

**Aging and  
Long-Term  
Support  
Administration**

Bill Moss, *Assistant Secretary*

2013-2015

# Strategic Plan

January 2015



**VISION**

Seniors and people with disabilities living with good health, independence, dignity, and control over decisions that affect their lives

**MISSION**

To transform lives by promoting choice, independence and safety through innovative services

**VALUES**

Collaboration  
Respect  
Accountability  
Compassion  
Honesty and Integrity  
Pursuit of Excellence  
Open Communication  
Diversity and Inclusion  
Commitment to Service

## Introduction

The Department of Social and Health Services Aging and Long-Term Support Administration (AL TSA) offers services that empower adults who are older and people with disabilities to remain independent and supported in the setting of their choice. This is accomplished through person-centered case management that works with individuals to build a care plan that reflects individual choices and preferences.

AL TSA offers a variety of services that support people in the community, including:

- Determining Medicaid eligibility for services provided in home and community-based settings and nursing facilities.
- Support services and resources for family and kinship caregivers.
- Personal care and supportive services for individuals living in their own homes, adult family homes and assisted living settings.
- Assistance with skilled nursing needs available in all settings.
- Assistance with movement from nursing homes to independent living.
- Information and assistance regarding services available in-home, and in adult family homes, assisted living facilities, and nursing homes, including options counseling for individuals regardless of income.
- Locally-designed programs focused on the needs of adults who are older.
- The Stanford University Chronic Disease Self-Management Education Programs and other evidence-based health promotion programs.
- Care coordination for foster children to support improved outcomes for children and their families.

AL TSA is also responsible for protecting the safety, rights, security, and well-being of people in licensed or certified care settings and for the protection of adults who are vulnerable from abuse, neglect, abandonment, and exploitation. AL TSA conducted more than 16,000 abuse investigations last year. In addition to investigating abuse, AL TSA offers protective services when the situation requires action in order to ensure adults who are vulnerable are safe.

### AL TSA Core Principles

AL TSA's strategies are driven by several bedrock principles. Staff are essential in carrying out these core principles and are one of the primary reasons the state's long-term care system is ranked as one of the best in the nation.

We believe the people we support:

- Should have the central role in making decisions about their daily lives.



- Will choose supports that promote health, independence, community integration, and self-determination.
- Succeed best when support is person-centered and recognizes that their needs are interrelated.

We believe families and friends of the people we support:

- Are an essential reason many people can live successfully in their own homes and communities.
- Can realize a positive difference in their lives, and the lives of their loved one, with even a small investment in support.
- Act as advocates for quality support and services in the best interest of their family member or friend.

We believe the **system of services** administered by ALTSA must be:

- Accountable for outcomes and costs.
- Informed by evidence of effectiveness.
- Responsive to changing needs.
- Sustainable over time and within realistic resource estimates.
- Collaborative with service recipients, families, communities, providers, partners, and other stakeholders.
- Accessible to individuals who are Limited English Proficient or have a communication barrier due to a disability.
- Able to keep people free from abuse and neglect, and support shared responsibility with individuals, families, providers, advocates and communities to prevent or respond to abuse and abusers.

## Goals

### Governor Jay Inslee's Results Washington Goals

ALTSA is a partner in Governor Jay Inslee's **Results Washington**, a focused effort to create effective, efficient, and accountable government.

**Results Washington** Goal Area number 4 is Healthy and Safe Communities. Under this goal area, ALTSA has lead responsibility for two success metrics under the Supported People: Quality of Life success indicator.

The ALTSA **Results Washington** success metrics are:

- Increase the percentage of supported seniors and individuals with a disability served in home and community-based settings from 86.6 percent to 87.2 percent by 6/30/2015.
- Increase the percentage of aging and long-term service and support clients served in home and community-based settings from 82.9 percent to 83.7 percent by 6/30/2015.
- Decrease the percentage of vulnerable adult abuse and neglect investigations open longer than 90 days from 29% percent to 12.05 percent by 6/30/2015.



## Department of Social and Health Services (DSHS) Goals

As a member of the DSHS team, AL TSA also has lead responsibility for performance metrics that fit within DSHS' departmental goals. DSHS has the following five broad goals:

- Health – Each individual and each community will be healthy.
- Safety – Each individual and each community will be safe.
- Protection – Each individual who is vulnerable will be protected.
- Quality of Life – Each individual in need will be supported to obtain the highest possible quality of life.
- Public Trust – Strong management practices will be used to ensure quality and efficiency.

## AL TSA Success Metrics Supporting the DSHS Goals

### Health:

- Increase the number of individuals with high medical risks receiving Health Home services.
- Increase the number of individuals receiving coordinated services through Medicare and Medicaid.
- Increase the number of contacts and care recommendations for children referred to the Fostering Well-Being Care Coordination Unit as well as increasing discharges from the unit once services are no longer needed.

### Safety:

- Timely licensing re-inspections of Adult Family Homes, Assisted Living Facilities and Nursing Homes.
- Timely quality assurance for Residential Habilitation Centers and Supported Living Facilities.

### Protection:

- Timely response to abuse and neglect allegations for adults who are vulnerable who live in their own home or in licensed or certified long-term care facilities.
- Decrease the number of open cases per investigative staff (caseload).
- Decrease the percentage of abuse investigations open longer than 90 days.

### Quality of Life:

- Increase the percentage of long-term services and support clients receiving services in home and community-based settings.
- Increase the number of clients who relocate from nursing homes to home and community-based settings.
- Increase the percentage of caregivers supported in the Family Caregiver Support Program, as an alternative for care recipients who remained without Medicaid long-term care services for 90 days or longer.
- Increase the number of applications approved within required timeframes. Improve the determination of functional and financial eligibility and access to services.
- Increase the number of completed captioned relay calls to better serve people who are deaf, hard of hearing or deaf-blind from 248,181 to 276,210 by July 2015.
- Increase number of sites with assistive listening systems to better serve people who are deaf, hard of hearing or deaf-blind from 4 to 40 by December 2015.
- Successfully meet benchmarks to develop and fully implement the Medicaid Community First Choice Option not later than August 30, 2015.



- Successfully meet benchmarks outlined in Substitute Senate Bill 6124 to develop a state Alzheimer’s plan and submit findings with recommendations including draft legislation to the Governor and both health care committees of the Legislature by January 1, 2016.
- Begin implementation of an employment pilot project for working age individuals receiving long-term care services and supports by January 2015.
- By Spring of 2015, complete Phase I of the Money Follows the Person Tribal Initiative demonstration project with approval from the Centers for Medicare and Medicaid Services to move to Phase II of the project.

**Public Trust:**

- Implement Track 1 of an electronic payment system that will significantly increase overall payment integrity for social services organizations (known as 1099 providers) that contract with DSHS to provide long-term services and supports to DSHS clients by the end of 2014.
- Implement Track 2 of an electronic payment system and subsystem that will significantly increase overall payment integrity for Individual Providers that contract with DSHS to provide personal care services to DSHS clients by Fall of 2015.
- Train all new staff in their core work functions and provide ongoing skills development to existing staff throughout 2014.
- Implement the IT Security Project to increase safeguards to consumer identities and personal health information.
- 100% timely completion of Home and Community Services Division case management and financial eligibility compliance record reviews.
- 100% timely completion of on-site monitoring visits of Area Agency on Aging operations.
- 95% of audited Nursing Home Statement of Deficiencies (SODs) are sent to the facility within the federal regulatory standard of 10 working days.

## Strategic Plan

Below are the details of AL TSA’s Strategic Plan to meet each Strategic Objective. Strategic Objectives are discussed under the respective DSHS goal area. Strategic Objectives include a statement of importance, a quantified success measure, a timeline and, most importantly, an Action Plan. Strategic Objectives are monitored and reported quarterly at:

<http://www.dshs.wa.gov/ppa/strategic.shtml>. Action Plans are updated quarterly (where applicable).

The AL TSA Management Team is responsible for monitoring each objective to ensure progress is made towards meeting success measures.

### Strategic Objectives, Importance, Success Measures and Action Plans

**DSHS Goal 1: Health – Each individual and each community will be healthy.**

**Strategic Objective 1.1:** Improve health outcomes for individuals with high medical risk factors through implementation of the Medicaid Health Home services.



**Importance:** Individuals with high medical risk factors continue to experience poor health outcomes, in many cases because of low engagement in managing their health needs. This results in poor outcomes for the individual and higher costs for the state. Assisting individuals to self-manage their chronic conditions through the provision of Health Homes can empower them to take charge of their health care.

**Success Measure:** Increase the number of individuals who are engaged in Health Home services to 28% through the establishment of a Health Action Plan. Reporting requirements and benchmarks for performance measures are currently being finalized.

**Action Plan:** Implementation of Health Home services went into effect in July and October of 2013. The state will begin reporting on the final outcome measures in June 2015. Collaborate with the Health Care Authority and Behavioral Health and Service Integration Administration/DSHS to address implementation issues related to consumer enrollment and engagement in Health Home services. Provide subject matter expertise for care coordination training and the delivery of long-term care services and supports through Health Home services. Train care coordinators in Motivational Interviewing to support clients in changing behaviors to achieve their health goals. Participate in regional meetings to promote ongoing communication and coordination between Health Home coordinators and the broader long-term care system to make appropriate client referrals for Health Home services.

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**Strategic Objective 1.2:** Improve health outcomes, coordination of care and the individual's experience of care through implementation of the HealthPath Washington Integration demonstration project in Snohomish and King Counties.

**Importance:** Washington is partnering with the federal Centers for Medicare and Medicaid Services to improve care for individuals receiving both Medicare and Medicaid services. HealthPath Washington is a joint demonstration project between DSHS and the Health Care Authority (HCA). The project will test a managed care financial model that integrates the purchase and delivery of Medicare and Medicaid medical care, behavioral health and long-term services and supports through a single health plan. Enrollment will be voluntary and participants will be able to choose between health plans. Both counties have provided valuable input into the design and will continue with implementation efforts, monitoring and evaluation. The target date for implementation is July of 2015.

