WASHINGTON STATE PLAN ON AGING 2014-2018

ATTACHMENTS

Washington State Department of Social & Health Services

ALTSA Aging and Long-Term Support Administration

Washington State Department of Social & Health Services
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Contents

ATTACHMENT A- STATE PLAN ASSURANCES

STATE PLAN ASSURANCES AND REQUIRED ACTIVITIES
Older Americans Act, As Amended in 2006

By signing this document, the authorized official commits the State Agency on Aging to performing all listed assurances and activities as stipulated in the Older Americans Act, as amended in 2006.

ASSURANCES

The State of Washington as part of its state plan 2014-2018 does make and reaffirm the following assurances from the Older Americans Act as Amended through the year 2006.

Sec. 305(a) - (c), ORGANIZATION

(a)(2)(A) The State agency shall, except as provided in subsection (b)(5), designate for each such area (planning and service area) after consideration of the views offered by the unit or units of general purpose local government in such area, a public or private nonprofit agency or organization as the area agency on aging for such area.

(a)(2)(B) The State agency shall provide assurances, satisfactory to the Assistant Secretary, that the State agency will take into account, in connection with matters of general policy arising in the development and administration of the State plan for any fiscal year, the views of recipients of supportive services or nutrition services, or individuals using multipurpose senior centers provided under such plan.

(a)(2)(E) The State agency shall provide assurance that preference will be given to providing services to older individuals with greatest economic need and older individuals with greatest social need, (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas) and include proposed methods of carrying out the preference in the State plan;

(a)(2)(F) The State agency shall provide assurances that the State agency will require use of outreach efforts described in section 307(a)(16).

(a)(2)(G)(ii) The State agency shall provide an assurance that the State agency will undertake specific program development, advocacy, and outreach efforts focused on the needs of low-income minority older individuals and older individuals residing in rural areas.

(c)(5) In the case of a State specified in subsection (b)(5), the State agency and area agencies shall provide assurance, determined adequate by the State agency, that the area agency on aging will have the ability to develop an area plan and to carry out, directly or through contractual or other arrangements, a program in accordance with the plan within the planning and service area.

States must assure that the following assurances (Section 306) will be met by its designated area agencies on agencies, or by the State in the case of single planning and service area states.

Sec. 306(a), AREA PLANS
(2) Each area agency on aging shall provide assurances that an adequate proportion, as required under section 307(a)(2), of the amount allotted for part B to the planning and service area will be expended for the delivery of each of the following categories of services-
(A) services associated with access to services (transportation, health services **(**including mental health services**)**, outreach, information and assistance (which may include information and assistance to consumers on availability of services under part B and how to receive benefits under and participate in publicly supported programs for which the consumer may be eligible), and case management services);
(B) in-home services, including supportive services for families of older individuals who are victims of Alzheimer's disease and related disorders with neurological and organic brain dysfunction; and
(C) legal assistance;
and assurances that the area agency on aging will report annually to the State agency in detail the amount of funds expended for each such category during the fiscal year most recently concluded.

(4)(A)(i)(I) provide assurances that the area agency on aging will—
(aa) set specific objectives, consistent with State policy, for providing services to older individuals with greatest economic need, older individuals with greatest social need, and older individuals at risk for institutional placement;
(bb) include specific objectives for providing services to low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas; and
(II) include proposed methods to achieve the objectives described in items (aa) and (bb) of subclause (I);
(ii) provide assurances that the area agency on aging will include in each agreement made with a provider of any service under this title, a requirement that such provider will—
(I) specify how the provider intends to satisfy the service needs of low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas in the area served by the provider;
(II) to the maximum extent feasible, provide services to low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas in accordance with their need for such services; and

(III) meet specific objectives established by the area agency on aging, for providing services to low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas within the planning and service area; and
(4)(A)(iii) With respect to the fiscal year preceding the fiscal year for which such plan is prepared, each area agency on aging shall--
(I) identify the number of low-income minority older individuals and older individuals residing in rural areas in the planning and service area;
(II) describe the methods used to satisfy the service needs of such minority older individuals; and
(III) provide information on the extent to which the area agency on aging met the objectives described in clause (a)(4)(A)(i).

(4)(B)(i) Each area agency on aging shall provide assurances that the area agency on aging will use outreach efforts that will identify individuals eligible for assistance under this Act, with special emphasis on--
(I) older individuals residing in rural areas;
(II) older individuals with greatest economic need (with particular attention to low-income minority individuals and older individuals residing in rural areas);
(III) older individuals with greatest social need (with particular attention to low-income minority individuals and older individuals residing in rural areas);
(IV) older individuals with severe disabilities;
(V) older individuals with limited English proficiency;
(VI) older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and
(VII) older individuals at risk for institutional placement; and
(4)(C) Each area agency on agency shall provide assurance that the area agency on aging will ensure that each activity undertaken by the agency, including planning, advocacy, and systems development, will include a focus on the needs of low-income minority older individuals and older individuals residing in rural areas.

(5) Each area agency on aging shall provide assurances that the area agency on aging will coordinate planning, identification, assessment of needs, and provision of services for older individuals with disabilities, with particular attention to individuals with severe disabilities, and individuals at risk for institutional placement, with agencies that develop or provide services for individuals with disabilities.

(6)(F) Each area agency will:

in coordination with the State agency and with the State agency responsible for mental health services, increase public awareness of mental health disorders, remove barriers to diagnosis and treatment, and coordinate mental health services (including mental health screenings) provided with funds expended by the area agency on aging with mental health services provided by community health centers and by other public agencies and nonprofit private organizations;

(9) Each area agency on aging shall provide assurances that the area agency on aging, in carrying out the State Long-Term Care Ombudsman program under section 307(a)(9), will expend not less than the total amount of funds appropriated under this Act and expended by the agency in fiscal year 2000 in carrying out such a program under this title.

(11) Each area agency on aging shall provide information and assurances concerning services to older individuals who are Native Americans (referred to in this paragraph as "older Native Americans"), including-
(A) information concerning whether there is a significant population of older Native Americans in the planning and service area and if so, an assurance that the area agency on aging will pursue activities, including outreach, to increase access of those older Native Americans to programs and benefits provided under this title;
(B) an assurance that the area agency on aging will, to the maximum extent practicable, coordinate the services the agency provides under this title with services provided under title VI; and
(C) an assurance that the area agency on aging will make services under the area plan available, to the same extent as such services are available to older individuals within the planning and service area, to older Native Americans.

(13)(A) Each area agency on aging shall provide assurances that the area agency on aging will maintain the integrity and public purpose of services provided, and service providers, under this title in all contractual and commercial relationships.

(13)(B) Each area agency on aging shall provide assurances that the area agency on aging will disclose to the Assistant Secretary and the State agency--
(i) the identity of each nongovernmental entity with which such agency has a contract or commercial relationship relating to providing any service to older individuals; and
(ii) the nature of such contract or such relationship.

(13)(C) Each area agency on aging shall provide assurances that the area agency will demonstrate that a loss or diminution in the quantity or quality of the services provided, or to be provided, under this title by such agency has not resulted and will not result from such non-governmental contracts or such commercial relationships.

(13)(D) Each area agency on aging shall provide assurances that the area agency will demonstrate that the quantity or quality of the services to be provided under this title by such agency will be enhanced as a result of such non-governmental contracts or commercial relationships.

(13)(E) Each area agency on aging shall provide assurances that the area agency will, on the request of the Assistant Secretary or the State, for the purpose of monitoring compliance with this Act (including conducting an audit), disclose all sources and expenditures of funds such agency receives or expends to provide services to older individuals.

(14) Each area agency on aging shall provide assurances that funds received under this title will not be used to pay any part of a cost (including an administrative cost) incurred by the

area agency on aging to carry out a contract or commercial relationship that is not carried out to implement this title.

(15) provide assurances that funds received under this title will be used-
(A) to provide benefits and services to older individuals, giving priority to older individuals identified in paragraph (4)(A)(i); and
(B) in compliance with the assurances specified in paragraph (13) and the limitations specified in section 212;
(17)Each Area Plan will include information detailing how the Area Agency will coordinate activities and develop long-range emergency preparedness plans with local and State emergency response agencies, relief organizations, local and State governments and other institutions that have responsibility for disaster relief service delivery.

Sec. 307, STATE PLANS

(7)(A) The plan shall provide satisfactory assurance that such fiscal control and fund accounting procedures will be adopted as may be necessary to assure proper disbursement of, and accounting for, Federal funds paid under this title to the State, including any such funds paid to the recipients of a grant or contract.

(7)(B) The plan shall provide assurances that--
(i) no individual (appointed or otherwise) involved in the designation of the State agency or an area agency on aging, or in the designation of the head of any subdivision of the State agency or of an area agency on aging, is subject to a conflict of interest prohibited under this Act;
(ii) no officer, employee, or other representative of the State agency or an area agency on aging is subject to a conflict of interest prohibited under this Act; and
(iii) mechanisms are in place to identify and remove conflicts of interest prohibited under this Act.

(9) The plan shall provide assurances that the State agency will carry out, through the Office of the State Long-Term Care Ombudsman, a State Long-Term Care Ombudsman program in accordance with section 712 and this title, and will expend for such purpose an amount that is not less than an amount expended by the State agency with funds received under this title for fiscal year 2000, and an amount that is not less than the amount expended by the State agency with funds received under title VII for fiscal year 2000.

(10) The plan shall provide assurance that the special needs of older individuals residing in rural areas will be taken into consideration and shall describe how those needs have been met and describe how funds have been allocated to meet those needs.

(11)(A) The plan shall provide assurances that area agencies on aging will--
(i) enter into contracts with providers of legal assistance which can demonstrate the experience or capacity to deliver legal assistance;
(ii) include in any such contract provisions to assure that any recipient of funds under division (A) will be subject to specific restrictions and regulations promulgated under the Legal Services Corporation Act (other than restrictions and regulations governing eligibility for legal

assistance under such Act and governing membership of local governing boards) as determined appropriate by the Assistant Secretary; and
(iii) attempt to involve the private bar in legal assistance activities authorized under this title, including groups within the private bar furnishing services to older individuals on a pro bono and reduced fee basis.

(11)(B) The plan contains assurances that no legal assistance will be furnished unless the grantee administers a program designed to provide legal assistance to older individuals with social or economic need and has agreed, if the grantee is not a Legal Services Corporation project grantee, to coordinate its services with existing Legal Services Corporation projects in the planning and service area in order to concentrate the use of funds provided under this title on individuals with the greatest such need; and the area agency on aging makes a finding, after assessment, pursuant to standards for service promulgated by the Assistant Secretary, that any grantee selected is the entity best able to provide the particular services.

(11)(D) The plan contains assurances, to the extent practicable, that legal assistance furnished under the plan will be in addition to any legal assistance for older individuals being furnished with funds from sources other than this Act and that reasonable efforts will be made to maintain existing levels of legal assistance for older individuals;

(11)(E) The plan contains assurances that area agencies on aging will give priority to legal assistance related to income, health care, long-term care, nutrition, housing, utilities, protective services, defense of guardianship, abuse, neglect, and age discrimination.

(12) The plan shall provide, whenever the State desires to provide for a fiscal year for services for the prevention of abuse of older individuals, the plan contains assurances that any area agency on aging carrying out such services will conduct a program consistent with relevant State law and coordinated with existing State adult protective service activities for--
(A) public education to identify and prevent abuse of older individuals;
(B) receipt of reports of abuse of older individuals;
(C) active participation of older individuals participating in programs under this Act through outreach, conferences, and referral of such individuals to other social service agencies or sources of assistance where appropriate and consented to by the parties to be referred; and
(D) referral of complaints to law enforcement or public protective service agencies where appropriate.

(13) The plan shall provide assurances that each State will assign personnel (one of whom shall be known as a legal assistance developer) to provide State leadership in developing legal assistance programs for older individuals throughout the State.

(15) The plan shall provide assurances that, if a substantial number of the older individuals residing in any planning and service area in the State are of limited English-speaking ability, then the State will require the area agency on aging for each such planning and service area—
(A) to utilize in the delivery of outreach services under section 306(a)(2)(A), the services of workers who are fluent in the language spoken by a predominant number of such older individuals who are of limited English-speaking ability; and

(B) to designate an individual employed by the area agency on aging, or available to such area agency on aging on a full-time basis, whose responsibilities will include--
(i) taking such action as may be appropriate to assure that counseling assistance is made available to such older individuals who are of limited English-speaking ability in order to assist such older individuals in participating in programs and receiving assistance under this Act; and
(ii) providing guidance to individuals engaged in the delivery of supportive services under the area plan involved to enable such individuals to be aware of cultural sensitivities and to take into account effectively linguistic and cultural differences.

(16) The plan shall provide assurances that the State agency will require outreach efforts that will—
(A) identify individuals eligible for assistance under this Act, with special emphasis on—

(i) older individuals residing in rural areas;

(ii) older individuals with greatest economic need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas;

(iii) older individuals with greatest social need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas;

(iv) older individuals with severe disabilities;

(v) older individuals with limited English-speaking ability; and

(vi) older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and

(B) inform the older individuals referred to in clauses (i) through (vi) of subparagraph (A), and the caretakers of such individuals, of the availability of such assistance.

(17) The plan shall provide, with respect to the needs of older individuals with severe disabilities, assurances that the State will coordinate planning, identification, assessment of needs, and service for older individuals with disabilities with particular attention to individuals with severe disabilities with the State agencies with primary responsibility for individuals with disabilities, including severe disabilities, to enhance services and develop collaborative programs, where appropriate, to meet the needs of older individuals with disabilities.

(18) The plan shall provide assurances that area agencies on aging will conduct efforts to facilitate the coordination of community-based, long-term care services, pursuant to section 306(a)(7), for older individuals who--
(A) reside at home and are at risk of institutionalization because of limitations on their ability to function independently;

(B) are patients in hospitals and are at risk of prolonged institutionalization; or
(C) are patients in long-term care facilities, but who can return to their homes if community-based services are provided to them.

(19) The plan shall include the assurances and description required by section 705(a).

(20) The plan shall provide assurances that special efforts will be made to provide technical assistance to minority providers of services.

(21) The plan shall
(A) provide an assurance that the State agency will coordinate programs under this title and programs under title VI, if applicable; and
(B) provide an assurance that the State agency will pursue activities to increase access by older individuals who are Native Americans to all aging programs and benefits provided by the agency, including programs and benefits provided under this title, if applicable, and specify the ways in which the State agency intends to implement the activities.

(22) If case management services are offered to provide access to supportive services, the plan shall provide that the State agency shall ensure compliance with the requirements specified in section 306(a)(8).

(23) The plan shall provide assurances that demonstrable efforts will be made--
(A) to coordinate services provided under this Act with other State services that benefit older individuals; and
(B) to provide multigenerational activities, such as opportunities for older individuals to serve as mentors or advisers in child care, youth day care, educational assistance, at-risk youth intervention, juvenile delinquency treatment, and family support programs.

(24) The plan shall provide assurances that the State will coordinate public services within the State to assist older individuals to obtain transportation services associated with access to services provided under this title, to services under title VI, to comprehensive counseling services, and to legal assistance.

(25) The plan shall include assurances that the State has in effect a mechanism to provide for quality in the provision of in-home services under this title.

(26) The plan shall provide assurances that funds received under this title will not be used to pay any part of a cost (including an administrative cost) incurred by the State agency or an area agency on aging to carry out a contract or commercial relationship that is not carried out to implement this title.

(27) The plan shall provide assurances that area agencies on aging will provide, to the extent feasible, for the furnishing of services under this Act, consistent with self-directed care.

Sec. 308, PLANNING, COORDINATION, EVALUATION, AND ADMINISTRATION OF STATE PLANS

(b)(3)(E) No application by a State under subparagraph (b)(3)(A) shall be approved unless it contains assurances that no amounts received by the State under this paragraph will be used to hire any individual to fill a job opening created by the action of the State in laying off or terminating the employment of any regular employee not supported under this Act in anticipation of filling the vacancy so created by hiring an employee to be supported through use of amounts received under this paragraph.

Sec. 705, ADDITIONAL STATE PLAN REQUIREMENTS (as numbered in statute)

(1) The State plan shall provide an assurance that the State, in carrying out any chapter of this subtitle for which the State receives funding under this subtitle, will establish programs in accordance with the requirements of the chapter and this chapter.

(2) The State plan shall provide an assurance that the State will hold public hearings, and use other means, to obtain the views of older individuals, area agencies on aging, recipients of grants under title VI, and other interested persons and entities regarding programs carried out under this subtitle.

(3) The State plan shall provide an assurance that the State, in consultation with area agencies on aging, will identify and prioritize statewide activities aimed at ensuring that older individuals have access to, and assistance in securing and maintaining, benefits and rights.

(4) The State plan shall provide an assurance that the State will use funds made available under this subtitle for a chapter in addition to, and will not supplant, any funds that are expended under any Federal or State law in existence on the day before the date of the enactment of this subtitle, to carry out each of the vulnerable elder rights protection activities described in the chapter.

(5) The State plan shall provide an assurance that the State will place no restrictions, other than the requirements referred to in clauses (i) through (iv) of section 712(a)(5)(C), on the eligibility of entities for designation as local Ombudsman entities under section 712(a)(5).

(6) The State plan shall provide an assurance that, with respect to programs for the prevention of elder abuse, neglect, and exploitation under chapter 3—
(A) in carrying out such programs the State agency will conduct a program of services consistent with relevant State law and coordinated with existing State adult protective service activities for--
(i) public education to identify and prevent elder abuse;
(ii) receipt of reports of elder abuse;

(iii) active participation of older individuals participating in programs under this Act through outreach, conferences, and referral of such individuals to other social service agencies or sources of assistance if appropriate and if the individuals to be referred consent; and
(iv) referral of complaints to law enforcement or public protective service agencies if appropriate;
(B) the State will not permit involuntary or coerced participation in the program of services described in subparagraph (A) by alleged victims, abusers, or their households; and
(C) all information gathered in the course of receiving reports and making referrals shall remain confidential except--
(i) if all parties to such complaint consent in writing to the release of such information;
(ii) if the release of such information is to a law enforcement agency, public protective service agency, licensing or certification agency, ombudsman program, or protection or advocacy system; or
(iii) upon court order

Sec. 307(a) STATE PLANS

(1)(A)The State Agency requires each area agency on aging designated under section 305(a)(2)(A) to develop and submit to the State agency for approval, in accordance with a uniform format developed by the State agency, an area plan meeting the requirements of section 306; and

(B) The State plan is based on such area plans.

Note: THIS SUBSECTION OF STATUTE DOES <u>NOT</u> REQUIRE THAT AREA PLANS BE DEVELOPED PRIOR TO STATE PLANS AND/OR THAT STATE PLANS DEVELOP AS A COMPILATION OF AREA PLANS.

(2) The State agency:

(A) evaluates, using uniform procedures described in section 202(a)(26), the need for supportive services (including legal assistance pursuant to 307(a)(11), information and assistance, and transportation services), nutrition services, and multipurpose senior centers within the State;

(B) has developed a standardized process to determine the extent to which public or private programs and resources (including Department of Labor Senior Community Service Employment Program participants, and programs and services of voluntary organizations) have the capacity and actually meet such need;

(4) The plan shall provide that the State agency will conduct periodic evaluations of, and public hearings on, activities and projects carried out in the State under this title and title VII, including evaluations of the effectiveness of services provided to individuals with greatest economic

need, greatest social need, or disabilities (with particular attention to low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas). Note: "Periodic" (defined in 45CFR Part 1321.3) means, at a minimum, once each fiscal year.

(5) The State agency:

(A) affords an opportunity for a public hearing upon request, in accordance with published procedures, to any area agency on aging submitting a plan under this title, to any provider of (or applicant to provide) services;

(B) issues guidelines applicable to grievance procedures required by section 306(a)(10); and

(C) affords an opportunity for a public hearing, upon request, by an area agency on aging, by a provider of (or applicant to provide) services, or by any recipient of services under this title regarding any waiver request, including those under Section 316.

