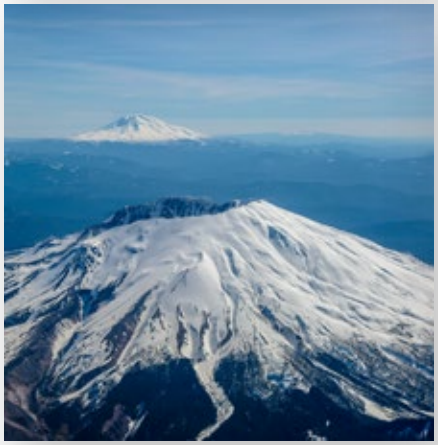
MAY 2023

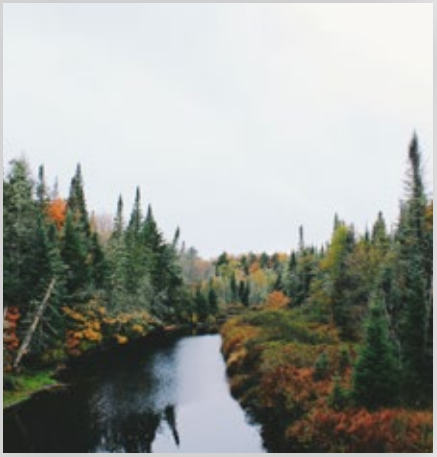
WASHINGTON STATE REPORT

2022 LTSS ACCOMPLISHMENTS

TABLE OF CONTENTS

TABLE OF CONTENTS





INTRODUCTION

The Aging and Long-Term Support Administration (ALTSA) is Washington's State Unit on Aging (SUA), as defined in the Older Americans Act. ALTSA is an administration inside the Department of Social and Health Services (DSHS). Within ALTSA are four service divisions: Home and Community Services (HCS), Residential Care Services (RCS), Adult Protective Services (APS), and Office for Deaf and Hard of Hearing (ODHH). Management Services Division (MSD) is also responsible for supporting all ALTSA divisions and the Developmental Disabilities Administration (DDA) with critical administrative functions such as budgeting, accounting, leased facilities, contracting, etc. HCS administers the Older Americans Act (OAA), providing a framework for over four decades of community-based services enhanced by Washington's State Legislature. In addition to OAA services that reach over 170,000 individuals and 13,000 unpaid family caregivers annually, Washington has a strong Medicaid long-term care network. As of October 2022, Washington serves a monthly caseload of nearly 67,000 individuals in Medicaid home and community-based (HCBS) long-term care. Another 7,600 receive monthly services in skilled nursing facilities. Of the Medicaid HCBS individuals, over 48,500 receive services in-home and are offered care planning and case management through Washington's 13 Area Agencies on Aging (AAA).

This report on accomplishments provides an overview of the significant policy and operational elements that keep Washington's LTSS system strong, even as we approach the end of the pandemic. Individual sections may also contain more detailed COVID responses. As the unthinkable pandemic continued through Federal Fiscal Year 22 (FFY 22), our services and operations continued under the Public Health Emergency and Major Disaster Declaration flexibilities established in 2020. We became even more proficient in operating remotely, crafted reopening plans that had the flexibility to respond to local disease prevalence conditions and focused on direct workforce recruitment and retention. The volume of policy writing and communication remained high.

The story of administering programs during the COVID-19 pandemic is woven throughout this report. One challenge that may not be told elsewhere is the additional funding through enhanced FMAP for Medicaid and the virtual doubling of funding for OAA programs through multiple grants. At the same time, a boon came with challenges to operationalize the spending and accounting for the grants without commensurate accounting and program staff. ALTSA and AAAs staff have gone above and beyond, juggling these new priorities to meet the most urgent needs.

IMPLEMENTATION OF THE OLDER AMERICANS ACT STATE PLAN ON AGING AND INTRASTATE FUNDING FORMULA UPDATE

As mandated under the OAA, ALTSA submits a State Plan on Aging every four years to the U.S. Department of Health and Human Services Administration on Community Living (ACL). The purpose of the State Plan on Aging is to document achievements and planned activities related to the state's long-term supports and services planning efforts, provide a state framework for activities related to programs/activities/services to Older Adults, and provide assurances to ACL that ALTSA will follow the provisions of the Older Americans Act. This report is, in part, documentation of work carried out under our approved State Plan on Aging.

The current plan covers the period of October 1, 2018, to September 30, 2022, with a one-year extension to September 30, 2023, approved by ACL. In 2021, ALTSA filed the one-year waiver request to have time better to assess the current and future needs of older Washingtonians while continuing to address the effects of the COVID-19 pandemic. At the same time, ALTSA engaged in extensive collaboration with the Washington Association of Area Agencies on Aging (W4A) to amend our Intrastate Funding Formula for the first time in 30 years. This effort addressed equity concerns related to how the two tribally-sponsored AAAs were funded compared to the other eleven AAAs. Population size restrictions were removed from the base allocation formula, and contiguous counties were counted like other multi-county AAA receiving a modest increase in base allocation. ACL approved the revised IFF for use in allocating funds beginning January 1, 2023. Considerations for other changes were tabled until another revision, along with the next four-year State Plan, will be submitted to ACL by July 1, 2023.

- Washington State Plan on Aging

IMPLEMENTATION OF OLDER AMERICANS ACT PERFORMANCE SYSTEM (OAAPS) DATA REPORTING OF SERVICES AND FISCAL SERVICE EXPENDITURES

The OAA is a significant piece of legislation (passed by Congress in 1965) providing for the infrastructure and delivery of social and nutrition to older adults and unpaid caregivers. Services supplied with OAA funds are reported to ACL annually. These annual reports have been restructured, and compliance with this restructure, titled The Older Americans Act Performance System (OAAPS), was organized and trained to statewide throughout 2021 and 2022 to allow the Area Agencies on Aging to implement data collection by October 1, 2021, to meet the new reporting requirements for Federal Fiscal Year (FFY) 2022. OAAPS is the new reporting tool for ACL and Administration on Aging (AoA) to monitor performance and collect information on Older Americans Act (OAA) Title III, VI, and VII programs. Below is an outline of the work carried out through 2021 and 2022 to ready the state for the initial FFY 22 Annual OAAPS reporting of OAA data.

- Considerable work was completed to refine OAAPS documentation and FFY 22 data entry guidance. This work included refining OAA service, fiscal reporting definitions, and related data entry structures. It updated service recording processes to meet the OAAPS requirements. For the first time, these refinements to the data structure are being pulled into the annual FFY 22 OAAPS reporting tool. The annual FFY OAAPS reporting tool provides each AAA with a summary of all their data collection of that FFY for OAA programs. The OAAPS data reporting process and the first FFY 22 OAAPS annual AAA wrap-up of OAA data reporting remain highly collaborative with AAA partners to ensure data fidelity and secure ongoing quality assurance.
- The largest AAA in Washington, King County, Aging and Disability Services (ADS), changed their data entry process into the ALTSA support application. This AAA began direct data entry for the bulk of their OAA services to ready their AAA for data capture in the first annual FFY 22 OAAPS annual wrap-up report of OAA data. Since ALTSA initiated using its vendor system in October 2014, ADS has uploaded its data, utilizing its data warehouse to compile and upload OAA activity into the state's system. Effective October 1, 2021, this upload approach changed to direct entry. Technical assistance for this transition was provided to ADS well into 2022 and extended into the initial FFY 22 OAAPS reporting season.

INNOVATIVE SYSTEM APPROACHES IN PLANNING AND DEVELOPMENT

SOCIAL ISOLATION PROJECT WORKGROUP

The Social Isolation Project workgroup was a multi-organizational and multi-agency effort to brainstorm/inventory activities that could reduce social isolation and identify whether they could be done within existing or new resources. Participating organizations included the W4A, WA Association of Senior Centers, State Council on Aging, AARP, WA State Long Term Care Ombudsman, WA State Department of Health, and provider representatives (Adult Day Health and Home Care Agencies).

View the Social Isolation in Washington State paper created by the Social Isolation Project Workgroup.

ALTSA and AAA partners implemented programs to combat social isolation in 2021, and programs continued into 2022.

ROBOTIC PETS

State Unit on Aging partnered with 13 AAA statewide to implement a robotic pet program to bring 700 robotic pets to adults 60+ in Washington State. The carefree companion pets offer engagement to those experiencing loneliness and social isolation. These robotic pets can also support unpaid caregivers and people with dementia by providing a carefree interactive activity with the potential to create a sense of safety and security. Seven hundred pets were distributed to our AAA partners in 2022, and we will continue to collect data using GetCARE in 2023 as pets are given to people.

In addition, HCS and Developmental Disability Administration (DDA) executed a Medicaid Assistive Technology contract with the vendor for use in the Medicaid Community First Choice program with HCS and DDA. This will be a sustained option in that program.

