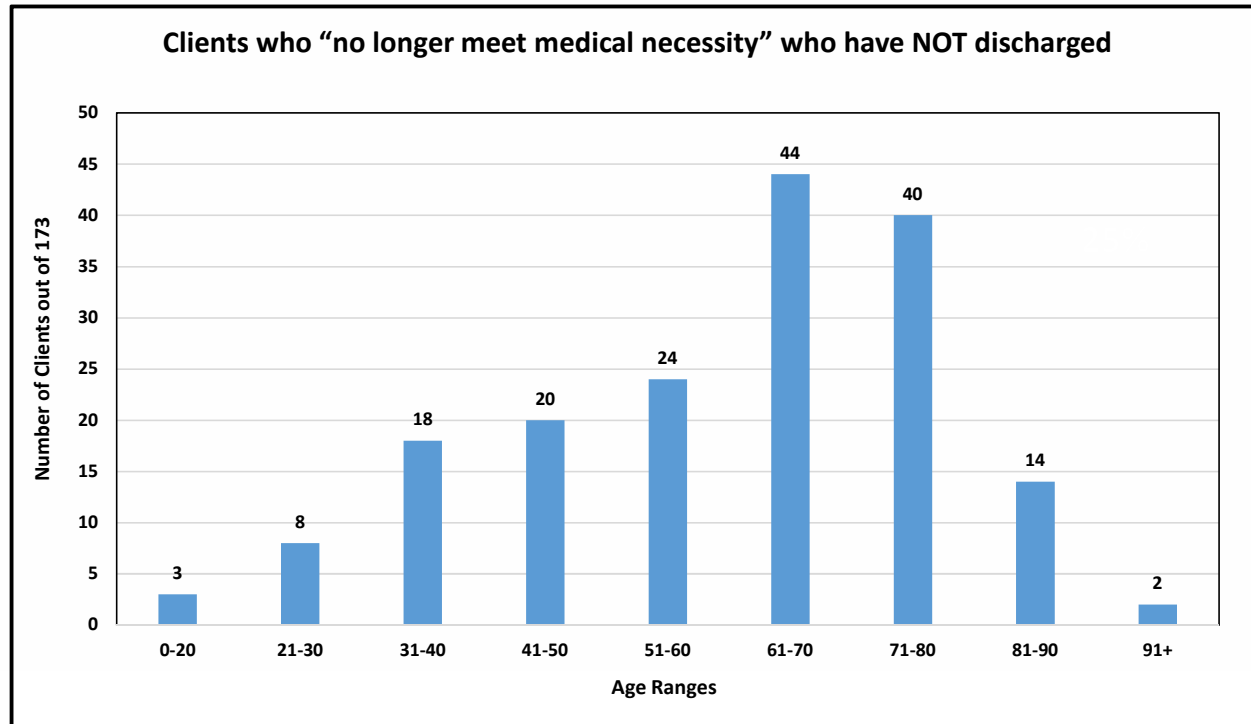**Successfully Transitioned: 255 out of 430 (59%)**
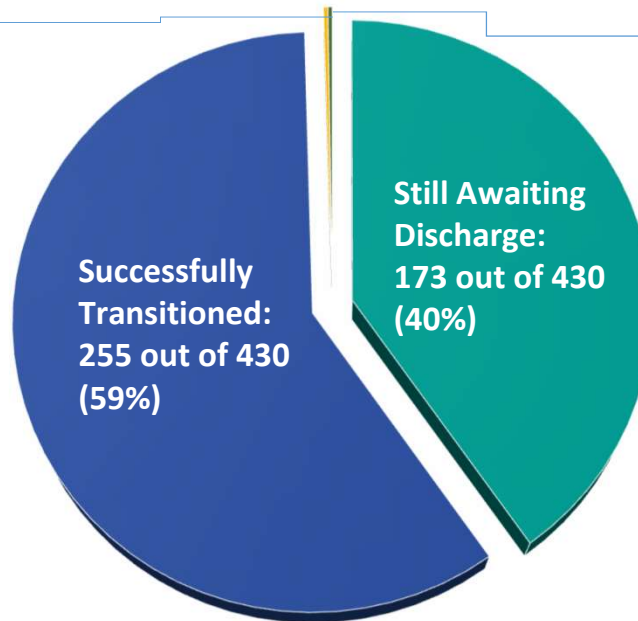
■ Still Awaiting Discharge   ■ Successfully Transitioned   ■ Not Financially Eligible   ■ Refused ALTSA Services
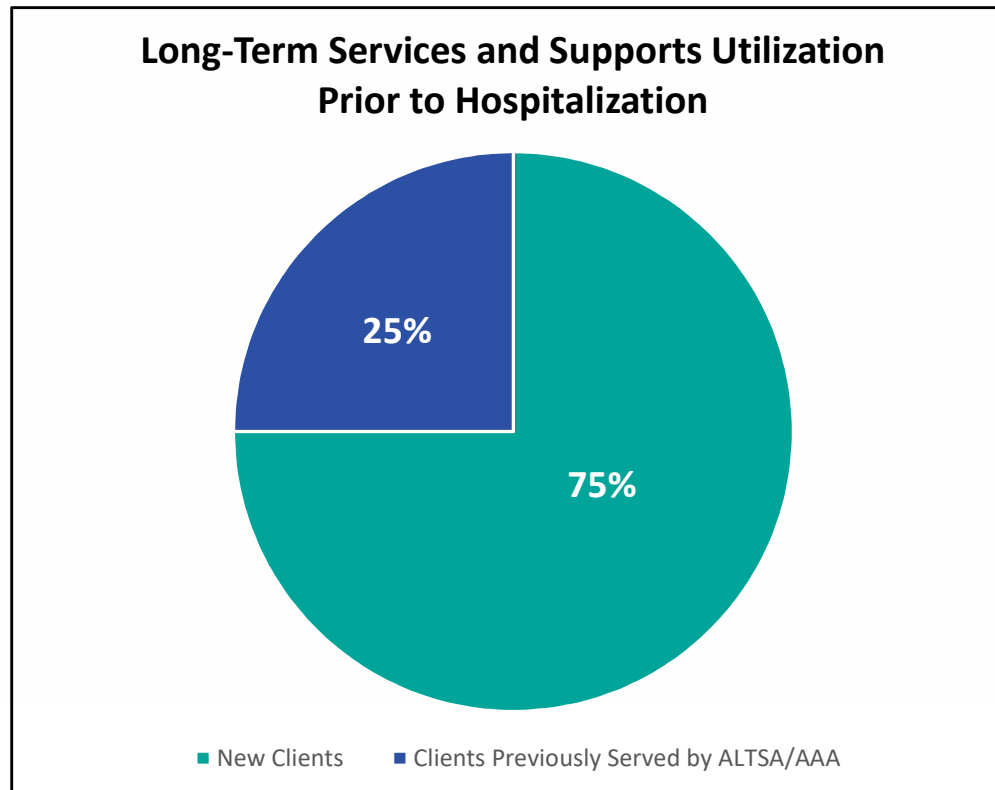
Age ranges of clients who "No Longer Meet Medical Necessity" who have not discharged as of Oct 31st