(6) The State agency will make such reports, in such form, and containing such information, as the Assistant Secretary may require, and comply with such requirements as the Assistant Secretary may impose to insure the correctness of such reports.

(8)(A) No supportive services, nutrition services, or in-home services are directly provided by the State agency or an area agency on aging in the State, unless, in the judgment of the State agency

(i) provision of such services by the State agency or the area agency on aging is necessary to assure an adequate supply of such services;

(ii) such services are directly related to such State agency's or area agency on aging's administrative functions; or

(iii) such services can be provided more economically, and with comparable quality, by such State agency or area agency on aging.

7/3/2014

Signature and Title of Authorized Official *Date*

ATTACHMENT B – INFORMATION REQUIREMENTS

States must provide all applicable information following each OAA citation listed below. The completed attachment must be included with your State Plan submission.

Section 305(a) (2) (E)

Describe the mechanism(s) for assuring that preference will be given to providing services to older individuals with greatest economic need and older individuals with greatest social need, (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas) and include proposed methods of carrying out the preference in the State plan;

The Intrastate Funding Formula (IFF) (see appendix C) includes methods to address distribution of funds in part based on minority, poverty and rural populations. The Area Agencies on Aging are also required to address how services will be targeted to individuals who are in greatest economic and/or social need.

Section 306(a) (17)

Describe the mechanism(s) for assuring that each Area Plan will include information detailing how the Area Agency will coordinate activities and develop long-range emergency preparedness plans with local and State emergency response agencies, relief organizations, local and State governments and other institutions that have responsibility for disaster relief service delivery.

See Appendix R of this State Plan for a description of emergency preparedness planning requirements

Section 307(a) (2)

The plan shall provide that the State agency will:

(C) Specify a minimum proportion of the funds received by each area agency on aging in the State to carry out part B that will be expended (in the absence of a waiver under sections 306)

(c) or 316) by such area agency on aging to provide each of the categories of services specified in section 306(a)(2) *(Note: those categories are access, in-home, and legal assistance).* *Provide specific minimum proportion determined for each category of service.*

See appendix C for Washington's current IFF for the minimum proportion of funds to be dedicated to access, in-home, and legal assistance services

Section (307(a)(3)

The plan shall: (B) with respect to services for older individuals residing in rural areas:

(i) provide assurances the State agency will spend for each fiscal year of the plan, not less than the amount expended for such services for fiscal year 2000.

(ii) *identify, for each fiscal year to which the plan applies, the projected costs of providing such services (including the cost of providing access to such services).*

(iii) *describe the methods used to meet the needs for such services in the fiscal year preceding the first year to which such plan applies.*

See appendix C. The IFF includes a description of the method used to meet the needs of individuals in need of services in rural areas

The State of Washington assures that the State agency will not spend less than the amount expended in the fiscal year 2000 for services to older individuals residing in rural areas.

Section 307(a)(10)

The plan shall provide assurance that the special needs of older individuals residing in rural areas are taken into consideration and shall *describe how those needs have been met and describe how funds have been allocated to meet those needs.*

The state's IFF assures in part through the IFF distribution for rural needs and also through established collaborations for delivery of services in rural areas.

Section 307(a)(14)

(14) The plan shall, with respect to the fiscal year preceding the fiscal year for which such plan is prepared—

(A) *identify the number of low-income minority older individuals in the State, including the number of low income minority older individuals with limited English proficiency*; and

(B) *describe the methods used to satisfy the service needs* of the low-income minority older individuals described in subparagraph (A), including the plan to meet the needs of low-income minority older individuals with limited English proficiency.

The Administration on Community Living/Administration on Aging's AGing Integrated Database (AGID), 2011 estimates indicate that 30,270 individuals in Washington, defined as minority are below the federal poverty level. There is not data available on how many of these individuals have limited English proficiency, however as of 2012, 19.3% of state residents lived in households where language other than English is spoken.

The IFF provides the population component factor addressing this area and service delivery incorporates the need to target individuals with the highest need. The State Plan also stresses the importance of maintaining the capacity to provide culturally relevant and appropriate services including a comprehensive language access policy to ensure appropriate translation and interpretive services are provided for non-English and limited-English speaking clients

Section 307(a)(21)

The plan shall: (B) provide an assurance that the State agency will pursue activities to increase access by older individuals who are Native Americans to all aging programs and benefits provided by the agency,

including programs and benefits provided under this title *(title III),* if applicable, *and specify the ways in which the State agency intends to implement the activities .*

The State of Washington assures that the State agency will pursue activities to increase access to older individuals who are Native Americans to all aging programs and benefits provided by the agency. Please see Goal section for applicable objectives.

Section 307(a)(29)

*The plan shall include information detailing how the State wil*l coordinate activities, and develop long-range emergency preparedness plans, with area agencies on aging, local emergency response agencies, relief organizations, local governments, State agencies responsible for emergency preparedness, and any other institutions that have responsibility for disaster relief service delivery.

Please see attachment Q for a description of state and local emergency preparedness planning requirements

Section 307(a)(30)

The plan shall include information describing the involvement of the head of the State agency in the development, revision, and implementation of emergency preparedness plans, including the State Public Health Emergency Preparedness and Response Plan.

Please see attachment Q for a description of state and local emergency preparedness planning requirements

Section /05(a)(/)

In order to be eligible to receive an allotment under this subtitle, a State shall *include in the State plan submitted under section 307:*

(7) a description of the manner in which the State agency will carry out this title in accordance with the assurances described in paragraphs (1) through (6). *(Note: Paragraphs (1) of through (6) of this section are listed below)*

In order to be eligible to receive an allotment under this subtitle, a State shall include in the State plan submitted under section 307: (1) an assurance that the State, in carrying out any chapter of this subtitle for which the State receives funding under this subtitle, will establish programs in accordance with the requirements of the chapter and this chapter;

(2) an assurance that the State will hold public hearings, and use other means, to obtain the views of older individuals, area agencies on aging, recipients of grants under title VI, and other interested persons and entities regarding programs carried out under this subtitle;

(3) an assurance that the State, in consultation with area agencies on aging, will identify and prioritize statewide activities aimed at ensuring that older individuals have access to, and assistance in securing and maintaining, benefits and rights;

(4) an assurance that the State will use funds made available under this subtitle for a chapter in addition to, and will not supplant, any funds that are expended under any Federal or State law in existence on the day before the date of the enactment of this subtitle, to carry out each of the vulnerable elder rights protection activities described in the chapter;

(5) an assurance that the State will place no restrictions, other than the requirements referred to in clauses (i) through (iv) of section 712(a)(5)(C), on the eligibility of entities for designation as local Ombudsman entities under section 712(a)(5);

(6) an assurance that, with respect to programs for the prevention of elder abuse, neglect, and exploitation under chapter 3--

(A) in carrying out such programs the State agency will conduct a program of services consistent with relevant State law and coordinated with existing State adult protective service activities for:

(i) public education to identify and prevent elder abuse;

(ii) receipt of reports of elder abuse

(iii) active participation of older individuals participating in programs under this Act through outreach, conferences, and referral of such individuals to other social service agencies or sources of assistance if appropriate and if the individuals to be referred consent; and

(iv) referral of complaints to law enforcement or public protective service agencies if appropriate;

(B) the State will not permit involuntary or coerced participation in the program of services described in subparagraph (A) by alleged victims, abusers, or their households; and

(C) all information gathered in the course of receiving reports and making referrals shall remain confidential except--

(i) if all parties to such complaint consent in writing to the release of such information;

(ii) if the release of such information is to a law enforcement agency, public protective service agency, licensing or certification agency, ombudsman program, or protection or advocacy system; or

(iii) upon court order.

The State of Washington assures its commitment to carrying out the requirements of Title VII. See the State Plan's program descriptions for Elder Rights and Justice and related goal and objectives

Washington State Department of Social & Health Services
ALTSA Aging and Long-Term Support Administration

ATTACHMENT C-INTRASTATE FUNDING FORMULA

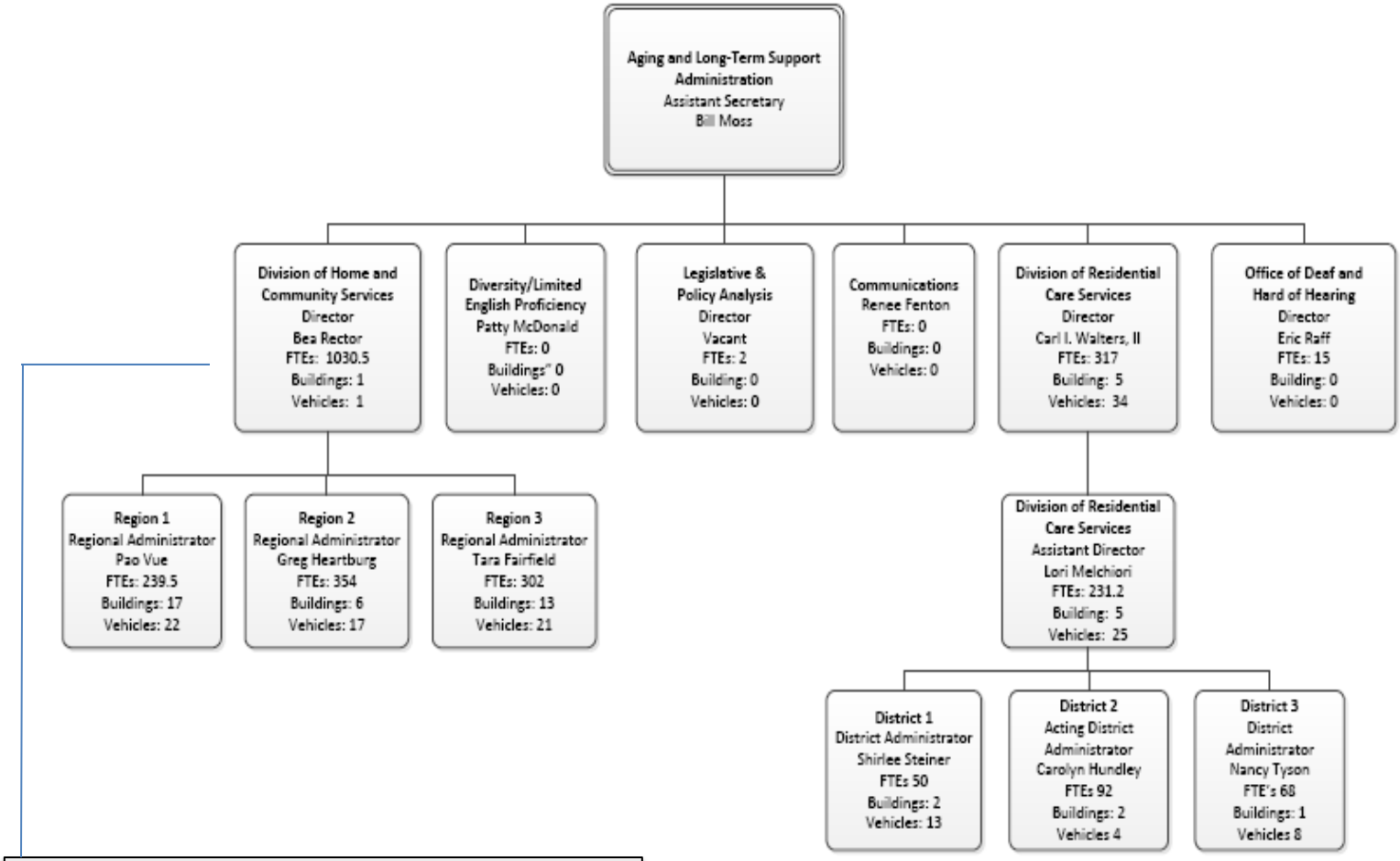
(ATTACHED SEPARATELY AS PER GUIDLINES)

ATTACHMENT D- LIST OF ACRONYMS

LIST OF ACRONYMS

AAA - Area Agencies on Aging
ACA- Affordable Care Act
ACL- Administration on Community Living
ADA – Americans with Disabilities Act
ADL – Activities of Daily Living
ADRC – Aging & Disability Resource Center
ALTSA - Aging and Long -Term Support Administration
AP – Area Plan for AAAs
APS - Adult Protective Services
ASL – American Sign Language
CARE - Comprehensive Assessment Reporting and Evaluation (tool)
CLC - Community Living Connections (WA's ADRC)
CFCO- Community First Choice Option
DSHS - Department of Social and Health Services
EESI- Elder Economic Security Index
FCSP – Family Caregiver Support Program
FTE – Full Time Equivalent (employee)
GAL – Guardian Ad Litem
HCA-Health Care Authority
HCS - Home and Community Services
HCR-Health Care Reform
I&A – Senior Information and Assistance
LES – Limited English Speaking ability
LGBT-Lesbian, gay, bisexual, and transgender
LTCO-Long Term Care Ombuds Program
OAA – Older Americans Act
OFM – Office of Financial Management
PSA – Planning and Service Area (same as AAA)
QA - Quality Assurance
SCOA – State Council on Aging
SDC - Self-Directed Care
SUA – State Unit on Aging
W4A – Washington Association of Area Agencies on Aging

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



Division Home and Community Services
Director Bea Rector

- **Chief of Operations**
- **Regional Administrators**
- **State Unit on Aging**
- **Training Communications and Development**
- **Financial Services**

ATTACHMENT E, continued
ALTSA Division Descriptions

Home and Community Services

Home and Community Services (HCS) develops and implements state-wide community based services and supports for adults with functional disabilities including state plan and home and community based waivers; determines functional and financial eligibility for long term care Medicaid; provides/contracts for case management, care planning and service authorization for individuals receiving long term care services in community based settings including their own homes or licensed residential settings. HCS is responsible for the protection of vulnerable adults through operation of the state's Adult Protective Services program. HCS also provides oversight and administration of federal and state programs related to older adults and oversees services provided through the Area Agencies on Aging and Aging Network providers. HCS develops innovative programs to further develop service infrastructure and expand participant choice and control as well as promote healthy aging through the dissemination of evidence based practices. HCS contracts for the Home Care Referral Registries that provide access to qualified Individual Providers for Medicaid funded personal care services. HCS also develops rules and curriculum for community-based providers of personal care and develops training curriculum for staff and providers of services under Medicaid. HCS provides quality assurance, improvement and compliance functions for consumers receiving long term care services under Medicaid and develops communication materials for long term care consumers. The division also analyzes, develops, and monitors legislation affecting older adults and disabled persons.

Home and Community Services, Local Offices

Financial workers, Social workers and community nurses in this division provide direct long-term care services in 43 statewide locations to persons age 18 and above. The division is administratively divided into three geographic regions, headed by three regional administrators. Programs administered in these regions include: Adult Protective Services, Title XIX functional and financial eligibility determination (residential and in-home), Title XIX Case Management for Adult Family Home, Boarding Home, and Nursing Home diversion.

Residential Care Services

Residential Care Services (RCS) performs an array of services designed to ensure a high quality of care for residents living in facilities. Program services include licensing, survey compliance with state and federal requirements, planning and development of policies resulting in a resident-oriented delivery system, participation in innovative quality assurance programs, development of services that are an integrated part of the long-term care system, and management coordination with providers.

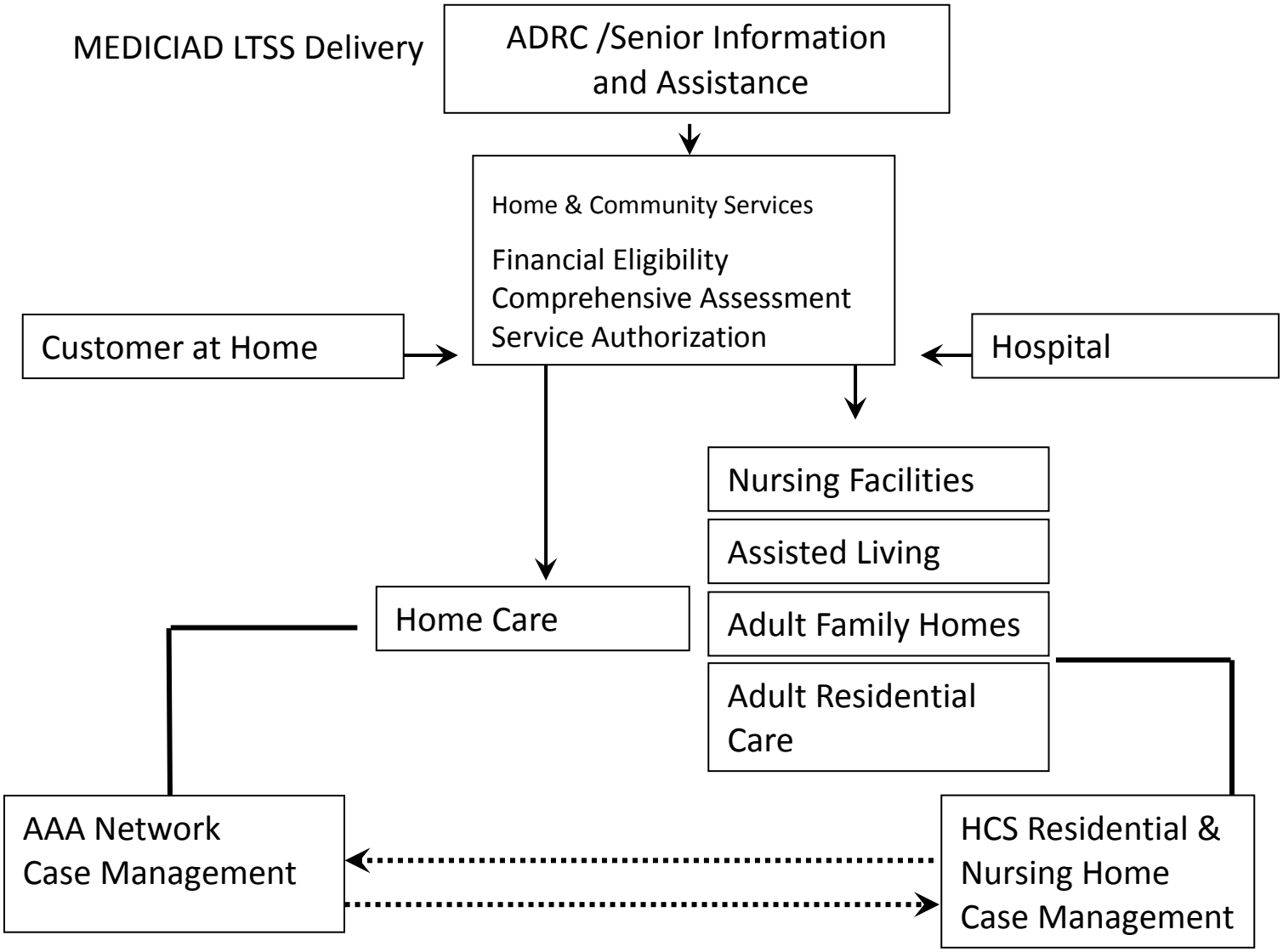
Office of Deaf and Hard of Hearing (ODHH)

ODHH has served the deaf, hard of hearing and deaf-blind communities for more than thirty years. ODHH provides equal access opportunities to effective communication in telecommunications, DSHS, and the daily lives of the people we serve. We operate in

accordance to the law, plan for the future, budget to fund our services, hold ourselves accountable, and partner with our stakeholders to address gaps in services

Management Services Division

This division of ALTSA is responsible for: Fiscal and Contracts, Data Analysis and Forecasting, Rates Management and Personnel. This division is responsible for biennial budget development for all programs areas, allotments and monitoring all fund sources and expenditures; contracts; data development and analysis, forecasting budgets and caseloads; personnel management; rates development; and development and maintenance of technical applications, network access and computer hardware support.