**Success Measure:** Increase the number of individuals receiving coordinated services through Medicare and Medicaid.

**Action Plan:**

- Collaborate and partner with other DSHS administrations to provide input and guidance toward implementation of the fully-capitated model. Determine policy, coordination, waiver authorities and communication strategies on how to incorporate long-term services and supports in the managed care model.
- Continue to work with King and Snohomish County Area Agencies on Aging and ALTSA field offices regarding implementation planning.
- Develop and execute a 3-way contract between the Centers for Medicare and Medicaid Services, the state and the health plans.
- DSHS and HCA will provide ongoing beneficiary, stakeholder and staff outreach and training prior to implementation.



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**Strategic Objective 1.3:** Improve health outcomes for children in foster care through delivery of care coordination services.

**Importance:** The Fostering Well-Being Care Coordination Unit supports the health and well-being of children in foster care by providing an overview of the health care needs of the child, supporting access to health care providers, navigating systems of care as needed, and providing medical, nursing and benefit expertise to social workers and families. On average, children served by the Fostering Well-Being program have substantially greater health needs than other children receiving Medicaid services in Washington State, including hospitalization<sup>1</sup>. These children experience a dramatic reduction in medical utilization in the 12 months after program entry<sup>2</sup>.

**Success Measure:** Increase the number of contacts and care recommendations for children referred to the Fostering Well-Being Care Coordination Unit as well as increasing discharges from the unit once services are no longer needed.

**Action Plan:** Results of the March 2014 Lean Value Stream Map will be used to implement improvements to unit workflow, products, and communication. A plan will be developed with the Children’s Administration and the Health Care Authority, outlining changes to unit functions and responsibilities when children begin receiving health care through managed care organizations.



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## **DSHS Goal 2: Safety - Each individual and each community will be safe.**

**Strategic Objective 2.1:** Affirm Adult Family Homes, Assisted Living Facilities and Nursing Homes are providing quality care and residents are safe through timely licensing re-inspections.

**Importance:** This measure ensures licensing re-inspections are completed timely, provider practice is consistent with quality care, and that adults who are vulnerable are protected from abuse. Licensing re-inspections are a valuable tool to ensure the quality of care.

**Success Measure:** Maintain the percentage of timely re-inspection at 99 percent.

**Action Plan:** At the end of 2013 and early in 2014, Washington had several late nursing home surveys. Performance is back on track due to changes to the scheduling process to better anticipate and respond to workload; and recruitment and retention to reduce vacancies in nursing home surveyor positions.

*[This Strategic plan cycle does not have the nursing home re-inspection data updated due to staff changes and a decision that followed to align this report with how the measure is currently reported to the Centers for Medicare and Medicaid. This action will reduce duplication of work and associated data tracking challenges.]*

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<sup>1</sup> <http://www.dshs.wa.gov/sesa/rda/research-reports/washington-states-fostering-well-being-program-impacts-medical-utilization>.

<sup>2</sup> <http://www.dshs.wa.gov/sesa/rda/research-reports/washington-states-fostering-well-being-program-impacts-medical-utilization>.

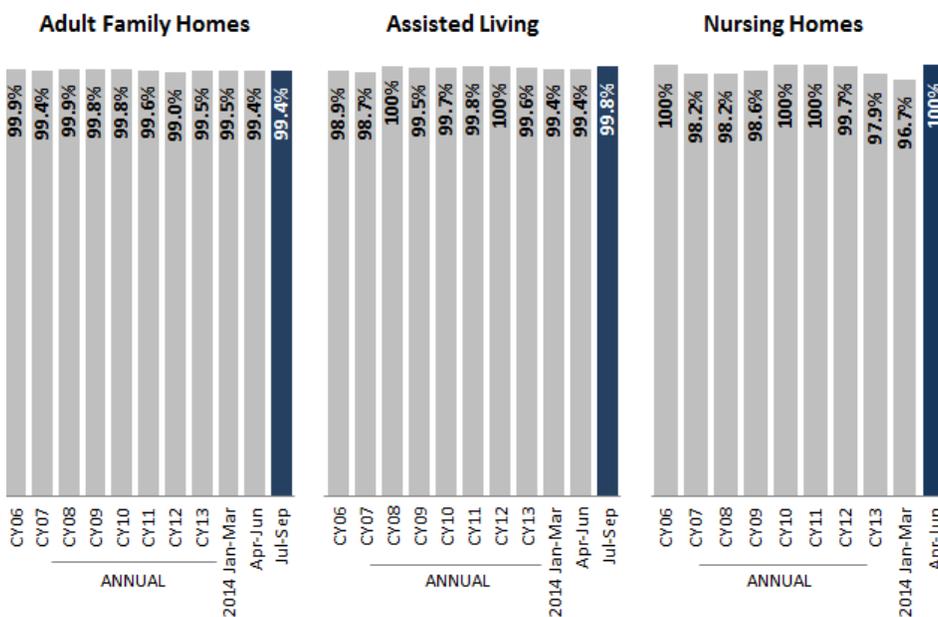


AL TSA will continue to pursue re-inspection of these facilities within the required statutory timeframe and assess the provider’s ability to ensure residents’ quality of life, care, and safety needs. AL TSA will seek additional staffing to enhance our capacity to conduct unscheduled inspection visits, which ensure that the Department is getting an accurate picture of the quality of care provided in each facility. Implement quality improvement initiatives identified in the March 2014 A3 problem solving process. See corresponding chart, below.

See analysis and plan at: [AL TSA Action Plan 2.1 – Affirm Adult Family Homes, Assisted Living Facilities and Nursing Homes are Providing Quality and Safe Care](#)

**CHART 2.1 Timely Licensing Re-inspections of Adult Family Homes, Assisted Living Facilities, and Nursing Homes**

Statewide Average



**Strategic Objective 2.2:** Affirm Residential Habilitation Centers and Supported Living Facilities are providing quality care and residents are safe through timely quality assurance activities.

**Importance:** This measure ensures quality assurance activities are completed timely to help promote the quality of care and protect adults who are vulnerable from abuse and neglect.

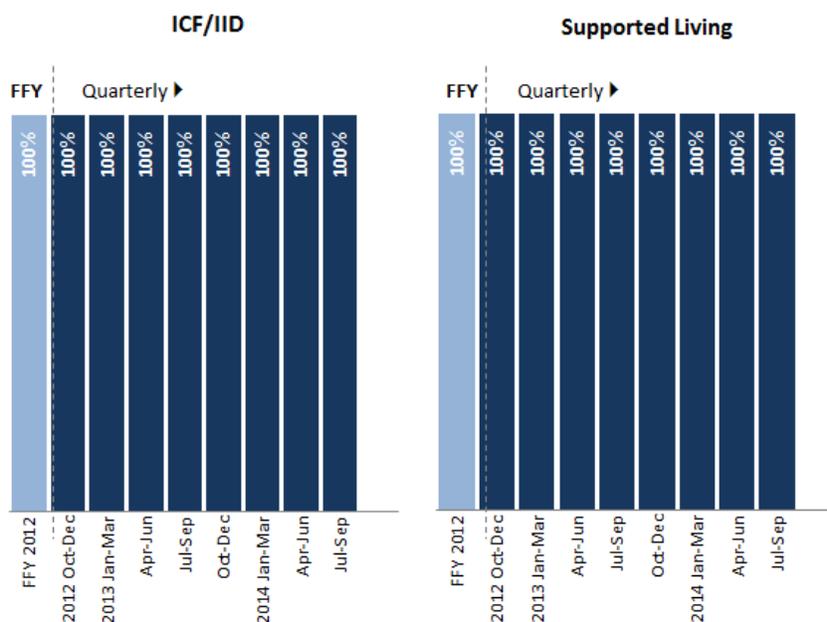
**Success Measure:** Maintain timely quality assurance activities at 100 percent.

**Action Plan:** Conduct quality assurance activities in Residential Habilitation Centers and Supported Living Facilities within the required statutory timeframes and assess the provider’s ability to ensure residents’ quality of life, care, and safety needs.

See analysis and plan at: [AL TSA Action Plan 2.2 – RCS – Enforcement Action Process](#)



**CHART 2.2 Timely Quality Assurance for Residential Habilitation Centers and Support Living Facilities**



**DSHS Goal 3: Protection - Each individual who is vulnerable will be protected.**

**Strategic Objective 3.1:** Protect adults who are vulnerable who live in their own homes and in facilities through timely responses to allegations of abuse and neglect.

**Importance:** Adult Protective Services has two primary duties: **1)** ensure adults who are vulnerable are protected and **2)** investigate allegations to determine if abuse occurred. Timely response is essential in order to provide protective services to individuals who are aged and disabled.

**Success Measure:** Maintain timely response to high-priority investigations at 99 percent, increase percentage for medium-priority investigations to 98 percent and increase percentage for low-priority investigations to 97 percent by the end of 2014. While a rapid response to individuals at risk of abuse is very critical, it comes at the expense of completing investigations timely. As a result, the backlog of open cases and the quality and comprehensiveness of investigations is impacted when resources are targeted to meet initial response times.

**Action Plan:** The Department has leveraged staffing received for increases in workload and caseload to secure additional staff to meet response times. The state’s new consolidated automated system; Tracking Incidents of Vulnerable Adults (TIVA) went live on May 12, 2014 and is expected to significantly improve incident tracking of individuals who are aged and have disabilities. Finally, the Department is also in the process of implementing improvements resulting from several quality initiatives conducted using Lean techniques. Examples of improvements and efficiencies include reductions in time spent on intakes and referrals as well as in time spent from assignment to investigation.

