H-3796.1

HOUSE BILL 2180

State of Washington 54th Legislature 1996 Regular Session

By Representatives Dyer, L. Thomas and Carlson

Read first time 01/08/96. Referred to Committee on Health Care.

AN ACT Relating to long-term care discharge planning; and amending RCW 70.41.310, 70.41.320, 74.39A.040, and 74.42.057.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

Sec. 1. RCW 70.41.310 and 1995 1st sp.s. c 18 s 3 are each amended to read as follows:

(1)(a) The department of social and health services, in consultation with hospitals and acute care facilities, shall promote the most appropriate and cost-effective use of long-term care services by developing and distributing to hospitals and other appropriate health care settings information on the various chronic long-term care programs that it administers directly or through contract <u>and facilities licensed by the department of health</u>. The information developed by the department of social and health services shall, at a minimum, include the following:

(i) An identification and detailed description of each long-term care service available in the state;

(ii) Functional, cognitive, and medicaid eligibility criteria that may be required for placement or admission to each long-term care

service, including full disclosure of estate recovery regulations required under medicaid; and

(iii) A long-term care services resource manual for each hospital, that identifies the long-term care services operating within each hospital's patient service area. The long-term care services resource manual shall, at a minimum, identify the name, address, and telephone number of each entity known to be providing long-term care services; a brief description of the programs or services provided by each of the identified entities; and the name or names of a person or persons who may be contacted for further information or assistance in accessing the programs or services at each of the identified entities.

(b) The information required in (a) of this subsection shall be periodically updated and distributed to hospitals by the department of social and health services so that the information reflects current long-term care service options available within each hospital's patient service area.

(2) To the extent that a patient will have continuing care needs, once discharged from the hospital setting, hospitals shall, during the course of the patient's hospital stay, promote each patient's family member's and/or legal representative's understanding of available long-term care service discharge options by, at a minimum:

(a) Discussing the various and relevant long-term care services available, including eligibility criteria;

(b) Making available, to patients, their family members, and/or legal representative, a copy of the most current long-term care services resource manual;

(c) Responding to long-term care questions posed by patients, their family members, and/or legal representative;

(d) Assisting the patient, their family members, and/or legal representative in contacting appropriate persons or entities to respond to the question or questions posed; and

(e) Linking the patient and family to the local, state-designated aging and long-term care network to ensure effective transitions to appropriate levels of care and ongoing support.

Sec. 2. RCW 70.41.320 and 1995 1st sp.s. c 18 s 5 are each amended to read as follows:

(1) Hospitals and acute care facilities shall:

(a) Work cooperatively with the department of social and health services, area agencies on aging, and local long-term care information and assistance organizations in the planning and implementation of patient discharges to long-term care services.

(b) Establish and maintain a system for discharge planning and designate a person responsible for system management and implementation.

(c) Establish written policies and procedures to:

(i) Identify patients needing further nursing, therapy, or supportive care following discharge from the hospital;

(ii) Develop a documented discharge plan for each identified patient, including relevant patient history, specific care requirements, and date such follow-up care is to be initiated;

(iii) Coordinate with patient, family, caregiver, and appropriate members of the health care team;

(iv) Provide any patient, regardless of income status, written information and verbal consultation regarding the array of long-term care options available in the community, including the relative cost, eligibility criteria, location, and contact persons;

(v) Promote an informed choice of long-term care services on the part of patients, family members, and legal representatives; and

(vi) Coordinate with the department and specialized case management agencies, including area agencies on aging and other appropriate long-term care providers, as necessary, to ensure timely transition to appropriate home, community residential, or nursing facility care.

(d) Work in cooperation with the department which is responsible for ensuring that patients eligible for medicaid long-term care receive prompt assessment and appropriate service authorization.

(2) In partnership with selected hospitals, the department of social and health services shall develop and implement pilot projects in up to three areas of the state with the goal of providing information about appropriate in-home and community services to individuals and their families early during the individual’s hospital stay.

The department shall not delay hospital discharges but shall assist and support the activities of hospital discharge planners. The department also shall coordinate with home health and hospice agencies whenever appropriate. The role of the department is to assist the

hospital and to assist patients and their families in making informed choices by providing information regarding home and community options.

The department shall by December 12, ((~~1995~~)) 1996, report to the house of representatives health care committee and the senate health and long-term care committee regarding the progress and results of the pilot projects along with recommendations regarding continuation or modification of the pilot projects.

In conducting the pilot projects, the department shall:

(a) Assess and offer information regarding appropriate in-home and community services to individuals who are medicaid clients or applicants; and

(b) Offer assessment and information regarding appropriate in-home and community services to individuals who are reasonably expected to become medicaid recipients within one hundred eighty days of admission to a nursing facility.

Sec. 3. RCW 74.39A.040 and 1995 1st sp.s. c 18 s 6 are each amended to read as follows:

The department shall work in partnership with hospitals who are selected as pilot sites under RCW 70.41.320 in assisting patients and their families to find long-term care services of their choice. The department shall not delay hospital discharges but shall assist and support the activities of hospital discharge planners. The department also shall coordinate with home health and hospice agencies whenever appropriate. The role of the department is to assist the selected pilot hospitals and to assist patients and their families in making informed choices by providing information regarding home and community options to individuals who are hospitalized and likely to need long-term care.

(1) To the extent of available funds, the department shall assess individuals who:

(a) Are medicaid clients, medicaid applicants, or eligible for both medicare and medicaid; and

(b) Apply or are likely to apply for admission to a nursing facility as a medicaid recipient.

(2) For individuals who are reasonably expected to become medicaid recipients ((~~within one hundred eighty days of~~)) upon admission to a nursing facility, the department shall, to the extent of available

funds, offer an assessment and information regarding appropriate in-home and community services.

(3) When the department finds, based on assessment, that the individual prefers and could live appropriately and cost-effectively at home or in some other community-based setting, the department shall:

(a) Advise the individual that an in-home or other community service is appropriate;

(b) Develop, with the individual or the individual's representative, a comprehensive community service plan;

(c) Inform the individual regarding the availability of services that could meet the applicant's needs as set forth in the community service plan and explain the cost to the applicant of the available in-home and community services relative to nursing facility care, including full disclosure of medicaid estate recovery regulations; and

(d) Discuss and evaluate the need for on-going involvement with the individual or the individual's representative.

(4) When the department finds, based on assessment, that the individual prefers and needs nursing facility care, the department shall:

(a) Advise the individual that nursing facility care is appropriate and inform the individual of the available nursing facility vacancies;

(b) If appropriate, advise the individual that the stay in the nursing facility may be short term; and

(c) Describe the role of the department in providing nursing facility case management.

Sec. 4. RCW 74.42.057 and 1995 1st sp.s. c 18 s 8 are each amended to read as follows:

If a nursing facility has ((~~reason to know~~)) been notified by a resident or his or her legal representative that ((~~a~~)) the resident is likely to become financially eligible for medicaid benefits within one hundred eighty days, the nursing facility shall notify the patient or his or her representative and the department. The department may:

(1) Assess any such resident to determine if the resident prefers and could live appropriately at home or in some other community-based setting; and

(2) Provide case management services to the resident.

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