ATTACHMENT F- AAA'S

PLANNING AND SERVICE AREA	AREA AGENCY ON AGING	COUNTIES SERVED
1	**Olympic Area Agency on Aging** 11700 Rhody Drive Port Hadlock, WA 98339 Phone: (360) 379-5064	Clallam, Jefferson, Grays Harbor, Pacific
2	**Northwest Regional Council** 600 Lakeway Drive, Suite 100 Bellingham, WA 98225 Phone (360) 676-6749	Island, San Juan, Skagit, Whatcom
3	**Snohomish County Aging & Disability Division** 3000 Rockefeller Ave. M/S 305 Everett, WA 98201 Phone (425) 388-7200	Snohomish
4	**Aging & Disability Services** PO Box 34215 Seattle, WA 98124-4215 Phone: (206) 684-0660	King
5	**Pierce County Aging and Disability Resources** 3580 Pacific Avenue Lakewood, WA 98418 Phone (253) 798-7236	Pierce
6	**Lewis/Mason/Thurston Area Agency on Aging** 2404 Heritage Court SW Olympia, WA 98502 Phone (360) 664-2168	Lewis, Mason, Thurston
7	**Area Agency on Aging and Disabilities of Southwest Washington** 201 NE 73rd St., Suite 201 Vancouver, WA 98665 Phone (360) 735-5720	Clark, Cowlitz, Klickitat, Skamania, Wahkiakum
8	**Aging & Adult Care of Central Washington** 50 Simon St. SE East Wenatchee, WA 98802 Phone (509) 884-6943	Adams, Chelan, Douglas, Grant, Lincoln, Okanogan

9	**Southeast Washington Aging & Long Term Care** 7200 W. Nob Hill Blvd Ste. 12 (Office) P.O. Box 8349 (Mail) Yakima, WA 98908-0349 Phone (509) 965-0105	Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Yakima, Walla Walla
10	**Yakama Nation Area Agency on Aging** 91 Wishpoosh (Office) P.O. Box 151 (Mail) Toppenish, WA 98948 Phone (509) 865-5121	Yakama Reservation
11	**Aging & Long Term Care of Eastern Washington** 1222 North Post Spokane, WA 99201 Phone (509) 458-2509	Ferry, Pend Oreille, Spokane, Stevens, Whitman
12	**Colville Indian Area Agency on Aging** P.O. Box 150 Nespelem, WA 99155 Phone (509) 634-2759	Colville Reservation
13	**Kitsap County Division of Aging & Long Term Care** 1026 Sidney Avenue (Office) 614 Division, MS-5 (Mail) Port Orchard, WA 98366 Phone (360) 337-7068	Kitsap

ATTACHMENT G-ELDER ECONOMIC SECURITY STANDARD INDEX

Washington Elders Living on the Edge:
The Washington Elder Economic Security Initiative™

Today's retirees are pressured by increasing housing, health care, fuel and utility expenses while the value of their assets and incomes have been eroded by weaknesses in the economy since the great recession. These realities compelled the Washington Association of Area Agencies on Aging (W4A) to create the Elder Economic Security Initiative™ in partnership with Wider Opportunities for Women (WOW), a Washington, DC-based national advocacy organization. Washington was the thirteenth state to participate with WOW when the initiative was officially launched in March 2011.

The Washington Elder Economic Security Initiative™ offers a conceptual model and concrete tools to reframe the discussion about economic security for individuals 65 years of age and older who have a range of needs for health care and long term support. The centerpiece of this effort is the annual publication of the *Elder Economic Security Standard™ Index for Washington.* The tables in this document show the cost of living at home, for renters and homeowners, for singles and couples. The Elder Index is calculated for all 39 counties in the state based on publicly-available, geographically-specific data related to the costs of housing, food, transportation, health care and other miscellaneous expenses. The Elder Index is also now available online for every county in each of the 50 states and is updated annually.

Uses for the Washington Elder Economic Security Standard™ Index (Elder Index):

Adults age 65 and older are vital to Washington's communities. Opportunities for personal and public planning and community economic development guided by accurate and relevant information are critical to ensuring economic security for current and future generations of Washington elders. The Elder Index is a useful tool for local and state policymaking, as well as education and outreach. Current uses include:

Policymakers, Legislators, and Advocates: As the Elder Index shows, it is almost impossible for an elder to survive on the average Social Security payment, even though Social Security is the only source of income for over one out of five retired elders in Washington State. The Elder Index demonstrates the real cost of being secure in a particular county, and can help determine what policies are most appropriate in bringing elders closer to their goal of aging in their homes. The Elder Index data has been presented to the state legislature and special legislative study committees every year since 2011. The Area Agencies on Aging also utilize the data in their four-year planning process and with local policy-makers.

Single Elders and Elder Couples: The Elder Index shows how much single elders and elder couples need in order to be secure in their own homes based on their location and need for

health care and other assistance in retirement. Through regular public education offerings, the Area Agencies on Aging encourage seniors to use the Elder Index to see how their finances match what is needed.

Younger Adults and Families Planning for Retirement: We all have one plan in common – making it to retirement age. Once we get there, though, we need to have a plan in place if we want to be economically secure. The Elder Index can help community members determine what they would need to live in economic security and what policy changes can help make this possible. It serves as an advocacy tool to promote better retirement planning with consumers and state policy-makers.

Washington State Department of Social & Health Services
ALTSA Aging and Long-Term Support Administration

ATTACHMENT H- ELDER JUSTICE

Protection from Elder Abuse, Neglect and Exploitation

Presented to the Joint Legislative/Executive Committee on Aging and Disability June 18, 2014

In 2010, DSHS convened the Adult Abuse/Neglect Response workgroup. Since that time the workgroup has developed multiple recommendations to improve Washington State's adult abuse response system.

Members include:

- AARP
- ARC
- Developmental Disabilities Council
- Disability Rights Washington
- DSHS Employees (RCS, HCS, DDA)
- Office of Public Guardianship
- State Ombuds
- Self-Advocates
- State Council on Aging
- Tribal Representatives

DSHS has adopted and implemented many of the recommendations; others are still in progress, and several initiatives need the ongoing compassionate voice of stakeholders as well as additional support from the Legislature to complete.

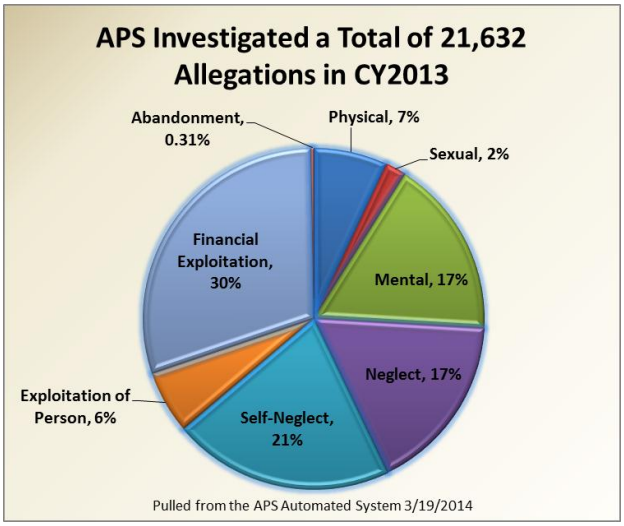
What has been accomplished:

- Successful implementation of the Tracking Incidents of Vulnerable Adults (TIVA) database system. The purpose of TIVA is to track, trend, and report on critical incidents across settings related to vulnerable adults and perpetrators that fall under ALTSA's jurisdiction. The system focuses on vulnerable adults living in licensed and certified settings as well as those who live in their own homes. TIVA is simple to use and is increasing overall data accuracy and integrity.
- Improved communication with law enforcement: A referral form is now faxed to law enforcement directly from the TIVA application.
- Live Intake Call Response during business hours implemented by Residential Care Services, Complaint Resolution Unit (CRU).
- Consistent method of report assignment prioritization implemented across both the Resident Client Protection Program (RCPP) and APS: 24-hour response, 5-day response, and 10-day response.
- Reduced the time it takes to assign a case for investigation by CRU.

- Through use of a 24-month federal grant (Money Follows the Person) RCS is strengthening its divisional quality assurance program across all RCS-regulated settings. The intent is improved quality assurance reporting, standardization and consistency of practice and proactive identification of areas of improvement.
- Alerts sent electronically to Medicaid case manager to improve response and risk management.

What is currently in progress:

- Potential request legislation to amend the definitions in Chapter 74.34 RCW to improve the clarity of the language, expand the definition of Vulnerable Adult to included people with developmental disabilities that have not had a formal department determination and remove barriers to substantiating allegations.
- Potential request legislation to allow DSHS to impose intermediate sanctions in the Supported Living program. This will bring the regulatory structure in line with what is available in other settings such as Adult Family Homes, Assisted Living Facilities, and Nursing Homes. This is a recommendation from Disability Rights Washington and DSHS put this request legislation forward last session with support from, and collaboration with legislators, providers, and advocacy groups.
- APS is participating in local and national pilots designed to improve and standardize identification of vulnerable adults who are unable to understand consequences of their decisions and are in need of further capacity evaluation. This includes collaboration with Cornell University and New York APS in a pilot project to develop a training curriculum on assessing decision-making capacity.
- Incorporating concepts of the 'person-centered' trauma model into the APS Training Academy. This model focuses on the alleged victim. For example, methods can be used to minimize the number of interviews for a victim who has experienced trauma.

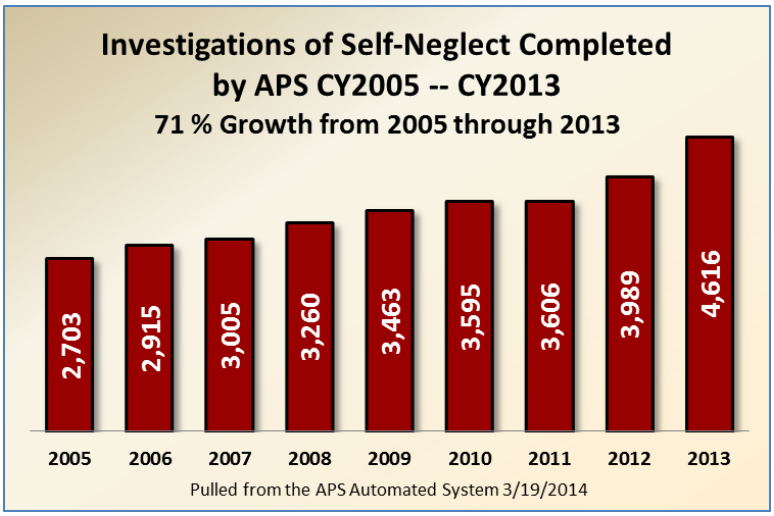


Challenges that impact the Department's ability to respond timely to protecting vulnerable adults:

Financial Exploitation Cases

- Financial Exploitation grew by 96% from FY2005-FY2013. 30% of all 21,632 APS investigations in FY2013 were Financial Exploitation Cases.
- Social workers do not have the training and expertise necessary to efficiently investigate financial exploitation cases.

- Financial exploitation cases are complex; investigations are frequently open longer than 90 days and often resolved after the victim's resources are gone.



Protecting Individuals with Diminished Capacity

- Self-neglect cases have grown by 71% since 2005.
- APS investigators need a consistent and standard way to assess whether individuals have decision-making capability for health care and financial decisions.
- Most screening tools can only be administered by professionals with higher educational levels and specialized training. The tools currently available to investigators do not adequately assess executive function or decision-making capability.

Continued support needed from the legislature:

1. Funding is needed to create six (6) positions in APS that have high-level expertise in financial investigations to provide consultation to other investigators; manage complex investigations; and establish local relationships with financial institutions and others to increase awareness and improve coordination needed for successful investigations and outcomes. This will also allow current staff to focus on other types of investigations in order to close investigations within ninety 90 days and protect vulnerable adults.
2. Funding to create three (3) positions in APS that will focus on facilitating protective orders and guardianships. This will allow APS to more quickly address protective services required by individuals who have diminished decision-making capability.
3. Continued funding is needed for RCS Quality Assurance Program Enhancements: CMS Home and Community Based Services (Money Follows the Person grant) is only funded for a two-year cycle for $720,000 (began February 2014). Funding is used for six (6) FTEs.
4. Support for legislation to amend the definition of Vulnerable Adult and the definitions of abuse
in Chapter 74.34 RCW. This will allow APS to protect more people and substantiate more allegations.

5. Support for legislation granting DSHS authority to impose intermediate sanctions in the Supported Living Program.

ELDER JUSTICE

Description of Elder Abuse Services in Washington

The Older Americans Act Title VII funding is administered in two parts. One part goes to the Ombudsman via the Department of Commerce; the other is allocated to the AAA's. The AAA's are responsible for elder abuse advocacy, community education & prevention and referrals (mandatory reporting). Protection of vulnerable adults is provided by Adult Protective Services (APS) which is funded by the state.

Washington State provides Ombudsman services through a contract with a non-profit agency, managed through the Department of Commerce. The program is active in all regions of the state and responds to complaints in Nursing Homes, Boarding Homes, Assisted Living, and Adult Family Homes.

The Ombudsman program has a total budget of over 1.5 million dollars, and is comprised of 14.56 staff, 347 certified volunteer ombudsman volunteers and 100 additional volunteers. Seven of 13 paid Regional Ombudsman and their volunteers are located in the Area Agencies the other 6 located in independent community based agencies. During FFY 2013 the LTCO received 4835 complaints and investigated and closed 3149 complaints. Currently the LTCO is also implementing three year grant focused on informing long-term care residents and their legal decision- makers about the known adverse side effects of taking antipsychotics and their legal rights to be informed and free of "chemical restraints". The LTCO provides independent systems-level advocacy by representing interests of residents before governmental agencies. This includes analyzing, commenting on, monitoring and suggesting changes to the laws, policies and regulations that impact long-term care residents and services. The State LTCO also independently determines when to release information to public and private agencies, legislators, and other persons, regarding: (1) the problems and concerns of individuals residing in long-term care facilities; (2) and recommendations related to these problems and concerns.

ALTSA ensures that the Ombudsman program meets the OAA requirements, adheres to State law, and coordinates with existing state adult protective services activities by allocating the Title VII money among the AAA's according to the state's intrastate funding formula. ALTSA uses administrative funds from Title VII to fund some statewide projects such as sponsoring the Access to Justice Conference annually.

AAA's provide the following services with Title VII funding based upon their approved Area Plans:

Public education to identify and prevent elder abuse; participation with local law enforcement and other entities in coalitions to provide a multi-discipline approach to victim advocacy;

Advocacy at the state and federal levels to strengthen policies and laws regarding the protection of vulnerable adults.

State law requires referral of complaints to law enforcement by the department and to the department by a group of mandated reporters to public protective service agencies. (Mandatory Reporting)

The state continues to support abuse prevention activities by offering caregiver training and workshops for family and other unpaid caregivers.

Elder rights policies are reviewed and discussed annually at the Access to Justice Conference, which is sponsored by the Washington State Bar Association with sponsor funding from ALTSA (Title VII). This three-day conference brings together attorneys, judges, and consumers to determine how to improve access to justice in the state. This organized group discusses legal needs of the Justice System, and comments on the plans and needs of elders. These work products are followed up on in the various committees and meetings. One of the outcomes of this group was a legal needs survey. The survey found low-income vulnerable seniors and domestic abuse survivors get attorney assistance for legal problems most often but still face more than three quarters of legal problems on their own. There is a great need for more funding for legal services.

Another aspect of Elder rights, are focused on at the "Making the Case for Justice—An In-Depth Look" Conference, which is sponsored by the King County Prosecutor's Office, AARP and ALTSA. This two-day conference is held annually and brings together law enforcement and prosecutors, investigators of elder abuse, including APS, RCS, Ombudsmen, and others to determine how to enhance the investigation of elder abuse through education and collaboration with related agencies in the state. ALTSA contributes (Title VII) annually toward this event and has an active role on the planning committee.

Access to professional guardians is another important right that ALTSA supports. ALTSA contracts with the King County Bar Association to train 275-300 individuals per year as Guardian Ad Litems (GAL). In addition, through the contract they maintain a training manual for GAL. In the coming year the manual will be created in a secure CD and internet version. The King County Bar Association will post and maintain a webpage where the public can access the Title 11 Guardianship Guardian Ad Litem Manual. In addition, ALTSA continues to collaborate with the Attorney General's Office regarding legislative and funding changes necessary to support elder abuse and prevention activities and services.

State Protective Services

Aging and Long-Term Support Administration (ALTSA) implements the department's statutory mandate to investigate allegations of abuse, abandonment, neglect, self-neglect, and financial exploitation of adults who are vulnerable. The entities responsible to carry out this function are Adult Protective Services (APS) and Residential Care Services (RCS), both housed within ALTSA.

Adult Protective Services: Investigations and Protective Services to Adults who live in their Own Homes

Adult Protective Services (APS) receives and investigates allegations of abuse (physical, mental, sexual, and exploitation of person), abandonment, neglect, self-neglect, and financial exploitation of vulnerable adults living in their own homes and in facilities, such as adult family homes or nursing homes, where there is an allegation of mistreatment by someone outside of the facility (not an employee of that facility).

An APS investigator will make an unannounced home visit; interview the alleged victim in private, the alleged perpetrator, and other people who may have information. APS will report to law enforcement if a crime is suspected, or file for an injunction if access to the alleged victim is denied.

APS may offer protective services as soon as a need for protection is determined.

Protective services may include assisting with, or pursuing, protection orders, filing for guardianship, providing a referral for legal assistance, referrals to case management, in-home care services, long-term care residential services, and referrals to other agencies. Vulnerable adults, or their legal representatives, must give written consent for protective services such as in-home and residential services, and may end services at any time. APS is not able to remove alleged victims from their homes without their permission, or detain due to capacity issues.

Any person with an initial, substantiated APS finding, has a right to an administrative hearing to challenge the finding. If the APS finding is upheld in the administrative hearing, the finding becomes final and the person's name is placed on the Abuse Registry. The Abuse Registry is a database, maintained by the Department that contains a list of names with final, substantiated findings.

Placement on this registry permanently disqualifies the person from being a paid, Medicaid provider of long-term care services. Additionally, APS field staff participate in community task groups addressing the awareness and prevention of, and the protection against, the abuse, abandonment, neglect, self-neglect, and financial exploitation of vulnerable adults.

In 2012 FY (July 2012 – June 2013) APS received over 20,826 reports of suspected abuse, neglect, self-neglect, financial exploitation, and abandonment of vulnerable adults, an increase of 48% since 2008.

Residential Care Services Division: Investigations in Residential Facilities and Supported Living Settings

RCS is responsible for provider/facility licensure or certification as well as investigating reports of abuse, abandonment, neglect, and financial exploitation of adults who are vulnerable living in long-term care facilities and supported living. The centralized Complaint Resolution Unit

screens reports against statutory criterion, and prioritizes these reports for a range of 2-day to 90-day response times. Investigators in each of six statewide regions interview, observe, and review facility records to determine if the facility complied with long-term care licensing regulations. RCS may take enforcement actions ranging from requiring the licensee to pay a civil fine to the permanent removal of a license, which the facility can appeal.

RCS and APS coordinate investigations when a situation involves an adult who is vulnerable that lives in a residential facility and the alleged perpetrator is not affiliated with the facility. If RCS moves to close a facility because of resident safety or other issues, APS and HCS staff will assist in the relocation of residents to other facilities or the person's own home, and arranging individual or agency provider services.

Investigators make a finding based upon a preponderance of the evidence. Persons found to have abused, abandoned, neglected, exploited, or financially exploited residents or clients in the above programs can challenge the finding in an administrative hearing. If RCS prevails in the hearing, the name of the person is submitted to a department database and the person is disqualified from being employed in any long-term care setting or obtaining a license or certification to operate a long-term care facility or program.
In addition to provider/facility licensure and/or certification, RCS also receives and investigates reports of abuse (physical, mental, sexual, and exploitation of person), abandonment, neglect, self-neglect, and financial exploitation of vulnerable adults receiving services from those programs. Primary authority regarding the abuse of vulnerable adults is found in Chapter 74.34 RCW.

