STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
Aging and Long-Term Support Administration
Home and Community Services Division
PO Box 45600, Olympia, WA 98504-5600

September 1, 2020

To: Data Dissemination Committee

ALTSA works with Administrative Service Organizations (ASOs), Managed Care Organizations (MCOs), state hospitals and community providers when a state hospital identifies that an individual who is ready for discharge may have an unmet need for assistance with activities of daily living. The State Hospital Discharge and Diversion Team assists with transitions from the Western State Hospital and Eastern State Hospital, the two state psychiatric hospitals in Washington State. The team consists of three Transition Coordinators and three Behavior Support Trainers assigned to each region. Additionally there is a Mental Health Nurse Program Manager, and a Behavior Support Trainer.

Transition Coordinator's work directly with their regions and state hospitals in bridging gaps to transitions for those individual's transitioning with Long Term Service Supports with Home and Community Services in addition to collecting data needed to report to the legislative body and the governor of the State of Washington.

There have been instances where Home and Community Services has learned of information found in JIS by Providers post transition or have not been made aware of relevant information prior to an individual transitioning into a community setting. Gaining access to charging and case information in JIS will aid in the transition planning for Home and Community Services.

State Hospital staff share information with Home and Community Services about clients' criminal convictions, but not always the charges against them that have been dropped. That information is not a matter of public record and therefore not kept in the clients' medical charts. If a psychologist or a social worker does not summarize, or copy, information from the JIS report in their assessments (which happens frequently), Home and Community Services does not have access to it. In order for our providers to fully understand the needs of the clients they are serving, they need the full picture of their criminal histories. Providers also need to fully understand the risks to their other clients, the community, and themselves before they decide to serve a client. In instances where we don't have this information, we may transition clients with histories of sex abuse crimes, yet no requirement to register as a sex offender, into homes near children or into homes with others who might be vulnerable to them.

Why HCS needs access to the JS report:

- Clients discharge from WSH to community based placements where they live in the same home with other vulnerable adults and are cared for by paid caregivers. HCS has a responsibility to do a thorough and complete assessment for our clients and part of this assessment is an accurate recording of past behavioral and/or criminal history. WSH documentation does not always provide this.
- HCS Transition Coordinators need access to charging and case information in order to serve the client in the prudent manner. If Transition Coordinators have the ability to see charging and case information, they will be able to prepare the potential care provider with greater information. The ability to have the most detailed charging and case information will allow for better transitions for the clients we serve, and better outcomes for the general public as well.