Washington State Department of Social & Health Services
Transforming lives

DEVELOPMENTAL DISABILITIES ADMINISTRATION
Olympia, Washington

| TITLE: | RHC ADMISSIONS FOR INTERMEDIATE CARE AND NURSING FACILITY SERVICES | POLICY 17.01.02 |
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| Authority: | 42 C.F.R. 440 | *Services: General Provisions* |
| | 42 C.F.R 483, Subpart B | *Requirement for Long-Term Care Facilities* |
| | 42 C.F.R. 483.440 | *Requirements for States and Long-Term Care Facilities* |
| | Title 71A RCW | *Developmental Disabilities* |
| | Chapter 388-825 WAC | *Developmental Disabilities Administration Services Rules* |
| | Chapter 388-835 WAC | *ICF/ID Program and Reimbursement* |
| | Chapter 388-837 WAC | *Residential Habilitation Center ICF/ID Program* |
| | Chapter 388-97 WAC | *Nursing Homes* |
| | Chapter 71A.20 RCW | *Residential Habilitation Centers* |
| | RCW 71A.20.180 | *Closure of Yakima Valley School—Department duties—Continuation of services* |

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| Reference: | DDA Policy 5.04 | *Access to Education for School Age Clients in Residential Habilitation Centers* |
| | DDA Policy 5.14 | *Positive Behavior Support Principles* |
| | DDA Policy 5.22 | *Restrictive Procedures and Restraints* |
| | DDA Policy 5.24 | *Functional Assessments and Positive Behavior Support Plans: RHC's* |
| | DDA Policy 7.03 | *Informed Consent* |
| | DDA Policy 9.06 | *Health Services: Residential Habilitation Centers* |
| | DDA Policy 12.01 | *Incident Reporting and Management for DDA Employees* |
| | DDA Policy 12.02 | *RHC Incident Investigations* |
| | DDA Policy 16.01 | *Responding to PASRR Program Referrals* |
| | DDA Policy 16.07 | *Planned Action Notices for PASRR* |
| | DDA Policy 17.01.01 | *RHC Governing Body* |
| | Engrossed Substitute House Bill 1109, Sec. 203(2)(e)(i) | |

## BACKGROUND

Residential Habilitation Centers are state-operated facilities certified to provide intermediate care, nursing services, or both to people with intellectual or developmental disabilities. The primary purpose of intermediate care facilities is to provide temporary habilitative services. Nursing facilities provide long-term nursing care, rehabilitative, and health care services.

Effective July 1, 2012, the Washington State Legislature amended Chapter 71A.20 RCW to prohibit the admission of any person under age sixteen from receiving services at a Residential Habilitation Center. Additionally, no one under age twenty-one may receive ICF/IID or NF services at an RHC unless: "there are no service options available in the community" and "such admission is limited to the provision of short-term respite or crisis stabilization services" (RCW 71A.20.010).

Effective October 19, 2017, the Washington State Legislature amended RCW 71A.20.180 to prohibit new long-term admissions to the Yakima Valley School (YVS) Residential Habilitation Center. YVS shall continue to operate crisis stabilization and respite beds based upon funding.

## PURPOSE

This policy establishes eligibility, referral, and admission criteria for clients:

1. Requesting admission to a Residential Habilitation Center (RHC); or
2. Currently admitted at an RHC who are requesting:
    a. ICF/IID or NF services at a different RHC; or
    b. A different service at an RHC (e.g., switching from ICF/IID services to NF services).

ICF/IID services are provided at the following RHCs:

- Fircrest School
- Lakeland Village
- Rainier School

NF services are provided at the following RHCs:

- Fircrest School
- Lakeland Village

Crisis stabilization services are provided at Yakima Valley School.

## SCOPE

This policy applies to all DDA field services, headquarters, and RHC staff working with clients requesting admission to an RHC for ICF/IID or NF services. For planned respite at an RHC, see DDA Policy 17.01.03, *Planned Respite Provided by a Nursing Facility at an RHC*.

## DEFINITIONS

**Active treatment** as defined in 42 C.F.R. 483.440(a)(1)(2), means a continuous program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services directed toward:

1. Acquiring the behaviors necessary for the client to function with as much self-determination and independence as possible; and

2. Preventing or slowing the regression or loss of optimal functional status.

Active treatment does not include services to maintain generally independent clients who are able to function with little supervision or in the absence of a continuous active treatment program.