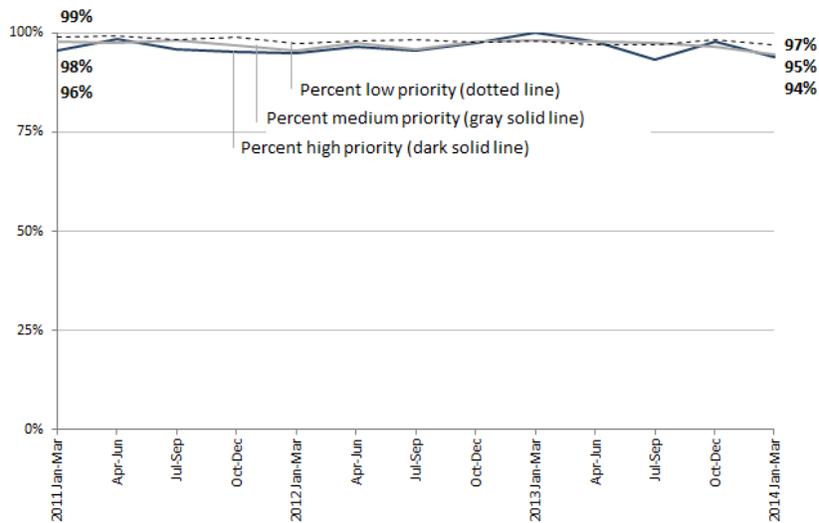
Note: The first three months of the TIVA roll-out may impact the data for response times for in-home



cases while staff learn and become familiar with the new system. This Strategic Plan cycle does not include the latest quarterly data update due to IT system migration, data conversion as well as the recent integration of the Resident Client Protection Program (RCPP) within Adult Protective Services (APS). Additional time is needed to validate and fully integrate RCPP data into a single measure.

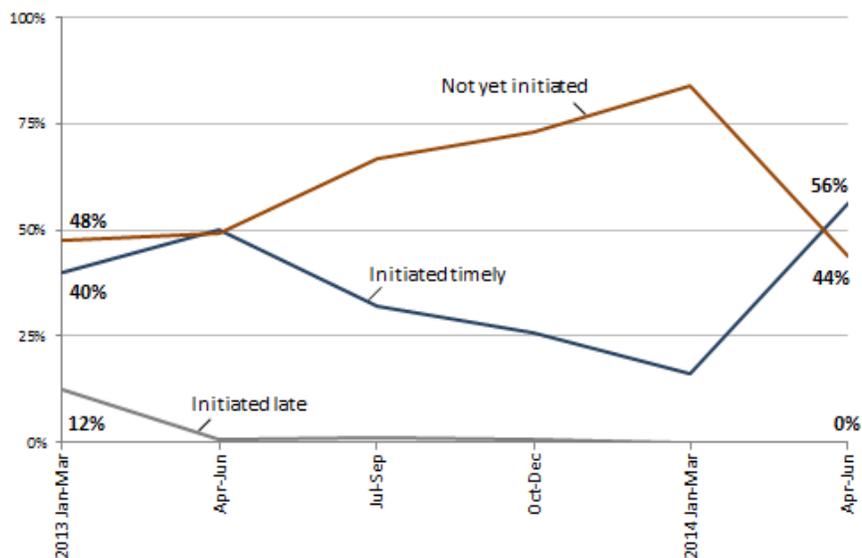
**CHART 3.1a Timely Initial Response Based on Adult Protective Service Case Priority**

Percent timely APS initial contact based on case priority - Statewide



**CHART 3.1b Timely Response to Abuse and Neglect by Alleged Perpetrators in Long-Term Care Facilities**

Statewide - Percentage of timely initial contact for RCPP investigations



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**Strategic Objective 3.2:** Obtain an adequate number of Adult Protective Services staff in order to ensure the quality of investigations and timely provision of protective services.

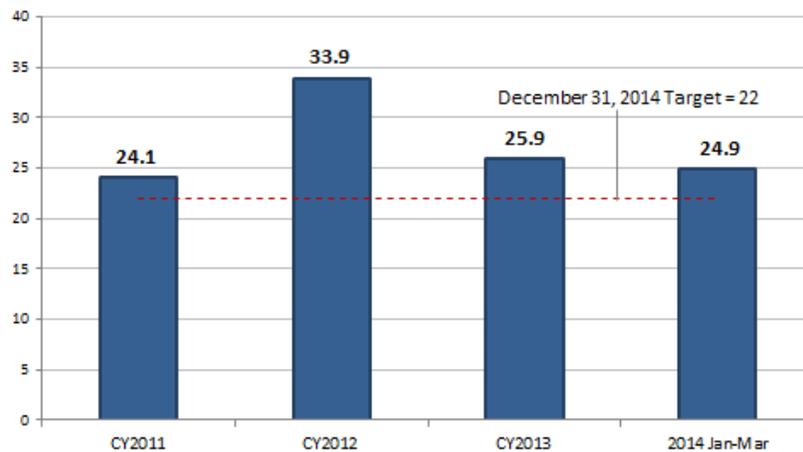
**Importance:** Current Adult Protective Services caseloads are too high. This creates a backlog in the number of cases open and makes it difficult for staff to meet response times, especially for medium and low priority cases. The current caseload ratio is anticipated to be 22:1 for July forward, once data during the TIVA migration period has been verified. However, the increase in intakes coupled with continued staff turnover in some areas of the state make it difficult to consistently maintain the targeted ratio statewide.

**Success Measure:** Reduce abuse and neglect caseloads from 27:1 to 22:1 by the end of 2014.

**Action Plan:** Monitor open cases on a monthly basis. In order to mitigate the lack of staff resources, the Department has leveraged current funding to hire additional staff. A 2013 Lean A-3 Problem Solving Strategy is being used to identify opportunities to improve effectiveness, create efficiencies and reduce turnover. Additional activities are outlined in a related March 2014 A3 update under strategic goal 3.3, below. This Strategic Plan cycle does not include the latest quarterly data update due to IT system migration, data conversion as well as the recent integration of the Resident Client Protection Program (RCPP) within Adult Protective Services (APS). Additional time is needed to validate and fully integrate RCPP data for this measure.

CHART 3.2 Adult Protective Services Workload: Open Investigations per Worker

Average Open Investigations per Worker - Statewide



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**Strategic Objective 3.3:** Ensure investigations are thorough, documented properly, and completed timely to maintain an efficient work flow that eliminates re-work caused by investigations which remain open longer than necessary.



**Importance:** Protection of adults who are vulnerable requires adequate staffing to conduct thorough screening and consistent investigations, and provide protective services and referrals. When this does not occur, these adults are put at greater risk of harm and experience untimely access to critical resources such as guardianship for those who lack decision-making capacity. The lack of adequate staffing has produced a backlog in the number of cases remaining open longer than 90 days. This creates re-work for staff and delayed results or findings against the alleged perpetrator. These delays expand the time it takes to place a perpetrator on the Aging and Disability Services Registry. Reducing this backlog will ensure faster results regarding findings of abuse and improve workflow and efficiency.

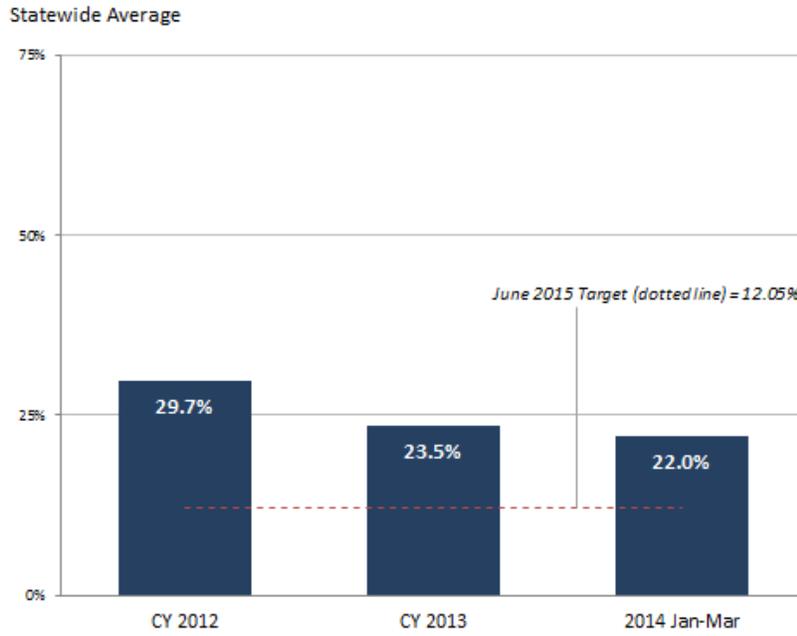
**Success Measure:** Decrease the percentage of vulnerable adult abuse and neglect investigations open longer than 90 days from 29 percent to 12.05 percent by 6/30/2015. This measure is only attainable if additional resources are appropriated to achieve adequate staffing levels.

**Action Plan:** The Department leveraged maintenance level funding to hire additional staff. This, in combination with Lean activities described below, will ensure the success measure is met by the projected date. Staff will monitor investigations open beyond 90 days and track data for use in staffing projections and streamlining opportunities. A [Value Stream Mapping \(VSM\)](#) activity was conducted in April 2014 to examine the intake process which identified efficiencies in the process that will lessen the “touch time” (time it takes to process each referral) allowing staff to work toward elimination of the backlog. Washington is participating in the development of a decision-making screening tool to ensure consistent screening and referral for capacity assessments. Additional activities are outlined in a related March 2014 A3 update: [ALSA A3 Action Plan 3.3 – Investigations Closed within 90 Days](#).