GETSETUP

GetSet Up is an online service for older adults that helps them learn, connect and share with peers in small virtual classrooms. This online forum provides step-by-step instructions to help older adults learn and navigate technology. ALTSA purchased an initial 25,000 classes as a pilot in May 2021; by the end of 2022, over 90,000 had been used. Due to the robust engagement rate, GetSet Up was re-engaged to provide unlimited classes for 2023. Local AAA are providing outreach and education with support from GetSet Up.

TRUALTA

Trualta is an online service option for unpaid family caregivers delivering education, tips, and strategies to reduce caregiver stress while improving outcomes and reducing costs for unpaid family caregivers and those they care for. Unpaid family caregivers can access the service through the Washington Caregivers Learning Portal in its second year. It is free to unpaid family caregivers caring for an adult in Washington.

WA STATE LONG-TERM SERVICES AND SUPPORTS (LTSS) TRUST ACT CREATES NEW BENEFIT

Enacted in 2019, WA Cares Fund (formerly known as LTSS Trust)(RCW 50B.04) is a contributory long-term service and supports insurance program with a maximum lifetime benefit of $36,500 in its first year for eligible Washington employees. WA Cares Fund is financed by an employee premium of 0.58 percent of wages ($0.58 for every $100 earned). Individuals who have met the Trust's work and contribution requirements (ten years with no more than a five-year interruption or three out of the last six years) and determined to need assistance with activities of daily living (ADL) may claim LTSS Trust benefits from approved providers. The LTSS Trust is a cross-agency project administered collaboratively by DSHS, the Employment Security Department (ESD), the Health Care Authority (HCA), and the Office of the State Actuary. A twenty-one (21)-member LTSS Trust Commission, chaired by DSHS, oversees the WA Cares Fund.

In the 2022 legislative session, lawmakers passed reforms to improve the program and address coverage gaps. This included adding a pathway for near-retirees to earn partial benefits each year they work and voluntary exemptions for certain workers who would be unlikely to qualify or use their benefits. The program was delayed by 18 months to give state agencies more time to implement the changes. Employers will deduct premiums on July 1, 2023; by July 1, 2026, the first eligible beneficiaries will be able to use services.

In addition, the legislature tasked the LTSS Trust Commission to address the following topics:

- Developing options to make benefits available nationwide
- Requiring people who applied for a permanent exemption from WA Cares Fund to recertify that they have maintained their private long-term care insurance coverage to remain exempt
- Allowing people who received a permanent exemption to come back into the program voluntarily
- Working with insurers to support the development of long-term care insurance products that supplement the program's benefits
- Establishing criteria for determining that an individual has met the requirements to become an eligible beneficiary

The LTSS Trust Commission studied these issues in 2022 and other topics to improve the program's operations and will issue its report to the legislature and state agencies on January 1, 2023. View the information at https://wacaresfund.wa.gov/commission/.

NO WRONG DOOR (NWD) SYSTEM

NO WRONG DOOR BUSINESS CASE DEVELOPMENT GRANT

The No Wrong Door Business Case Development Grant (2018-2022) was a national effort to quantify the return on investment associated with streamlining access to long-term services and supports (LTSS) allowing older adults and people with disabilities to live independently in the community. This effort was led by the ACL with the hope that by demonstrating the impact of state No Wrong Door (NWD) systems, we can better sustain system change that increases access to community living while reducing unnecessary healthcare utilization. Our project was focused on the improvement of person-centered practices and care transition interventions.

Washington's primary goal is to impact Community Living Connections (CLC) users in ways that increase access to services, as well as improve the user's ability to document person-centered practices and strategies in the existing client management information system (GetCare). This is necessary to understand the outcomes and impacts of our investments in person-centered practices and care transitions. Additional project goals included working collaboratively with ACL and its partners to develop a methodology and toolkit for calculating a return on investment (ROI) for NWD systems. Finally, we were able to create an enhanced end user experience for consumers connecting with the consumer website. This work included the addition of a guided search feature, updating of state and national resources and collaboration with other organizations to invite the possibility of a centralized resource directory.

COMMUNITY LIVING CONNECTIONS -GETCARE INCLUSIVE PLANNING AND STREAMLINING EFFORTS WITH GRANT PARTNER AND USER/ PARTICIPANT FEEDBACK

ALTSA consistently participated in Virtual Work Meetings, topic-specific workgroups, and Business Case Collaborative Meetings, Client Management System (CLC GetCare) Core Team, and GetCare Policy Maintenance and Recommendation Committee (PMRC) Meetings, to focus improvement efforts on our client management information system database and its impact to the No Wrong Door (NWD) System.

We have continued collaboration with our GetCare vendor RTZ on system improvements, including the development of enhanced tools to increase the ability of GetCare to track and record person-centered actions and services in ways that contribute to the analysis of impact and return on investment.

Continued And Expanded Access to the Person-Centered Thinking In-Person Mentorship, Training, And Curriculum

In place of in-person trainings, which were still on hold for 2022 due to the pandemic, virtual person-centered thinking options were developed for the ADRC/AAA network. These virtual trainings include; Person-Centered Thinking and Practices, Person-Centered Active Listening and Person-Centered Dementia Capability. These trainings were offered to

Aging and Disability Resouce Center (ADRC) COVID Response Grant

2022 wrapped up the ADRC COVID Rapid Response grant funded through ACL. All activities completed through this grant were in collaboration with AAA:

- Technology needs for both workforce and consumers to facilitate telecommunication and implementing proactive Information and Assistance (I&A) outreach calls to people at risk to combat social isolation.
- Targeted tribal liaison support for bridging ADRC services within Tribal nations.
- Purchasing goods and services to address emergent needs of consumers affected by COVID-19. This could include rent, grocery, utility assistance, and assistive technology, as well as, other needs.
- Work with current client management system vendor, RTZ, to provide enhancement of the public facing website and statewide resource directory to assist both AAA staff and consumers throughout state to locate and access local community long term services and supports.

Continued Funding of EBP Network Development

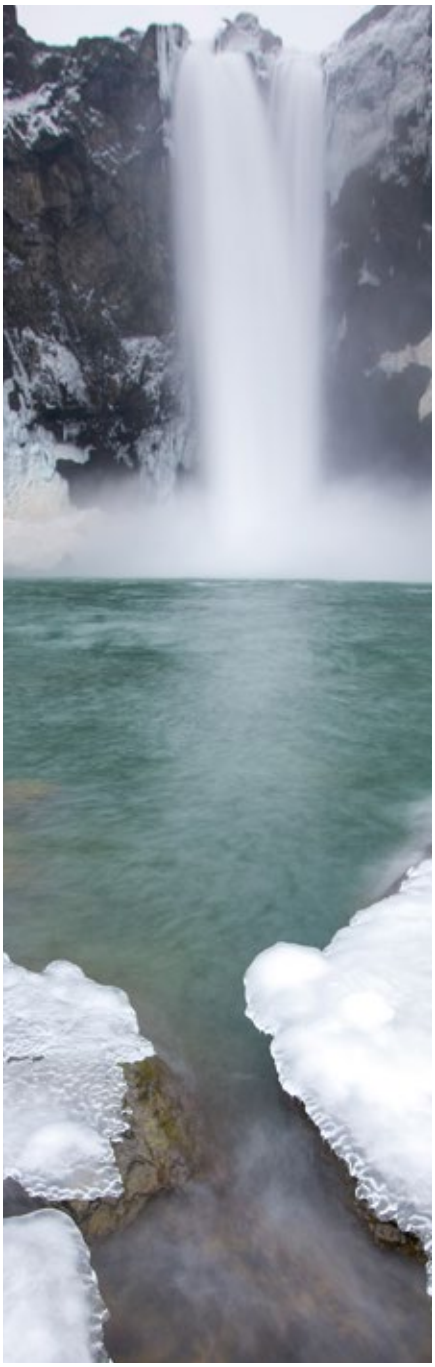
ALTSA was accepted into the National Council on Aging (NCOA)'s Network Development Learning Collaborative, a national initiative to enhance the efforts of several states that are working on supporting infrastructure for Evidence-Based Programs (EBPs) that address social determinants of health. The focus in our state is on designing a centralized statewide structure that will have capacity for a referral and billing platform and the networking required to support and sustain Chronic Disease Self-Management Education (CDSME) and other EBPs at a regional and local level. Cultural and systemic barriers to health care infrastructure that incorporates these programs continue to be assessed and problem-solved through bi-monthly meeting with Network Development partners. This learning collaborative ended after identifying a lead organization that moved the work forward while continuing to develop the partnerships and work toward building a network hub that provides information and access to partners and clients about evidence-based programs. In development is a robust statewide bi-directional referral and billing platform. The CDSME and hub work is now funded under a three-year ACL grant that was awarded to ALTSA, HCS, WIN Team May of 2019 which was recently extended at no cost to April 2023.

