RCW 70.41.320 Long-term care—Patient discharge requirements for hospitals and acute care facilities—Pilot projects. (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) Subject to RCW 70.41.322, 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, lay caregiver as provided in RCW 70.41.322, and appropriate members of the health care team which may include a long-term care worker or a home and community-based service provider. For the purposes of this subsection (1)(c)(iii), long-term care worker has the meaning provided in RCW 74.39A.009 and home and community-based service provider includes an adult family home as defined in RCW 70.128.010, an assisted living facility as defined in RCW 18.20.020, or a home care agency as defined in RCW 70.127.010;

(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;

(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; and

(vii) Inform the patient or his or her surrogate decision maker designated under RCW 7.70.065 if it is necessary to complete a valid disclosure authorization as required by state and federal laws governing health information privacy and security, including chapter 70.02 RCW and the federal health insurance portability and accountability act of 1996 and related regulations, in order to allow disclosure of health care information, including the discharge plan, to an individual or entity that will be involved in the patient's care upon discharge, including a lay caregiver as defined in RCW 70.41.020, a long-term care worker as defined in RCW 74.39A.009, a home and community-based service provider such as an adult family home as defined in RCW 70.128.010, an assisted living facility as defined in RCW 18.20.020, or a home care agency as defined in RCW 70.127.010. If a valid disclosure authorization is obtained, the hospital may release information as designated by the patient for care coordination or other specified purposes.

(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.

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. [2016 c 226 § 5; 1998 c 245 § 127; 1995 1st sp.s. c 18 § 5.]

Conflict with federal requirements—Severability—Effective date—1995 1st sp.s. c 18: See notes following RCW 74.39A.030.