Washington State Department of Social and Health Services

Transforming Lives

PRELIMINARY REPORT TO THE LEGISLATURE

Caring for individuals under Department of Corrections jurisdiction in Skilled Nursing Facilities

Enacted by budget proviso in ESSB 5693(204) (54) in the 2022 Legislature

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1 Executive summary

This report, entitled "Caring for individuals under Department of Corrections jurisdiction in Skilled Nursing Facilities," was prepared by the Washington State Department of Social and Health Services (DSHS) (department) Aging and Long-Term Support Administration (ALTSA) in collaboration with the Department of Corrections (DOC) and the Health Care Authority (HCA). This preliminary report was prepared in accordance with the budget proviso in ESSB 5693(204) (54), to be followed by a final report by June 30, 2023.

The report includes a review of the clinical parameters identified within DOC records indicative of needs for medical treatments/therapies or assistance with mobility or cognitive deficits. It provides—based on DOC administrative data—profiles of the medical condition, behavioral health, and long-term care needs of individuals under DOC jurisdiction who would likely benefit from long-term care services and supports in a Skilled Nursing Facility (SNF) setting. It also provides an assessment of Medicaid funding eligibility for individuals under DOC jurisdiction who would be eligible for such placement. In this context, "placement" is used to reflect that these individuals are still under DOC jurisdiction.

Based on this assessment from DSHS, HCA, DOC, and the Office of the Attorney General, the report determines that while some individuals currently under DOC jurisdiction could meet functional eligibility criteria for SNFs established under the state's Medicaid-funded long-term services and supports program, the custody status of the individuals and the residents' rights requirements of SNFs make the ability to obtain Medicaid funds more challenging without additional statute changes allowing SNF-eligible incarcerated individuals an opportunity for other levels of confinement such as the DOC's Extraordinary Medical Placement (EMP) program and other successful partial confinement arrangements that the legislature has already placed into statute.

2 Purpose

In accordance with Engrossed Substitute Senate Bill 5693, as outlined in Section 204 (54), by October 1, 2022, in collaboration with DOC and HCA, DSHS must submit a preliminary report to the Governor and the relevant fiscal and policy committees of the Washington State Legislature.

At a minimum, the preliminary report must review the medical condition, behavioral health, and long-term care needs of the relevant individuals and assess whether the state could be eligible for and obtain federal funding for providing health care and long-term care services for individuals under the jurisdiction of DOC if they were served in SNFs.

The proviso requirements within Section 204 (54) additionally require that by June 30, 2023, the department, in collaboration with DOC, submit a final report to the Governor and the relevant legislative fiscal and policy committees.

The final report shall:

(a) Assess the relevant characteristics and needs of the potential patient population;

(b) Assess the feasibility, daily operating costs, staffing needs, and other relevant factors of potential locations or contractors, including the Maple Lane Corrections Center, for placement of long-term care individuals under the jurisdiction of DOC for a potential nursing home facility to be licensed by the department;

(c) A cost-benefit analysis of placing individuals under the jurisdiction of DOC in potential facilities identified in subsection (b) of this subsection, including the possibility or absence of federal funding for operations. DOC must provide daily operating costs of prisons where these individuals may be coming from, the fiscal year 2021 daily costs per incarcerated individual assigned to the Sage living unit, and the costs associated with electronic home monitoring costs per individual. This analysis shall consider both state-run and privately contracted options;

(d) Assess the ability of potential facilities identified in subsection (b) of this subsection to better meet clients' medical and personal needs; and

(e) Assess the ability to provide Medicaid-funded services to meet the healthcare needs of these individuals.

3 Data constraints

It should be noted that under current conditions, it is very difficult to fully and accurately assess the eligibility of individuals under DOC jurisdiction for treatment in an SNF. DOC does not maintain an electronic database of individuals' medical conditions and long-term care needs, and the data required to assess these is currently maintained in paper records held at each individual facility. This necessitates a manual, case-by-case review of individuals that is time consuming and labor intensive.