Chronic Disease Self-Management Education Sustainability Grant Project

ALTSA continues work on the 3-year ACL Chronic Disease Self-Management Education (CDSME) Sustainability grant project that has been extended for an additional year through April 2023 due the pandemic. Together with project partners, ALTSA continues to:

- Develop a pilot project testing the feasibility of a sustainable, regionalized approach for providing evidence-based CDSME.
- Build infrastructure and support administrative services to help spread, scale, and sustain CDSME.
- Create a regionalized hub-and-spoke or "dandelion" network model for providing CDSME, with Comagine Health as the core organization, various regional health organizations, including Accountable Communities of Health (ACHs) as regional hubs, and various community partners and host organizations as spokes.
- Promote health equity by increasing access to CDSME for underserved, primarily rural populations.
- Create a dual bi-directional referral and reporting network to identify and track CDSME participants' health care utilization and other outcome measures to help sustain and expand CDSME programs.

Working with many partners, ALTSA has defined the roles that various organizations will play in the statewide network and the relationships between network entities and continue to identify several organizations interested in filling those roles. Partnership agreements to formalize these relationships are currently being developed. While in-person CDSME workshops were suspended due to the COVID-19 pandemic, some organizations are planning for in-person workshops in 2023. We have worked with Comagine Health, the Cascade Pacific Action Alliance (an ACH), and the Southwest Washington Accountable Community of Health to provide virtual alternatives that allow adults with chronic conditions access to CDSME programming while maintaining social distancing measures. Collaboration with numerous partners on several aspects of the project has yielded actionable progress toward sustainability and expanded CDSME infrastructure which will continue into 2023.



IMPLEMENTING A STATE PLAN TO ADDRESS ALZHEIMER'S DISEASE AND OTHER DEMENTIAS

ALTSA convened the full Dementia Action Collaborative (DAC) virtually in April, September, October, and December of 2022, with multiple subcommittee and project team meetings in the alternating months. The DAC is a group of public-private partners committed to implementing the Washington State Plan to Address Alzheimer's Disease and Other Dementias. The group includes members who were appointees in the development of the state plan – people with dementia, family caregivers, representatives of advocacy groups, the aging network, Alzheimer's organizations, long-term care providers, health care professionals, legislators, and governmental agencies.

In this year's legislative session, HB 1646 codified the DAC bringing new facets to the group, including a specific roster of Governor Appointed members, requiring an update of the state plan by October 1, 2023, and annual recommendations to the Governor and legislature each year after that through 2028, and creating a Co-Chair position from an Alzheimer's organization to share leadership. This legislation requires that the DAC devote most of its time this year to an update of the plan. ALTSA will continue to be the convener with ALTSA Assistant Secretary, Bea Rector, serving as Co-Chair and recently elected Co-chair from the Alzheimer's Association, Brad Forbes. Lynne Korte, Dementia Care Program-Policy Manager, supports and coordinates the process. ALTSA also provides OAA Title 3B funding to support the cost of professional meeting facilitation. In the six years since the plan was published, the DAC has done as much as possible on recommendations that could be addressed within existing resources and through heightened collaboration. This included the development of foundational tools and resources for individuals and community organizations such as a Dementia Safety Info Kit, Dementia Friendly Communities fact sheet, a Dementia Road Map: A Guide for Family and Care Partners (English and Spanish), an Action Guide on Connecting with Asian and Pacific Islanders about Dementia, guidance documents on how to start Alzheimer's/Memory Cafes and Dementia Friendly Walking Groups, a module on dementia for Community Health Workers and a "Let's Talk Dementia" mini-video series featuring people with early-stage dementia. The DAC also developed materials for health care providers, i.e., a position paper on Brief Cognitive Screening Tools for Primary Care Practice, evidence-based Bree Alzheimer's Disease and Other Dementias Report and Recommendations for primary care around the diagnosis and ongoing care, as well as a Clinical Provider Practice Tool for guidance around the diagnosis and post-diagnosis support. Added in 2022 are Caregiver Tip Sheets (English/Spanish) that offer tips around challenging issues and behaviors in dementia, a clinical provider practice tool that provides guidance for care 'beyond the diagnosis,' and an educational program for families on Partnering with Your Health Care Provider to help families work in partnership towards optimal care and avoid preventable hospitalizations. These documents are available on the DAC website – and DAC members disseminate them at meetings and through their respective networks as possible

In 2022, the DAC continued to meet virtually as a full group, and its three topic-focused subcommittees - Public Awareness/Community Readiness, Health/Medical, Long-Term Services, and Supports – and worked together to support the three state-funded DAC initiatives funded through legislative proviso three years prior that focus on early diagnosis and support. And the DAC Advocacy Subcommittee achieved funding for a new initiative to support the statewide expansion of the global awareness program, Dementia Friends. These initiatives are designed to:

Train primary care practitioners in best practice dementia care

The University of Washington (UW) began hosted the new Project ECHO Dementia. Under the leadership of UW, a multi-disciplinary medical panel formed for the purpose of providing education through an all-teach, all-learn model. Project ECHO Dementia is offered virtually twice a month; each session is 75 minutes with a didactic on dementia care and review of a case example provided from the community of participating clinicians. Participation is voluntary, and CEs are offered. Since its launch in June 2020, ECHO Dementia has provided education for 114 clinicians from 49 different clinics across the state. [SFY20 $256,000/SFY21 $226,000]

Increase public awareness of dementia/the value of early diagnosis.

DOH is funded to develop digital public awareness campaigns on dementia and the value of early diagnosis to include communities at heightened risk of dementia. In 2022, DOH contracted with professional media companies to develop campaign strategies and materials focused on the Latinx community. This work resulted in adding new materials to a campaign landing page at DOH that offers consumer information/materials and houses materials for community agencies, such as social media messages, sample newsletter articles, and resources for more information. See doh.wa.gov/memory. [SFY20 $150,000/SFY21 $150,000]

This work was added to the materials created last year for the African American community. In addition, in 2022, ALTSA contracted Older American Act (OAA) funds to DOH to financially support two community organizations serving the African American target audience in using the new materials – the First AME (FAME) and Center for Multicultural Health (CMCH) - in self-determined events/ways to promote awareness of dementia and the value of early diagnosis in their communities. FAME incorporated the materials and topic of dementia: an in-person health fair incorporating health screenings (blood pressure, glucose, cholesterol, mini-cognitive screenings), a 'Get out the Vote' luncheon, and a Virtual Town Hall with sister AME churches. CMCH disseminated awareness through a newsletter aligned with Memory Sunday awareness, hosted four interactive health and resource fairs in May and June in varied locations in King County, health screenings at smaller senior centers, and offered materials in mobile food distribution events.

Promote early legal and advance care planning

ALTSA continues to promote early legal and advanced care planning, including disseminating the collaborative development of the Dementia Legal Planning Toolkit for the public and promoting its availability. This project transitioned in 2021 to a new contractor, the Pro Bono Council of Washington (PBC), now offering the Dementia Legal Planning Project. PBC provides attorney training on dementia and promotes local pro bono legal services – to assist adults 60+ and people with dementia of any age in completing powers of attorney and health directives. In 2022, the PBC offered 17 client-focused presentations and resource fairs (attended by 8-10 people each time); provided attorney Continuing Legal Education (CLE) for attorney training and recruitment;

established a roster of 19 volunteer attorneys who are specifically trained and ready to assist with dementia legal planning; served 25 clients in completing Power of Attorney (POAs) and health care directives during attorney consultations with more registered for event after holidays. While these numbers are currently relatively small, the program has had increasing referrals reaching now around 6/month, with several in-person clinics planned for early 2023 in addition to an ongoing 1-2 outreach presentations per month [SFY20 $117,000/SFY21 $116,000]

Build Dementia Capable Communities (Dementia Resource Catalyst + Service Funds)

In 2022, the state funded pilot projects in two AAA planning and service areas – one AAA in eastern Washington and one AAA in Western Washington. The Building Dementia Capable Communities (BDCC) program is designed to help people with possible or diagnosed dementia live their best lives and stay at home as long as possible. The program funds a new role of Dementia Resource Catalyst staff to embed dementia-capability more systemically into their organizations and network, foster more dementia-capable communities, and optimize existing services while providing funds to increase the availability of new dementia-capable services. The two selected AAA - Aging and Long-Term Care of Eastern Washington (ALTCEW) and the Northwest Regional Council (NWRC) – have spent this year developing and providing training for AAA and aging network partner staff around dementia, building awareness and knowledge of partners and community around dementia, and developing and launching services in their areas that fill gaps related to early-stage engagement/supports, meeting complex and behavioral/safety needs, and reaching diverse communities. Developing reporting for this program within the Client Management System (Get Care) has resulted in the development of functionality to enhance tracking inquiries related to memory loss/dementia. [SFY21 $750,000/SFY22 $750,000]

