

## Economic Sense - Twentieth Edition

# Stuck in the Hospital: A Human Tragedy

*A proposed bipartisan remedy to spare individuals who have developmental disabilities but no medical need from being “warehoused” and abandoned in hospitals.*

**"We are approaching Christmas, and, in all likelihood, Mason will be spending it confined to a hospital room . . . Is this really the role of an acute care hospital?..."**

**"As a vulnerable person, someone who needs care, is this the way that Mason deserves to be treated?..."**

**"The support has been horrendous. I feel like banging my head against the wall."**

*- ER doctor, Mason General Hospital, summarizing his experience with the state Developmental Disabilities Administration in attempting to find appropriate care for a patient warehoused without having a medical need<sup>1</sup>*

...

**"This is a preventable problem."**

*- Office of Developmental Disabilities Ombuds<sup>2</sup>*

## Bottom line up front:

The Developmental Disabilities Ombuds, an independent watchdog for issues impacting individuals with developmental disabilities, has identified a pattern of mistreatment and neglect of adults with developmental disabilities stuck in a hospital without any medical need -- often for weeks or months upon end.

The problem is detrimental to the care of the individuals, whose mental health often declines while in this setting, as well as to the hospital, which neither gets reimbursed for the care provided nor whose staff are trained to properly care for the individual.

[SB 5483](#), a bipartisan proposal, is designed to remedy this human tragedy.

## 1) Ombuds Report

Last month, the Developmental Disabilities Ombuds issued a report on a "systemic issue" identified in the care of developmentally disabled adults in Washington.<sup>3</sup> Simply put, persons who are clients with the Developmentally Disabled Administration are being dropped off at hospitals by private caregivers who assert they could no longer manage their care. These individuals often have no immediate medical need, so a hospital is an inappropriate setting for them. Yet the individuals often remain there for weeks or months on end.

### A. Tony lived in the emergency room department for over 100 days<sup>4</sup>

Tony was an autistic adult who needed 24/7 support and resided in a supported-living facility with two other individuals. The provider had trouble supporting Tony and dropped off him at the local hospital. There was no medical reason for Tony to be in the hospital.

After two months of living in the emergency department, Tony's mental health predictably declined. People with autism like Tony understandably could not adjust to living in confined space with little to no social interaction or constructive activities. – Frustrated hospital staff, who are not trained to support an individual with autism, were forced to call the police, hire a security guard, and eventually use chemical and physical restraints to manage Tony's behavior. More than 100 days elapsed before an appropriate non-hospital setting was found for Tony. But by then the damage was done.

## B. This situation is dangerous for the individuals<sup>5</sup>

These vulnerable individuals who are clients of the DDA are being abjectly failed by the agency. As one nurse with firsthand knowledge of the situation stated, "The hospital environment is detrimental for most of them . . . This is not a safe plan, nor is it good for patients with these unique needs."<sup>6</sup>

Clients are often emotionally triggered and overstimulated by a hospital environment, exacerbating their stress and contributing to challenging (and at times dangerous) behaviors. Hospital staff, not trained to deal with these issues, often have their own well-being severely compromised as a result, according to the report.

## C. Costly to the medical system: Hospitals are financially hung out to dry because of such care, and the inappropriate use of beds means that people with medical needs do not get timely treatment<sup>7</sup>