**Admission** means the process by which a client enters the RHC and begins receiving ICF/IID or NF services.

**Comprehensive Assessment and Reporting Evaluation (CARE)** is a tool under Chapter 388-106 WAC.

**Crisis stabilization** means a direct service that assists with deescalating the severity of a person's level of distress or need for urgent care intended to prevent a behavioral health crisis or reduce acute symptoms of mental illness.

**CRM** means the field services DDA case resource manager, social worker, or social service specialist.

**Discharge** means the permanent movement of a client to another facility or setting not under the jurisdiction of an RHC Governing Body.

**Discharge goal** means a habilitation goal identified by a client's interdisciplinary team that, when achieved, suggests the client is ready to live in a more independent setting.

**Habilitation** means services intended to help a client acquire, retain, or improve upon the self-help, socialization, and adaptive skills necessary to reside successfully in a community-based setting.

**Individual habilitation plan** or **IHP** means a comprehensive plan developed by the client's interdisciplinary team that includes a detailed description of the client's needs, supports, and preferences to aid in the client's transition to a less-restrictive environment.

**Interdisciplinary team** or **IDT** means a group of people who collaborate to develop the individual habilitation plan under DDA Policy 17.06.03, *Interdisciplinary Team*, or develop the individual plan of care under DDA Policy 17.06.04, *Interdisciplinary Team: Nursing Facility*.

**Intermediate care facility for individuals with intellectual disabilities** or **ICF/IID** means a Medicaid-certified facility operating under Title XIX of the Social Security Act in 42 C.F.R. 440.150 to furnish health or rehabilitation services.

**Legal representative** means a parent of a client if the client is under age eighteen, a court-appointed guardian if a decision is within the scope of the guardianship order, or any other person authorized by law to act for the client.

**myUnity** means a cloud-based electronic health record system.

**Necessary supplemental accommodation representative** or **NSA** means a person who receives copies of DDA planned action notices and other department correspondence to help a client understand the documents and exercise the client's rights. The NSA representative is identified by a client when the client does not have a legal guardian and the client is requesting or receiving DDA services.

**Preadmission screening and resident review** or **PASRR** means a federally mandated program that requires a client be assessed for nursing facility level of care before admission to a Medicaid-certified nursing facility.

**PASRR assessor** means a regionally designated CRM who completes the PASRR process.

**Residential Habilitation Center** or **RHC** means a state-operated facility under RCW 71A.20.020 certified to provide ICF/IID or nursing facility services.

**Nursing facility** or **NF** means a nursing facility regulated by 42 C.F.R. 483, subpart B, 42 C.F.R., subpart C, and Chapter 388-97 WAC.

**Transition** means the process by which a client moves from an RHC into the community.

**Treating professional** means an individual who specializes in the discipline within their scope of practice.

**Youth** means a DDA client aged 16 through 20.

## POLICY

A. ICF/IID services are temporary. DDA staff must discuss the client's discharge goal during the admission process. The IDT will develop targets based on the client's needs to meet the discharge goal. Permanent or long-term admission at an ICF/IID is not available.

B. For ICF/IID services, federal guidance establishes criteria for when a client can be discharged from the facility for good cause, absent an emergency, and provide reasonable time for the client to prepare for such discharge. The RHC must monitor and document by treating professional assessments, progress notes and IDT discussions if a client has met the following discharge criteria:

1. The RHC cannot meet the client's needs;

2. The client no longer requires an active treatment program;

3. The client chooses to reside elsewhere; or

4. The RHC determines that another level of service or living situation would be more beneficial to the client.

C. Before admission to an RHC, the client's CRM must present the options to receive available community-based services, such as crisis stabilization services.