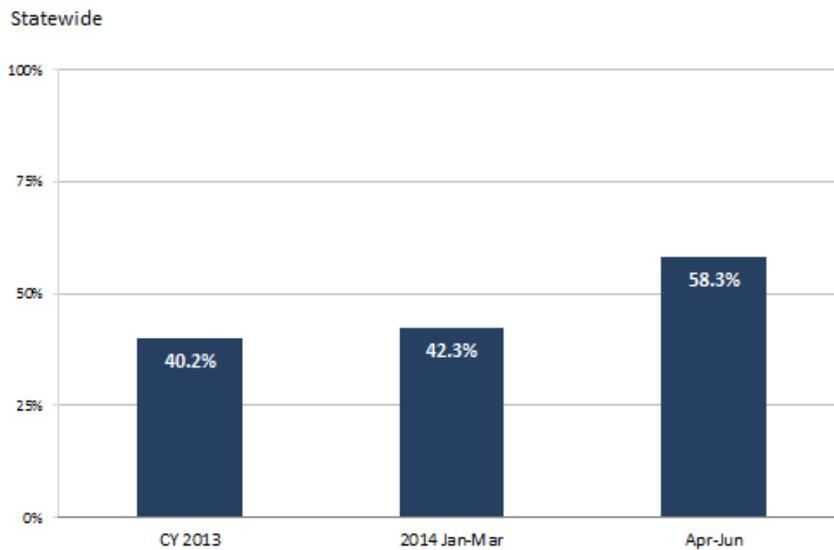
ALSA will merge all investigations related to Chapter 74.34 RCW under Adult Protective Services in the Fall of 2014. This is being done to: 1) align all protective services policies and statutes under one single division within ALSA; 2) provide business efficiencies and integrate local oversight, supervision and structure; 3) leverage staffing forecasting models; and 4) better coordinate and communicate with stakeholders, providers and community members. Additional time is needed to validate and fully integrate 90-day open investigation data into a single measure. As a result, this Strategic Plan cycle does not include the latest quarterly data update.



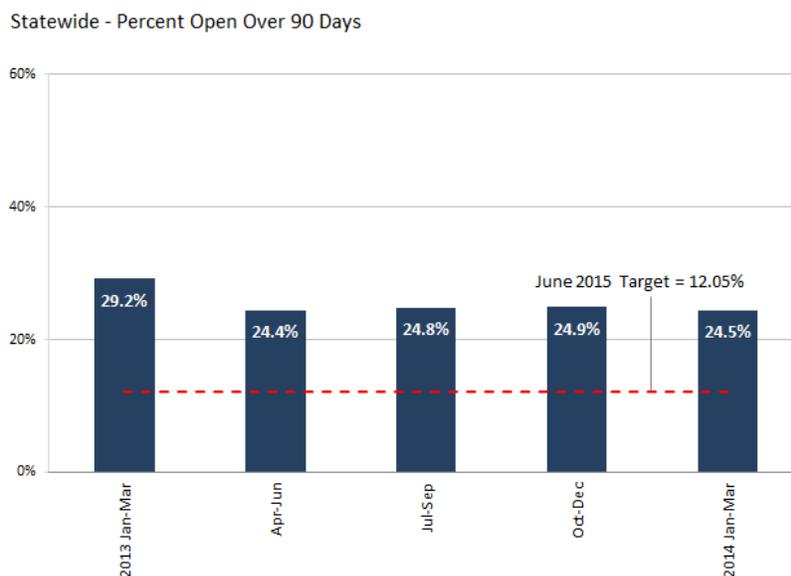
**CHART 3.3 Percent of Vulnerable Adult Abuse and Neglect Investigations Open Longer than 90 Days (Adult Protective Services)**



**CHART 3.3a Percent of Abuse/Neglect Investigations Open Longer than 90 Days (Alleged Perpetrators in Facilities)**



**CHART 3.3b Vulnerable Adult Abuse and Neglect Investigations Open Longer than 90 Days (Adult Protective Services and Resident and Client Protection Program Combined)**



## **DSHS Goal 4: Quality of Life - Each individual in need will be supported to attain the highest possible quality of life.**

**Strategic Objective 4.1:** Ensure seniors and individuals with a disability who are in need of long-term services and supports are supported in their community.

**Importance:** The hallmark of Washington’s long-term services and supports system is that, whenever possible, individuals are given the opportunity to live and receive services in their own home or a community setting. Developing home and community-based services has meant Washingtonians have a choice regarding where they receive care, and has produced a more cost effective method of delivering services. The development of home and community-based services resources continues to evolve as individuals’ support needs change. Washington is recognized as a national leader in this area.

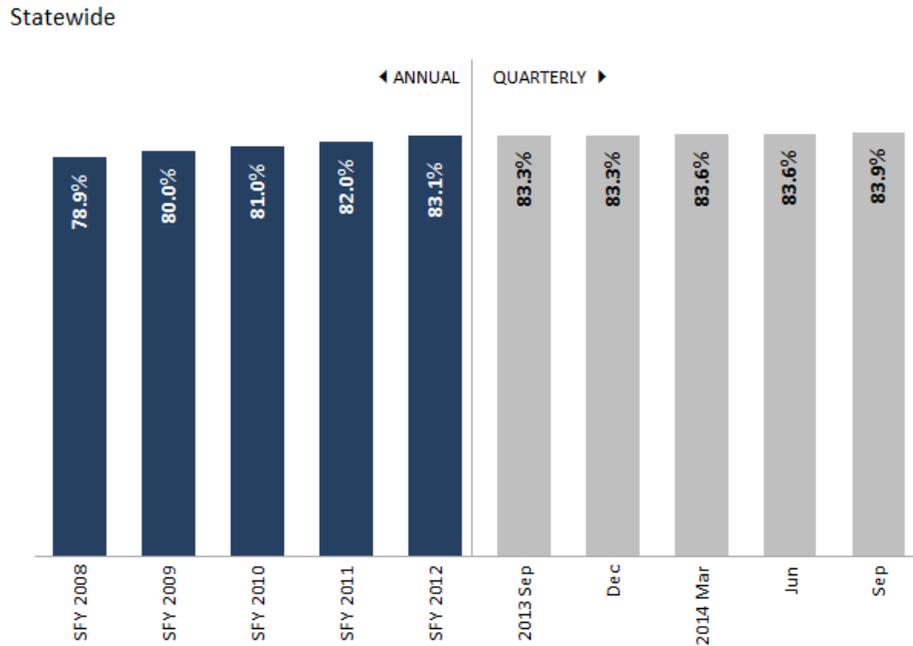
**Success Measure:** Increase the percentage of long-term services and supports clients served in home and community-based settings from 82.9 percent to 83.7 percent by 6/30/2015.

The Administration has met and slightly exceeded this performance measure to 83.9 percent as of 09/30/2014.

**Action Plan:** Monitor performance in the next six months and determine what the next target goal will be. Continue to work with individuals in person-centered service planning to develop service plans that reflect individual needs and preferences. Develop more strategies that utilize available services to support individuals with complex physical and behavioral support needs. Work both at the statewide and local, regional levels to continue the development of home and community-based resources to ensure individual needs can be met in the least restrictive setting, including services for specialized populations. Evaluate current specialty training to identify recommended improvements. Consistently offer outreach and training for case management staff regarding services planning and authorization of services to best support individuals to remain in their setting of choice. Create consumer-friendly, web-based information to assist individuals in locating and choosing appropriate facilities. Develop additional resources to support families and informal caregivers. Additional activities are outlined in a related March 2014 A3 update, below.



CHART 4.1 Percent of Long-Term Services and Supports Clients Served in Home and Community-based Settings



**Strategic Objective 4.2:** Increase the number of individuals AL TSA is able to assist in transitioning to their homes or the community from nursing homes.

**Importance:** The majority of individuals who require support choose to receive help in their home or a community-based setting. Washington State has developed a system that is cost effective and offers individuals choices regarding how and where they will be supported. We believe there is opportunity to increase the number of individuals being supported in the community. By doing so, we facilitate choice, increase quality of life, and contribute to the financial health of Washington. Washington is recognized as a national leader in this area.

**Success Measure:** Increase the average number of individuals relocated from nursing homes quarterly to 950 by the end of 2015.

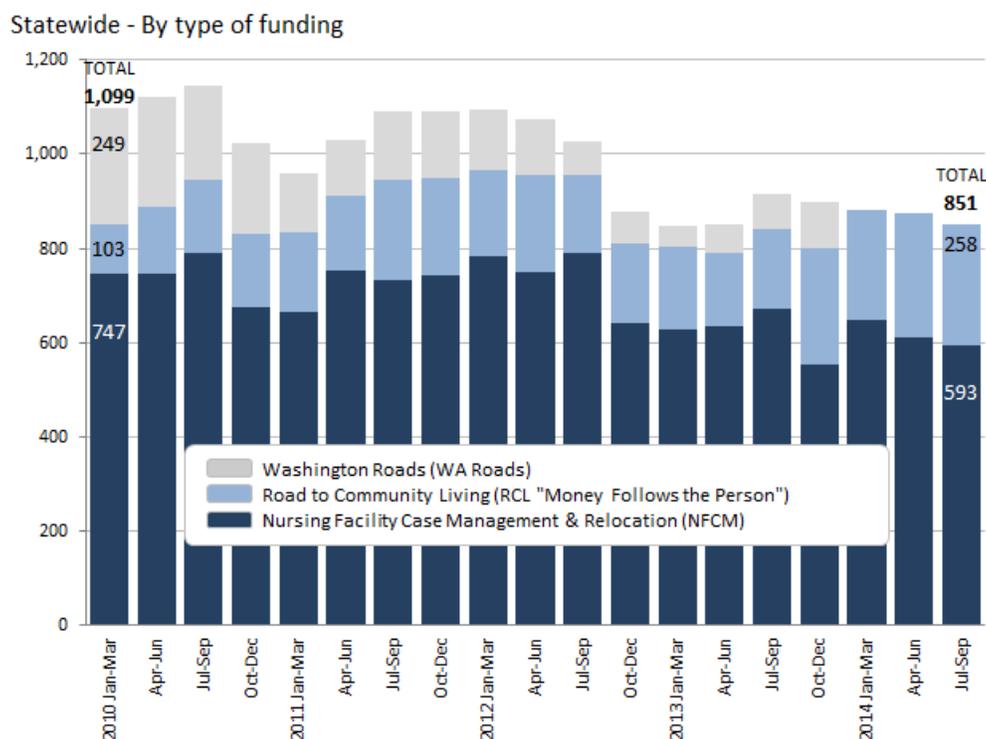
**Action Plan:** Continue the emphasis on assisting individuals who elect to relocate or divert from nursing homes to community settings. Work with individuals and available resources to develop service plans that address barriers to living in the community. Leverage the federal “Money Follows the Person” (Roads to Community Living) funding to enroll eligible clients into the program. Track continuous eligibility of Roads to Community Living clients for 12 months. Provide motivational interviewing training to nursing facility case management staff to improve nursing facility case management practice and to build the skill set required to help people live successfully in the community setting of their choice. Develop strategies to actively engage hospitals and their discharge personnel. Emphasize the availability of the “Washington Roads” program to meet client needs when federal funding is not available.