In the process of preparing this report, DOC used available administrative data to identify a group of individuals that are potentially functionally eligible for placement in an SNF. DSHS staff contacted the various DOC facilities housing these individuals and spoke directly with DOC medical staff in order to obtain the more detailed information necessary for a more definitive determination.

A review of DOC administrative data identified a total of 117 individuals whose clinical characteristics indicate the need for medical treatments/therapies or assistance with mobility, cognitive deficits, or other activities of daily living (ADLs). Out of these 117 individuals, 23 were identified as most likely to meet SNF criteria, and 94 individuals were identified as potentially eligible for long-term care services with more information required for a definitive determination. However, the administrative data available from DOC does not contain the level of medical and functional information necessary to closely approximate eligibility for SNF admission. Further information would be needed to accurately assess the individuals for functional eligibility.

Cases considered most likely eligible to be served by an SNF according to DOC data are identified as having:

(1) Significant health services needs that may require assistance with ADLs or 24/7 onsite medical care and/or

(2) Mobility restrictions including the inability to transfer themselves or move around without assistance.

Cases considered potentially eligible for placement in an SNF according to DOC data with more information needed include patients identified as having:

(1) A health condition which requires frequent onsite monitoring/care and require mobility assistance such as a wheelchair pusher or inability to transfer themselves and complete their own ADLs; or

(2) A health condition which requires frequent onsite monitoring/care and have a disability that requires Americans with Disabilities Act (ADA) coordinator involvement; or

(3) Have a disability that requires ADA coordinator involvement and require mobility assistance such as a wheelchair pusher or assistance transferring themselves and perform their own ADLs.

It is likely that this population at DOC would need to have a broader definition that is more inclusive of those who might be eligible for a Skilled Nursing, Assisted Living, or Adult Family Home setting if in the community, but have care and medical needs that exceed the resources and environmental limitations of DOC facilities. This might mean a broader definition that is not congruent with established Medicaid definitions.

Although these individuals may not meet the DSHS definition for long-term care support eligibility, their health care is not best managed in a prison environment. Most cells are not ADA accessible, and most individuals must walk a distance for daily meals, medical needs, medication pill lines, programming, and recreation, which is challenging for individuals with mobility restrictions or cognitive limitations. Prison life is based on following rules, and if individuals have an underlying condition that limits the ability to understand the directions being given, it impacts the safety of the individual as well as the safety and security of the facility. Prison simply may not be the best placement option for these individuals, and yet they may not meet the criteria for long-term care support either, since—considering the laws associated with residents' rights—there are limits to serving individuals in these settings.

Due to the limitations of data collection and the lack of electronic health records (EHRs), further review of cases will be required to definitively determine which individuals meet the functional eligibility criteria. It is difficult to have data that is reflective of real-time information with the limitations of DOC's current paper healthcare records.

4 Profiles of the medical condition, behavioral health, and long-term care needs of individuals under Department of Corrections jurisdiction who would likely benefit from long-term services and supports in a Skilled Nursing Facility setting

The following section represents a breakdown of the demographics, medical conditions, and long-term care needs of the 117 individuals in DOC custody who have been identified as potentially eligible for care in an SNF. As noted above, this eligibility determination is a preliminary assessment based on information available from DOC administrative data, which does not necessarily represent sufficient information to make a definitive determination.

Table 1 represents a breakdown of the 117 potentially eligible individuals by DOC facility and eligibility classification (see Appendix for facility abbreviations).