In 2012, RCS received over 37,000 reported concerns about suspected abuse, neglect, self-neglect, financial exploitation and abandonment of vulnerable adults, as well as concerns about quality of life or quality of care. This includes reports from community members, family members, and the general public (permissive reporters) as well as self-reports from mandated reporters such as nursing homes (NH), adult family homes (AFH), assisted living facilities (ALF), intermediate care facilities for persons with intellectual disabilities (ICFs/ID) and certified community residential services and support (CCRSS) providers. The majority of these are privately owned businesses.

Mandated Reporters
By law, certain people must report suspected abuse and neglect. Mandated reporters include: DSHS employees; individual providers contracted to provide services to a DSHS client; county coroners or medical examiners; employees of a facility licensed by DSHS, including assisted living facilities, adult family homes, nursing homes, residential habilitation centers, and soldiers' homes; social workers; health care providers as defined in Chapter 18.130 RCW; Christian Science practitioners; employees of a social service, welfare, mental health, adult day health, adult day care, home health, home care, or hospice agency; law enforcement officers; and professional school personnel. RCW 74.34.035 tells mandated reporters what, when, and to whom to report.

Calls about suspected abuse or neglect in these programs go to the RCS's Complaint Resolution Unit (CRU) at 1-800-562-6078. This hotline is set up to receive both mandated and permissive reports, so anyone can call. Calls are processed on a daily basis, and the information is reviewed and prioritized for investigation. Complainants are contacted for additional information.

In addition to the CRU Hotline, DSHS has also established a toll-free number for the general public for reporting suspected abuse. Callers are routed to the appropriate DSHS entity based on where the alleged victim resides. 1-866-ENDHARM (363-4276) or TTY (1-800-737-7931)

When RCS receives an allegation of abuse, neglect, or misappropriation of resident funds, investigation response times range from two working days to 90 working days. Concerns that are serious or pose life-threatening harm to a resident are investigated more quickly than issues that are of lower risk. Professional nurses review all of the complaints received by RCS to determine how quickly the complaint needs to be investigated.

RCS staff conducts on-site investigations. If an investigation shows that the facility has failed to provide safe quality care to residents, RCS actions can range from work with the facility (to correct problems and ensure against repetition) to citation, fine, or stop placement. When appropriate, RCS can forward information to other agencies such as local law enforcement.

The facility is responsible to ensure safe and quality care for each resident. RCS holds the facility responsible throughout the complaint investigation process.

Resident & Client Protection Program

Federal and state laws, including state law at Chapter 74.34 Revised Code of Washington (RCW), include requirements for reporting and preventing vulnerable adult abandonment, abuse, neglect, exploitation, or financial exploitation. The department investigates individuals alleged to have abandoned, abused, neglected, exploited, or financially exploited a vulnerable adult.

In 1996, a unit within the department began investigating individuals associated with nursing homes alleged to have abandoned, abused, neglected, exploited, or financially exploited vulnerable adults. In 2006, a separate unit began investigating similar individuals in the Certified Community Residential Services and Support program.

The Resident and Client Protection Program (RCPP) unit conducts investigations of individuals alleged to have abandoned, abused, neglected, exploited and financially exploited a resident or client in the following programs:

- Nursing homes,
- Assisted living facilities;
- Adult family homes;
- Intermediate care facilities for persons with intellectual disabilities, and

- Certified community residential services and support.

The provider is required under licensure and/or certification requirements to keep the vulnerable adults under their care safe. The field units investigate whether the provider (or facility) has kept residents safe in accordance with the law. The RCPP investigates to see if it is more likely than not that and named individual working in those licensed and/or certified programs has abused or neglected those vulnerable adults.

Department investigations of individuals include allegations of rape, physical or verbal assault, neglect, and financial exploitation as well as cases of a more subtle nature such as resident intimidation, humiliation or harassment. RCPP is able to make an administrative finding where criminal convictions or licensing and/or certification actions cannot be taken or are not appropriate. The names of those individuals are placed on a department list.

Nursing homes cannot employ any individual found to have abandoned, abused, neglected, exploited or financially exploited a vulnerable adult. Other department licensed/certified programs cannot hire these same individuals if they might have unsupervised access to vulnerable adults.

LONG TERM CARE OMBUDSMAN SYSTEMS ADVOCACY

The Older Americans Act (OAA) mandates that LTCOPs provide systems-level advocacy to assure that the needs of long-term care residents are fully represented. The LTCO represents the interests of residents before governmental agencies and seek administrative, legal, and other remedies to protect the health, safety, welfare, and rights of residents.

This includes analyzing, commenting on, monitoring and suggesting changes to the laws, policies and regulations that impact long-term care residents and services and facilitating public comment about the laws, regulations and policies. The State Ombudsman Office provides when deemed to be necessary, this information to public and private agencies, legislators, and other persons, regarding: (1) the problems and concerns of individuals residing in long-term care facilities; (2) and recommendations related to these problems and concerns

LTCO Systems Advocacy through participation in the Adult Family Home Quality Assurance Panel
(Excerpts from the Panel Report)

In 2011, the Washington State Legislature examined problems with the quality of care and oversight of some adult family homes (AFHs). Washington has over 2,800 AFHs, serving approximately 14,000 vulnerable residents and/or residents with disabilities in small residential homes. The 2011 Legislature passed HB 1277 to address these care quality and oversight issues. The new law increased requirements for AFHs—the homes now had to have a qualified caregiver on-site, as opposed to on-call; owners needed to understand English; and more prior caregiving experience was required of new AFH owners. HB 1277 also augmented the civil fine

authority of the Department of Social & Health Services (DSHS), the agency that licenses and inspects AFHs, and directed the agency to increase penalties for AFHs that are consistently deficient. The changes went into effect in January 2012. In addition, through Initiative 1163 and effective January 2012, the basic training requirements for newly licensed AFH owners and newly hired caregivers in AFHs were increased.

In order to examine the issues more fully, HB 1277 also directed DSHS to convene a Quality Assurance panel, selected by DSHS and the State Long-Term Care Ombudsman (LTCO) and chaired by the latter, to review problems with neglect and abuse in AFHs, and the oversight of new providers, de minimus violations, and overall licensing, investigation and enforcement issues regarding AFHs. The Panel was directed to provide a report to the Governor and Legislature by December 1, 2012.

The Long-Term Care Ombudsman (LTCOP) and DSHS assembled a Panel representing AFH associations and providers, resident advocates and families, nursing/hospice, public guardianship, and DSHS oversight and management divisions. The Panel met five times and discussed a broad array of topics and recommended action steps. These steps are not based upon a rigorous study, but upon the pooled knowledge of an experienced, diverse group of stakeholders working in this field.

A team of ombudsmen also reviewed a random sample of 160 unredacted DSHS licensing and investigation files, and a representative sample of those cases was then considered by the Panel. The case reviews revealed both effective and ineffective enforcement actions. For example, an AFH teetering on the brink of financial crisis and with staff mistreating residents was shut down promptly. On the other hand, an AFH with residents with dementia who were wandering repeatedly out of the home, and a caregiver who could not read residents' records, was permitted to operate for a year before DSHS required a second caregiver.

Summary of Recommendations

While not every member of the Panel agreed with the every statement in this report, overall, nearly all members of the panel concluded that the quality of care in AFHs would be improved, and abuse and neglect would decline, if some caregivers and AFH owners received better training and mentoring, residents and their families were better informed and selected the right AFH, and DSHS oversight was more vigorous and prompt against poorly performing AFHs.

When Should I Be Concerned?

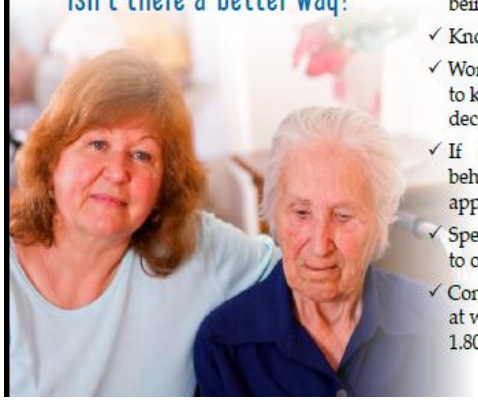
Behaviors communicate symptoms that are warning signs telling us something is wrong. Look for increased behavioral symptoms such as: anger, agitation, screaming, swearing, hitting, pacing, paranoia, delusions, continuous wandering, or any other significant change in behavior.

IF these symptoms are present and then suddenly go away and are replaced with lethargy, unresponsiveness, increased drooling, and/or lack of expressiveness, that's when there is reason to believe something has changed.

"She changed so fast!

Her dementia isn't easy, but the drugs being used to sedate her, have taken "her" and her quality of life away.

Isn't there a better way?"



What Can I Do?

- ✓ Request a care plan conference and ask the right questions – use why, when, where, and how questions to consider as many reasons for the behavior as possible.
- ✓ Ask the right questions: Why was the drug prescribed? What are the potential side effects? How will it interact with other drugs? Was this communicated to the resident/family?
- ✓ Keep the focus on the resident's needs and monitor the care plan. If it's not being followed, speak up immediately.
- ✓ Know your rights under the law.
- ✓ Work closely with staff to help them get to know the resident. What is the plan to decrease or stop the drug?
- ✓ If drugs are being considered for behavioral symptoms, ask that other approaches be tried first.
- ✓ Speak with the doctor if he or she wants to order an antipsychotic.
- ✓ Contact your long-term care ombudsman at www.waombudsman.org or call 1.800.562.6028.

Washington State Long-Term Care
OMBUDSMAN PROGRAM

For More Information
Call Toll Free: 1-800-562-6028
or visit www.waombudsman.org

Washington State Long-Term Care
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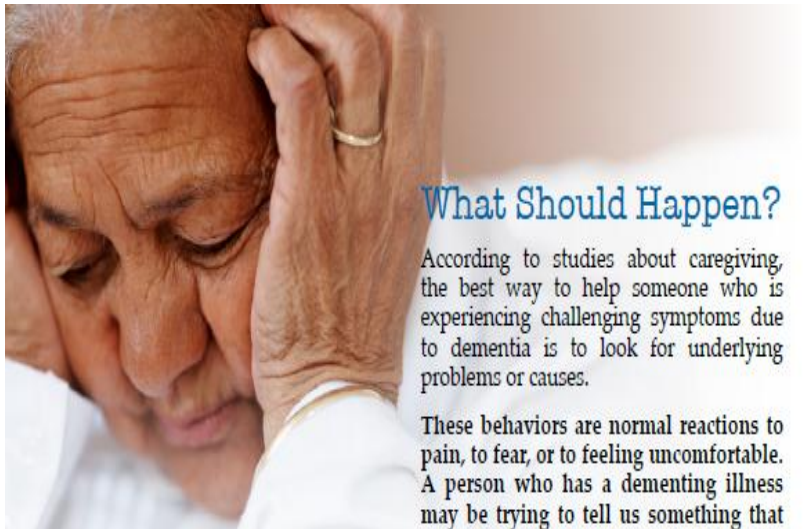
Reduce the Misuse

Long-Term Care Ombudsmen are informing long-term care residents and their legal decision makers about the known adverse side effects of taking antipsychotics and their legal rights to be informed and free of "chemical restraints".

Washington State Department of Social & Health Services
ALTSA Aging and Long-Term Support Administration



What's the Problem?

Used appropriately, medications can cure disease, ease pain, and enhance quality of life. Used inappropriately, drugs can cause disability, pain, and decrease quality of life. Antipsychotics (psychoactive drugs) affect the brain and influence thinking, feeling, and reacting. These drugs pose special risks for older people and increase the risk for harm in persons with dementia. Common antipsychotics used in long-term care settings include: Risperdal, Risperidone, Risperadal Consta, and Invega (Paliperidone).

Often, these drugs are used when a person acts in ways that are challenging or disturbing to caregivers or others such as: confusion, hitting, yelling, screaming, swearing, refusing care, pacing, paranoia, "wandering", crying, or other significant change in behavior.

Antipsychotic drugs used to treat behavioral symptoms in place of good care are called **chemical restraints.**

What Should Happen?

According to studies about caregiving, the best way to help someone who is experiencing challenging symptoms due to dementia is to look for underlying problems or causes.

These behaviors are normal reactions to pain, to fear, or to feeling uncomfortable. A person who has a dementing illness may be trying to tell us something that they need:

- Food because the resident is hungry.
- Water or juice to drink because the resident is thirsty.
- To take a nap because they are tired.
- To go to the bathroom.
- Be given some task or activity to do because they are bored.

Skilled caregivers should look to resident needs and what the resident may be trying to ask for through their behaviors, since their expressive abilities may be increasingly limited by dementia. Skilled caregivers meet the needs of residents by looking at physical, environmental, and emotional triggers of behavior to predict the needs that residents are trying to ask for through their behaviors.

Agitation, confusion or other behavioral changes can be caused by untreated infections, dehydration, pain, medication reactions, boredom, loneliness, or other physical or psychosocial reasons. The resident's doctor should be asked to evaluate possible medical causes of any behavioral concerns.

What Can't These Drugs Do?

- Stop someone from repeated yelling or from asking the same questions.
- Calm down restlessness; stop fidgeting or feelings of uneasiness.
- Stop memory problems or forgetfulness; instead they worsen memory.
- Help persons do more for themselves, interact better, or stop saying inappropriate things.

Antipsychotics are not treatments for dementia or Alzheimer's disease. They are medications with sedation properties and are appropriate only for specific mental disorders and under specific circumstances.

Legal Rights

If you are a person living in a long-term care facility, you have legal rights known as "Residents' Rights".

Laws (RCW 70.129) to note are:

- ✓ The right to be informed about any medication prescribed.
- ✓ The right to not be chemically restrained.
- ✓ The right to refuse medication.
- ✓ The right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences.
- ✓ The right to not be transferred or discharged on the grounds that the facility cannot meet his or her needs, unless those needs meet very specific medical criteria.

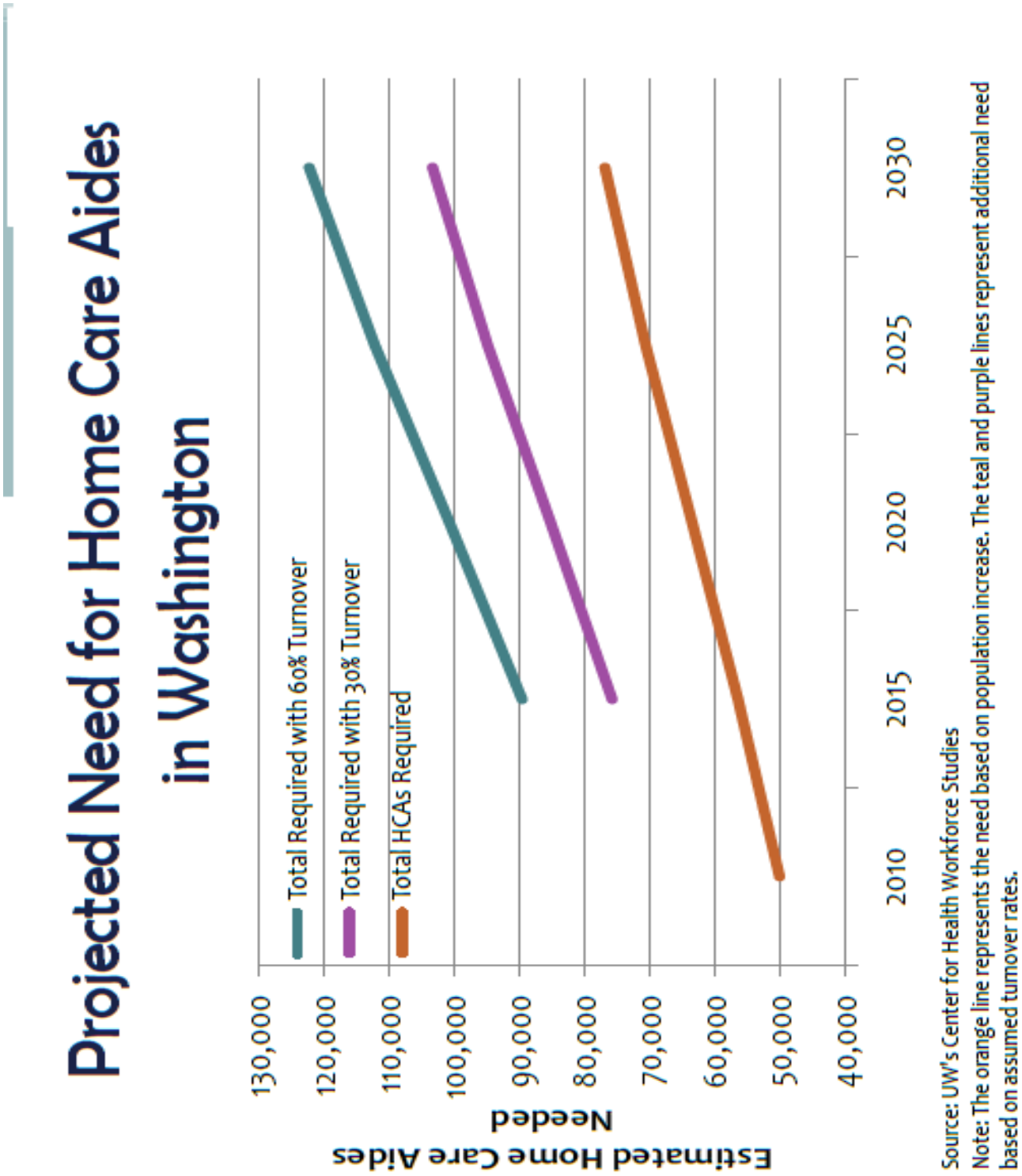
Washington State Administrative Code (WAC) provides further clarification as to residents' consumer rights to reasonable accommodations and lawful discharge. Please consult your Ombuds for more information.

Washington State Long-Term Care
OMBUDSMAN PROGRAM

For More Information
Call Toll Free: 1-800-562-6028
or visit www.waombudsman.org

Washington State Department of Social & Health Services
ALTSA Aging and Long-Term Support Administration

ATTACHMENT I- WORKFORCE PROJECTIONS INCLUSIVE OF HIGH TURNOVER RATES



ATTACHMENT J – FAMILY CAREGIVER SUPPORT PROGRAM-Description and Evaluation

Family Caregiver Support Program

The Family Caregiver Support Program (FCSP) was established in 2000 through legislative action (SHB 2454) to provide needed supports and services to unpaid caregivers throughout the state. The 850,000 plus family caregivers are the backbone of our state's long-term care system.

In 2001, federal funding was authorized for the newly created National Family Caregiver Support Program (NFCSP) through Title IIIE of the Older Americans Act.

In Fiscal Year (FY) 2007, the legislature mandated (RCW 74.41) the use of an evidence-based caregiver assessment and referral tool that could be used to better tailor the support and services to caregivers' own unique needs.

Beginning in July 2009, the state's 13 Area Agencies on Aging began incorporating a screening, assessment and consultative care planning intervention, called Tailored Caregiver Assessment and Referral (TCARE®), developed by Rhonda Montgomery, Ph.D. (University of Wisconsin-Milwaukee). TCARE® provides an objective and reliable tool designed to assess the stress, depression and burdens of unpaid family caregivers and recommend strategies and services that can best help those caregivers who are most burdened with their caregiving responsibilities.

In state fiscal year 2013, a total of 8,599 caregivers received one or more of the following services:

- Information about long-term care and caregiver support services;
- Evidence-based screening and assessing of caregivers' needs and care planning tailored to meet individuals' needs;
- Caregiver training and education (to increase skill building and self-care, including three evidence based models;
- Caregiver support groups (disease specific or general);
- Counseling/Consultation services to cope with challenges (e.g. dementia);
- Respite care services (in and out-of home settings) to provide breaks;
- Supplemental Services such as bath bars and incontinent supplies; and
- Health and wellness referrals to cope with depression and medical issues.

A caregiver is a spouse, relative, or friend who has primary responsibility for the care of an adult with a functional disability and who does not receive financial compensation for the care.