DAC staff liaison positions, funded through DAC advocacy, continue in their respective agencies – ALTSA, DOH, DDA, and HCA- to support DAC subcommittee work and foster collaboration and connectivity as we strive to implement specific recommendations and integrate dementia into the consciousness and planning of various service systems. In addition to the above initiatives, other DAC staff accomplishments within agencies this year included:

- An Introduction to I/DD and Dementia Train-the-Trainer course was developed by DAC partners over the last couple years. The course was offered five times in 2022 – preparing 69 individuals to teach the material in their own settings. Trainees were from DDA Community Residential programs and headquarters as well as from ARC, a Parents Coop Society and DOH.
- Support of the Dementia Friendly WA Learning Collaborative, a sister network to UW-Memory and Brain Wellness Center (MBWC) Project Extension for Community Healthcare Outcomes (ECHO) Dementia, has occurred monthly to support community agency staff who organize or facilitate dementia-friendly programs.
- A monthly document, Resources for Dementia Caregivers During the Covid-19 Outbreak, features online or virtual opportunities for training, education, support or connection offered by DAC partners.
- DOH has been implementing the Trust for America's Health (TFAH) grant to develop an Age-Friendly Public Health System. In 2022, this project supplied mini-grants to support work towards age-friendly initiatives and be a part of the Age-Friendly Public Health Learning and Action Network System (AFPHS). The following local health jurisdictions (LHJs) and tribal entities are working on their projects: Benton-Franklin Health District, Kitsap Public Health, Settle and King County Public Health, Spokane Regional Health District, Walla Walla County Department of Health and the NW WA Indian Health Board representing 6 area tribes. Each project has support from their partner AAA serving the same areas

STAR-C/Dementia Behavior Consultation

STAR-Caregiver (STAR-C), developed by the University of Washington's (UWs)School of Nursing Northwest Research Group on Aging, is an evidence-based in-home behavioral intervention designed to decrease depression and anxiety in individuals with Alzheimer's disease and their family caregivers.

- Initiated as a collaboration between ALTSA and UW and piloted in 2011, with funding provided through existing allocations in participating Family Caregiver Support Programs (FCSPs). It is now available from six AAA, serving 24 counties. Star-C remained sustainable through 2022, buoyed by its inclusion in the two new Building Dementia Capable Communities programs in Northwest and Eastern Washington.

- This collaboration adapted the original 8-session home visit program to a shortened version – 4 in-home visits and 2 phone calls over 6 weeks, followed by monthly phone calls for 4 months – all with the same content as the original.
- Ongoing challenges with the STAR-C program include maintaining a roster of certified STAR-C coaches due to the length of time and cost of certification. In addition to completing the two-day training, coaches must complete two cases with monitoring (UW review of audiotaped in-home sessions) to acquire their initial certification, and a further four cases within two years.
- Star-C is a relatively time-intense commitment for families who are already struggling to balance care responsibilities, and it can be challenging for coaches to recruit families to participate. Because of this, some coaches drop out, change jobs, or retire, before obtaining full certification. There was one training this year, with three coaches having since completed their initial certification, and four others still in the pilot/initial certification phase. Coaches are once again able to visit people in their homes, while also continuing to utilize virtual meetings to maximize outreach.
- ALTSA staff, certified STAR-C coaches, and the AAA that deliver the program are strong advocates for sustaining the program. Its most enthusiastic promoters are those who have experienced it for themselves.

HEALTH HOME PROGRAM

In 2022 the Health Home (HH) program continued to be a model of how community-based care coordination can improve coordination and quality of care and increase an individual's participation in their own care while reducing costly hospital visits, nursing home stays, and other medical interventions. In response to the COVID pandemic, the HH program allowed telephonic visits for its delivery model to enable care coordinators to continue their work.

The state's HH programs, part of a demonstration project under the Centers for Medicare and Medicaid Services (CMS), has yielded millions of dollars in cumulative Medicare savings since its beginning in 2013 while transforming the lives of thousands of Washingtonians. The state can receive up to 50% of the Medicare savings based on meeting the quality measure reporting requirements and benchmarks outlined in the agreement with CMS. To date, Washington has received more than $97.7 million in preliminary shared savings related to the demonstration, with $11.4 million received during year seven of the demonstration. The HH program continues to grow, including increasing engagement of tribal entities as Care Coordination Organizations. Currently, the program is working towards operationalizing the extension of the HH program to Dual Special Needs Medicare Plan (DSNP) enrollees as a Medicare benefit to begin in 2023.

The HH program continues to positively impact the lives of individuals who receive services resulting in improved client care while cutting costs, as seen with "Miss L," an HH program participant in Pierce County.

Miss L, a 52-year-old client, has an Intellectual Disability, Hypertension, Hyperlipidemia, and pre-Diabetes. Miss L had received Developmental Disability Administration (DDA) services for years. Miss L's father had been her paid caregiver until he passed away. Miss L's family stepped in to provide informal support. Still, Miss L had set a short-term goal of wanting to be independent and move to an Adult Family Home.

Finding a good fit for Miss L was challenging due to the possible language barrier, as Miss L's primary language is not English. Miss L had never lived with anyone other than family, and the family wanted an all-female Adult Family Home with other women with similar disabilities. ALTSA works within the preferences of Miss L and their family members. While working within the constraints of the preferences, Miss L was reassigned to a new DDA Case Manager who was new to the program. It was challenging to find an Adult Family Home that met Miss L and the family's requirements while meeting the needs of the Adult Family Home. Many Adult Family Homes wanted a higher daily rate, although Miss L had low care needs. Working with Miss L and her family members, ALTSA contacted several Adult Family Homes and did site visits to determine if the home was safe and a good fit for Miss L. Miss L, her family members, and the HH Care Coordinator decided it would be a good idea to have the DDA Ombudsman involved to help with the changes and transition.

For weeks, the DDA Case Manager, DDA supervisor, DDA administrator, Miss L, family members, DDA Ombudsman, and Care Coordinator met via Zoom to determine how best to proceed to help Miss L meet this identified goal. Finally, the Care Coordinator, Miss L, and family members found a good fit in the fall. Miss L met the Adult Family Home homeowner, and they immediately connected. Things fell into place, and Miss L moved into her first Adult Family Home. The HH Care Coordinator visited Miss L, her family members, and the Adult Family Home homeowner the following week. Miss L showed the HH Care Coordinator the joys of work performed in both the garden and with in-home chores.

Moving into an Adult Family Home has been very exciting and scary for Miss L as this is her first time living without family. Miss L reports finally feeling "independent ."Through this experience, Miss L has remained upbeat, knowing that "her HH friend" has been able to help, support, and provide encouragement to meet goals.


LEGISLATIVE · BUILDING

1115 MEDICAID TRANSFORMATION WAIVER

2022 marked the sixth year of Washington State's five-year 1115 Medicaid Transformation Demonstration waiver. This included an extension year approved by CMS due to COVID impacts on goals across the waiver. The waiver is an opportunity to accelerate changes in our state's Medicaid program that support the goals of Healthier Washington—better health, better care, and lower costs. There were originally three initiatives included:

1. Transformation Projects through Accountable Communities of Health
2. Long-Term Services and Supports
3. Foundational Community Supports

In late 2018, CMS approved an amendment to add new Initiative: 4) Substance Use Disorder, and Initiative 5) for Mental Health was approved in November 2020. CMS also approved the extension of the current demonstration for another six months into 2023, as the program awaits approval for a five-year renewal of the waiver with some new program concepts to test.

Initiative One: Accountable Communities of Health and the Chronic Disease Self-Management Program

Initiative One, led by HCA, aims to create transformation statewide through regional Accountable Communities of Health (ACH). Accountable Communities of Health (ACHs) are a central component of Initiative 1, part of Washington's Medicaid Transformation and 1115 Waiver Agreement and Delivery System Reform Incentive Payment (DSRIP) program with the Centers for Medicare & Medicaid Services (CMS). The 1115 Waiver is a five-year agreement that seeks to improve health outcomes for Medicaid beneficiaries in Washington State. Initiative One focuses on implementing of regional health transformation projects through ACHs and Indian Health Care Providers (IHCPs).

The 1115 Waiver spans from 2017 through 2022, with incentives paid out through June 2023. ACHs are engaging with health and social service partners to focus on care coordination, health information technology, enhancing connections to social determinants of health, and working on ways to address regional health disparities and care gaps. This work is building new connections, increasing capacity, and highlighting the value of ACHs as change agents and neutral conveners to promote better health outcomes statewide.

In support of the Washington State 1115 Medicaid Transformation Project and its strategic goal to "Care for the whole person and use resources more wisely through the Accountable Communities of Health," ALTSA partnered with Southwest Washington Accountable Communities of Health to deliver the Chronic Disease Self-Management Program. Our partnership is on CDSME "infrastructure building." Chronic Disease Self-Management Education programs provide older adults and adults with disabilities with education and tools to help them better manage chronic conditions such as diabetes, heart disease, arthritis, chronic pain, and depression.