Facility	Total Population	Distinct # of Patients in Parameter(s)			% of Total Population
		Most Likely	More Info Needed	Total	
AHCC	1,842	1	11	12	0.7%
CBCC	376	0	1	1	0.3%
CCCC	271	0	0	0	0.0%
CRCC	1,854	7	20	27	1.5%
LCC	219	0	0	0	0.0%
MCC	1,488	5	20	25	1.7%
MCCCW	117	0	0	0	0.0%
OCC	158	0	0	0	0.0%
SCCC	1,747	4	19	23	1.3%
WCC	1,671	0	4	4	0.2%
WCCW	536	1	1	2	0.4%
WSP	1,908	5	18	23	1.2%
Total	**12,187**	**23**	**94**	**117**	**1.0%**

Table 1: Potentially eligible individuals by DOC facility and eligibility classification.

Table 2 shows the number of individuals per specialized need as determined from DOC data. 82 (70.1%) of these individuals fall into more than one of these categories. 28 (23.3%) fall into four or more.

Parameter	Distinct # of Patients in Parameter	% of Total Sample
Special transportation needs	61	52.1%
Significant mobility restrictions	8	6.8%
Significant health services which may require assistance with ADLs	19	16.2%
Organic system disease requiring frequent monitoring and on-site medical care with moderate mobility restrictions	59	50.4%
Organic system disease requiring frequent monitoring and on-site medical care with disability, including hearing and significant sight impairment	45	38.5%
Disability, including hearing and significant sight impairment, with moderate mobility restrictions	42	35.9%
Dementia or other debilitating neurological condition	8	6.8%
Age 75+	18	15.4%

Table 2: Potentially eligible individuals by specialized need.

For the sample of 117 individuals potentially eligible for SNF placement, ages ranged from 23 to 87 years old, with an average age of 61.2 years. 115 (98.3%) of this group are male, and two (1.7%) are female.

For the 23 individuals identified as most likely to meet the criteria for SNF placement, ages ranged from 33 to 87 years old, with an average age of 61.4 years. 22 (95.7%) of this group are male, and one (4.3%) is female.

To determine SNF functional eligibility, the clinical complexity of potential participants must be considered relevant to the diagnosis and the extent to which they require assistance with their ADLs or daily skilled nursing tasks. For this reason, it is difficult to determine eligibility by examining the simple diagnosis alone. Considerations include treatments and frequency of need, wound care/skin issues (pressure ulcers, stasis ulcers, wound care, repositioning program), incontinence care, bowel program, catheter care, and issues with swallowing. Individuals with bariatric needs sometimes receive significant assistance with transfers, and individuals with decreased levels of cognition due to dementia or other conditions may need assistance with eating, toileting, mobility, and exit-seeking behaviors.

Detailed data was obtained and examined for 15 individuals from the group identified as most likely to qualify for SNF care. These individuals display a variety of chronic conditions of a physical, cognitive,

and/or psychiatric nature. Their ages range from 44 to 81 years old, with an average age of 66.8 years. Of these, 9 (60%) require regular assistance with ADLs, 10 (67%) have mobility issues, 8 (53%) have neurocognitive conditions, and 6 (40%) have psychiatric diagnoses. All have chronic conditions that require regular medical care and/or assistance with ADLs.

Two individuals, profiled below, were chosen as prime examples of clearly eligible individuals who could benefit from SNF placement: Client A and Client B, both 70-year-old males.

Client A suffers from type 1 diabetes, paraplegia, chronic hepatitis C, cirrhosis, neurogenic bowel, heart disease, and end-stage renal disease. He has a suprapubic catheter that requires monthly changing and cleaning around the site, routine labs, fluid restriction, blood sugar checks, insulin injections, and dialysis three times per week. He requires extensive assistance with nearly all ADLs. He eats independently, but often requires encouragement. He has no balance and cannot sit up on his own, requiring regular Hoyer lift transfers with a limited ability to propel a wheelchair. He wears incontinence briefs that need changing every two hours, and it takes staff 90 minutes to shower him.