State Fiscal Year 13 State Funding Expenditures: $10,965,439 (80%)

Federal Funding Expenditures: $2,665,057 (20%)

Average cost per caregiver client: $ 1,585

Washington State Department of Social & Health Services
ALTSA Aging and Long-Term Support Administration

Expanding Eligibility for the Family Caregiver Support Program in SFY 2012

Updated Findings

Bridget Lavelle, PhD • David Mancuso, PhD • Alice Huber, PhD • Barbara E.M. Felver, MES, MPA

In collaboration with Susan Engels, Office Chief, State Unit on Aging, Aging and Long-Term Support Administration, Home and Community Services Division.

WASHINGTON STATE'S FAMILY CAREGIVER SUPPORT PROGRAM (FCSP) serves Washingtonians who provide uncompensated care for a parent, spouse, or another adult with medical issues, mobility limitations, or decreased cognitive functioning. In a 2007 statewide survey, the Washington State Department of Health found that many family caregivers feel time-constrained and have high levels of stress.[1] Designed to mitigate these burdens, FCSP services include information and outreach, screening and assessment, respite care, support groups, and resources to assist with mobility limitations and other needs. One goal of providing FCSP services is to delay or make unnecessary the placement of care receivers in long-term care facilities.[2]

The 2011 Legislature increased the state funding for FCSP in State Fiscal Year (SFY) 2012 by $3.45 million dollars. The expansion allowed FCSP to broaden its reach to family caregivers with a wider range of caregiver burdens, as identified by an evidence-based screening tool, the Tailored Caregiver Assessment and Referral System (TCARE®).[3] A legislatively mandated evaluation of the expansion, completed by the Washington State Institute for Public Policy (WSIPP) in November 2012, demonstrated promising findings. Using data from the short follow-up period available at that time, WSIPP found that the expansion was associated with delayed use of Medicaid long-term care services (LTC).[4] This report revisits the question of how the FCSP expansion affected the use of Medicaid LTC, now that care receivers' outcomes have been observed for a longer period of time.

Key Findings

- Due to the FCSP expansion, caregivers screened in SFY 2012 were more likely to receive a full assessment and a broader range of support services than those screened in prior years.
- Care receivers whose caregivers were screened post-expansion were about twenty percent less likely to enroll in Medicaid LTC services in the 12 months following screening compared to prior years (9 vs. 11 percent), despite the fact that more post-expansion care receivers were already enrolled in Medicaid medical coverage at the time of screening.
- Care receivers whose caregivers were screened post-expansion were slower to transition to Medicaid LTC, controlling for differences in baseline characteristics; the FCSP expansion is likely a contributing factor to this positive outcome.

Use of Medicaid LTC Services
In 12 Months After First TCARE Screen

Family Caregiver Support Program Changes

Pre- versus Post-Expansion Differences

In SFY 2010, FCSP began using an evidence-based screening tool, the Tailored Caregiver Assessment and Referral System (TCARE®), to assess the caregiving situations of family caregivers in Washington State and to help determine what levels and types of services are needed.[3] The TCARE® screening tool identifies and categorizes caregivers' levels of burden (High, Medium, Low) in five domains: 1) relationship burden; 2) objective burden; 3) stress burden; 4) depression; and 5) caregiver identity discrepancy. Caregivers who complete the screening are eligible for the standard level of FCSP services. Those whose screening results indicate a higher level of caregiver burdens become eligible to additionally receive a full TCARE® assessment from a Family Caregiver Specialist, followed by consultation, the development of a care plan, and a higher tier of FCSP services.

The 2011 Legislature increased the state funding for the FCSP in SFY 2012 by $3.45 million dollars. Washington's Aging and Long-Term Support Administration used most of this funding to lower eligibility thresholds for the higher tier of services, and to provide that tier of services to a greater number of family caregivers. Prior to the expansion (up through the end of SFY 2011), caregivers were eligible if they scored "High" in at least four out of five burden domains on the TCARE® screen. Starting in SFY 2012, caregivers were eligible if they scored "High" in at least one domain or "Medium" in at least three domains.[5] For additional background on the Family Caregiver Support Program and its expansion, please refer to WSIPP's November 2012 report[4] or the website of Washington's Aging and Long-Term Support Administration.[6]

Table 1 (adjacent page) presents the number and characteristics of caregivers who first received a TCARE® screen in the two pre-FCSP-expansion years (SFY 2010, SFY 2011) and in the first post-expansion year (SFY 2012), as well as the number and characteristics of caregivers in both periods who screened into the higher tier of FCSP services. The caregivers who met eligibility criteria to receive the higher level of services including first assessments were a subset of those screened. In the post-expansion year, not only were caregivers screened at a higher rate (nearly the same number in SFY 2012 than in the previous two fiscal years combined) but a greater proportion of them were screened into the higher tier of services (71 percent vs. 61 percent).

Public awareness of the expansion was expected to yield a post-expansion screening population with somewhat lower needs than the pre-expansion screening population; that is indeed reflected in the data. Of caregiver-receiver dyads screened in SFY 2012, caregivers reported fewer burdens and receivers were less likely to have dementia. Care receivers were also more likely to be enrolled in Medicaid medical coverage.[7] The analyses in this report use statistical models to control for these and other compositional differences between caregivers screened in the two time periods.

The eligibility changes instituted under the expansion also resulted in different characteristics for caregiver-receiver dyads who screened into the higher tier of FCSP services before and after the expansion. Consistent with the lowered eligibility thresholds, caregivers who screened into the higher tier of services in SFY 2012 reported lower levels of burden on the TCARE® screening, cared for their care receivers for fewer hours per week, and had been caring for care receivers for a shorter period of time. Care receivers were also slightly younger, less likely to be the spouse of the caregiver, less likely to have a dementia diagnosis, and more likely to be enrolled in Medicaid medical coverage.

Despite these differences, it is important to note that caregivers served in both time periods had high levels of burdens and needs. The average number of caregiving hours per week was lower for those screened into the highest service tier after the expansion (52 versus 43), but post-expansion caregivers still provided care at a level of hours equivalent to a full-time job. A recent analysis of 2007 statewide survey data found that "high-intensity caregivers"— those who provide more than 20 hours per week of care for a period of one year or longer—were five times more likely than non-caregivers to have severely poor mental health and also had significantly worse physical health

compared to non-caregivers, controlling for age, gender, and income. Although those findings derive from survey data with a different wording of the hours of caregiving question, a parallel measure constructed from the TCARE® assessment data shows that nearly three-quarters (73 percent) of caregivers screened into the higher tier of FCSP services in the pre-expansion period could be considered "high-intensity" caregivers, as well as the majority of caregivers (61 percent) screened into the higher tier of FCSP services in the post-expansion period.[8]

TABLE 1.
Number and Characteristics of Caregiver-Receiver Dyads

	Caregivers Receiving First TCARE® Screen			Caregivers Screened into Higher Tier of FCSP Services		
EXPANSION PRE vs. POST ▸	PRE	POST	*Diff.*	PRE	POST	*Diff.*
STATE FISCAL YEAR ▸	2010, 2011	2012		2010, 2011	2012	
Number of caregiver-receiver dyads	3,347	3,266		2,039	2,321	
Characteristics of caregiver-receiver dyads						
Total number of "High" burdens	2.7	2.4	*	3.2	2.8	*
High burden scores on individual items:						
Relationship burden	39%	33%	*	47%	38%	*
Objective burden	58%	46%	*	72%	55%	*
Stress burden	51%	44%	*	62%	53%	*
Depression	51%	43%	*	61%	51%	*
Identity discrepancy	72%	70%		82%	79%	
Caregiver is caring for:						
Spouse	52%	45%	*	57%	48%	*
Parent	37%	41%	*	34%	40%	*
Child	2%	2%		2%	3%	
Other	9%	11%		7%	9%	
Caregiver age	65.8	63.1	*	66.5	63.8	*
Care receiver age	77.9	77.0	*	78.5	77.7	*
Care receiver is male	48%	47%		50%	49%	
Caregiver would definitely consider placing receiver out-of-home	7%	7%		6%	7%	
Care receiver has diagnosed dementia	39%	35%	*	42%	38%	*
Care receiver enrolled in Medicaid medical coverage at screen	10%	14%	*	7%	11%	*
Hours of caregiving per week	*Not available*			52	43	*
Caregiver has been providing care:						
Less than 6 months	*Not available*			10%	13%	*
6 to 12 months	*Not available*			9%	12%	*
13 to 24 months	*Not available*			13%	15%	
24 months to 5 years	*Not available*			30%	29%	
Over 5 years	*Not available*			39%	31%	*
"High-Intensity" caregiver *More than 20 hours per week for more than 1 year*	*Not available*			73%	61%	*

NOTE: All variables come from the TCARE® screen with the exception of hours of caregiving, length of time caregiver has been providing care, and "high-intensity" caregiver. These three, from TCARE® assessment data, are not available for the larger population of caregivers receiving the first TCARE® screen. Significant differences shown: *p<0.01.

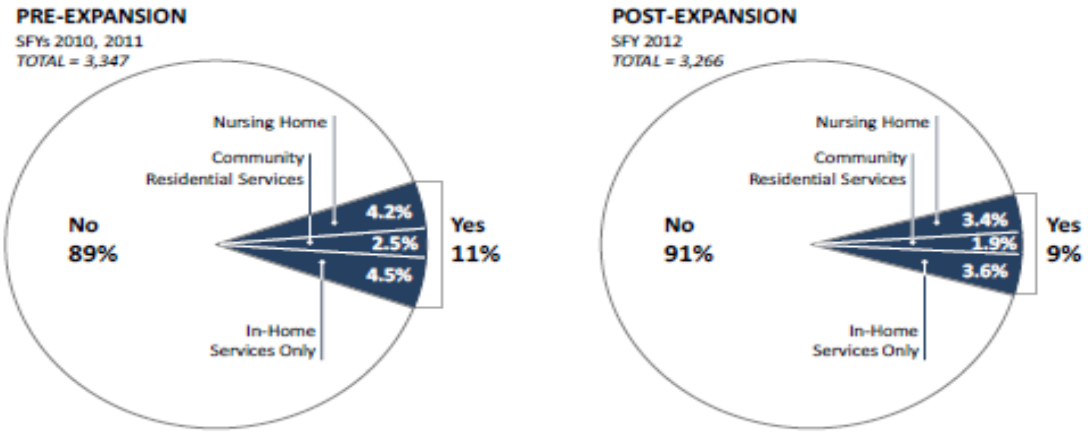
Use of Medicaid Long-Term Care in Year after TCARE® Screen

Pre- versus Post-Expansion Comparison

Because caregivers screened in SFY 2012 were more likely to receive the higher level of FCSP services, they may also have been able to continue providing care for a longer period of time, delaying the need for their care receivers to enroll in Medicaid long-term care services.

The data shows that the great majority of care receivers whose caregivers are served by FCSP (roughly 9 in 10) do not utilize Medicaid long-term care services within a one-year period. But those whose caregivers completed TCARE® screens in the post-expansion period (SFY 2012) were about 20 percent less likely to use Medicaid LTC services in the year following the screen compared to care receivers whose caregivers were screened in the pre-expansion period (SFY 2010, SFY 2011): 9 percent of care receivers of dyads screened in the post-expansion period enrolled in Medicaid LTC within 12 months, compared to 11 percent of care receivers of dyads screened in the pre-expansion period. Among those who did go on to receive Medicaid LTC in the follow-up year, the proportion in nursing home services, community residential services, and in-home services only was roughly equal for care receivers whose caregivers were screened in the two time periods.

Used Medicaid Long-Term Care services in 12 months following TCARE® screen?



Time until Use of Medicaid Long-Term Care

Controlling for Baseline Differences

The lower overall use of Medicaid LTC for care receivers whose caregivers were screened in the post-expansion period could be due to the expansion itself—more caregivers screened in SFY 2012 received services that enabled them to keep caring for their care receivers in the home—or could be attributable to differences in characteristics of the caregiver-receiver dyads screened in the two time periods. We use statistical models to control for those compositional differences between caregivers served in the two time periods that were captured by the TCARE® screening.

Using statistical survival models, we compare the time elapsed between a caregiver's first TCARE® screening and his or her care receiver's first use of Medicaid LTC services, for pre- and post-expansion FCSP family caregivers. The many FCSP care receivers who never use Medicaid LTC are accounted for in these models, as are care receivers with varying lengths of follow-up time.

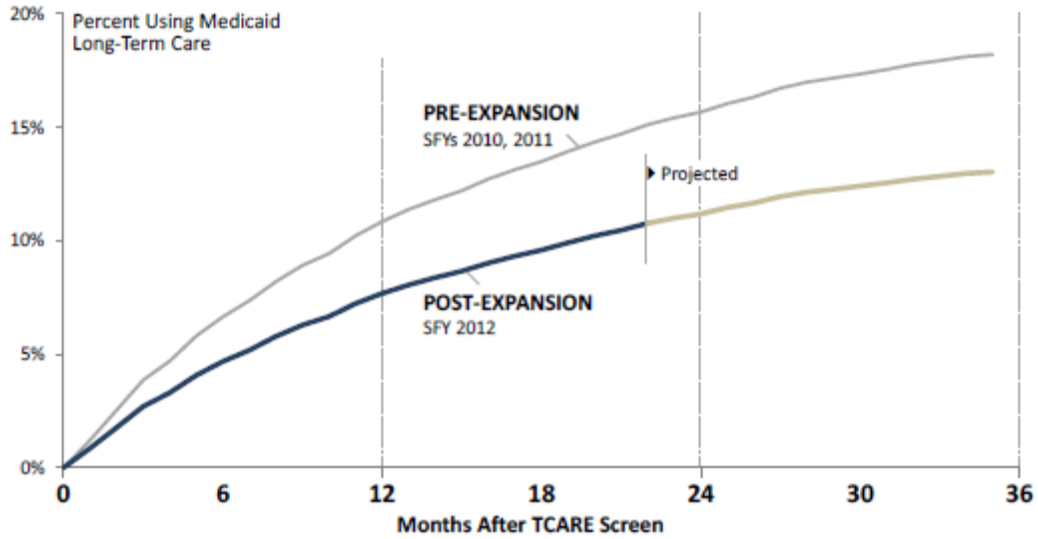
Results indicate that the expansion of FCSP was associated with a statistically significant delay in the use of Medicaid LTC services, controlling for baseline differences (differences at screening) between pre- and post-expansion caregiver-receiver dyads. The full model can be found in the technical notes. Although results suggest that the expansion successfully helped more family caregivers better

manage their caregiving and decreased the rate at which their care receivers move onto Medicaid LTC services, it remains a possibility that other differences between pre- and post-expansion caregiver-receiver dyads, that were not possible to identify and control using existing data, also influenced study findings.

The figure below shows the estimated time from TCARE® screen until first use of Medicaid long-term care services, by the time period in which the caregiver was screened, if they were to share the same set of baseline characteristics (measured at the time of the TCARE® screen).[9] As shown, care receivers whose caregivers were screened in the pre-expansion period transitioned onto Medicaid LTC services more quickly than those screened in the post-expansion period—who were more likely to be eligible for a full TCARE® assessment and a higher level of TCARE® services. The difference in the percent using Medicaid LTC was minimal in the first months after the TCARE® screen, but grew over time.

Time from TCARE® Screen until First Use of Medicaid Long-Term Care

Pre- and Post-Expansion, Controlling for Baseline Differences



The full survival analysis results indicate, as one might expect, that care receivers enrolled in Medicaid medical coverage at the time their caregivers completed a TCARE® screening are much quicker than their peers to transition onto Medicaid long-term care services – their estimated hazard of transitioning onto Medicaid LTC is more than five times that of care receivers not already enrolled in Medicaid medical.[10] It is worth noting that fewer care receivers transitioned onto Medicaid LTC services in the post-expansion period, despite the fact that more care receivers in the post-expansion period were already enrolled in Medicaid medical coverage at the time of TCARE® screening (14 vs. 10 percent).

TECHNICAL NOTES

This report evaluates the effects of the Family Caregiver Support Program expansion on care receivers' time to enrollment in Medicaid long-term care services. We compared Medicaid long-term care (LTC) utilization in the months following a TCARE® screen for those caregivers screened during the pre-expansion period (SFY 2010, 2011) with those screened during the post-expansion period (SFY 2012). To compile data for this evaluation, TCARE® screening and assessment records were linked with Medicaid enrollment and payment records as well as death records.

IDENTIFYING FIRST SCREENS

Because the FCSP expansion targeted caregivers new to the program, we identified caregiver-receiver dyads receiving their first TCARE® screens. (Only 2 percent of caregivers care for more than one receiver; these caregiver-receiver dyads were treated separately in the FCSP program and in this evaluation.) From a comprehensive file of TCARE® screens and assessments over the relevant period, we combined records from all valid screens with non-missing dates and care receiver DOBs, with similar records from initial assessments not preceded by screens (these were treated as screens for the purposes of the analysis). When caregiver-receiver dyads were associated with multiple screens, we identified the earliest screen based on the date administered.

IDENTIFYING FIRST ASSESSMENTS

Caregiver-receiver dyads who met the applicable eligibility threshold went on to get a full TCARE® assessment and a higher level of FCSP services. To identify dyads which did so, we determined whether those with a first screen during the study period (SFY 2010 through SFY 2012) received an assessment in a short window of time following their screening date. FCSP guidelines specify that an assessment should occur within 30 days of the screen. To be inclusive of exceptions to the policy and assessments with possible data entry errors, we include assessments administered up to 3 days before and up to 45 days after the screening date.

SELECTION CRITERIA FOR CAREGIVER-RECEIVER DYADS INCLUDED IN ANALYSIS

The caregiver-receiver dyads in this analysis included all those with a first TCARE® screen from FCSP during the study period (SFY 2010 through SFY 2012) who: 1) Were not being served by two other ALTSA programs, Nursing Home Diversion and the Dementia Partnerships Program; 2) Were receiving no Medicaid LTC services at the time screened; 3) Were not in public or private residential care at screening; and 4) Did not present administrative data linkage errors. Dyads in the "pre-expansion" group were those first screened in SFY 2010 and SFY 2011 (n = 3,347); dyads in the "post-expansion" group were those first screened in SFY 2012 (n = 3,266).

SURVIVAL ANALYSIS WITH STATISTICAL CONTROLS

Because the central evaluation question concerns the timing of an event—transition to Medicaid LTC services—the evaluation utilizes survival analysis, a type of regression analysis designed to examine outcomes across persons with varying lengths of follow-up time. In this evaluation, dyads first receiving TCARE® screens have more or less follow-up time depending on the date the screening was administered and the death date of the care receiver, if applicable. We used Cox regression, the standard approach for survival analysis. Survival analysis is a regression-based statistical model of longitudinal outcomes that can control for baseline characteristics. In this evaluation, we controlled for characteristics of the individual caregiver-receiver dyads identified on the TCARE® screening instrument. (Because the more extensive information gathered using the full TCARE® assessments was only available for the subset of dyads which screened into this higher level of services, it was not used among the controls for the survival analyses.)

SURVIVAL ANALYSIS RESULTS: *Predicting Hazard of Transitioning to Medicaid LTC*

Characteristic of Caregiver-Receiver Dyad at TCARE® Screening	Parameter Estimate	Standard Error	Chi-Square	p-value	Hazard Ratio
Screened post-expansion (SFY 2012)	-0.3630	0.0718	25.5509	<.0001	0.6960
Caregiver's total number of "high" burdens	0.1163	0.0196	35.1806	<.0001	1.1230
Caregiver is spouse of receiver	0.0863	0.0756	1.3033	0.2536	1.0900
Care receiver age	0.0088	0.0026	11.8401	0.0006	1.0090
Care receiver is male	-0.2914	0.0746	15.2397	<.0001	0.7470
Caregiver would definitely consider placing receiver out-of-home	0.5845	0.1063	30.2453	<.0001	1.7940
Care receiver enrolled in Medicaid medical coverage at screen	1.7035	0.0809	443.9300	<.0001	5.4930
Care receiver has diagnosed dementia	0.1528	0.0726	4.4302	0.0353	1.1650
TOTAL = 6,613					

NOTES

[1] Washington State Department of Health 2007 Behavioral Risk Factor Surveillance System (BRFSS).