Southwest Washington, which covers three counties, serves over 133,000 residents, including two federally recognized tribes, in urban and rural communities. Southwest ACH began incentivizing WSU-Extension's completion of the PAM assessments through outcome base payments (OBPs) and utilizing the regional OBP payment schedule for HealthConnect Hub community care coordination reimbursement. SWACH's HealthConnect Hub will serve as a resource and referral infrastructure for providers and community members to connect to Chronic Pain and Chronic Disease Self-Management Programs. The HealthConnect Hub platform will collect and report data on program participation, PAM assessments, and outcomes.

The contract provides funds for program materials (books, toolkit) for community members to participate in CDSMP / CPSMP programs fully- supporting the transition to virtual delivery of programming in response to COVID.

The contract resulted in the completion, tracking, and evaluation of 150 Patient Activation Measure (PAM) assessments for 50 participants (Pre-assessment, post-assessment, and four months follow-up assessment) to measure program impact and support sustainability through evaluation of return on investment (ROI).

This work continued through 2022 with the plan to deliver workshops virtually or in person to Medicaid beneficiaries with chronic disease using an upstream approach.

Initiative Two: Long Term Services and Supports

Led by ALTSA, Initiative Two, was designed to broaden the array of service options that enable older individuals to stay at home and delay or avoid needing more intensive care, including supporting unpaid caregivers modeled after the State Family Caregiver Support Program (FCSP). This initiative was implemented in September 2017 and contains two main components:

- Creating a benefits package for older individuals who are functionally eligible for Medicaid but are not currently accessing Medicaid-funded LTSS. This benefit package will primarily support unpaid caregivers, avoiding or delaying the need for more intensive Medicaid-funded services. This benefit package, called Medicaid Alternative Care (MAC), requires a dyad (caregiver and care receiver) and is based upon the current model within the FCSP, utilizing an evidence-based assessment (Tailored Caregiver Assessment and Referral [TCARE®]) to help provide tailored services.
- Establishment of a new eligibility category and benefit package for older individuals at risk of future Medicaid LTSS who currently do not meet Medicaid financial eligibility criteria. This benefit package, called Tailored Supports for Older Adults (TSOA), is designed to help individuals avoid or delay impoverishment and the need for Medicaid-funded services by providing tailored services and supports. This program supports both unpaid family caregivers and the care receiver (dyad) as well as individuals without a caregiver.

In 2022, AAA and HCS field offices had enrolled over 14,000 clients since implementing the two new programs in September 2017. Some of the major accomplishments for Initiative 2 during 2022 include:

- Bi-monthly trainings for field staff to introduce enhancements and policy changes within GetCare (the client management system) and other resources to improve care planning and coordination across LTSS systems.

Trainings included Overview of the Quality Assurance (QA) Process and Performance Measures, When, Where and How to Use Client/Care Receiver Letters & Forms for MAC and TSOA programs, Those Rascally Recipient Access Codes (RACs) and Other Errors from CARE and Provider 1, Updates on TCARE® 5.0, What's Lost, What's Gained when transitioning between Long Term Care and the MAC and TSOA programs. We also provided Office Hours on the even months offering an opportunity for the field staff to ask questions or get clarification about the information they received during the previous months' training.

- CMS set nineteen (19) performance measures and the State has met or is approaching 100% proficiency in all 19 areas measured.
- Outreach projects completed in 2022 included working on an interview video focused on talking with tribal elders and their caregivers about how the caregiver programs have benefited them. ALTSA sent out a casting call to ask for volunteers to participate in the interview video and got a few people interested. 2023 will be setting up the interviews and producing the video. Placemats were updated in 2022 based on recommendations by the AAA and are available to order through the DSHS Print Shop. AAA has also received a digital copy they can print locally and distribute to meal sites, hospitals, and other places where meals are served to promote the caregiver programs.
- Despite the many challenges faced by the 2020 pandemic, Washington continued to ensure clients (caregivers and care receivers) received the benefits and services requested. In many instances, it meant being creative and thinking outside the box. This creative included calling clients via phone to check on them, completing no-contact errands to pick up medications and groceries, and delivering them to clients' homes. It also included conducting visits, assessments, and support groups virtually with those who had access to the Internet in hopes of reducing social isolation. During the pandemic, Washington experienced changes to service delivery trends. One such change was an increase in the use of home-delivered meals and a decrease in personal care and respite services. In the fall of 2021, MAC and TSOA field staff resumed home visits with caregivers and care receivers using mandated COVID safety measures and have continued to do so through 2022. Our state has faced a caregiver shortage for some time now, but it appears to have become an increased shortage since COVID. The Case Management for MAC and TSOA have done a great job of thinking outside the box and accessing resources and services to get some support for care receivers and caregivers enrolled in the MAC and TSOA programs since getting Respite and personal care services have been a big challenge. In the last quarter of 2022, MAC and TSOA Subject Matter Experts (SMEs) have been working in collaboration with Consumer Direct Care Network Washington (CDWA) to implement a plan to enroll individual providers (IPs) in the MAC and TSOA programs so care receivers and caregivers can have increased options for service provision for respite and personal care services.

In support of the Washington State 1115 Medicaid Transformation Project and its strategic goal to "Support families in caring for loved ones while increasing the well-being of the caregivers," ALTSA partnered for the fifth year with Sound Generations. Sound Generations supports nearly 65,000 older adults, adults with disabilities, and those that care for them. It is a 501 (c)(3) non-profit organization with six partners. Our partnership has focused on delivering Powerful Tools for Caregivers (PTC). This evidence-based education program offers a unique combination of elements and skills to help a caregiver while caring for someone else. Over six years, Sound Generations trained more than 81 persons to teach PTC. These trainers are committed to teaching two caregiver classes each within nine months.

Initiative Three: Foundational Community Supports

Foundational Community Supports (FCS) is a partnership between the Health Care Authority (HCA) and DSHS, aiming to provide the targeted services of supportive housing and supported employment to individuals receiving Medicaid services through Health Care Authority (HCA) and ALTSA. The Foundational Community Supports are built around the growing body of evidence linking homelessness and unemployment with poor physical and mental health.

FCS provides direct support services to individuals; Medicaid funds will not be used to subsidize housing or jobs. HCA, Behavioral Health & Recovery (BHR), and ALTSA have worked closely together to develop a single, statewide program for FCS that assures individuals from all three systems and supportive housing and supported employment programs will receive uniform services and supports through an extensive network of contracted providers.

The process included contracting and developing a single, statewide Third-Party Administrator (TPA) to administer both programs for all three partner agencies.

ALTSA clients have been applying for eligibility determinations and have been assigned to providers since January 2018. Enrollment continues to be strong. DSHS Research and Data Analysis (RDA), HCA, and ALTSA are working together to evaluate the project as required by the Center for Medicare and Medicaid Services (CMS) for sustainability purposes.ces (CMS) for sustainability purposes.

INTEGRATED MANAGED CARE TRANSITION

HCS needs coordination and collaboration with managed care organizations (Medicare and Medicaid) that manage the physical and behavioral health of individuals we serve in the LTSS system. As the complexity of client situations grows and we continue to transform our mental health system, the need to develop transition and care management teams to ensure individuals have the correct supports in place at the time of transition and community care coordination to help ensure success for stability in the community. Increased visibility of the importance of coordination has been achieved with the work of dedicated staff to assist the coordination of the regions with managed care organizations and to help provide escalation processes in the regions to staff complex cases both internally and with our external partners (e.g.: Medical Community Organizations [MCOs]). This has directly impacted our acute hospital work and diversion work, reducing lengths of stays and ensuring accountability and participation across the care systems.

HCS continues to successfully manage the behavioral health personal care (BHPC) process, ensuring shared funding across systems to support complex behavioral clients in the community and has made improvements to ensure proper authorizations and educate new plans and regional staff. HCS continues to partner with the HCA on developing a 1915(i), which will transition residential BHPC-funded services to a Medicaid benefit in the BH system with an implementation date of July 2023.

This new benefit has an overarching Community Behavioral Health Support Services (CBHS) title. It includes two distinct services: 1) supportive supervision and 2) skill development and restoration. CBHS are individually-tailored services designed to assist individuals in restoring or acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings.

With feedback and coordination with HCA and the MCOs, HCS has developed a statewide training plan, including outreach to our AAA partners. HCS also continues to work on a transition plan for clients receiving BHPC services, CARE system updates/improvements for the CBHS implementation, process and documents review and progress, and increased and ongoing communication between the partners on the 1915(i) development.

Dual Eligible Special Needs Plans (D-SNP) Enhancements and Reporting

HCS has been partnering with the state Medicaid agency, Health Care Authority (HCA), to enhance the management and monitoring of the D-SNP contracts with a goal of more integrated and aligned care. For 2022, contract language was added to the SMAC, incentivizing Medicare Advantage (MA) Health Plans to align their network and expand their coverage areas in preparation for future contract changes toward greater alignment. We will continue to build on this language and requirements for CY2023.