Client B suffers from type 2 diabetes, chronic hepatitis C, severe dementia, and is blind in one eye. He requires blood glucose checks twice per day and insulin injections once per day (if levels remain within normal limits). He requires assistance with all ADLs, including eating and walking (he is very unsteady with a walker and often uses a wheelchair). He frequently wanders in a confused state, sometimes attempting to exit the medical facility. He is not aware of what day it is, experiences sundowning and bladder incontinence, and is resistant to care.

Many other individuals represented in the sample also require complex medical care and accommodations that can place a significant strain on DOC facilities, staff, and other resources.

5 Custody considerations

Custody classification is the management tool used to assign incarcerated individuals to the least restrictive custody designation that addresses programming and other needs, while providing for the safety of personnel, the community, and the individuals themselves. Incarcerated individuals are placed in custody levels based on their scores and type(s) of crimes from least restrictive Minimum Custody to most restrictive Maximum Custody. Each level has different restrictions. Incarcerated individuals in Maximum Custody will require more security—such as handcuffs—during movement and less time out of their cell for hygiene and yard time. Minimum Security individuals have less supervision, more freedom of movement, and more program opportunities.

The assisted living Sage unit at CRCC only houses Minimum Security individuals or individuals who can have an override to this classification, so people at higher custody levels may not have any current opportunity to access an assisted living unit in DOC facilities. There are concerns about being able to provide care that matches a community standard and DOC regulation. For example, the Sage unit cannot be a locked unit due to being at Minimum Custody level and the need to maintain individual rights, yet a dementia patient may be recommended for a unit with delayed egress if being treated in a community setting. With the prison population aging, many individuals who may require long-term care have long or life sentences and cannot currently meet the requirements for a lower custody level or be eligible for a

current avenue for placement in the community prior to the fulfillment of the requirements of their sentence.

Table 3 shows a breakdown of the 117 individuals identified as potentially eligible by security and custody level.

Security and Custody Level	Distinct # of Patients	% of Total Sample
Security Level 5 - Maximum Custody	1	0.9%
Security Level 4 - Close Custody	7	6.0%
Security Level 3 - Medium Custody	15	12.8%
Security Level 2 - Minimum Custody	94	80.3%

Table 3: Potentially eligible individuals by security and custody level.

Table 4 shows a breakdown of the 23 individuals identified as most likely eligible by security and custody level.

Security and Custody Level	Distinct # of Patients	% of Total Sample
Security Level 5 - Maximum Custody	0	0.0%
Security Level 4 - Close Custody	1	4.3%
Security Level 3 - Medium Custody	8	34.8%
Security Level 2 - Minimum Custody	13	56.5%

Table 4: Most likely eligible individuals by security and custody level.

Three individuals who are potentially eligible (one of whom is most likely eligible) are also listed as having active mental health symptoms that cause serious impairment in functioning in one or more areas and may pose a safety risk for the individual or others. They may also require more intensive treatment such as that provided in a residential treatment unit. In addition, 16 individuals who are potentially eligible (4 of whom are most likely eligible) are also listed as having current active mental health symptoms with moderate severity and with some noted problems with daily functioning.

Conditions such as these may warrant safety and security considerations beyond those represented by custody level and must be addressed on an individual basis.

6 Assessment of funding options

Federal law prohibits states from using federal Medicaid matching funds for healthcare services provided to adult and juvenile inmates of public institutions. The Centers for Medicare and Medicaid Services (CMS) defines a public institution as "an institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control." While in the custody of a public institution, the institution is required to provide medical care to an "inmate."

Whether a person is eligible to receive Medicaid-funded care depends on whether they meet the Medicaid definition of an inmate, what exactly an individual's custody and release conditions are, the level of involvement DOC would have in their release and care, and the ability of long-term care Medicaid providers furnishing their care to otherwise meet federal Medicaid requirements while providing that care. Furthermore, to obtain Medicaid Federal Financial Participation (FFP), individuals involved with the justice system could not have any conditions of confinement that would cause them to meet Medicaid's definition of an inmate or otherwise interfere with their ability to enjoy—or a facility's ability to comply with—Medicaid resident rights laws. We have been successful in the past in creating programs that allow for this.