D. A request for ICF/IID or NF services at an RHC requires prior approval (see Procedures Section (A)).

E. Admission to an RHC to receive ICF/IID services is limited to 180 consecutive days.

F. ICF/IID ELIGIBILITY

A person is eligible to receive ICF/IID services if:

1. DDA-eligible under Chapter 388-823 WAC;

2. Eligible for Medicaid under Title 182 WAC; and

3. Assessed to be in need of, likely to benefit from, and willing to participate in active treatment.

G. NF ELIGIBILITY

1. A person is eligible to receive NF services if:

a. DDA eligible under Chapter 388-823 WAC;

b. Eligible for Medicaid under Title 182 WAC; and

c. Assessed to meet PASRR eligibility criteria.

2. Before admission to a nursing facility, a PASRR assessor must complete the PASRR determinations and provide a copy of the determinations and planned action notice (PAN).

H. RHC ELIGIBILITY

1. A client is eligible for admission to an RHC (including crisis stabilization at YVS) if the client:

a. Is eligible for ICF/IID or NF services under Policy Section (F) or (G);

b. Has an identified health and welfare need that cannot currently be met by residential habilitation services available through:

i. A DDA Home and Community Based Services waiver;
ii. Roads to Community Living; or
iii. Medicaid State Plan services in a community setting;

c. Does not require inpatient treatment related to a behavioral health care need, where such treatment is available through the Medicaid State Plan and prescribed by the client's treating professional;

d. Is not incarcerated in jail or prison for a crime or detained under Chapter 71.05 RCW or Chapter 71.09 RCW and any pending civil commitment proceedings have been dismissed; and

e. Is requesting ICF/IID services and the RHC has conducted a preliminary evaluation determining the client agrees to participate in, has a need for, and will likely benefit from a continuous active treatment program.

2. Before a client is admitted to an RHC, the case manager must discuss community-based services with the client and document the discussion in the client's record.

3. For a client aged 16 through 20, a client may be admitted to an RHC only if there are no service options available in the community to appropriately meet the client's needs.

4. Under RCW 71A.20.010, a client under age 16 must not be admitted to an RHC.

## PROCEDURES

A. REFERRAL FOR ADMISSION TO AN RHC

1. Before submitting a request for admission for ICF/IID or NF services provided by an RHC, the CRM must discuss Medicaid State Plan benefits and community-based services with the client and legal representative and explain the difference between ICF/IID and NF (see RHC ICF/IID brochure, RHC FAQ, and RHC Fact Sheets).

a. If the client and the client's legal representative request ICF/IID services, the CRM must document the following in the clients CARE record:

i. Information has been provided regarding applicable community-based services including but not limited to crisis stabilization services;

ii. Discussion of the temporary nature of ICF/IID services[1], including:

A) Discharge planning begins during the admission process;

B) Once discharge criteria is met, the assigned regional field office will work with the client and the client's legal

[1] *Rethinking Intellectual and Developmental Disability Policy to Empower Clients, Develop Providers, and Improve Services*. https://app.leg.wa.gov/ReportsToTheLegislature/Home/GetPDF?fileName=Ruckelshaus%20Workgroup%202019%20DD-RHC%20Report%20to%20Legislature_d4838af6-7bf7-45f5-8416-f67a242b4f37.pdf

representative to identify appropriate services in the community.

iii. Notify the client and the client's legal representative that active treatment eligibility must continue to be met after admission as required under 42 C.F.R. 483.440; and

iv. Notify the client's legal representative (if applicable) of their obligation to:

A) Participate in care planning discussions; and

B) Respond promptly to the RHC when consent is needed.

b. If a client is not admitted to an RHC and the client or the client's legal representative request NF services, the CRM must work with the client to contact their primary care physician to explore community-based options to meet their needs.

2. If the client and the client's legal representative request ICF/IID or NF services in an RHC, the CRM must:

a. Submit the following referral packet materials to their supervisor:

i. DSHS 10-673, *Application for ICF/IID or NF Services in an RHC*;

ii. Current DDA Assessment details, unless the client is currently admitted to an RHC;

Note: For a client admitted to an RHC, instead of a DDA assessment, the referral packet will include current RHC documents that address the client's support needs, such as: an individual habilitation plan; a positive-behavior support plan; annual assessments; and 90-day reviews.

iii. DSHS 14-012, *Consent,* identifying any relevant people or entities outside of DSHS for which confidential information can be shared to plan, provide, and coordinate services; and

iv. Other relevant documents, such as a behavior support plan, a cross-system crisis plan, incident reports, evaluations, hospital records, or clinical notes.