As part of the reporting requirement noted above, the D-SNPs are reporting to HCS on a subset of fully integrated dual-eligible individuals receiving Home and Community Based Services (HCBS). This subset of individuals with an inpatient admission indicates the possibility of additional challenges to transition back to the community from an acute or behavioral hospital or a skilled nursing facility. In 2022, HCS, in coordination with HCA, has provided technical assistance to the MA Health Plans to improve the reports received so HCS, MA Health Plans, and MCOs can better coordinate clients' transitions.

Advancing Medicare and Medicaid Integration (AMMI) Project for Dual Eligible Beneficiaries

In continued efforts to improve care for Dual eligible beneficiaries, in early 2022, DSHS, in partnership with HCA, applied for and was awarded a grant from Arnold Ventures. In June, we launched the AMMI grant project activities made possible through grant funding from Arnold Ventures' Advancing Medicare & Medicaid Integration initiative. The AMMI project opportunity allows us to further our efforts to improve access to and participation in integrated care and services in Washington for clients on Medicare and Medicaid through making strategic improvements to the Highly Integrated Dual Eligible Special Needs Plan (DSNP) program. The state will leverage available data for improved tracking of quality measures and performance; utilize beneficiary feedback and literature to develop and expand education and information to dual beneficiaries; increase access to robust care coordination for DSNP enrollees; and use data to address health equity among dual-eligible clients better. We aim to achieve sustainable and meaningful transformation in care delivery for individuals eligible for Medicare and Medicaid through data analytics, program management, and communications. This project is funding positions at HCS, HCA, and Research and Development Administration (RDA), and a targeted client survey of dual eligible beneficiaries will be released in early 2023.

Program for All-Inclusive Care for the Elderly (PACE) expansion

Program for All-Inclusive Care for the Elderly (PACE) is an innovative Medicare and Medicaid program that provides frail individuals aged 55 and older comprehensive medical and social services. An interdisciplinary team of professionals coordinates these services in a community-based center and participants' homes, helping program participants delay or avoid long-term nursing home care.

Over the past year, the PACE program has continued to see a lot of interest from potential contractors and existing contractors as ALTSA has partnered to make this choice of service delivery accessible to more individuals across the state.

In 2022, new PACE provider Multicare (dba Pacific Northwest PACE Partners) opened a new site in Tacoma, WA, to provide PACE services to eligible clients in Pierce County (a new PACE service area for WA State) and south King County. International Community Health Services (ICHS) enrollment numbers in King County have continued to grow. They are still working to cement actions to open another PACE location in King County by early 2025. Providence Elderplace was approved for several additional zip codes in their existing Spokane service area in 2022, expanding their PACE footprint in an area with strong demographics for PACE-eligible clients. Providence Elderplace also opened a new PACE center in Everett in April 2022, expanding its services to Snohomish County.

The COVID-19 pandemic brought additional innovation and collaboration between PACE and the State to change the service delivery model and ensure care to frail elderly enrollees. PACE contractors have continued to be innovative and mission-driven to meet the needs of enrollees, especially in working toward lessening the impacts of isolation and addressing it with the most at-risk clients.

With the addition of the new PACE provider Pacific Northwest PACE Partners providing PACE services in Pierce County, and an existing PACE provider Providence Elderplace opening a new site in Snohomish County, PACE services availability in WA state was expanded across four counties in 2022.

ACUTE CARE HOSPITAL TRANSITIONS

Washington State has more than 54 acute care hospitals. Most referrals, 75%, are new to HCS and need functional and/or financial eligibility determinations. Timely eligibility determination is a critical first step in Medicaid transitions. Still, the more significant lift is in building plans of care that require cross-systems coordination with MCOs and/or other allied partners, housing/long-term care setting searches, and authorizing multiple wraparound supports needed to create a client-driven plan that provides community stability.

During this year, the average monthly number of referrals from acute hospitals is 782, a 27% increase over the past year, while transitions increased by 22% in the same period. Close to 75% of referrals transition out of acute care hospitals within 30 days of referral. Although the volume of work was high before the pandemic, operating in pandemic conditions for a prolonged period heightened the need for increased focus and attention by ALTSA, resulting in:

- The ability to assess individuals within 4 calendar days, rather than 7 days as stipulated in policy. Thereby reducing turnaround time for initiating client assessments for hospital referrals.
- Shifting staff from other job duties and utilizing staff overtime to address the lack of FTE to transition individuals to services sooner. Additional FTEs are necessary to maintain the work currently being undertaken to meet the ongoing demand.
- Implementing provider incentives for individuals discharging from acute care hospitals coupled with close monitoring of admissions into specialized provider contracts.
- Reducing the overall statewide average length of stay for individuals still hospitalized by 26% from 50 days at the beginning of December 2020.
- Streamlining the referral process for specialized services, escalation procedures, and case staffing to enhance coordination with limited staff and wraparound services.

Approximately 18% of individuals referred from acute hospitals remain hospitalized for more than 60 days post-acute care. This population has been reduced by 54% from October 2020 to date. However, most of these clients manifest multifaceted barriers such as extensive criminal history, complex behavior challenges, medical complexity, bariatric conditions, and lack of a decision-maker. Such conditions make transitions more complicated and time intensive. Most of these individuals would best be served by resources in the behavioral health system and transition to settings focused on providing behavioral health support—lack of such resources in the community results in spending more days in acute settings.

NON-MEDICAID COMMUNITY RESOURCES AND SUPPORTS

TRAUMATIC BRAIN INJURY

In collaboration with the Traumatic Brain Injury (TBI) Council, DSHS supported the following activities this fiscal year:

- TBI Resources **Traumatic Brain Injury Resources Washington State | DSHS (wa.gov)**

Supportive materials providing education, TBI and supportive video series, advocacy, information, and injury prevention were developed and provided to state partnerships, local communities, and all persons looking for TBI resources, including versions in thirteen languages for the DSHS TBI Caregiver Course.

TBI Information And Referral Services

Traumatic Brain Injury: Let's Help You - Washington 211 (wa211.org)
Washington 211 is providing No Wrong Door (NWD) Information and Referral and Navigation Services to all Washingtonians affected by or caring for someone with a Traumatic Brain Injury.

NWD refers to the social service concept of providing a single point of access across multiple programs, simplifying the labyrinth of potential applications, eligibility, and restrictions that often come from seeking social and health services. This approach is simple, empathetic, and customer service centered.

When relating to all Information and Referral, a highly trained Information and Referral Community Resource Specialist (CRS) answers the call and assesses the caller's needs. From there, the CRS provides a list of referrals to available resources in the caller's community utilizing a database of over 30,000 resources.

Virtual Support Groups HeyPeers - Where Peers and Support Groups Connect
Virtual Support Groups (VSG) efforts across all regions of WA State are held on the "Hey Peers" platform, providing access to the state's rural and frontier regions. VSGs emphasize education, interpersonal support, and a place for Caregivers and Veterans to attend in groups. VSGs have seen a steady increase to over 2000 attendees participating.

Traumatic Brain Injury (TBI) Events Portal
The TBI Events Portal provides access to all upcoming and past events in the Building Capacity in Brain Injury Workshop series. Workshop topics are carefully chosen to cover key topics relevant to brain injury. Speakers include regional, national, and international experts.
The Workshop Library provides access to recordings of all previous events and as a portal to other TBI Council projects and resources.

Traumatic Brain Injury (TBI) Skill Builder: Skillbuilder WA
TBI Skill Builder is a 14-module, no-charge, self-paced online training program designed for frontline staff new to working with adults with brain injury across a range of settings (e.g., residential support programs, day programs). Skill Builder can also be used as a refresher course for staff with more experience working with this population.
Completion of this course is approved for 5 clock hours through the Washington State Department of Social and Health Services—an Approved Clock Hour Provider.

Return to School (after concussion) Website
The website includes the In the Classroom (ITC) course for: Educators – Classroom Teachers, Special Educators, Educational staff, School Psychologists, Counselors, Therapist, Health Care professionals, Administrators, and Families. ITC is an online self-paced course that provides information, practical strategies and resources for educators working with students with brain injury.
Washington State Professional Educator Standards Board (PESB), Approved Clock Hour Provider. Completion of this course is approved for 10 clock hours.

SafeKids Washington
Every day, kids get hurt having fun—riding their bike, playing sports, playing on the playground with friends—Safe Kids Washington provides important practical tips for parents to keep kids safe. TBI Prevention, awareness, and outreach are a key part of the TBI Council work towards Healthy Community planning efforts.

Safe Kids Washington is part of the larger partnerships with WA Department of Health (DOH) Injury and Prevention, WA Safe Kids Coalitions, Washington Traffic Safety Commission, and local community efforts in the development of Traffic Safety Gardens.