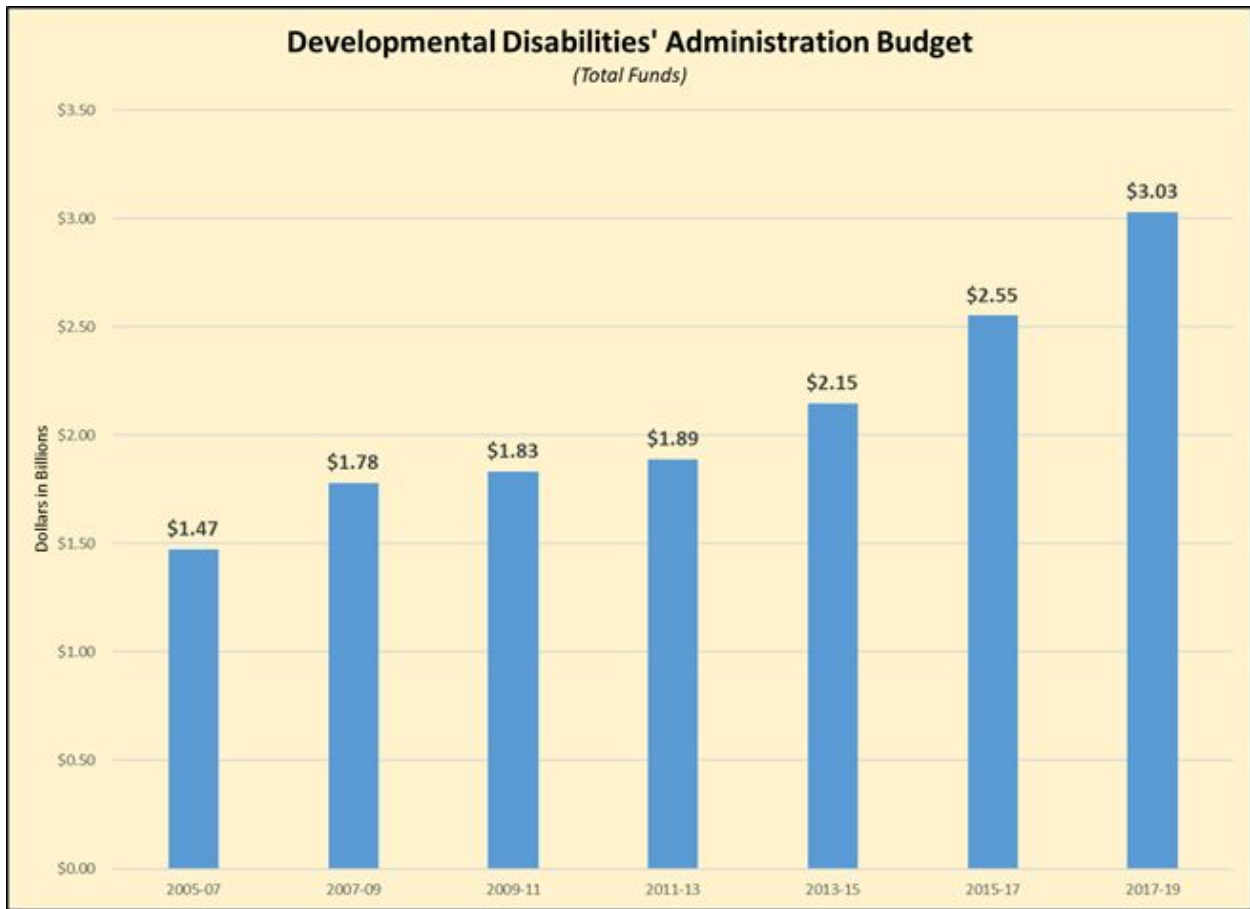
Hospitals are put in a Catch-22. There typically is no medical need for the individual, so the hospital largely cannot charge or get reimbursed for the care provided. Yet, due to federal guidelines and basic human decency, the hospital also cannot discharge the individual until there is an appropriate setting.

And, of course, the occupied beds mean that other patients -- people with actual medical needs -- do not receive the timely care they need or for which the hospital is actually designed to treat.

## D. DDA Doesn't Even Know Scope of Problem

Perhaps most damning of all, DDA admits it does not even know the scope of the problem of how often or how long their clients are warehoused in a hospital, without having need for any medical treatment.<sup>8</sup>

This is an agency with a biennial budget exceeding \$3 billion, and nearly 4,000 staff, which has seen its funding more than double in 12 years -- with a particularly acute spike occurring in the past six years (funding up over \$1 billion).<sup>9</sup> Given the size of this agency's staff and budget, there is simply no excuse for DDA's failure to track treatment and outcomes for this vulnerable population.



## 2) “Mason”: A Case Study

A recent case, documented by an emergency room doctor at Shelton’s Mason General Hospital on the blog, "Stuck in the Hospital," is an eye-opening account of this issue first-hand.<sup>10</sup>

"[A]n injustice perpetrated by the WA state government against a disabled person" is how Dr. John Short begins his first entry, detailing the case of "Mason" (a pseudonym) who was brought to Mason General Hospital.<sup>11</sup>

Dr. Short's initial post was made on Christmas Eve, at which point Mason had been in the hospital for nearly two weeks despite no medical need:

*"Mason" has been abandoned by DSHS and the State of Washington at Mason General Hospital (MGH) in Shelton, WA since the 12th of December, 2018 . . .*

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*"His first six days were spent in the chaotic environment of the emergency department where lights are on 24/7, it is noisy, and potentially dangerous. He had to be confined to his own room for his safety. Other patients came and went as they pleased. No progress was made regarding finding Mason a home. On December 16th I was finally able to reach Kristine Pederson, the Region 3 administrator of the DDDA. She assured me that work would begin Monday morning on Mason's case . . .*

*"We heard nothing that Monday but on Tuesday we held a telephone conference with members of our hospital administration, representatives of the medical staff, a State Attorney General, myself, and several DDA staff. During that and the meetings that followed in subsequent days, we were informed there was no progress on finding a home for Mason and that the state would no longer be accommodating our request for further daily updates. We were given the impression that there would likely be no progress on Mason's case until after the holiday. Of course, unlike hospitals, the state is unavailable on weekends and holidays, even in crisis situations.*

*"We proposed to discharge Mason and take him to a DDA office. At this point in the conversation, a DDA staff member said that we would be met with the charge of "unsafe discharge," a blatant reminder of who holds the upper hand."<sup>12</sup>*

On Christmas Day, Dr. Short posted a picture of Christmas gifts intended for Mason, writing:

*"Thanks to all who donated gifts to Mason. Thanks to the awesome staff at MGH who have taken up the mantle of caring for him. It appears that we are his only family at this point. I wonder what the staff of WA State and DSHS are doing today."<sup>13</sup>*

A subsequent blog entry again lamented the absence of communication from DDA, noting the agency's inaction and lack of urgency amounted to a "shameful abdication of responsibility" and that despite not having the expertise, the staff at the hospital "continue to do what we do best in addition to doing what DSHS/DDA is supposed to do best."<sup>14</sup>

Finally, after 15 days in the hospital, the story of Mason began generating some press attention, with NPR, KOMO, and newspapers inquiring and reporting on the events.