Continue to work both at the state and local, regional levels to develop specialized community resources, such as Enhanced Service Facilities, to serve individuals with complex needs in their homes and community. Refine the data gathered to identify the most efficient and effective relocation practices and improve reporting consistency. Standardize how relocations are counted statewide beginning June 2014.

Additional activities are outlined in a related March 2014 A3 update: [AL TSA A3 Action Plan 4.2 – Relocated from Nursing Homes](#)

**CHART 4.2 AL TSA Clients Who Actively Relocate from Nursing Homes to Home and Community-based Settings**



**Strategic Objective 4.3:** Ensure individuals who apply for services receive them timely so they are supported in the setting of their choice.

**Importance:** This objective has two success measures as both are related. In order to receive support, an individual must be both functionally eligible (meaning they require assistance with activities of daily living) and they must be financially eligible (meaning their assets and income must be within limits). This is not only necessary for determining eligibility but also ensures federal funding can be used to pay for services. When both functional and financial eligibility has been established, support services may be provided. It is very important to provide support services in a timely manner to avoid problems that may occur absent the support services, such as loss of mobility, poor nourishment, medication errors and other problems that can produce poor health outcomes for individuals.



**Success Measure:** Increase the percentage of timely approvals of applications from 79 percent to 90 percent by the end of 2014.

**Action Plan:** AL TSA has prioritized recruitment efforts and will continue to develop strategies to recruit and retain quality staff. AL TSA will also continue to audit a statistically significant sample of client files to measure compliance; continue to require supervisors to audit files and monitor compliance with policies and timelines; and provide training and emphasize the federal requirement for financial eligibility of processing cases within the 45-day timeframe. AL TSA working in collaboration with the Health Care Authority implemented a simplified application for individuals in need of long term care and classic Medicaid coverage in May. Changes in the electronic eligibility database occurred in July that streamline and reduce workload associated with clients who apply for Medicaid and have indicated a need for assistance with long term services and supports. Policies have been revised to reduce workload associated with renewals and changes in medical deductions. The Administration is not likely to meet the target for this year, in part, due to diversion of staff resources to complete client care assessments before ProviderOne go-live date for social service providers. Additional data analysis at the Area Agency on Aging and regional level will be done to assess where problems exist to inform the best course of action.

CHART 4.3 **Timely Determination of Functional Eligibility and Access to Services**

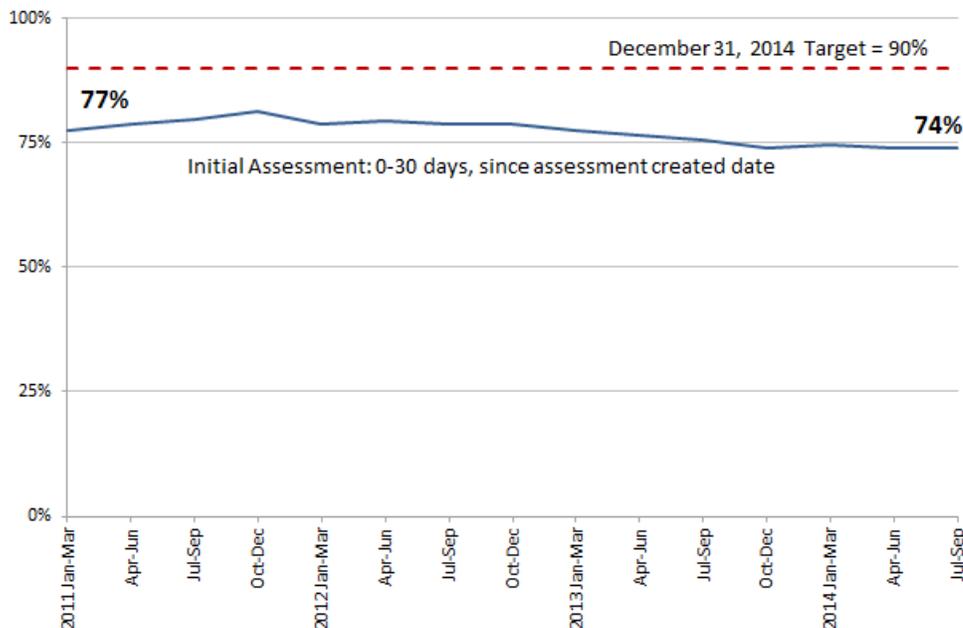
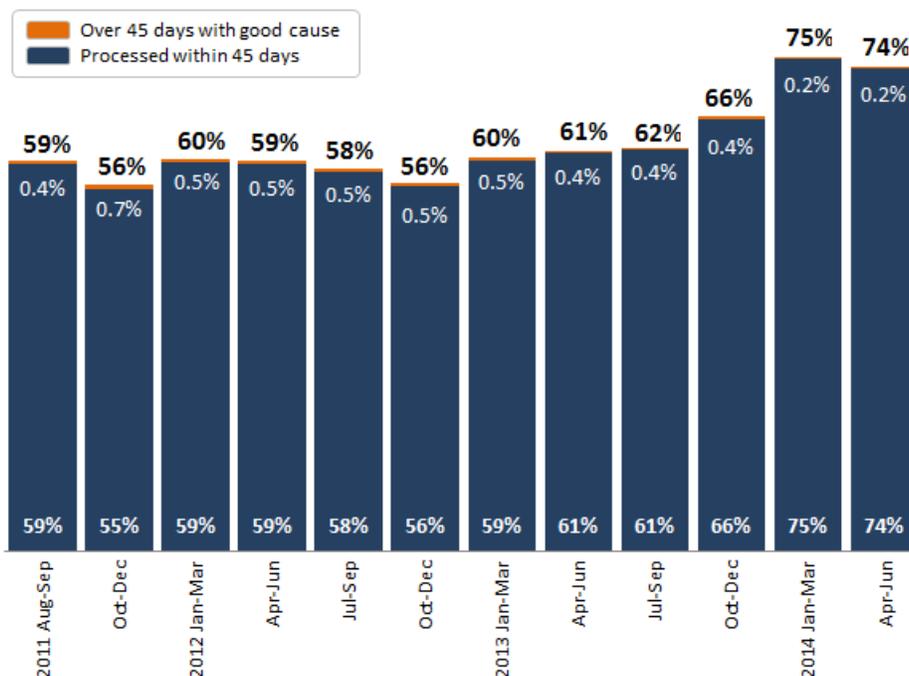


CHART 4.3a **Percent of Financial Eligibility Determinations Completed in 45 Days**

Percent processed timely (within 45 days) or late with good cause



**Strategic Objective 4.4:** Support families and informal caregivers who provide unpaid support to those in need.

**Importance:** Families and other informal support providers are integral to Washington’s long-term services and supports system. An investment to support informal caregivers ensures that Washington continues to be a national leader in providing critical family and caregiver services and resources. Data indicates that the higher the level of engagement with proven interventions, the greater the level of avoidance to access Medicaid long-term services and supports. A recent Research and Data Analysis report has been completed showing updated Family Caregiver Support Program expansion data<sup>3</sup> (see footer).

**Success Measure:** Increase the percentage of caregivers supported in the Family Caregiver Support Program as an alternative for care recipients who remain without Medicaid long-term care services for 90 days or longer.

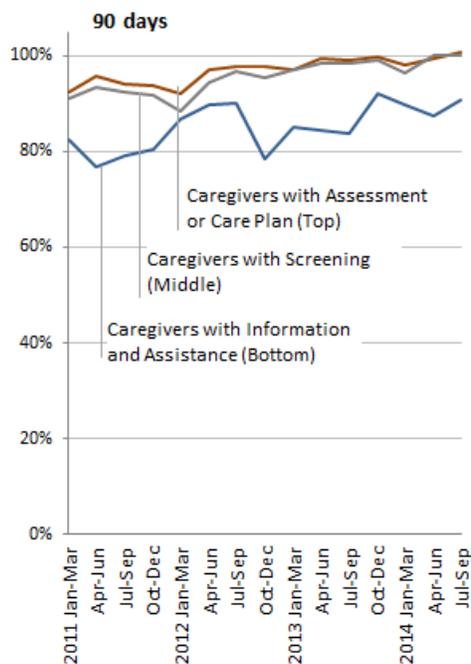
**Action Plan:** Continue to train and certify TCARE® assessors and screeners. Work with partners and consultants to translate TCARE® tools into three additional languages. Continue to trend caregiver and care receiver outcomes of TCARE® and the Family Caregiver Support Program. Explore opportunities for federal matching funds. Identify strengths and opportunities for improvements to the Family Caregiver Support Program. Continue to develop helpful caregiver services and resources (including evidence-

<sup>3</sup> <http://www.dshs.wa.gov/sesa/rda/research-reports/expanding-eligibility-family-caregiver-support-program-sfy-2012>.



based practices) at the local, community levels. Conduct a multi-faceted program evaluation to learn more about the needs of individuals who are: (1) family caregivers currently active in the program, (2) family caregivers no longer active in the program, and (3) potential future users; in order to inform planning and program effectiveness.