The Safe Kids Washington website, with statewide partners, is currently developing modules designed to deliver easy, brief materials that teach injury and safety awareness, while also providing additional resources for kids and families in a fun and educational way.
Example - The Adventures with Mylin - Adventures with Mylin | SafeKids WA

WA State Department of Corrections TBI Inside Corrections - YouTube

In partnership with Department of Corrections (DOC), the TBI in DOC project moved forward in providing the tools and supports necessary for staff and incarcerated individuals a more robust understanding about TBI and how it can affect incarcerated individuals' behaviors and actions. The DOC project established a first of its kind primary and secondary TBI screening system for all individuals as they enter the prison system and a screening process after an injury while incarcerated. The steps have also included a package of materials for adding training for staff and incarcerated individuals, Virtual Support Groups, resource materials, and supports for families.

FAMILY CAREGIVER SUPPORT PROGRAM

The Washington State legislature authorized state funds to support family caregivers with respite beginning in 1984. In 2000, the legislature approved a family caregiver long-term care program to help unpaid family caregivers with resources, support, and other services in addition to respite. Family Caregiver Support Program (FCSP) uses OAA and Washington state funding. AAA operates this program. Since 2008, the Washington State legislature required an evidence-based assessment process to evaluate the strengths and burdens of caregivers and authorize services to address their needs. Washington uses the Tailored Care Assessment and Referral (TCARE®) evidence-based assessment to address this requirement.

The FCSP program has continued to expand, and in 2014, an evaluation was published showing the positive impact this program has on delaying the utilization of Medicaid long-term care services. FCSP was the basis for Initiative Two of an 1115 Demonstration Waiver currently in Washington to support unpaid family caregivers in a Medicaid framework. The FCSP program continues to grow alongside the 1115 Demonstration Waiver with similar services and caregiver assessment process. 1115 Initiative Two programs are Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults (TSOA). The AAA Lead Managers Group (LMG) meets quarterly to collaborate with the State Unit on Aging (SUA) on MAC, TSOA, and FCSP policy.

- Most AAA continued to hire new staff throughout 2022 as some AAA staff changed jobs, quit working, or moved out of the area in reaction to the pandemic.
- The pandemic also exacerbated the shortage of home care providers, which was already a concern pre-COVID.
- In September 2020, the TCARE assessment process was integrated into the Information and Assistance storage/reporting portal, Community Living Connections/GetCare for all unpaid family caregivers enrolled in the FCSP and MAC/TSOA. In 2022, the fully integrated system offers a faster, more straightforward process to provide assessment and care plan to Washington's unpaid family caregivers and reliable data surrounding Washington's unpaid family caregivers.
- The FCSP and the MAC/TSOA demonstration programs have grown due to increased statewide attention and marketing efforts. Some AAA have had to consider waiting lists in 2022 due to a lack of funding from the increased numbers of unpaid family caregivers looking for information and services who aren't eligible or chose not to participate in other long-term services and supports.
- FCSP state and federal funding can serve about 1.5% of Washington's 860,000 unpaid family caregivers with information, referral, education, counseling, consultation, respite care, and other family caregiver-related services. As prices for services and personnel increase, AAA have little choice but to reduce the number of caregivers they serve with the funding they have.
- COVID funding has offered some much-needed relief, but AAA are bracing for reducing what they can provide now that pandemic dollars will be removed from the funding total.

KINSHIP CARE ACTIVITIES

2022 Kinship caregivers and services publications

The Kinship Program partnered with Legal Voice to produce an updated Legal Guide for Kinship Caregivers. This guide addresses the legal options available for caregivers' seeking custody of the children in their care. The guide is available on the Kinship Website

Voices of Children

The State Unit on Aging (SUA)/ALTSA co-sponsored the 19th annual Voices of Children - Raised by Grandparents and Other Relatives Contest. The contest solicits poems, essays, and drawings submitted by children (ages 5-19) living in WA State. They added a new category for Voices of Kinship Caregivers to the Voices of Children contest in 2021. All entries were included in a contest booklet and distributed widely to Tribes, Kinship Caregivers, community agencies, and advocates. Children and Caregiver winners were given prizes for their solicitations in a virtual celebration on July 14th, 2022. The celebration prizes included a $100 check and a Washington State Park Pass for the child and family of the prize winners. Governor Inslee also proclaimed Kinship Caregiver Day on May 18th, 2022. will be removed from the funding total.

Kinship Navigator Program and Kinship Caregiver Support Program (KCSP) Accomplishments

The state legislature continued funding the KCSP (urgent need fund) and the Kinship Navigator Program, operated by the AAA and their community partners.

The Kinship Navigators continued to cultivate local resources. They continued hosting kinship support groups and other activities by offering virtual and in-person formats.

In 2022, several programs donated free recreational passes for kinship care families. ALTSA applied and was awarded 1,000 free passes to the Seattle Woodland Park Zoo through their Community Access Program. The tickets were distributed to nine AAA and seven Tribes. Free Kinship Care Annual Passes continue for all kinship care families and the Seattle Aquarium and Pacific Science Center.

Kinship Navigators and the AAA providing KCSP funds became agile during the pandemic. ALTSA staff, in collaboration with the AAA, were able to adjust service delivery to continue to support kinship caregivers statewide who, without support, were at risk of being unable to maintain the caregiver role.

COVID-19 Kinship Navigator Program and Kinship Caregiver Support Program (KCSP) Policies

In 2022, the collaboration between the ALTSA staff and the AAAs continued to follow the temporary Kinship Navigator Program and KCSP COVID-19 Policies. Some of the temporary policies include:

- Increase the frequency that a kinship caregiver may request and/or receive services in a year from one to up to two times a year.
- Computer/tablets may be purchased for kinship caregivers when necessary for tele-medicine, mental/behavioral health appointments and online support groups for children or caregivers when all other resources have been exhausted. ($800 cap)
- Allowed for telephonic or video conferencing for intake and services.

Tribal Kinship Navigators Accomplishments

The WA State Legislature continued funding for Tribal Kinship Navigator Program delivered by seven Tribes around the state.

Local Tribal staff can support kinship care families through tangible supports and services and guide the caregivers in applying for various benefits.

During the pandemic, the tribes used innovative ways to continue to provide kinship navigators services to tribal kinship families remotely.

A new ACL Lifespan Respite Grant allowed for a pilot project to occur. One tribe participated in the pilot. Several of their tribal members went through training to provide respite for their tribal families needing a break. Some of the families that received respite were kinship caregivers. While Lifespan Respite is a different grant, this allows the tribes to develop culturally responsive respite activities to support grandparents and relatives raising children and others needing respite.

Collaboration efforts with local, state, and national partners included

ALTSA staff continue participating in the state legislature-created Kinship Care Oversite Committee (KCOC). This committee is led by the Department of Children, Youth, and Families (DCYF) and collaborates with DSHS/ALTSA and other state and community partners and kinship caregivers on matters of importance to kinship caregivers.

Now going into its fifth year, ALTSA staff continue to collaborate with staff from DCYF and researchers from the University of Washington on the federal Administration of Children and Families grant to evaluate Washington States' Kinship Navigator Program for the Family First Prevention Services Act (FFPSA).

ALTSA and DCYF staff continue collaborating with 211 statewide to connect kinship caregivers with necessary community resources, Kinship Caregiver Support Program (KCSP), and kinship navigators.

ALTSA staff continues to collaborate with tribal staff at tribes who administer a Tribal Kinship Navigator Program.

Kinship Navigator Research Project Accomplishments

ALTSA staff continued to collaborate with staff from DCYF and researchers from the University of Washington (UW) on the federal Administration of Children and Families grant to evaluate Washington States' Kinship Navigator Program for the Family First Prevention Services Act (FFPSA).

Washington State received an additional grant to continue funding through the end of October 2023 for the FFPSA Kinship Navigator research project. The goal of the research is for the Washington State Kinship Navigator Program to reach evidence-based status making the program eligible to receive federal matching funds for eligible participants.

Now entering the 5th year of the FFPSA research project, the researchers plan to submit to the clearing house for review in early 2023.

One of the local tribes tested the Needs Assessment used as part of the FFPSA research project in their community and created adaptions for a more culturally relevant tool.

The UW research team wrote several reports detailing early findings from collected data.

In 2022 the UW research team, DCYF staff, and ALTSA staff presented information about the FFPSA Kinship Navigator research project during a National Generations United Conference, a Kempe International Conference, and a Child Welfare Information Gateway podcast.