[2] According to Washington State law, (RCW 74.41.020) it is intended that FCSP program shall, "Encourage family and other nonpaid individuals to provide care for adults with functional disabilities at home, and thus offer a viable alternative to placement in a long-term care facility."

[3] Montgomery, R. & Kwak, J. (2008). Tailored Caregiver Assessment and Referral (TCARE): An evidence-based model to target services for caregivers. *American Journal of Nursing,* 108, 54-57; and Montgomery, R. et al. (2011). Effects of TCARE® intervention on caregiver burden and depressive symptoms: Preliminary findings from a randomized controlled study. *The Journals of Gerontology, Series B: Psychological Sciences and Social Sciences*, 66, 640-647.

[4] Miller, M. (2012). *Did expanding eligibility for the Family Caregiver Support Program pay for itself by reducing the use of Medicaid-paid long-term care?* (Document No. 12-11-3901). Olympia, WA: Washington State Institute for Public Policy. Note: Minor differences in sample definitions between WSIPP's 2012 report and the current report yield differences in sample characteristics.

[5] Some area agencies on aging (AAAs) lowered the eligibility criteria for a TCARE® assessment and consultation to three high burdens prior to the SFY 2012 expansion.

[6] Washington State Department of Social and Health Services, Aging and Long-Term Support Administration, Caregiver Assessment and Planning (http://www.altsa.dshs.wa.gov/Professional/TCARE/).

[7] Enrollment in Medicaid coverage is distinguished from receipt of Medicaid-paid long-term services and supports. Only the subset of persons enrolled in Medicaid coverage who apply and are determined functionally eligible receive Medicaid-paid long-term services and supports.

[8] To gauge weekly hours of caregiving, the Washington State Department of Health's 2007 Behavioral Risk Factor Surveillance System (BRFSS) survey asks caregivers, "In an average week, how many hours do you provide for [care receiver] because of his/her long-term illness or disability?" In FCSP, the weekly hours of caregiving is the sum of responses to four separate questions in the TCARE® assessment: "During the past week, about how many hours total did you help the care receiver with the following activities: (a) Eating, bathing, dressing, or helping with toilet functions? (b) Meal preparations, laundry, or light housework? (c) Providing transportation to appointments and/or shopping? (d) Legal matters, banking, or money matters?" In the analysis of "high-intensity" caregivers in the 2007 BRFSS conducted by Mary LeMier, Washington State Department of Health, "high-intensity" caregivers are defined as those providing more than 20 hours per week of care for a period of one year or longer. In available TCARE® assessment data, "high-intensity caregivers" are defined as those providing more than 20 hours per week of care for a period of longer than one year.

[9] In particular, the plotted numbers reflect the estimated time to Medicaid LTC for pre- and post-expansion caregivers who both have baseline characteristics reflecting the overall average from both groups.

[10] Hazard is the instantaneous risk that an individual who has not yet experienced the event in question will do so. For additional detail, see Singer, J. & J. Willett. (2003). *Applied Longitudinal Data Analysis: Modeling Change and Event Occurrence*. New York: Oxford Press.

ATTACHMENT K – COMMUNITY LIVING CONNECTIONS

Washington State's *Community Living Connections* (CLC) network is part of the Federal Aging and Disability Resource Center (ADRC) initiative. CLC is a network of state and community organizations that coordinate to provide consumers with seamless access to private pay and/or publically funded long- term services and support (LTSS) options in their local community; regardless of what program or organization they may contact or currently utilize. CLCs are located in highly visible and trusted places where consumers can access the full range of LTSS available in the local community and tailor these options to meet the personal preferences, goals and health and safety needs of each consumer.

CLCs are currently serving 16 counties in Washington State covering Pierce County, northwest, southeast and eastern Washington. The remaining counties of the state are planning and developing their local CLC through the expansion and formalization of community partnerships. Through the CLC Network, individuals who are older and/or have a disability of all ages and income circumstances, receive an unbiased and coordinated system of information, person-centered options counseling and access assistance as needed.
Includes individual who are any of the following:

- older adults and/or persons of all ages with a disability from all economic circumstances
- seeking to learn about and understand the full range of public and/or private-pay LTSS options for both present and future needs
- seeking assistance to access LTSS options that meet their personal preferences and goals, as well as, health and safety needs
- unpaid family caregivers, legal representatives, family members loved ones, professionals and legal representatives of older adults and/or persons with disabilities
- veterans

Federal Funding
Title 3B: $1,876,453
Title 3E$1,180,879
Title XIX: $610,749
Total Federal Expenditure: $3,744,028
State Funding
Sen. Drug Education: $142,923
SCSA**:$2,984,564
SFCSP***: $1,577,334
MIPPA*: $98,024
Total State Expenditure: $4,726,898
Total Federal and State Expenditure: $8,470,926
Collaborative partnerships support high quality, responsive, and accountable service delivery. Listed are just a few of our robust partnerships providing services and working toward our goal of a *No-Wrong Door System* within the CLCs as they expand across the state. Partners include: *Center for Independent Living*, *The Brain Injury Association of Washington, Statewide Health Insurance Benefit Advisors*, *Legal Advocacy Organizations, Developmental Disabilities Administration*, *Veterans Services, Tribal Governments*, *211s, National Alliance of Mental*

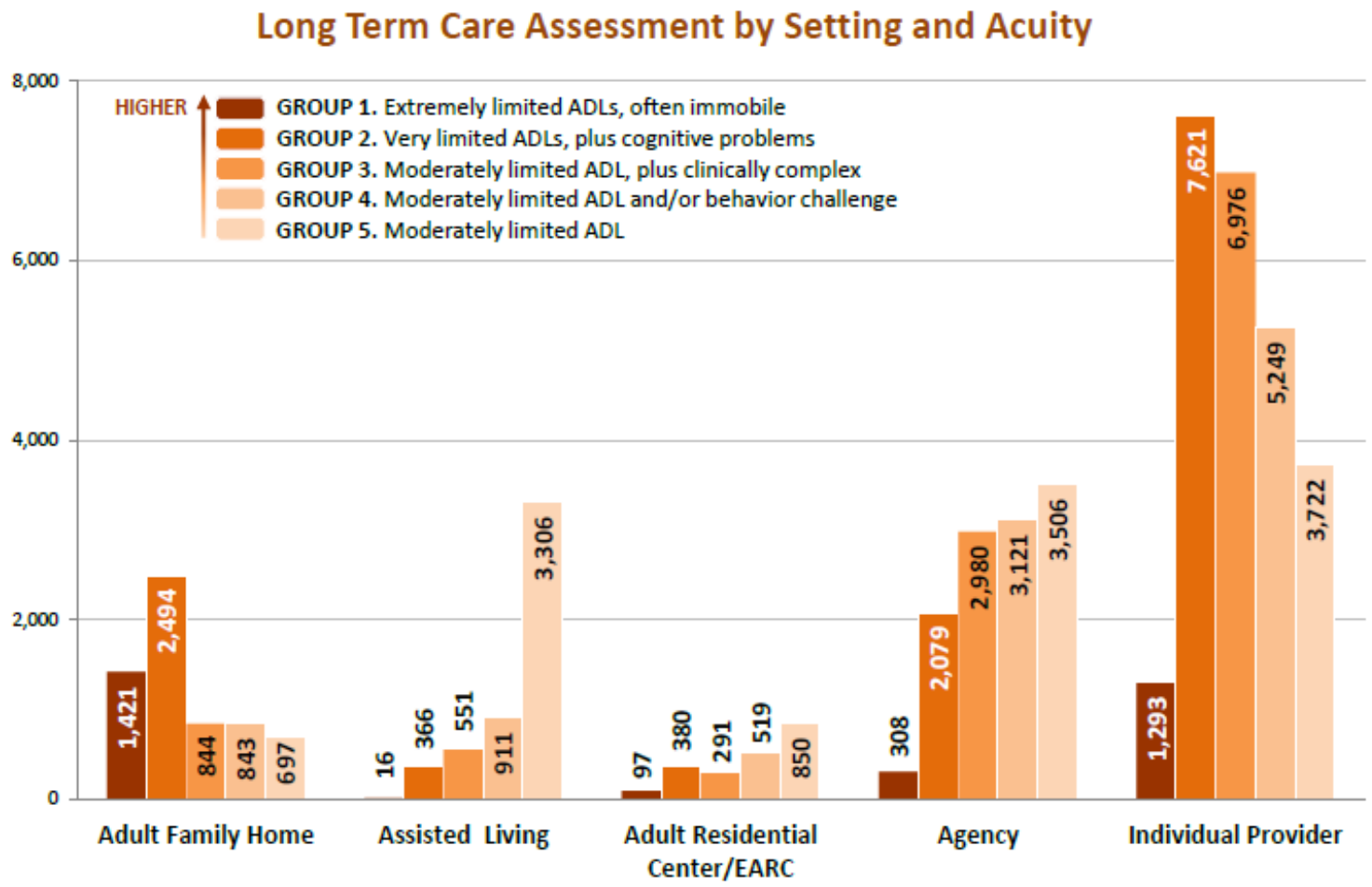
Health, Alzheimer's and Dementia Organizations, Office of the Deaf and Hard of Hearing, Department of Services for the Blind, Department of Vocational Rehabilitation, Long-Term Care Ombudsman

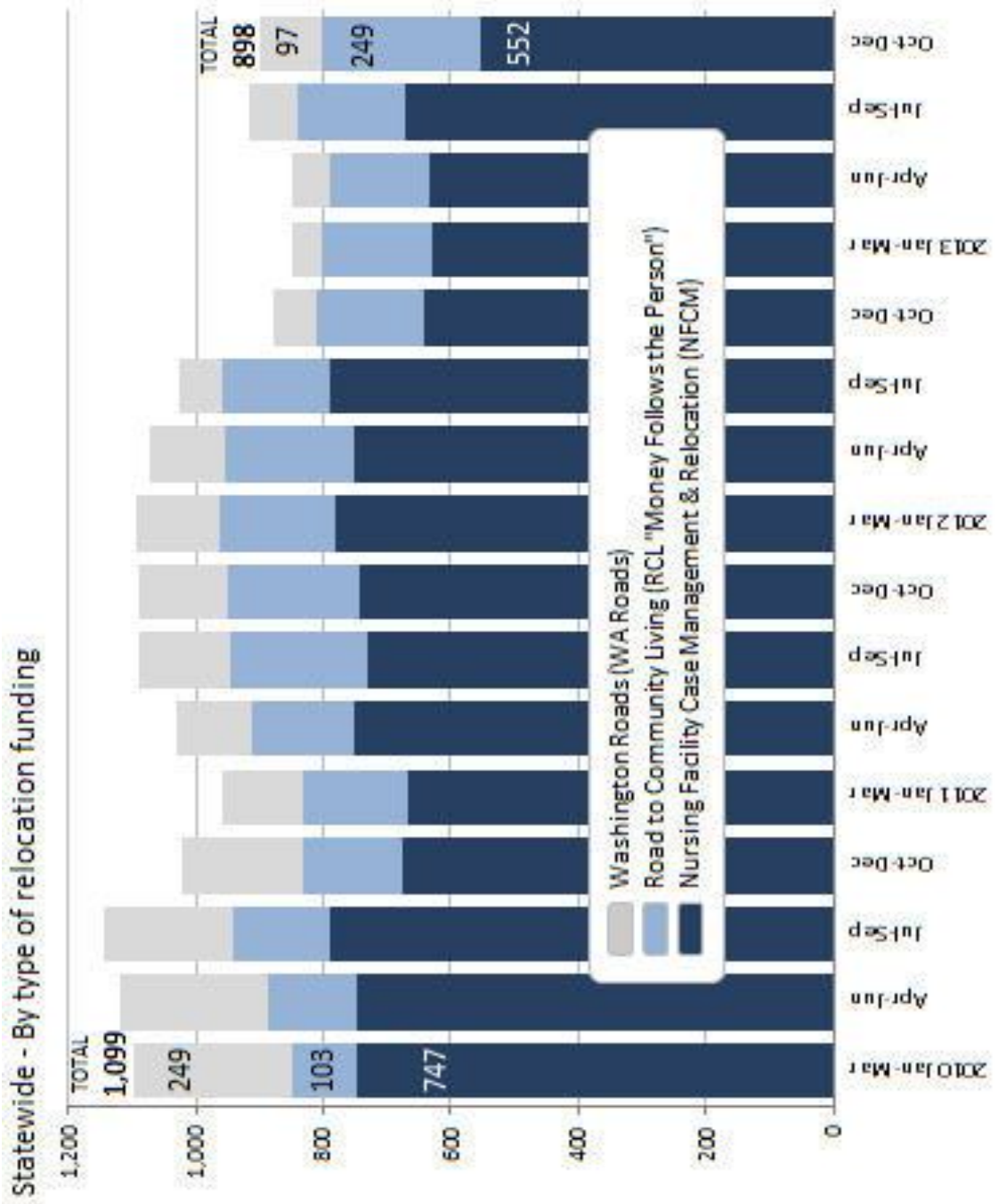
Continuing the shift to home and community-based services—progress to date

Year	LTSS Caseload	Number in Community	Percent in Community	Number in Nursing Homes	Percent in Nursing Homes
1995	36,141	19,496	54%	16,645	46%
2005	47,600	35,515	75%	12,085	25%
2015*	62,220	52,428	84%	9,792	16%

* Based on CFC informal estimates

Supporting people of all acuity levels in community-based settings has been key




Statewide - By type of relocation funding
Washington Roads (WA Roads)
Road to Community Living (RCL "Money Follows the Person")
Nursing Facility Case Management & Relocation (NFCM)
TOTAL
1,099
249
103
747
TOTAL
898
97
249
552
1,200
1,000
800
600
400
200
0
2010 Jan-Mar
Apr-Jun
Jul-Sep
Oct-Dec
2011 Jan-Mar
Apr-Jun
Jul-Sep
Oct-Dec
2012 Jan-Mar
Apr-Jun
Jul-Sep
Oct-Dec
2013 Jan-Mar
Apr-Jun
Jul-Sep
Oct-Dec

Dimension and Indicator (Current Data Year)	Baseline Rate	Current Rate	Rank	Change	All States Median	Top State Rate
OVERALL RANK			2			
Affordability and Access			7			
Median annual nursing home private pay cost as a percentage of median household income age 65+ (2013)	221%	246%	31	✘	234%	168%
Median annual home care private pay cost as a percentage of median household income age 65+ (2013)	93%	88%	34	↔	84%	47%
Private long-term care insurance policies in effect per 1,000 population age 40+ (2011)	48	66	11	✓	44	130
Percent of adults age 21+ with ADL disability at or below 250% of poverty receiving Medicaid or other government assistance health insurance (2011-12)	52.1%	57.1%	11	✓	51.4%	78.1%
Medicaid LTSS participant years per 100 adults age 21+ with ADL disability in nursing homes or at/below 250% poverty in the community (2009)	54.5	63.0	3	✓	42.3	85.2
ADRC functions (composite indicator, scale 0-70) (2012)	**	58	14	↔	54	67
Choice of Setting and Provider			4			
Percent of Medicaid and state LTSS spending going to HCBS for older people & adults w/ physical disabilities (2011)	62.6%	62.5%	3	↔	31.4%	65.4%
Percent of new Medicaid aged/disabled LTSS users first receiving services in the community (2009)	66.5%	70.4%	7	✓	50.7%	81.9%
Number of people participant-directing services per 1,000 adults age 18+ with disabilities (2013)	*	58.5	4	*	8.8	127.3
Home health and personal care aides per 1,000 population age 65+ (2010-12)	45	48	10	↔	33	76
Assisted living and residential care units per 1,000 population age 65+ (2012-13)	54	49	5	↔	27	125
Quality of Life and Quality of Care			19			
Percent of adults age 18+ with disabilities in the community usually or always getting needed support (2010)	72.9%	76.7%	4	✓	71.8%	79.1%
Percent of adults age 18+ with disabilities in the community satisfied or very satisfied with life (2010)	85.9%	87.6%	16	✓	86.7%	92.1%
Rate of employment for adults with ADL disability ages 18–64 relative to rate of employment for adults without ADL disability ages 18–64 (2011-12)	28.1%	24.2%	21	✘	23.4%	37.2%
Percent of high-risk nursing home residents with pressure sores (2013)	*	5.9%	26	*	5.9%	3.0%
Nursing home staffing turnover: ratio of employee terminations to the average number of active employees (2010)	72.0%	52.1%	41	✓	38.1%	15.4%
Percent of long-stay nursing home residents who are receiving an antipsychotic medication (2013)	*	20.1%	25	*	20.2%	11.9%
Support for Family Caregivers			7			
Legal and system supports for family caregivers (composite indicator, scale 0-14.5) (2012-13)	**	6.89	2	✓	3.00	8.00
Number of health maintenance tasks able to be delegated to LTSS workers (out of 16 tasks) (2013)	14	16	1	✓	9.5	16
Family caregivers without much worry or stress, with enough time, well-rested (2011-12)	60.6%	60.0%	38	↔	61.6%	72.8%
Effective Transitions			4			
Percent of nursing home residents with low care needs (2010)	6.7%	6.4%	6	↔	11.7%	1.1%
Percent of home health patients with a hospital admission (2012)	*	23.3%	9	*	25.5%	18.9%
Percent of long-stay nursing home residents hospitalized within a six-month period (2010)	14.4%	13.4%	11	↔	18.9%	7.3%
Percent of nursing home residents with moderate to severe dementia with one or more potentially burdensome transitions at end of life (2009)	*	16.4%	16	*	20.3%	7.1%
Percent of new nursing home stays lasting 100 days or more (2009)	*	16.9%	11	*	19.8%	10.3%
Percent of people with 90+ day nursing home stays successfully transitioning back to the community (2009)	*	11.8%	4	*	7.9%	15.8%

* Comparable data not available for baseline and/or current year. Change in performance cannot be calculated without baseline and current data.

** Composite measure. Baseline rate is not shown as some components of the measure are only available for the current year. Change in performance is based only on those components with comparable prior data. See page 73 and page 83 in *Raising Expectations 2014: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers* for more detail. Notes: ADL = Activities of Daily Living; ADRC = Aging and Disability Resource Center; HCBS = Home and Community Based Services; LTSS = Long Term Services and Supports.

Please refer to Appendix B2 on page 97 in the report for full indicator descriptions, data sources, and other notes about methodology; for baseline data years, please see Exhibit 2 on page 11. The full report is available at www.longtermscorecard.org

Key for Change:	
✓	Performance improvement
↔	Little or no change in performance
✘	Performance decline

Washington State Department of Social & Health Services
ALTSA Aging and Long-Term Support Administration

ATTACHMENT N – STATE ALZHEIMER'S PLAN

Developing a Washington State Plan to Address Alzheimer's Disease

In Washington State an estimated 110,000 individuals have Alzheimer's disease or related dementia. By 2025, this is projected to be 150,000.

In 2012, the first National Plan to Address Alzheimer's Disease was released. The National Plan calls for a comprehensive, collaborative approach and acknowledges the critical need to better coordinate towards effective prevention, treatment and management of Alzheimer's and other dementias.

With this heightened awareness and coordinated efforts at the national level, and the anticipated age-wave in Washington State, now is the time to begin our own comprehensive, coordinated effort to promote cognitive health and increase the dementia capability of our many intersecting systems of support and services for people with dementia and their family caregivers.

While Washington State has established a statewide system of home and community long-term supports and services that serves a substantial group of individuals with dementia, there is room for improvements by integrating best practices and dementia-capability into the health and long-term support systems. Also, there are potential opportunities to impact the trajectory of the disease through efforts to promote cognitive health, to diagnose AD earlier to facilitate better disease management, and to develop enhanced supports for individuals with dementia and their family caregivers that would allow them to plan for the future, access public and private supports and services to sustain community living longer.