**CHART 4.4 Percentage of Caregivers whose Care Receiver Remained Without Paid Long-term Care Medical Services for 90 Days**



**Strategic Objective 4.5:** Provide telecommunication relay services to people who are deaf, hard of hearing, deaf-blind so they can make calls independently.



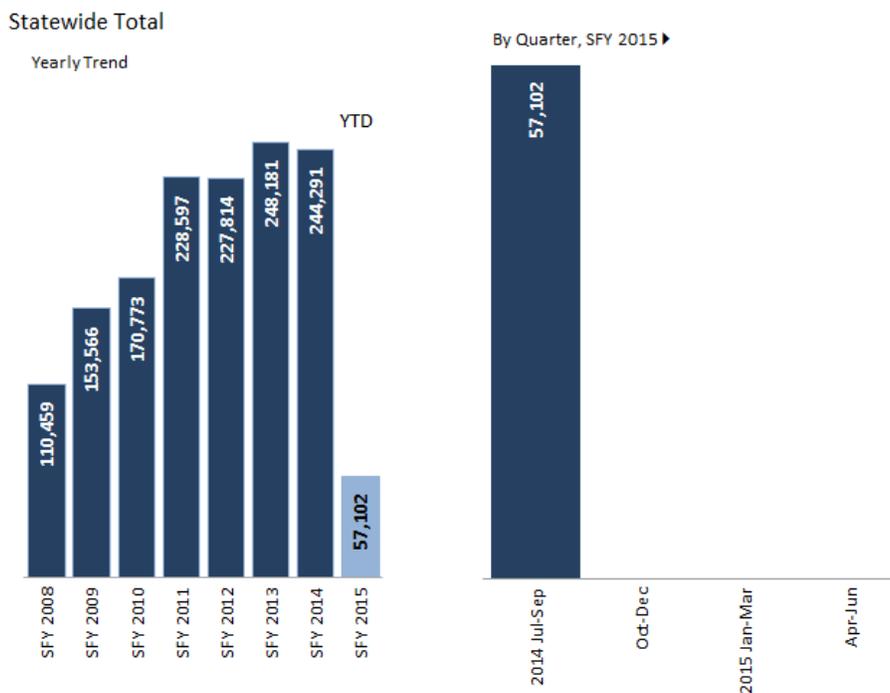
**Importance:** The rise in the prevalence of hearing loss in the general population, especially among returning veterans, youth and senior citizens, will affect many who experience increasingly limited access to telecommunications. Captioned Telephone Service (CTS) will enable affected persons to make telephone calls with ease.

**Success Measure:** Increase the number of completed captioned relay calls from 248,181 to 276,210 by July 2015.

**Action Plan:** ALTSA is currently executing an outreach plan to bring public awareness of CTS and the availability of CTS equipment from the Telecommunications Equipment Distribution (TED) program. July 2014 - June 2015 activities include

presentations, booth exhibits and publications. From January - June 2015, ALTSA is advertising CTS services in the Hearing Loss Association quarterly newsletter and promoting CTS services through radio and television public service announcements.

Chart 4.5 **Number of Completed Captioned Telephone Service (CTS) Relay Calls**



\* Note: SFY 2015 numbers, above, are Year-To-Date.

**Strategic Objective 4.6:** Provide assistive technology and captioning services on behalf of people who are deaf and hard of hearing so they can communicate effectively.

**Importance:** Many individuals with hearing loss do not use sign language. Assistive listening systems aid in ensuring that effective communication occurs between people with hearing loss and employees or contractors providing DSHS services during in-person office visits. These assistive listening systems help clients to access DSHS programs and services.

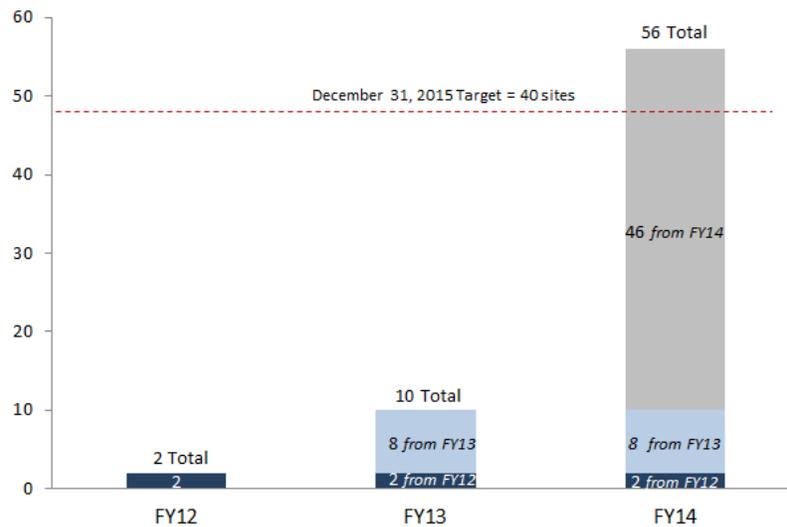
**Success Measure:** Increase the number of sites with assistive listening systems from 4 to 40 by December 2015.

**Action Plan:** Administer the contract with Hearing Loop NW. Initiate induction loop installation and distribution at Economic Services Administration (ESA) and Division of Vocational Rehabilitation (DVR) Area 1 offices. Continue training DSHS employees on using induction loops. Explore feasibility of an evaluation system to measure ESA and DVR client use of induction loops and DSHS employees' knowledge in using induction loops.



Chart 4.6 **Increase in the Number of DSHS and Contractor Sites with Assistive Listening Systems Installed**

Number of Sites Installed - Cumulative Totals



**Strategic Objective 4.7:** Design and implement a Medicaid Community First Choice Option (CFCO-State Plan) program in a manner consistent with legislative direction.

**Importance:** The Community First Choice Option is a new Medicaid entitlement state plan option established by the Affordable Care Act (ACA). Through CFCO, Washington State has the opportunity to leverage 6% in additional federal funding for the majority of home and community-based services, potentially freeing up state funds for long-term services and support reinvestments. Some of the enhanced match is necessary to meet maintenance of effort requirements, costs of new, required services and program staff necessary for design and implementation. A planning and implementation council made up of clients and their representatives must be involved in planning and implementation of the program.

**Success Measure:** Successfully meet benchmarks to develop and fully implement the Medicaid Community First Choice Option not later than August 30, 2015.

**Action Plan:** Major milestones include the activities below and progress in milestone completion is on schedule. For more information, visit our website at:

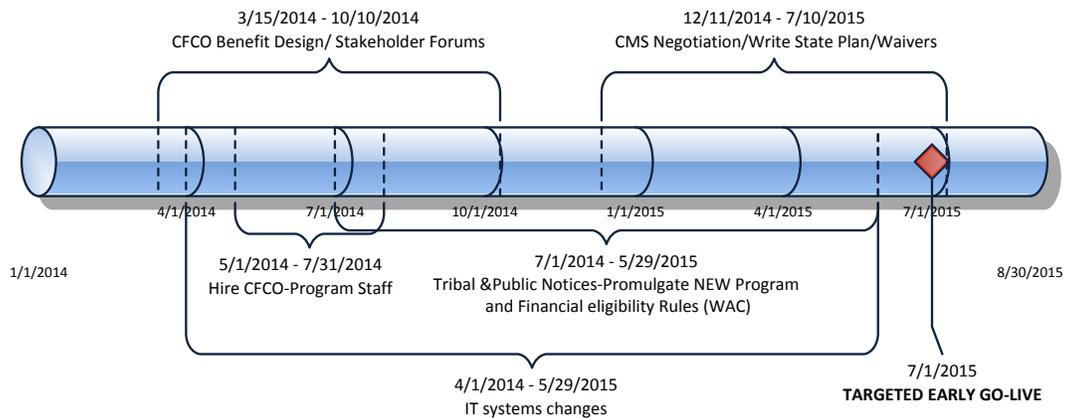
<http://www.dshs.wa.gov/altsa/stakeholders/community-first-choice-option>.

- Evaluate changes to current state plan and waivers and conduct CFCO benefit design forums through a federally-required development and implementation stakeholder process.
- Hire program staff to ensure adequate planning, development and implementation.
- Evaluate and implement necessary IT systems' changes for client CARE assessment, financial eligibility determination and provider payment.
- Issue public and Tribal notices and promulgate new rules.
- Develop new payment codes, policies, manuals and training materials.



- Negotiate to gain final federal approval and submit final state plan and waiver amendments.
- Implement the Community First Choice Option and establish ongoing program support.

**COMMUNITY FIRST CHOICE OPTION TIMELINE FOR JULY 2015 IMPLEMENTATION**



**Strategic Objective 4.8:** Develop a Washington State Alzheimer’s Plan, in response to SSB 6124.

**Importance:** The prevalence of dementia is projected to significantly increase as the number of individuals over age 60 is anticipated to double in the next 20 years.

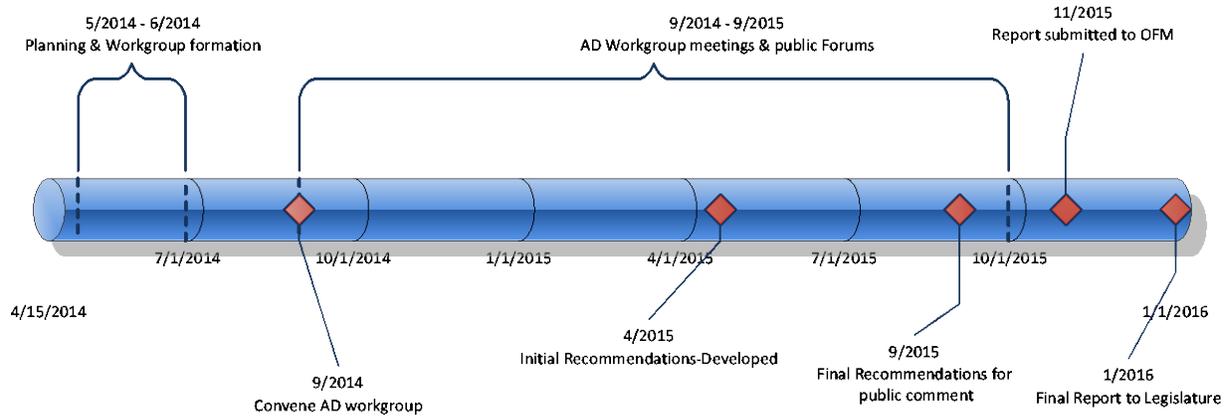
**Success Measure:** Successfully meet benchmarks outlined in SSB 6124 and submit findings and recommendations including draft legislation to the Governor and both health care committees of the Legislature by January 1, 2016. Additional information can be found on our website at: <http://www.dshs.wa.gov/altsa/stakeholders/developing-state-plan-address-alzheimers-disease>.