The press attention finally seemed to spur government action. The day after the KOMO news report appears on television, the hospital is "told by a high-level administrator that the DDA will have staff out to evaluate Mason on Monday for possible placement."

Finally, after 21 days in the hospital, Mason is transported to an appropriate facility that can adequately meet his needs. Even this is not without incident:

*"Mason's transport to his new facility had to be arranged entirely by our hospital as 'the DDA does not provide transport from a hospital.' This is truly unreal. Mason was brought to us, left for 3 weeks, and the DDA won't even arrange for transport. . . .*

*In addition, someone affiliated with the DDA arrived today with a bunch of Mason's clothing that had been washed, not dried, and placed in a garbage bag. The support has been horrendous. I feel like banging my head against the wall."<sup>15</sup>*

Local hospitals arranging for Mason's transport? Mason's wet clothes dropped off in a garbage bag? People with developmental disabilities should never be treated this way. Our state agencies must do better.

### 3) SB 5483: A Proposed Remedy

[SB 5483](#), a bipartisan proposal sponsored by Sen. Karen Keiser (D-Kent) and myself, incorporates many of the Ombuds recommendations and is designed to address and alleviate this tragic systemic issue. It would require greater tracking of information, assistance to community providers, placement of clients in a state-run residential habilitation center instead of a hospital if a provider abandons care, and, in the event a hospital placement does occur, the prioritization of the case and appropriate hospital compensation from DDA.

#### What the Bill Does

A. Requires DSHS to track and monitor certain information about DDA clients who are in the hospital without a medical need

This is a recommendation of the Ombuds report, as the Ombuds found that DDA did not currently track this information, so the scope of the problem is unknown.

B. DSHS shall provide, to the extent available, crisis stabilization services to support the provider and client in the client's current setting.

The Ombuds notes that the problem often arises from providers who feel overwhelmed by a client's behavior and resort to terminating client care by dropping them off at a hospital. The bill directs DSHS to prioritize crisis stabilization services, to the extent available, to help ensure continuing care in the client's present setting.

C. In the event a provider terminates a client's services, DSHS is required to transition the client to an alternative residential setting or a state-run residential habilitation center (RHC).

Both of these settings are better equipped to care for the individual and ensure proper treatment for a patient in crisis than a hospital.

As one commenter on Dr. Short's blog noted:

*"There are appropriate places to provide this care – it's called the Residential Habilitation Center (RHC) in our state. These are campus community settings which specialize in the care of people with developmental disabilities, many who may have behavior issues or mental health diagnoses."<sup>16</sup>*

There are four such facilities in the state, with over 2,300 staff serving 750 clients presently. These institutions have the expertise – and capacity – to serve high-needs individuals in crisis. The institutions have budgets of over \$200 million a year, providing care at an average cost per client of \$300,000 per developmentally disabled adult. As recently as seven years ago, these institutions served 200 more individuals than they are currently serving.<sup>17</sup>

D. Requires DSHS to reimburse any hospital caring for certain clients without a medical need at the daily RHC rate.

In the event a client without medical need is placed in a hospital, the bill requires the hospital to be reimbursed at the daily RHC rate. DSHS is also directed to make every effort to engage in frequent communication with the hospital and provide frequent updates on transitioning the client to a more appropriate setting.

Finally, the bill has an emergency clause, causing the provisions to go into effect immediately when the legislation is signed into law, rather than waiting the standard 90 days (after the end of the relevant legislative session) before taking effect.



## Footnotes:

1. <https://stuckinthehospital.home.blog/> (January 3, 2019)
2. <https://ddombuds.org/wp-content/uploads/2018/12/DD-Ombuds-Hospital-Report-12.10.18-Final.pdf> (p. 7)
3. Id., p. 2
4. Id., p. 4
5. Id., p. 2
6. Id., p. 4
7. Id., p. 2
8. Id., p. 7
9. [fiscal.wa.gov](http://fiscal.wa.gov).
10. <https://stuckinthehospital.home.blog/>
11. Id., Dec. 24, 2018 entry
12. Id.
13. Id., Dec. 25th entry
14. Id.
15. Id., January 3, 2019 entry
16. Id., January 4, 2019 comment to "Day 20 in the Hospital"
17. Legislative Budget Notes