In March 2014, Governor Jay Inslee signed Senate Bill 6124, which provides legislative authorization to develop an Alzheimer's disease Plan for Washington State. SSB 6124 requires the Department of Social and Health Services (DSHS) to convene an Alzheimer's disease working group, with members to be appointed by DSHS, unless indicated otherwise (see next page). The secretary of DSHS or the secretary's designee must convene the first meeting and serve as chair of the AD working group.

The Alzheimer's disease (AD) working group must examine the array of needs of individuals diagnosed with AD, services available to meet these needs, and the capacity of the state and current providers to meet these and future needs. The AD working group must consider and make recommendations and findings on a range of specifics; and identify needed policies or responses including, but not limited to, the promotion of early detection and diagnosis of Alzheimer's disease and dementia, the provision of coordinated services and supports to persons and families living with Alzheimer's disease or dementia disorders, the capacity to meet these needs, and strategies to address identified gaps in services.

DSHS must submit a report providing findings and recommendation of the AD working group, including any draft legislation necessary to implement the recommendations, to the governor and the health care committees of the Senate and House of Representatives by January 1, 2016.

To meet this timeline, the AD working group must submit to DSHS their final report and recommendations by September 1, 2015.

The Alzheimer's Disease (AD) Working Group is to consist of the following members to be appointed by the department unless indicated otherwise:

(1) At least one unpaid family caregiver of a person who has been diagnosed with Alzheimer's disease;
(2) At least one professional caregiver of a person who has been diagnosed with Alzheimer's disease;
(3) At least one individual provider caregiver of a person who has been diagnosed with Alzheimer's disease;
(4) At least one person who has been diagnosed with Alzheimer's disease;
(5) A representative of nursing homes;
(6) A representative of assisted living facilities;
(7) A representative of adult family homes;
(8) A representative of home care agencies that care for people with Alzheimer's disease;
(9) A representative of adult day services;
(10) A health care professional who treats people with Alzheimer's disease;
(11) A psychologist who specializes in dementia care;
(12) A person who conducts research on Alzheimer's disease;
(13) A representative of the Alzheimer's Association;
(14) A representative of the Alzheimer Society of Washington;
(15) The governor or the governor's designee;
(16) The secretary of the Department of Social and Health Services or the secretary's designee;
(17) The secretary of the Department of Health or the secretary's designee;
(18) The director of the Health Care Authority or the director's designee;
(19) The long-term care Ombuds or the Ombuds' designee;
(20) A member of the Senate health care committee, *appointed by the senate;*
(21) A member of the House of Representatives health care and wellness committee, *appointed by the House of Representatives;*
(22) Five health policy advocates including representatives of –
American Association of Retired Persons
Area Agencies on Aging
Elder Care Alliance, and
other advocates of the elderly or long-term care workers;
(23) A representative of the University of Washington's Alzheimer's Disease Research Center;
(24) A member with experience in elder law or guardianship issues; and
(25) A representative from the Washington State Department of Veterans Affairs.

ATTACHMENT O- AAA SAMPLE SERVICES

w4a
Advocacy. Action. And not just Aging.

Washington State's Aging Network: Partners in Care Management Solutions

Washington State's 13 Area Agencies on Aging and their network of health and social service providers bring new opportunities for health care savings and service delivery improvements.

Area Agencies— Not just "Aging."

Area Agencies serve adults of all ages in need of supportive home and community-based services.

Area Agencies are designated by the State to develop publicly accountable service plans for use of federal and state funds.

The Centers for Medicare and Medicaid Services and other federal and state agencies invest in Area Agencies as a crucial way to integrate a full range of long-term supports and services into a single, coordinated system.

With more than 40 years of on-the-ground local experience, Area Agencies have high public visibility and trust as the place to go for help accessing services to maintain a healthy life in the community.

High percentages of clients use multiple prescription drugs and have mobility limitations, chronic diseases and/or clinically significant depression.

Chronic Care Management

Currently six Area Agencies offer specialized care management by nurses and social workers to people with multiple chronic conditions — such as diabetes, heart disease, mental health and/or substance abuse — who are very high users of Medicaid-funded pharmacy, emergency room, and hospital care.

Area Agency RNs and case managers connect high-risk clients to medical homes, help them create health action plans and goals, and coach them for chronic disease self-management. Care managers offer diabetes, pain and medication management education and coaching, using evidence-based protocols, and coordinate with multiple health care providers.

Working in concert with their community partners, these Area Agencies have improved health outcomes, reduced unnecessary utilization, and controlled health care costs.

Care Transitions

Currently four Area Agencies play key roles in "care transitions" planning with hospitals and social service providers — collaboration that supports successful transition between hospital, skilled nursing facilities, and home, avoiding costly readmissions and ensuring that patients get the community-based care they need to live independently.

Care transitions coaches assist patients with goal setting, ongoing self-management, follow-up care arrangements, and effective communication with health care providers. They link patients to community services that help them avoid unnecessary hospitalization.

Area Agencies ensure greater attention to discharge plans through close follow-up with unstable clients, improving outcomes and reducing total costs of health care.

Access to Community Resources

Aging and Disability Resource Centers (ADRCs) support informed decisions about health and long-term care options, enabling individuals at high risk of nursing home placement to remain in their homes for as long as possible.

Key elements include:

- Seamless service from the consumer's perspective.
- A high level of public visibility and trust.
- Counseling about long-term care pathways.
- Partnerships across aging, disability and Medicaid.
- No income requirements.

ADRCs empower older adults and people with disabilities to stay active and healthy through evidence-based health promotion programs and prevent abuse, neglect and exploitation of older people through Elder Rights programs. At present, three Area Agencies are developing ADRC models for their communities.

All Area Agencies have provided public information and referral services for 40 years.

Washington Association of Area Agencies on Aging • w4a@agingwashington.org • www.agingwashington.org

ATTACHEMENT P- STATE PLAN SURVEY SUMMARY

Washington State Plan on Aging Survey - 2014

SurveyMonkey

1. Below, find a list of government funded services currently being offered. Please indicate how important each service is.

	1. Very important	2. Somewhat important	3. Less important	Rating Count
Support for people who provide unpaid care to family members	**84.5% (1,331)**	13.2% (208)	2.3% (37)	1,576
Information and assistance services about how to access older adult and/or disability services	**85.4% (1,341)**	13.4% (210)	1.3% (20)	1,571
Transportation (to medical appointments and other services)	**85.5% (1,352)**	12.3% (194)	2.3% (36)	1,582
Hot or frozen meals delivered to older adults (who can't leave home because they are sick or due to disability)	**81.6% (1,291)**	15.4% (244)	3.0% (48)	1,583
Help to prevent elder abuse and neglect	**86.3% (1,353)**	11.8% (185)	1.9% (30)	1,568
Personal care services that help people stay in their homes (e.g. help with bathing, getting dressed, making meals)	**93.6% (1,480)**	5.7% (90)	0.8% (12)	1,582
Programs that help people with dementia (including Alzheimer's disease)	**85.4% (1,345)**	13.5% (213)	1.1% (17)	1,575
Healthy living classes; including disease prevention and self-management for your condition, e.g., diabetes, heart disease	**60.3% (948)**	33.0% (519)	6.7% (106)	1,573
Help to get information about health insurance and how to sign up for plans (like Medicare, Medicaid, Long Term Care)	**69.5% (1,093)**	26.1% (410)	4.5% (70)	1,573
How to use the Health Benefit Exchange	**56.7% (882)**	34.9% (543)	8.4% (130)	1,555

Group meals (meals served at Senior Centers)	**54.9% (866)**	35.1% (553)	10.0% (157)	1,576
Legal Assistance Services	**57.1% (893)**	36.0% (564)	6.9% (108)	1,565
Nursing homes	**58.0% (899)**	32.4% (502)	9.7% (150)	1,551
Other residential and in-home care options	**77.2% (1,204)**	20.9% (326)	1.9% (30)	1,560
Help getting home and staying at home after a hospital of nursing home stay	**84.7% (1,324)**	13.0% (204)	2.3% (36)	1,564
Programs that give family a break (such as respite care or adult day care programs)	**81.2% (1,274)**	16.8% (263)	2.0% (32)	1,569
Get mental health services	**76.2% (1,191)**	21.0% (329)	2.8% (44)	1,564
Get drug and alcohol services	**55.0% (860)**	33.1% (518)	11.8% (185)	1,563
Help finding older adult job training & placement	**47.3% (740)**	40.4% (633)	12.3% (192)	1,565
How to prevent falls (fall prevention) and exercise programs in the community for older adults	**65.7% (1,023)**	27.8% (433)	6.5% (102)	1,558
Support for grandparents/other relatives who are raising children	**67.6% (1,054)**	25.7% (400)	6.7% (105)	1,559
			answered question	**1,594**
			skipped question	**5**

2. Below find a list of some services for older adults that are currently available. Please show how much you know about each program.

	I have used this program	I know a lot about this program	I know something about this program	I don't know about this program	Rating Count
Family Caregiver Support	19.2% (302)	18.4% (289)	**39.2% (616)**	23.1% (363)	1,570
Senior Employment (Older Adult)	3.8% (59)	8.7% (136)	30.5% (478)	**57.0% (892)**	1,565
Elder Abuse & Neglect Prevention	11.6% (181)	29.0% (450)	**40.4% (628)**	19.0% (295)	1,554
Health and Wellness (examples: exercise programs , preventing falls, preventing disease)	11.7% (183)	27.0% (423)	**40.5% (634)**	20.8% (325)	1,565
Help getting health insurance (like Medicare, Medicaid, long term services and supports)	13.9% (216)	23.5% (365)	**43.4% (674)**	19.2% (299)	1,554
Hot or frozen meals delivered to older adults homes (meals on wheels)	9.9% (154)	27.9% (436)	**41.8% (652)**	20.4% (318)	1,560
Group meals (at Senior Centers)	11.2% (174)	26.5% (412)	**39.5% (614)**	22.7% (353)	1,553
Help from case managers	26.4% (410)	27.3% (424)	**29.9% (464)**	16.5% (256)	1,554
Legal Assistance for older adults	7.3% (113)	16.8% (259)	36.7% (567)	**39.3% (607)**	1,546
Learning about healthy food	12.6% (196)	28.1% (437)	**35.4% (550)**	23.9% (372)	1,555
Programs at Senior Centers (recreation, health classes, etc.)	11.5% (178)	26.0% (402)	**41.7% (645)**	20.8% (321)	1,546
Transportation (to medical appointments, to Senior Center activities)	19.6% (306)	31.0% (484)	**34.1% (531)**	15.3% (238)	1,559
Respite services	16.2% (248)	23.2% (356)	**35.2% (540)**	25.3% (388)	1,532
Help with personal care at home (help with dressing, bathing, etc.)	29.4% (457)	**33.9% (526)**	24.9% (387)	11.7% (182)	1,552
How to get older adult and/or disability services	18.2% (282)	27.6% (426)	**33.8% (522)**	20.4% (316)	1,546

Kinship Care Programs (relatives raising children)	5.2% (80)	11.6% (178)	27.1% (418)	**56.1% (865)**	1,541
				answered question	**1,583**
				skipped question	**16**

3. In the past year have you received one or more of the services listed above in question 2?

		Response Percent	Response Count
Yes		42.6%	658
No		**57.4%**	**888**
		answered question	**1,546**
		skipped question	**53**

4. If yes, overall, how satisfied are you with the service you've received? (Check one)

		Response Percent	Response Count
Very satisfied		**49.9%**	**315**
Somewhat satisfied		31.4%	198
In the middle		14.7%	93
Somewhat dissatisfied		3.2%	20
Very dissatisfied		0.8%	5
		answered question	**631**
		skipped question	**968**

5. Do you have memory loss, Alzheimer's or other type of dementia?

	Response Percent	Response Count
Yes	5.0%	63
No	95.0%	1,199
answered question		1,262
skipped question		337

6. Are you a friend/family member of a person with dementia?

	Response Percent	Response Count
Yes	46.7%	588
No	53.3%	671
answered question		1,259
skipped question		340

7. Are you a caregiver for a person with memory loss/Alzheimer's/dementia?

	Response Percent	Response Count
Yes	33.4%	423
No	66.6%	844
answered question		1,267
skipped question		332

8. Thinking about services for people living with memory loss (or Alzheimer's or other dementia), which of the services below do you (or would you) VALUE the most, even if it isn't currently offered in your area? (Choose your top 3)

	Response Percent	Response Count
Adult day centers	39.9%	501
Assisted living facilities with specialized care units	39.6%	498
Education about memory loss/Alzheimers/dementia	36.8%	462
Family caregiver supports (individual consultation, counseling, support groups, guidance)	59.0%	741
Home delivered meals	23.1%	290
In-home personal care (like bathing, toileting, eating, and/or nursing)	**59.9%**	**752**
In-home programs such as housework, errands, chore, etc.	42.1%	529
Nursing homes with specialized care units	23.1%	290
Respite care/Companion services	47.1%	592
Transportation services/programs	34.7%	436
Other	4.0%	50
Please specify for "Other" above:		60
answered question		**1,256**
skipped question		**343**

9. If Washington State could improve services for people with memory loss/Alzheimer's disease/dementia, what would be the best first step to do so?

	Response Count
	675
answered question	675
skipped question	924

10. How important is it for you to have a choice about the services you get? (Check one)

	Response Percent	Response Count
Very important	90.9%	1,124
Somewhat important	8.7%	108
Not important	0.4%	5
answered question		1,237
skipped question		362

11. How important is it for you to direct (be in charge of) the services you get? (Check one)

	Response Percent	Response Count
Very important	84.1%	1,042
Somewhat important	15.1%	187
Not important	0.8%	10
answered question		1,239
skipped question		360

12. Which of the items below would help you have choice in and control of your services? (Check all that apply)

	Response Percent	Response Count
A personal budget you could use to buy the senior services you need	44.0%	528
More choice in what items and services you purchase to meet your needs, and how you purchase those items and services	58.0%	696
The ability to hire a friend or family member to help you with personal care at home	**67.9%**	**816**
Someone to help you develop an individual plan to meet your care needs	57.5%	691
	answered question	**1,201**
	skipped question	**398**

13. What are the most needed programs and services that allow older persons to live where they want to live?

	Response Count
	798
answered question	**798**
skipped question	**801**

14. What other programs or services would you like to see for older persons and/or persons with disabilities?

	Response Count
	642
answered question	642
skipped question	957

15. As you age, what do you think would be the most help in allowing you to remain in your own home?

	Response Count
	754
answered question	754
skipped question	845

16. As you age, what is your greatest worry/fear as you think about staying independent and in your own home?

	Response Count
	813
answered question	813
skipped question	786

17. Please provide any other comments you may have regarding the needs and priorities of older persons in Washington State.

	Response Count
	416
answered question	416
skipped question	1,183

18. Age:

		Response Percent	Response Count
Under 50		26.9%	332
50-55		14.7%	182
56-59		14.1%	174
60-64		14.5%	179
65-74		18.3%	226
75-84		8.7%	107
85 plus		2.9%	36
	answered question		1,236
	skipped question		363

19. Sex:

	Response Percent	Response Count
Male	19.4%	238
Female	**80.6%**	**986**
	answered question	**1,224**
	skipped question	**375**

20. Sexual Orientation:

	Response Percent	Response Count
Gay	2.5%	25
Lesbian	2.9%	29
Heterosexual	**94.1%**	**945**
Transgender	0.5%	5
	answered question	**1,004**
	skipped question	**595**

21. Ethnicity:

	Response Percent	Response Count
African American	4.0%	48
American Indian or Native Alaskan	3.5%	42
Asian/Pacific Islander	6.7%	80
Hispanic/Latino	4.4%	53
White	**81.9%**	**980**
Other (please specify)	2.9%	35
	answered question	**1,196**
	skipped question	**403**

22. Overall, how would you rate your health?

	Response Percent	Response Count
Excellent	20.3%	249
Good	**58.8%**	**723**
Fair	17.2%	211
Poor	2.8%	35
Very Poor	0.9%	11
	answered question	**1,229**
	skipped question	**370**

23. Please check the county where you reside:

	Response Percent	Response Count
Adams	0.2%	3
Asotin	0.4%	5
Benton	1.1%	13
Chelan	0.6%	8
Clallam	2.3%	28
Clark	9.7%	120
Columbia	0.1%	1
Cowlitz	9.7%	120
Douglas	0.3%	4
Ferry	0.6%	7
Franklin	0.4%	5
Garfield	0.0%	0
Grant	1.3%	16
Grays Harbor	1.5%	18
Island	0.7%	9
Jefferson	1.5%	19
King	**20.2%**	**250**
Kitsap	2.7%	33
Kittitas	0.4%	5
Klickitat	0.6%	7
Lewis	1.4%	17
Lincoln	0.3%	4
Mason	1.5%	18

Okanogan	0.5%	6
Pacific	0.5%	6
Pend Oreille	0.6%	8
Pierce	10.4%	129
San Juan	0.2%	3
Skagit	1.4%	17
Skamania	0.6%	7
Snohomish	10.0%	124
Spokane	5.0%	62
Stevens	1.1%	13
Thurston	4.7%	58
Wahkiakum	0.9%	11
Walla Walla	1.0%	12
Whatcom	2.1%	26
Whitman	1.1%	14
Yakima	2.3%	29
	answered question	**1,235**
	skipped question	**364**

24. Which Best Describes You? (More than one can be selected)

	Response Percent	Response Count
I am an older adult (age 60 and older)	37.6%	454
I am an older adult with a disability (age 60 and older)	8.8%	106
I am an adult with a disability (under age 60)	8.6%	104
None of the above	**47.7%**	**575**
If selected "None of the above", please explain:		400
answered question		**1,206**
skipped question		**393**

25. Are you: (More than one can be selected. If none apply, leave blank)

	Response Percent	Response Count
A paid caregiver for an older adult	**48.4%**	**445**
A relative of an older adult that needs care	44.0%	404
A friend/neighbor of an older adult that needs care	18.3%	168
I work as a provider of services to older persons	40.0%	368
Please describe what services you provide to older persons:		402
answered question		**919**
skipped question		**680**

26. Are you an unpaid caregiver for an adult who needs regular care and assistance?

	Response Percent	Response Count
Yes	21.0%	251
No	**79.0%**	**942**
	answered question	**1,193**
	skipped question	**406**

27. If you are not currently an unpaid caregiver, have you been an unpaid caregiver for an adult who needs regular care and assistance during the past year?

	Response Percent	Response Count
Yes	17.9%	160
No	**82.1%**	**735**
	answered question	**895**
	skipped question	**704**

Washington State Department of Social & Health Services
ALTSA Aging and Long-Term Support Administration

ATTACHMENT Q1- EMERGENCY PREPARADNESS

SUBJECT: **Emergency Planning for Vulnerable Populations Served by Area Agencies on Aging (AAAs)**

PURPOSE: To direct AAAs to develop emergency plans for their local offices.

BACKGROUND: In order to ensure all agencies prepare for any future emergency situations, Older Americans Act: Public Law 109-365 added new requirements for disaster and emergency planning. The law requires states and area agencies to include in their respective plans, information on how they will coordinate activities and develop long-term emergency preparedness plans. Potential partners to site in the plan include state and local emergency response agencies, relief organizations, state and local governments, and other organizations responsible for emergency preparedness and response.

WHAT'S NEW, CHANGED, OR CLARIFIED

- Older Americans Act: Public Law 109-365 added new requirements for state and area agencies disaster and emergency planning.
- DSHS Secretary's office has requested Aging and Disability Services Administration to develop emergency plans and require contractors to do so.