Clients who "no longer meet medical necessity" who have NOT discharged

Age Range	Number of Clients
0-20	3
21-30	8
31-40	18
41-50	20
51-60	24
61-70	44
71-80	40
81-90	14
91+	2

Service Utilization History of population who "No Longer Meets Medical Necessity"

Long-Term Services and Supports Utilization Prior to Hospitalization

25%

75%

■ New Clients   ■ Clients Previously Served by ALTSA/AAA

Barriers to Discharge for Patients Age 65+

Barriers to discharge fall in the 3 main categories:

1. The client cannot return to previous setting. This includes reasons such as:
   - Client is homeless
   - Client cannot return home
   - Client has significant behaviors

2. Behaviors that are aggressive or inappropriate related to a significant behavioral health condition or dementia.

3. Client is medically complex.

Timeframes for Determining Eligibility

- Functional and financial eligibility assessments/service planning completed within 45 days which includes finding a qualified provider.

- FTE staffing model based on this 45-day timeframe.

- For individuals with complex needs, creating individualized service plans and finding qualified and willing providers takes more time.

- **Institutional Bias** – determining prior eligibility for services/payment only authorized for individuals transitioning to nursing facilities. All other authorizations must be done only after financial and functional eligibility is confirmed.

Home & Community Services FTE Workload Model

- Developed in 1990's.

- Work performed, client acuity and needs, and state and federal requirements have become more complex.

- FTEs generated for acute hospital work is inadequate.

- HCS is allocating 3 times more FTE than the model generates to support this work.

- This has adverse impacts on performing timely eligibility for community clients and case managing clients in residential settings.

Exception to Rule Process

- Used to authorize additional personal care hours or higher daily rate for personal care services.

- Factors related to determining an exceptional rate or number of hours:
  - Needs of the client and how they differ from the majority of clients in the same classification group
  - How that impacts the need for and provision of personal care services

WAC 388-440-0001

ALTSA ETRs requested between October 2018 and October 2019

Total In-Home Requests = 2,530			Total Residential Requests = 1,427		
Approved	1,357	54%	Approved	817	57%
Partially Approved	593	23%	Partially Approved	315	22%
Denied	580	23%	Denied	295	21%

System Challenges

- Complex needs require multi-system coordinated approach.

- Overall workforce shortage.

- Families have reached a point of burn-out or do not feel they can meet needs of the individual

- Providers feel ill-equipped to safely care for individuals with complex behaviors and are concerned about their risk in admitting.

- Differences in timelines across systems.

- Availability of guardianship or other support.

- Some individuals are not eligible for Medicaid

Cross-System Staffing and System Improvements

- Routine cross-system meetings to coordinate LTSS, Behavioral Health and acute care across service systems.

- Lean activities to streamline coordination of BHO/MCO-funded personal care services.

- Implementation of centralized data source to track individuals in acute care hospitals. Field staff began piloting July 1, 2019.

- Early engagement case staffing at local level.

- Collaboration with hospital association and hospitals.

ALTSA's Role Assisting with Clients with Complex Behaviors

- Coordination with Behavioral Health System for MH/SUD needs
- Training and Technical Assistance for LTSS Providers and Staff
- Specialty LTSS Contracts, Training and Oversight
- Housing Development/Early Engagement with Developers
- Supportive Housing

Ongoing needs:
Additional Case Management FTEs
Specialized Dementia Care Rate Add-On