b. Complete and submit to their supervisor a prior approval that:

i. Includes in the "Request Description" tab in CARE:

A) The type of service requested (ICF/IID or NF);

B) The RHCs from which the client consents to receive services; and

C) The client's age if the client is aged 16 through 20.

ii. Includes in the "Justification for Request" tab in CARE:

A) Any significant events that occurred that led to the request; and

B) The client's plan for discharge, including:

1) The setting type and provider the client will discharge to, if known; and

2) The client's habilitation goals.

iii. Includes in the "Alternatives Explored" tab in CARE:

A) A list of alternatives explored and a description of why each alternative was not appropriate, available, or effective; and

B) A statement, if applicable, that the client or the client's legal representative is unwilling to consent to a DDA Home and Community-Based Services waiver, Roads to Community Living, or State Plan services in a community setting.

3. After reviewing the prior approval, the CRM supervisor must submit:

a. The prior approval to regional management for review; and

b. The completed referral packet to the RHCAdmission@dshs.wa.gov inbox.

4. After receiving the prior approval, the Regional Administrator or designee must:

   a. Review the prior approval;

   b. Include applicable comments about the urgency of the request, such as termination from current provider; and

   c. Submit the request in CARE to the DDA HQ RHC Admissions Committee.

5. The RHC Program Manager must review the prior approval and referral packet materials with the RHC Admissions Committee to determine which RHC should receive the referral.

B. ADMISSION DECISION

1. To determine if a client meets admission criteria for ICF/IID services, the RHC must:

   a. Review referral documentation, including relevant client history;

   b. Conduct a preliminary evaluation in-person or virtually using current functional assessments of the client's developmental, behavioral, social, health and nutritional status;

   c. Determine if the client is in need of, willing to participate in, and likely to benefit from active treatment; and

   d. Verify federal funding, vacancy, and sufficient staffing are available to meet the client's support needs.

2. No more than five business days after completing the preliminary evaluation, the RHC must communicate the admission decision to the RHC Program Manager.

3. No more than ten business days after completing the preliminary evaluation, the RHC must provide a copy of the written evaluation to the RHC Program Manager.

4. To determine if a client meets admission criteria for NF services, the RHC must:

   a. Review referral documentation, including relevant client history;

b. Verify the client meets nursing facility level of care under WAC 388-106-0355;

c. Ensure the client's needs can be safely met by the RHC;

d. Ensure the Medical Director or Medical Provider reviews the referral and provides input to the decision;

e. Verify federal funding, vacancy, and sufficient staffing are available to meet the client's support needs; and

5. No more than five business days after the evaluation, the RHC must communicate the outcome of their admission decision to the RHC Program Manager.

6. The RHC Program Manager must:

a. Notify the CRM and regional management of the RHC decision;

b. If applicable, deny the prior approval in CARE.

7. The DDA CRM must:

a. Notify the client and legal representative of the admissions decision; and

b. If applicable, send the appropriate planned action notice to the client and legal representative.

C. PRE- ADMISSION

1. If the RHC has determined they can support the client, the RHC must schedule and facilitate a pre-admission meeting and include: the client; the client's family or legal representative; and professionals or support staff from disciplines and service areas identified by the client's support needs. For NF services, notify regional PASRR staff.

2. The pre-admission meeting must:

a. Determine the need for an environmental evaluation, such as an assessment for structural modifications, durable medical equipment, accessibility needs, etc.;

b. Discuss the client's identified medical needs, including any future scheduled appointments with community providers;

c. Determine school coordination (if applicable) as required by DDA Policy 5.04, *Access to Education for School Age Clients in Residential Habilitation Centers*;

d. If admitting for ICF/IID services, inform the client and legal guardian of the requirement for continued ICF/IID eligibility once the client is admitted; and

e. Determine the client's admission date and the RHC staff coordinating the admission must communicate the date to the RHC Program Manager.

3. Once the admission date is determined, the RHC Program Manager must:

a. Finalize the prior approval in CARE (for youth aged 16 through 20, the prior approval will be reviewed and finalized by the Deputy Assistant Secretary or designee);

b. Send a notification email of the approval to the CRM, appropriate regional staff (e.g., PASRR for clients approved for NF services), RHC, and HQ staff, and include instructions for documenting the approved service in CARE; and

c. Provide the RHC's admission checklist to the CRM and supervisor.