**Action Plan:** Major milestones include:

- Planning, research and workgroup formation. - Complete
- Convene the Alzheimer’s disease workgroup and public forums. – In process
- Alzheimer’s disease workgroup approves and finalizes recommendations.
- The Department will submit the final report to the Office of Financial Management (OFM) by November 2015.



### Timeline for Developing the Washington State Alzheimer's Plan



**Strategic Objective 4.9:** Design and implement a pilot project to provide employment services to individuals with disabilities served by AL TSA. .

**Importance:** Although DSHS has nationally recognized employment programs for individuals with developmental disabilities, assisting individuals with physical or other functional disabilities is a new endeavor. Employment is a critical component of community integration for individuals with disabilities who are working age and receive long-term care services and supports. This project will involve the Area Agencies on Aging, the Community Living Connections and the Division of Vocational Rehabilitation (DVR), working collaboratively to determine project sites and implementation strategies.

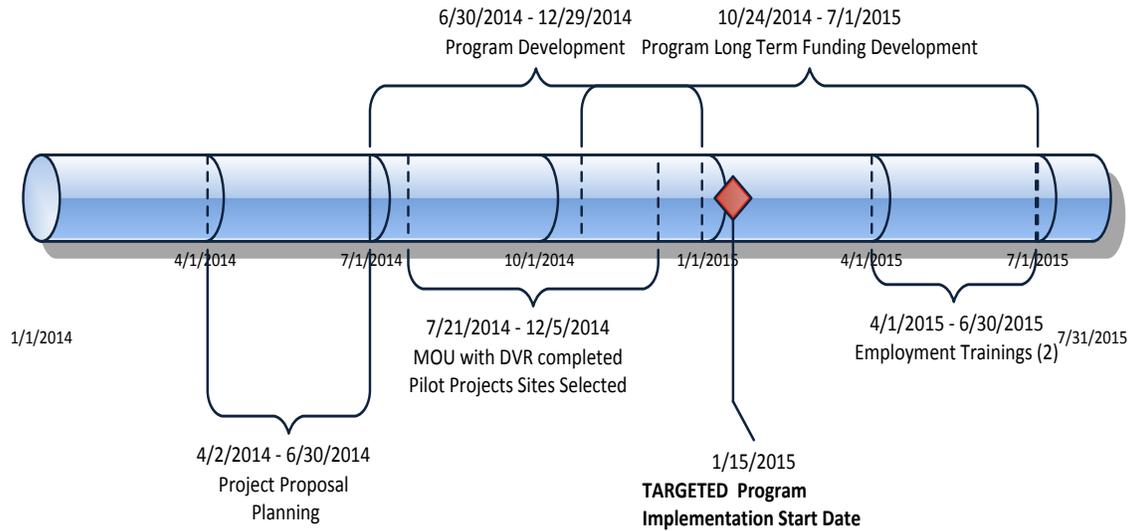
**Success Measure:** Implement an employment pilot project for working age individuals receiving long-term care services and supports by January 2015.

**Action Plan:** Major milestones include:

- Pilot project planning
- Acquire initial funding through rebalancing funds application
- Complete MOU agreement with DSHS Division of Vocational Rehabilitation
- Identify pilot project locations.
- Develop project policies, procedures and administration protocol.
- Implement pilot project.
- Ongoing development of strategic partnerships.



## ALISA Employment Program Pilot Project



**Strategic Objective 4.10:** Support Tribes in the design and implementation of sustainable community-based long-term services and supports infrastructure within Tribal communities through the Washington Money Follows the Person Rebalancing Demonstration Grant: Tribal Initiative.

**Importance:** This initiative provides an opportunity to expand formal relationships with key partners to focus on planning and developing community-based services that will support the return of Tribal members from institutions to their communities of choice with the necessary supports.

The multi-year initiative which includes four distinct phases will promote Tribal leadership in:

- 1) Designing an effective and culturally sensitive package of Medicaid, community-based, long-term services and supports;
- 2) The operation of delegated administrative responsibilities on behalf of state Medicaid agencies;
- 3) The elimination of barriers that prevent the use of Medicaid funds to support Tribal members with long-term services and supports needs; and
- 4) Strengthening the ability of state Medicaid programs to respond to the unique needs of Tribal communities.

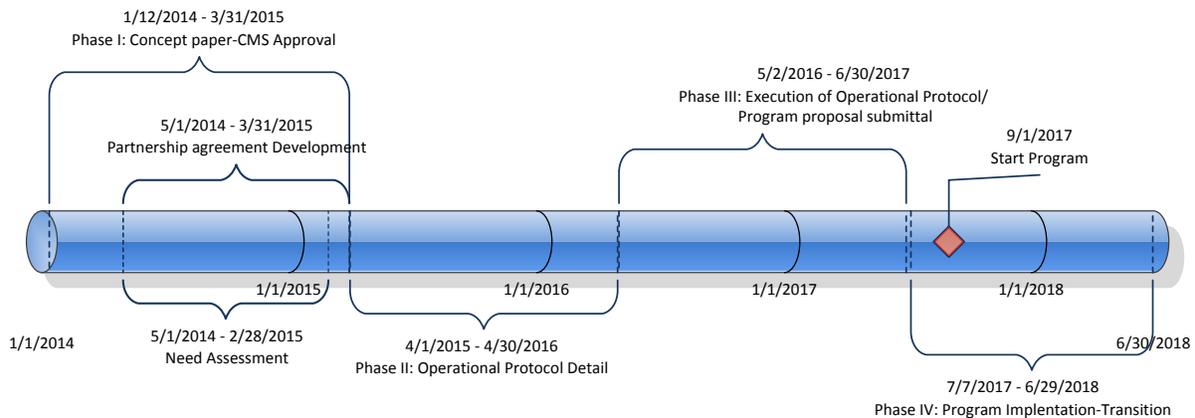
**Success Measure:** By Spring of 2015, complete Phase I of the demonstration project with approval from the Centers for Medicare and Medicaid Services to move to Phase II.



**Action Plan:** Major milestones include:

- Phase I: Completion and Centers for Medicare and Medicaid Services approval of the concept paper.
- Phase II: Development of a detailed operational protocol with timelines and activities.
- Phase III: Execution of the operational protocol and program proposal submittal to the Centers for Medicare and Medicaid Services.
- Phase IV: Program implementation.

**WASHINGTON MONEY FOLLOWS A PERSON REBALANCING DEMONSTRATION GRANT: TRIBAL INITIATIVE**  
Contingent on successful completion of prior phase with CMS Approval



**DSHS Goal 5: Public Trust – Strong management practices will be used to ensure quality and efficiency.**

**Strategic Object 5.1:** Implement an electronic payment system (known as ProviderOne Phase 2) that will significantly increase overall payment integrity for social service organizations and Individual Providers that contract with DSHS to provide long-term services and supports to DSHS clients.

**Importance:** Washington State is engaged in the second phase of consolidating long-term care services and supports’ payments into a single, federally-certified payment system (also referred to as ProviderOne Phase 2). This new payment system will significantly increase overall payment integrity impacting 75% of all social service Medicaid and state long-term care payments issued. Track 1 of this project pertains to payments made to 1099 social service providers while Track 2 implements a subsystem design for payment of Individual Providers who provide personal care services to DSHS clients. Every payment will be verified and accounted for by automatically checking client and provider eligibility, and other audit requirements, bringing the state into compliance with federal requirements. With these changes, Washington State will continue to be a model for other states to follow.

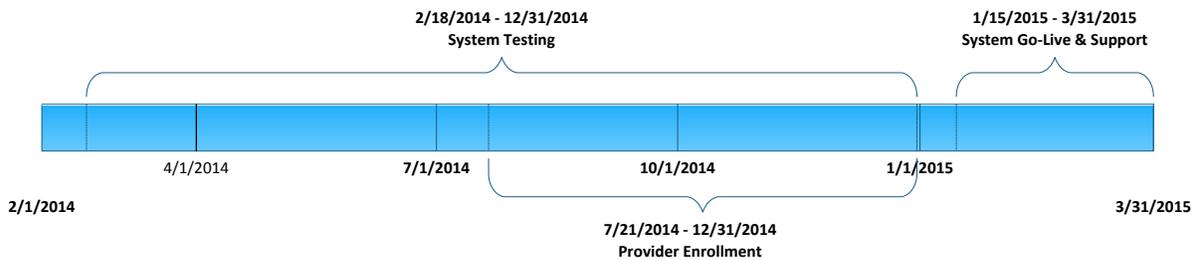
**Success Measure:** Meet identified benchmarks to successfully implement the payment system for social services organizations and Individual Providers that contract with DSHS to provide long-term services and supports to DSHS clients.