ACTION: AAAs must develop emergency plans for their local offices and submit them to the State Unit on Aging. The plans must contain a description of how the AAAs will incorporate these elements within their local plans:

- Each AAA must designate a staff person to oversee planning tasks and determine how emergency management is carried out in the local jurisdiction.
- Communicate and establish working relationships with local emergency operations leadership (county emergency management, fire department, law enforcement, local transportation providers and emergency medical services). Develop letters of agreement identifying responsibilities of each of the players.
- Participate in plan development, drills, exercises and other preparedness activities. Ask local emergency operations leadership for a schedule of their ongoing exercises and other preparedness activities for AAA staff to attend.
- Develop criteria to identify high risk clients in the community. Criteria may include: individuals who live alone and:
    1. Lack family or informal supports.

2. Have conditions such as dementia, insulin dependent, cannot transfer without assistance from bed or chair, etc.
3. Are technologically dependent, for example, clients who use a respirator.
4. Are in a geographically remote area.

As soon as your local business is operational, the AAA must contact high risk clients and refer to first responders as necessary.

ADSA headquarters will assist local offices in identifying these individuals from CARE if the local office is unable to run a report.

- Develop contract language for subcontractors to have an emergency plan developed to address conditions that may occur during a disaster. Example of language that could be used: "Contractor will have a plan for serving currently authorized clients during periods when normal services may be disrupted. This may include earthquakes, floods, snowstorms, etc. The plan needs to maintain lists, emergency provisions and pay particular attention to those clients, who are at most risk."
- Identify other local partners such as the American Red Cross, Salvation Army, members of voluntary organizations active in disaster (VOAD), and other senior and disability based organizations and incorporate them in your plan.
- As potential areas of unmet need are identified, alert and cooperate with appropriate community emergency preparedness entities for their review and action.
- Have a system in place to track unanticipated emergency response expenditures for possible reimbursement. Examples could be supplies, man-hours, and transportation costs, having to run your operations in another location or other unforeseen administrative costs during and following the disaster.
- Develop an internal Business Continuity Plan (BCP) for your agency to ensure that your mission can be carried out. Business continuity planning is a process that helps organizations prepare for disruptive events. Emphasize communications, back-up systems for data, emergency service delivery options and transportation.

ATTACHMENT Q2- DSHS COMPREHENSIVE EMERGENCY MANAGEMENT PLAN

Basic Plan

Comprehensive
Emergency Management
Plan

DSHS EMERGENCY MANAGEMENT

TABLE OF CONTENTS

FOREWORD

The primary goal of emergency management in the Department of Social and Health Services (DSHS) is to reduce the consequences of emergencies and disasters through reasonable preparation. Preparation includes planning, training and testing or drilling.

The objectives of the DSHS Emergency Operations Plan (EOP) include:

- Protecting the well-being and life safety of DSHS employees
- Minimizing the disruption to DSHS operations and mission essential functions during periods of emergency or disaster
- Protecting DSHS capital facilities and leased facilities, state equipment, essential records and other assets critical to the performance of DSHS mission essential functions
- Quickly enabling operational capability of continuity facilities
- Recovering from any disruption and returning to routine operations as soon as possible
- Training, testing and exercising employees to support preparedness at the organizational and individual employee levels

The DSHS EOP guides the Department's overall preparedness, response, and recovery activities.

The 2014 DSHS Emergency Operations Plan (EOP) includes a Basic Plan, and three annexes that provide specific procedures and information related to the Emergency Coordinating Center, emergency communications, and a glossary.

This EOP rescinds and replaces the 2013 Comprehensive Emergency Management Plan and any other DSHS agency level emergency management plans.

REVIEW

The DSHS Office of Emergency Management is responsible for reviewing the EOP in whole or in part annually and documenting that review. A review must be conducted at least annually.

REVIEW TABLE

Date	Section(s) Reviewed	Reviewer Name

PURPOSE, SCOPE, SITUATIONS AND ASSUMPTIONS

Purpose

Emergencies and disasters happen every year in Washington State, some of them impact DSHS operations disrupting services. A recent example is the severe winter weather of January 2012 when snow, ice, rain and wind disrupted transportation and utilities across the state for several days. Multiple DSHS offices were closed for several days, effectively suspending operations and DSHS mission essential functions. Three DSHS institution campuses were operating on generator power, with fuel running low. Significant damage to infrastructure impacted operations at one residential treatment facility.

The most recent federal disaster in Washington was the March 22, 2014 SR530 Slide in Oso, Washington. Although no DSHS facilities were impacted, 41 people – many of whom were DSHS clients – lost their lives. This was a devastating example of how catastrophic and sudden a disaster can be.

Approximately one out of every three people, including half the children, in Washington State rely on DSHS for support in the form of cash, food or medical assistance; protective services; rehabilitation or other treatment services; collection of child support and other services that are life-sustaining. Continuity of DSHS services is critical and all mission essential functions must be performed with minimal disruption even during emergencies or disasters.

The January 2012 storms clearly illustrated why every DSHS Administration and residential program needs complete and current continuity plans: to mitigate the impacts of emergencies and disasters so that DSHS mission essential functions are providing with minimal disruption.

The purpose of this EOP is to:

- Provide an overview of the Department's approach to emergency preparedness
- Describe roles and responsibilities
- Identify or provide relevant tools, templates and resources to facilitate planning, training, testing and drilling

Scope

DSHS headquarters has a single EOP, which is developed by the Office of Emergency Management. Separate EOP for any Administration's executive leadership, management or staff in DSHS headquarters need not and should not be developed.

The EOP describes how DSHS headquarters operations respond to a major emergency or disaster and provides overarching guidance for all DSHS institutions and offices to use in developing their own EOP. The EOP uses an all-hazards approach to planning and response and specifies the emergency response procedures for DSHS executive leadership and headquarters operations. (See Assumptions)

DSHS Administrations and institutions are responsible for developing continuity of operations plans (or simply: continuity plans) to provide formalized procedures and identify those responsible as key leaders and critical staff for continued delivery of DSHS mission essential functions.

Situations

The EOP prepares DSHS to respond to the natural disasters and cascading effects that are most likely to impact DSHS operations or mission essential functions: earthquakes, floods, severe storms, tsunamis, volcanoes, or wildland fires. The emergencies and disasters most likely to occur in Washington are described in the Hazard Identification and Vulnerability Assessment (HIVA), developed by the Military Department's Emergency Management Division (EMD). http://www.emd.wa.gov/plans/documents/hazard_identification_vulnerability_analysis.doc

Most emergencies and disasters that may impact DSHS operations occur with enough warning that appropriate notification can be issued to allow time for actions to mitigate the impacts to DSHS operations. Other incidents, such as earthquakes, are "no notice" and occur without warning, limiting the time available to take action to lessen the impacts.

Emergencies or disasters can occur causing human suffering, injury and death, property damage, environmental degradation, loss of essential services, economic hardship and disruption to state, local, and tribal governments.

Assumptions

- Preparation and response to emergencies and disasters begins and ends at the local level most directly impacted.
- Management of the incident is most effective at the level directly impacted and this is the proper locus for Incident Command.
- Most emergencies or disasters will occur with enough warning that appropriate notification will be issued to ensure some level of preparation.
- Other incidents will occur with no advanced warning.
- DSHS staff, resources or systems may become overwhelmed during a major or prolonged disaster.
- DSHS may be unable to satisfy all emergency resource requests during a major emergency or disaster.
- Emergencies may cause confusion and anxiety.
- Employees may want to make sure that their families and homes are safe and secure before they are able to focus on work.
- Managers must expect that employees on duty may want to leave work immediately with or without notice and that they may not be able or willing to return to duty due to the exigent circumstances of the incident.
- Some employees may sustain injuries or become ill.
- Key leaders and critical staff should expect that they may be assigned to different duties, at different locations, working different hours than usual.

- DSHS response to a given incident is limited by available resources and capabilities.
- Depending on the type and severity of the event, the Department's response may be limited by factors such as:
  - Damage to DSHS capital campuses or leased facilities
  - Damage to surrounding transportation infrastructure
  - Staff availability
  - Disruptions to communication capabilities
  - Actions by federal agencies or other state agencies
  - Other unforeseen limitations

CONCEPT OF OPERATIONS

The DSHS Office of Emergency Management is responsible for coordinating the actions of all DSHS Administrations and institutions (this includes all residential programs operated and staffed by DSHS) in response to emergencies and disasters when impacts to DSHS mission essential functions necessitate activating the Emergency Coordination Center (ECC). Please refer to Annex A – Emergency Coordination Center Operating Procedures for detailed information.

Every DSHS Administration supports the DSHS ECC by designating staff who are available to receive training, participate in drills and assist in the DSHS Headquarters response.

The ECC is organized using flexible and scalable components under a modified Incident Command System. It is designed to function at a level that is sufficient to meet the size and complexity of a given incident.

The primary actions of the ECC are to: communicate; coordinate; collect, analyze, and distribute information; and to dispatch and track staff and other resources. The ECC Operating Procedures describes how these actions are carried out to meet the objectives of any given incident. A program of training, testing and exercising is foundational to emergency preparedness. The DSHS Office of Emergency Management establishes related standards for all DSHS Administrations and provides expert level training and technical assistance to DSHS headquarters, regional offices and residential programs. DSHS Administrations and institutions are expected to incorporate standards in their respective continuity plans.

RESPONSE PLAN

Normal Operations – Level 1

DSHS offices and institutions are able to respond effectively to most emergencies without headquarters level support.

Incidents begin and end locally. For this reason, management and staff at the location where the emergency or disaster impacts DSHS operations are best able to address the response. Incident Command is established at the location of impact.

The only time that Incident Command is established at DSHS headquarters, is when the incident is impacting headquarters operations. For this reason, the lead position in the Emergency Coordination Center is titled "Emergency Manager" rather than Incident Commander.

Enhanced Operations – Level 2

DSHS headquarters responds in accordance with this plan when an emergency or disaster impacts one or more headquarters offices in the Olympia area and to support the response by management and staff at the institution or other office level, when needed.

The Director of the Office of Emergency Management or designee decides when to activate the Emergency Coordination Center. The decision to activate is based on information about an anticipated or actual emergency that is likely to cause or has caused impacts that disrupt DSHS mission essential functions to such an extent that local managers and staff would require support. This could be either a major incident at a single DSHS office or institution or a disruption across multiple locations.

The Office of Emergency Management is able to address the response needs of most emergencies by activating a minimal number of command and general staff positions, typically including the Emergency Manager, the Operations & Logistics Section Chief, and Administration Liaisons.

Descriptions for each of the above positions are detailed in the Emergency Coordination Center Procedures. Staff assigned to these positions are expected to carry out the responsibilities outlined in the Procedures. In most cases, responsibilities are limited to developing and maintaining situational awareness and a common operating picture by sharing information and reporting out at designated intervals. The Emergency Manager reports regularly to the Secretary, the SESA Assistant Secretary and other members of the Executive Leadership Team.

The Emergency Manager is also expected to participate in regular teleconference briefings with the State Emergency Operations Center when it is activated. The Emergency Coordination Center shares information with other state agencies, such as the Department of Health and Department of Enterprise Services, as directed by the Emergency Manager.

The Emergency Manager may also receive requests for information about the response from the legislature, the Governor's Office, or Congressional Offices. Responses to elected officials are coordinated with the Senior Director of the Communications Office.

Full Operations – Level 3

The EOP and Operating Procedures are based on standardized principles and guidance set forth by the Federal Emergency Management Agency (FEMA) that have proved effective in many major disasters across the country.

When an emergency or disaster causes serious disruption to operations at one or more DSHS locations, it may become necessary for the ECC Incident Command structure to expand to include a Finance & Administration Section, a Planning Section, a Safety Officer and multiple general staff positions in each section. Again, this requires that an adequate number of staff be trained in advance to fill these roles and drilled to the procedures.

During full operations, it may become necessary for staff to be detailed to the ECC in order to work together most effectively. Every DSHS Administration is expected to cooperate fully with the Emergency Manager by responding to requests for staffing and following the guidance and direction provided. It is important to remember that the ECC exists to manage the response to the incident and this sometimes will require setting aside the established reporting chains in order to meet the demands of the response.

One or more DSHS Administrations may recommend deploying additional staff to the impacted location. The receiving location may be an established DSHS institution or office or an alternate location at or near the impacted DSHS operations. These staff will either establish DSHS Incident Command at the receiving location or integrate with the existing Incident Command. Deploying staff or other assets must be coordinated through the Emergency Manager of the ECC prior to deployment to make sure that staff are fully equipped, briefed on safety considerations, and understand procedures for reporting.

It is also conceivable that the DSHS ECC may combine with the Department of Health's emergency response or the Department of Enterprise Services. The latter is responsible for coordinating the emergency response impacting Capitol Campus. In situations where DSHS headquarters must scale up to assist other state agencies in responding to an incident, agencies' combined actions are facilitated by the common use of the Incident Command System.

NOTIFICATION OF EMERGENCIES OR DISASTERS

The DSHS Office of Emergency Management receives notifications from the State Emergency Operations Center (SEOC) via text message, email and phone call of state level activations. SEOC activations do not necessarily trigger activations of the DSHS Emergency Coordination Center.

Notification to the Administration Liaisons

The DSHS Office of Emergency Management also receives alerts (advisory, watch, and warning) from the National Weather Service http://www.weather.gov/ for all counties in the state and will distribute NWS warnings to Administration Liaisons, when received. As a best practice, Administration Liaisons and other responsible staff across the state are expected to sign up for NWS alerts to be prepared for severe inclement weather conditions.

Notification to the Executive Leadership

The Director of the Office of Emergency Management will notify the SESA Assistant Secretary or designee when:

- The severity of the situation warrants such notification
- It is politically prudent to do so
- The SEOC has notified the Governor's Office

The Secretary and executive leadership will be notified directly by the Director when:

- The incident is potentially life-threatening
- The anticipated or actual incident is likely to cause widespread damage, injury or death
- Any tsunami warning
- Multiple DSHS locations are impacted and the disruption will last more than one business day
- DSHS mission essential functions are impacted for more than one business day
- The incident is likely to result in widespread media coverage

The Director's notification to the Secretary and executive leadership will include the following:

- Nature of the incident
- Impacts likely to ensue over the next 24-72 hours
- Actions being taken
- Actions recommended
- Schedule for conference calls and briefings

EMERGENCY COORDINATION CENTER ACTIVATION

The majority of emergency responses are related to minor (limited scope, small scale) incidents and include building evacuations for fire drills (or malfunctions) and summoning police, fire, or emergency medical services to address a situation involving one or more individuals.

The steps for activating the ECC are detailed in the Operating Procedures in Annex A. Typically, activation is within the discretion of the Director of the Office of Emergency Management or designee. This individual will report as soon as possible to the Office of Emergency Management in Office Building 2 and notify the SESA Assistant Secretary of the activation.

In the event that neither the Director nor designee is available, the SESA Assistant Secretary will designate a DSHS manager who is trained to fill the role of Emergency Manager.

The Emergency Manager will notify the Operations & Logistics Section Chief, typically an employee of the Office of Emergency Management. An Incident Briefing, including a plan for the first operational period, will be developed by the Emergency Manager and Operations & Logistics Section Chief. The Operations & Logistics Section Chief will notify the Administration Liaisons and other positions that are required for the initial activation, providing the Incident Briefing, direction regarding reporting requirements and any other pertinent information.

The following guide presents some considerations for decision making prior to activating the ECC or a continuity plan. In addition to following each Administration and residential program's internal reporting requirements, the DSHS Office of Emergency Management must be notified for all level 2 and level 3 incidents immediately.

ACTIVATION GUIDE

Decision Guide for Activation of Emergency Coordinator Center			
	Level 1	**Level 2**	**Level 3**
Scope of damage	Localized incident limited to a single building	Multiple buildings, offices within buildings	Significant impacts to infrastructure: roads and bridges, utilities, communications
	Minor damage to equipment or facility	Major damage to equipment or facility	Loss or destruction of significant equipment, systems or facility
Staff impact	No injuries or minor injuries	Injuries required a medical response	Multiple persons injured or casualties sustained
	Staff are able to return	Staff unable to get to work location or cannot remain	One or more mission essential functions must be transferred to alternate location
	Staff absence is within normal limits	Staff absence exceed normal limits	Insufficient staffing to sustain mission essential functions
Ability to recover and response coordination	RTO is < 24 hours	RTO is > 24 hours but < 72 hours	RTO is > 72 hours or uncertain
	Local response is sufficient; response coordination is uncomplicated	Multiple DSHS locations offline for > 24 hours; response coordination involves multiple DSHS programs	Significant external response is necessary, i.e., building owner, utility company, contractor, etc.

CONTINUITY OF OPERATIONS

As required by the Directive by the Governor 13-02, all state agencies must maintain continuity plans. In DSHS, continuity plans must be developed at the Administration and institution levels. Continuity plans detail how DSHS prepares for disruptions, continues to perform its mission essential functions during emergencies and disasters, and how we resume normal operations.

EOP describe those actions that must be taken immediately during an emergency or disaster to protect the well-being of employees and clients during transient disruptions – those generally lasting less than one business day. Continuity plans are needed to explain additional actions that must be taken when the disruption will last for more than a single business day. Another significant difference between EOP and continuity plans is: EOP combine the response actions of all DSHS (and non-DSHS) occupants at a given location while continuity plans are specific to the DSHS Administration or institution.

Continuity plan development, implementation and sufficiency are the responsibility of the organizational heads for each DSHS Administration and institution. Organizational heads must review continuity plans, in part or in whole, every year by June 1 and revise them as necessary. Approved continuity plans must be submitted in electronic format to the DSHS Office of Emergency Management for reference and record keeping purposes. Approved continuity plans will be posted to the Office of Emergency Management SharePoint site http://one.dshs.wa.lcl/em/Pages/default.aspx

DSHS Administrations are required to use the FEMA Continuity Plan Template for Non-Federal Governments for plans. Reasonable modifications may be made to the template, if programmatically necessary. All Administration and institution continuity plans must vertically align with the DSHS Headquarters EOP – all elements must be addressed.

DSHS institutions operate under requirements in addition to those applicable to non-institutional operations. Additional requirements for institutions are stipulated by the Joint Commission on Accrediting Hospital Organizations or the Centers for Medicare and Medicaid Services. These authorities require inclusion of other planning elements that exceed those stipulated under the FEMA guidance, but the FEMA template may be used as the foundation for institutional programs' continuity plans. Any other planning templates must be approved by the DSHS Office of Emergency Management prior to their implementation. For example, MED PASS Emergency Preparedness and Response Policy and Procedure Manual http://www.med-pass.com/emergency-preparedness-and-response-policy-and-procedure-manual-with-cd.html has been approved by the Office of Emergency Management and is being implemented by the Developmental Disabilities Administration. MED PASS may be used by any DSHS institution.

Suspension of Operations

DSHS continuity plans must be written and implemented to forestall suspension of operations. While it is sometimes necessary to temporarily close an office or a portion of a residential campus, and that decision making authority is delegated to appointing authorities, a suspension of operations is a rare occurrence.

A suspension of operations requires authorization from the Secretary. (See WAC 357-31-260 and DSHS Administrative Policy 18.32 Severe Inclement Weather) The period of suspended operations must not exceed fifteen calendar days without approval by the State Human Resources Director, Office of Financial Management. (See WAC 357-31-280)

AUTHORITIES AND REFERENCES

Public Law 93-288, The Disaster Relief Act of 1974, as amended by Public Law 100-707, the Robert T. Stafford Act as amended

Chapter 38.08, RCW, Powers and Duties of Governor

Chapter 38.52 Revised Code of Washington, Emergency Management http://apps.leg.wa.gov/rcw/default.aspx?cite=38.52

Chapter 43.06 RCW, Governor's Emergency Powers

Directive by the Governor 13-02, Continuity of Government Operations Preparation, http://www.governor.wa.gov/office/directives/2013/dir_13-02.pdf

DSHS Administrative Policy 9.11, Emergency Management http://asd.dshs.wa.gov/RPAU/RPAU-adminpolicy.htm#chapter9

DSHS Administrative Policy 18.32 Severe Inclement Weather http://asd.dshs.wa.gov/RPAU/documents/Admin-Policy/18-32%20housekeeping.htm