4. After receiving the approval email, the DDA CRM must:

a. Review DSHS 10-424, *Voluntary Participation Statement*, with the client, the client's family, and the client's legal representative;

b. Communicate with the client, family, or legal representative regarding the information and documents that will be required before admission;

c. Assist the RHC admission coordinator to obtain required documents outlined in the admission checklist;

d. Update CARE according to instructions provided by the RHC Program Manager; and

e. Notify the Long-Term Care and Specialty Unit using Barcode form 15-345 of the client's admission date to the RHC.

5. Before a client is admitted for NF services:

a. The referring regional PASRR assessor must complete the PASRR Level 1 assessment and determination as required by DDA 16.01, *Responding to Preadmission Screening and Resident Review Program Referrals*, and must send the planned action notice as required by DDA 16.07, *Planned Action Notices for PASRR*.

b. If admissions are anticipated to exceed 30 days, the PASRR assessor must complete the PASRR Level 2 assessment before the 31st day of services.

D. ADMISSION TO AN RHC

1. On or before the client's date of admission for ICF/IID or NF services, the RHC must:

a. Complete the RHC's admissions checklist;

b. Orient the client and the client's family or legal representative to the client's new living unit;

c. Update the STS tab in CARE and myUnity with admission information;

d. Establish a communication framework with the client's family or legal representative and field services case management staff;

e. Ensure a comprehensive admission evaluation is completed in accordance with the client's healthcare needs as required by DDA Policy 9.06, *Health Services: Residential Habilitation Centers*; and

f. Establish meeting dates and timelines for comprehensive assessments and development of the IHP or individual plan of care.

2. For a client whose services will exceed 30 consecutive days, prior to the 30th consecutive day:

a. The CRM must:

i. Update the client's person-centered service plan, as needed (e.g., terminate service authorizations or waivers); and

ii. Send planned action notices as appropriate.

b. The RHC must:

i. For clients receiving ICF/IID services, develop an IHP per 42 C.F.R 483.440 (c) and outline the discharge goals;

ii. For clients receiving NF services, ensure the PASRR level 2 is complete and develop a care plan that includes PASRR recommendations;

iii. Notify the Long-Term Care and Specialty Unit using Barcode form 15-345; and

iv. Notify the Social Security Administration of admission to the RHC.

3. For a client receiving ICF/IID services, no more than 60 days from admission, the IDT (which includes the client's case manager, and if applicable the client's managed care organization), must convene to review whether the client meets discharge criteria.

a. If the client **does not** meet discharge criteria, the IDT must make any necessary changes to the client's IHP, continue treatment, and schedule a subsequent review in the next 120 days; or

b. If the client **does** meet discharge criteria, the discharge process will begin.

i. The RHC must document the evidence of an assessment that evaluated the pros and cons of the discharge and rationale for the final decision.

ii. The assigned regional field office will work with the client to identify appropriate community-based services.

4. If the IDT determines the client has not met discharge criteria:

a. The RHC must apply to be the client's representative payee, unless the family or legal guardian request to continue as payee; and

b. The CRM must:

i. Move the DDA assessment to history;

ii. Work with the CRM supervisor to transfer the case to a Roads to Community Living CRM; and

iii. Update the client's residence type in CARE to capture the client's current location of residence.

5. For a client admitted to an RHC for ICF/IID services whose length of admission is approaching 180 days:

a. The IDT must continue to assess the client's discharge goals and determine if discharge criteria has been met.

b. The CRM must:

i. Consult with the client's IDT and regional management to determine barriers to community-based services; and

ii. Request an exception to policy every 180 days if the IDT determines the client still meets ICF/IID eligibility criteria.

## EXCEPTIONS

Any exception to this policy must have the prior written approval of the Deputy Assistant Secretary.

## SUPERSESSION

DDA Policy 17.02, *RHC Admissions for Intermediate Care and Nursing Facility Services*
Issued January 19, 2023

Approved: _____ Date: January 19, 2023

Deputy Assistant Secretary
Developmental Disabilities Administration