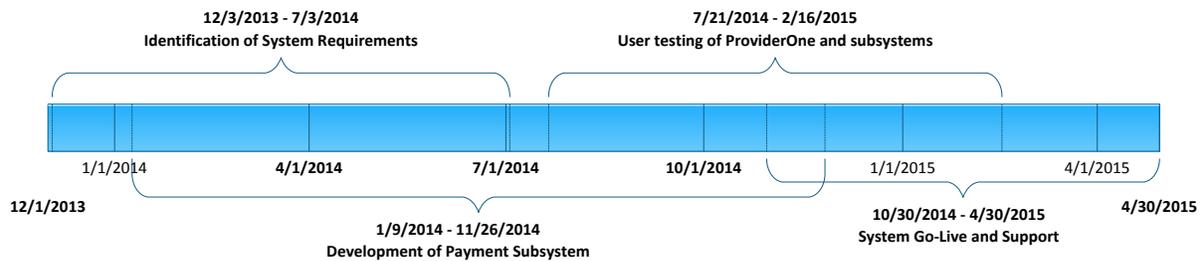
**Action Plan:** Key Milestones with timeline still subject to change:

- Identification of system requirements. - Complete
- User testing of ProviderOne. - In process
- Provider enrollment implementation. - To begin September 1, 2014
- System Go-Live and support. Scheduled for January 2015.

**Track 1: ProviderOne Phase 2 Implementation Timeline for Social Service Organizations**



**Track 2: ProviderOne Phase 2 Implementation Timeline for Individual Providers**



**Strategic objective 5.2:** Increase staff training and skills development to effectively support LTC clients in obtaining their optimum level of functioning.

**Importance:** Staff are essential in carrying out these core principles and are one of the primary reasons the state’s long-term care system is ranked as one of the best in the nation. AL TSA is continuing to serve an increasing number of clients with very challenging needs with the goal of assisting them to successfully reside in community-based settings. Building staff capacity and competency in evidence-based practices and other forms of training is crucial in accomplishing both AL TSA’s and DSHS’ agency-wide strategic goals.

**Success Measure:** Train all new staff in their core work functions and provide ongoing skills development to existing staff throughout 2014.

**Action Plan:** Staff are participating in the following activities:

- **Leadership events:** staff have identified areas where they would like to see improvements and are actively involved in workgroups and activities related to process and practice improvements.



- **Motivational Interviewing—MI:** an evidence-based practice communication skill initially targeted to ALTA managers, field supervisors and social workers. Some staff are also training as trainers and coders for staff sustainability.
- **Case Management and Program Training:** a five-day training provided to new staff throughout the year.
- **Adult Protective Services Academy:** a four-day intensive training to new APS staff. Training is offered at least three times a year.
- **Basic Financial Academy Long-Term Care Training for Financial Workers:** training is offered three times a year for new financial eligibility determination staff. Advanced training classes for ongoing learning for experienced workers is under development. In addition, staff were provided training on tribal-specific income rules and exemptions.
- **The University of Washington Core 3&4:** an online course on psychological and physical conditions of the aging population and disease management. It will be offered to social workers, case managers and nurses on a regular basis as soon as they start to work for Home and Community Services or the Area Agencies on Aging.
- **Safety Training:** will be enhanced for all staff that go into clients' homes or licensed settings to help them respond effectively in the event of safety concerns.
- **Lean Training:** staff go through the Developmental Job Assignment DSHS Lean Certification Program and other DSHS training sessions.
- **Staff Wellness activities:** Continue to promote and engage staff in wellness activities.

**Strategic objective 5.3:** Increase IT support to improve and enhance data security through implementation of the IT Security Project.

**Importance:** Recent state cybersecurity initiatives require increased server and application scanning, findings, gap analyses and mitigation plans to secure IT resources and client data.

**Success Measure:** Implement IT Security Project to meet action plan goals that assist with safeguarding consumer identities and personal health information.

**Action Plan:** Meet application and network database security standards by ensuring:

- Timely design reviews and modification as needed.
- Timely mitigation plans for server security problems.
- Timely mitigation plans for application security problems.
- Security application review during development to avoid security problems.
- Ongoing server security review to avoid problems.

**Strategic objective 5.4:** Timely quality assurance and oversight activities to ensure evidence of compliance with federal, state and program requirements.



**Importance:** Timely completion of quality assurance activities helps protect the health and safety of clients, secure and maintain federal funding and provides oversight of local operations. Through this function, ALTSA ensures that access to client services are timely and responsive to assessed needs, that providers and/or facilities are qualified to provide services, provider networks are adequate and federal assurances are met. Identified deficiencies are corrected and corrective action/performance improvement plans are developed and monitored to ensure continuous quality improvement. In addition, timely collection and provision of required documents including notation, and processing need to be within regulatory and operational standards.

**Success Measure 5a:** 100% timely completion of Home and Community Services Division case management and financial eligibility compliance record reviews.

**Success Measure 5b:** 100% timely completion of on-site monitoring visits of Area Agency on Aging operations.

**Success Measure 5c:** 95% of audited Nursing Home Statement of Deficiencies (SODs) are sent to the facility within the federal regulatory standard of 10 working days.

**Action Plan:** Conduct Medicaid social and financial services, and Area Agency on Aging operations reviews on an annual basis to assess statewide application of policies and procedures. Issue monitoring reports, develop and implement proficiency improvement plans to ensure areas of non-compliance are corrected and continuous quality improvement standards are achieved. Analyze statewide trends to determine where training, technical assistance, policy revisions or other action is necessary.

By July 2015, design and implement a system in the next six months to audit the nursing home Statement of Deficiencies to federal regulatory standards. Major activities will include: 1) data collection and analysis; 2) development of the audit tool and system; 3) establishment of a baseline identifying where standards are and/or are not being met; 4) train quality assurance staff ; and 5) implement the Statement of Deficiencies audit system.

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## Other important work in ALTSA

- Streamline the Area Agency on Aging contracting process to simplify Tribal government involvement and allocation of resources to serve Tribal people.
- Build a sustainable future through development and implementation of innovative services designed to leverage federal funding and assist individuals and their caregivers to manage their own care when possible.
- Develop and adapt performance measures for inclusion in Area Agency on Aging contracts as required under House Bill 1519, related to: improvements in client health status and wellness; reductions in avoidable high-cost services; increases in stable housing in the community; and improvements in client satisfaction with quality of life.
- Support the work of the Joint Legislative/Executive Committee on planning for aging and disability issues.
- Modify the five-year plan for sustainability of the Community Living Connections infrastructure and continue foundational work to improve access and quality to unbiased information,

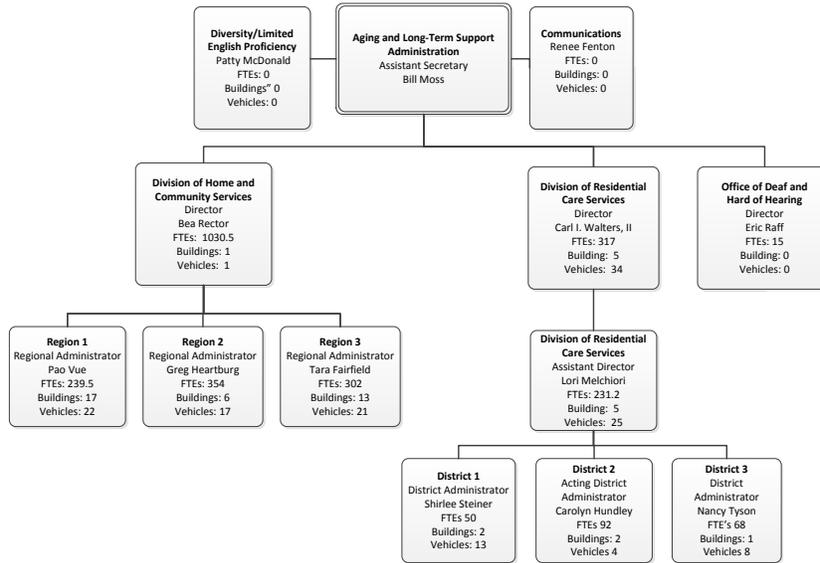


assistance, options counseling and access to community resources. Continue to build efficacy by rolling out the new Community Living Connections (CLCs) information system by September, 2015.

- Increase the reach and effectiveness of falls risk and falls prevention programs in collaboration with the Department of Health.
- Continue to develop specialized information, supports, and support groups for people with traumatic brain injury in community-based settings, in hospitals and in nursing homes.
- Continue to provide critical services and supports for relatives raising children who have many unmet needs and are not involved with the DSHS child welfare system.
- Support a statewide lifespan respite voucher system to serve unpaid family caregivers who are not served though, or do not qualify for, other existing formal respite services.
- Update the Cultural Competence Action Plan to address: cultural competence accountability measures; building community partnerships and ensuring language access. Strive for AL TSA staffing to better reflect the population served.
- Develop Enhanced Services Facilities to provide community-based long-term services and supports for people who are currently without a community-based option.
- Implement recommendations of the Adult Family Home Quality Assurance Panel enacted by the Legislature in Substitute Senate Bill 5630, which includes: completing the development of a care and service disclosure form for Adult Family Homes; developing a separate disclosure form for the financial cost of Adult Family Home care and services; creating a customer-oriented website; and reviewing specialty training to determine need for revision.
- Continue to ensure access to, and the availability of, a well-trained and qualified provider workforce statewide. Continue to work with service providers, training programs, the Department of Health, and disability advocates addressing barriers to a stable home and community-based workforce.
- Expand home and community-based services available to veterans by signing agreements with three additional Veterans Integrated Services Network (VISNs) to offer Veteran's Directed Home Services in all counties by the end of State Fiscal Year 2015.
- Continue to work with Area Agencies on Aging to deliver quality services pursuant to the federal Older Americans Act. This includes providing technical support and monitoring to ensure value-based service delivery according to local Area Plans.
- Within DSHS, work with the federal Housing and Urban Development, the State Department of Commerce, local housing authorities, and landlords to develop affordable and accessible housing options for individuals served by AL TSA.



## Department of Social and Health Services Aging and Long-Term Support Administration



February 20, 2014