CMS considers an individual of any age to be an inmate if the individual is in custody and held involuntarily through the operation of law enforcement authorities in a public institution. To be considered not an inmate for the purposes of Medicaid, the individual must have "freedom of movement." By federal and state rules, individuals living and receiving care in nursing facilities have the right to free access to the community and to community activities—such as social, religious, and other group activities—and the right to discharge planning for movement into the community. Individuals receiving services through Medicaid are also entitled to free choice between qualified providers. Section 1902(a) (23) provides that any individual eligible for medical assistance (including medications) may obtain such assistance from any institution, agency, community pharmacy, or person qualified to perform the service or services required that undertakes to provide them such services.

7 Conclusion

Based on the information presented in this report, we can conclude that there are numerous individuals incarcerated in DOC facilities who could meet functional eligibility requirements for services provided through a long-term care facility such as a nursing home. These individuals with high needs currently represent a strain on the medical staff and facilities of DOC institutions, which are not equipped to provide the services that these patients require.

If the state cannot secure the ability to consider partial release as it has with other partial confinement programs, Medicaid funds will simply not be allowed to be used as these individuals are in the custody of public institutions, those institutions are responsible for all their medical care, including any long-term care needs.

Providing the legislature is able to create partial confinement opportunities for SNF-eligible incarcerated individuals, Medicaid funds can be secured for a program involving treatment of these individuals in a facility that can specialize in offering Skilled Nursing services, therapies, treatments, and assistance with ADLs, which could benefit eligible individuals and improve their quality of life. It could also benefit the DOC facilities that are not adequately staffed to provide these needed medical and long-term care services. Having capacity in the community long-term care service delivery system for partially confined individuals will likely be more effective and efficient at meeting the clinical needs of these individuals while relieving DOC from the burden of their care, which detracts from the responsibility of care available to other incarcerated individuals.

It is important to note that SNFs would not be able to serve individuals who are in full, round-the-clock DOC custody under existing state and federal statutes. CMS requires that all SNFs be certified by CMS,

and as a result, they must adhere to federal rules and regulations regardless of payment source. Serving individuals in full DOC custody would require the creation of a separate licensing type or a waiver from current federal statutes. It would also require a specialized staffing model or partnership with DOC to meet custody requirements, making this option highly unlikely to come to fruition.

It should also be noted that DOC's current EMP program does not include incarcerated individuals with "Life Without Parole" sentences. The current language of the RCW governing this program severely restricts DOC's ability to release on EMP, and individuals often die prior to placement. It can take several months to find a viable community placement for individuals with long-term care needs who are being released from DOC custody. Consideration should be made for incarcerated individuals with terminal illnesses for release earlier in their disease progression in order to transfer their intensive medical care needs from DOC facilities to community facilities. Eight individuals in 2019 and 12 individuals in 2020 died while waiting for EMP transitions.

A final report on this matter will be presented to the Legislature by June 30, 2023.

8 Appendix

Abbreviations	Facility Name	Location
AHCC	Airway Heights Corrections Center	Airway Heights, WA
CBCC	Clallam Bay Corrections Center	Clallam Bay, WA
CCCC	Cedar Creek Corrections Center	Littlerock, WA
CRCC	Coyote Ridge Corrections Center	Connell, WA
LCC	Larch Corrections Center	Yacolt, WA
MCC	Monroe Correctional Complex	Monroe, WA
MCCCW	Mission Creek Corrections Center for Women	Belfair, WA
OCC	Olympic Corrections Center	Forks, WA
SCCC	Stafford Creek Corrections Center	Aberdeen, WA
WCC	Washington Corrections Center	Shelton, WA
WCCW	Washington Corrections Center for Women	Gig Harbor, WA
WSP	Washington State Penitentiary	Walla Walla, WA