LIFESPAN RESPITE WASHINGTON (LRW) ACTIVITIES

Lifespan Respite grants are funded by ACL. The Lifespan Respite grants aim is to strengthen respite systems to become more sustainable while expanding to specialized populations. This year the following was accomplished:

- During 2022, the Integration grant was spent. The enhancement grant continues to be used for service provision.
- Partnered with one American Indian tribal community to increase respite services to diverse groups of people not using traditional respite services.
- Partnered with ALTSA Training Unit to develop a tribal, culturally relevant training that tribes can use to train respite providers within their communities to provide respite services for tribal members.
- Continued partnership with grant vendor, Partnerships for Action Voices for Empowerment (PAVE), to further study Lifespan Respite voucher usage with PAVE's technological abilities.
- Maintained Respite Coalition collaboration as a response to the COVID 19 pandemic to continue to support respite providers. The Respite Coalition meetings create a space for the community of respite provider agencies to connect with resources and provide networking opportunities.
- Presented virtually at ARCH National Respite Conference regarding PAVE's work with data analysis, public awareness, and marketing of the Lifespan Respite Washington Respite Voucher Program website.

HOUSING RESOURCES

The Housing Team is a Statewide team of Housing Program Managers working to administer housing resources and Supportive Housing services to HCS-eligible clients. The Housing Team is the liaison between the field, various contractors, and available long-term services and supports, working to support independent housing options for HCS clients by focusing on subsidies and tenancy support—more information on programs on the Housing Resources website.

ALTSA Subsidy provides rental assistance for eligible ALTSA clients through a monthly rent subsidy. The client is responsible for a portion of the rent, paid directly to the landlord, calculated at approximately 30 percent of their income. ALTSA subsidies assist clients quickly in transitioning into affordable housing while they remain on waitlists for permanent, affordable housing.

- The ALTSA Bridge subsidy program was launched in 2012 as a part of the Roads to Community Living Demonstration program. Bridge rental subsidies are intended to support individuals moving from institutional to community settings.
- The ALTSA Governor's Opportunity for Supportive Housing (GOSH) subsidy was launched in 2017 and is available as part of the more extensive GOSH program for individuals discharging or diverting from Western State Hospital or Eastern State Hospital. The GOSH subsidy is paired with Supportive Housing services that assist a participant in finding and maintaining independent housing.

Supportive Housing Services provides dedicated housing support to people with complex care needs wishing to live independently. The service offers wraparound support, facilitating cross-sector coordination of all services the person needs, including LTSS, mental health, substance use disorder, physical disabilities, and legal or financial issues. Supportive Housing services may be an option for individuals who want to live independently and have a history of unsuccessful housing episodes without coordinated, focused support services. ALTSA seeks to provide person-centered, responsive, low-barrier services for these individuals. Supportive Housing services are available in two ways for ALTSA recipients:

- Individuals residing in the community may be eligible for Supportive Housing services under Healthier Washington Medicaid Transformation: Foundational Community Supports (FCS): Supportive Housing services. For more information about FCS-SH, see Long-Term Care Manual Chapter 30d.
- Individuals with challenging or complex needs currently residing at Eastern or Western State Hospital or can be diverted from these institutions may access Supportive Housing services through the GOSH. For more information about GOSH, see Long-Term Care Manual Chapter 5b.

Federal Partnerships

In 2011, the ALTSA Housing Team began collaborating with local Public Housing Authorities (PHAs) to increase accessibility to Housing and Urban Development (HUD) vouchers for ALTSA clients. Various voucher types are available in multiple locations and are listed in the Long-Term Care Manual Chapter 5b. Housing Program Managers are responsible for screening and directly referring eligible applicants.

811 Project Rental Assistance (PRA) provides site-based subsidies for newly built or converted housing units statewide, increasing the number of permanent, affordable housing units for non-elderly clients with disabilities. HUD administers this grant through the Washington State Department of Commerce, which partners with the ALTSA Housing Team to make referrals to the units and coordinate services for residents. Locations of properties can also be found in the Long-Term Care Manual Chapter 5b.

Emergency Rental Assistance (ERA) is a one-time payment made directly to landlords on behalf of an ALTSA client facing an immediate eviction due to non-payment of rent. ERA can also help pay for a short-term motel/hotel stay for an individual with a move-in date for permanent housing but nowhere to stay in the interim.

Housing Capacity: Beginning in 2019, the Housing Team dedicated a full-time position to increasing housing capacity to support the need for immediate/tangible housing to pair with our state subsidies. This position leans on existing partnerships and works to develop new opportunities. The partnerships braid services and subsidy funding through HCS with tangible housing via 'set asides' from housing developers, non-profits, and property management companies. Our housing capacity projects honor the community integration efforts of our work by ensuring a diverse portfolio of set-asides across the state.

ENHANCING MEDICAID LTSS THROUGH FEEDBACK AND TRAINING

SERVICE EXPERIENCE TEAM

The statewide Service Experience Team (SET) was developed in 2017 to create an opportunity for beneficiaries of Medicaid LTSS to work in partnership with HCS to promote choice, quality of life, health, independence, safety, and active engagement in programs developed and operated by HCS. Membership consists of individuals receiving a variety of services through the division and representatives from advocacy groups.

Since its inauguration in September 2017, SET has held twenty-two (22) meetings providing feedback on multiple HCS programs. Most recently the SET team advocated for the development of and has worked to build up the consumer facing webpage for ALTSA, with the goal of having a place where clients can go for relevant information that is user friendly and has meaningful information. This page is populated by the topics SET members request and are driven by the SET agenda.

Over the last year, The SET team has provided feedback on Consumer Direct of Washington implementation, client training, assistive technology, 1915i CBHC brochure, workforce development, and the Advancing Medicare and Medicaid Integration (AMMI) client survey and letter. In 2022, HCS staff and participants have continued meetings in a virtual platform using Microsoft Teams and have seen a continued comfort level in this meeting platform. HCS staff have learned more about how to engage the SET membership which has resulted in increased opportunities for engagement and feedback. As part of the engagement measures the HCS team included the SET membership early in the planning stages of new policy, offered more frequent meetings and provided support to membership with the goal of increasing participation in meetings.

In 2021, ALTSA received funding through Money Follows the Person (MFP) to have a dedicated position to focus on enhancing the SET team and processes. With a dedicated position, ALTSA continues to make significant strides in enhancing the work of the SET and recognition of its value.

In 2022 we developed a process to report out to leadership teams (regional, headquarters and Area Agency on Aging) so that a broader group is hearing their feedback and aware of their work, we have presented at regional meetings, continue to work to increase membership, created policy to compensate the members based on lived experience and expertise in their own care, created bylaws for the group, a conflict of interest policy and are in the process of creating voted positions for the members. Having positions within the SET will increase ownership and creates new avenues for the membership to engage with the State and gather feedback. We will continue engage SET to set the agenda for 2023, this group continues to express strong interest in the Legislative process, and we have made rule making, budget and bills a regular part of our agenda.

NATIONAL CORE INDICATORS – AGING AND DISABILITIES (NCI-AD)

ALTSA partnered with the Social Development Research Group of the University of Washington to participate in the 2021-22 National Core Indicators – Aging and Disabilities (NCI-AD) Adult Consumer Survey, developed and coordinated by ADvancing States and Human Services Research Institute (HSRI). The University of Washington (UW) conducted 1,200 NCI-AD survey interviews with recipients enrolled in on four Home and Community based programs as well as nursing home clients. Surveying was completed in April 2022, and results are still forthcoming from ADvancing States. The 2022-2023 survey began in August 2022 with UW again tasked with surveying 1,200 clients. Surveying is scheduled to be completed in March 2023.

WELLNESS EDUCATION FOR SERVICE RECIPIENTS

Wellness Education assists participants to obtain, process, and understand information needed to improve their health and well-being. Approximately 47,000 individuals receive a Wellness Education newsletter with customized articles that address health literacy and promote health behavior change. Short articles written in simple language provide participants with usable tools and actionable steps for informed decision-making and prepare participants for conversations with medical professionals. Topics may include strategies for improving nutrition and diet, adaptive exercise, fall prevention, strength, and balance activities, locating and seeking medical care, medication management, or planning emergencies.

In addition to the personally targeted articles, the newsletter has been used to educate recipients about COVID, the importance of vaccinations and boosters, infection control, managing stress and isolation, and implementing strategies to reduce spread and exposure.

WORKFORCE DEVELOPMENT STRATEGIES

Washington State is facing direct-care workforce shortages to serve the Medicaid Long-Term Services and Supports caseload of approximately 70,000 individuals receiving personal care in their own homes, Adult Family Homes and Assisted Living Facilities. ALTSA has undertaken the following goals and strategies to develop and retain the personal care workforce.

Goal 1-Create partnerships and awareness with workforce professionals/stakeholders, tribes, state departments, and agencies regarding the long-term caregiver shortage

Workforce Development and Retention Group (WDRG): WDRG is a diverse body of stakeholders and community partners who meet quarterly to combine efforts in reaching the following goals:

- Raise awareness statewide of the growing number of aging community members needing long-term care and support.
- Understand the long-term care workforce gap in relation to the growing need for caregivers.
- Build and amplify long-term care career ladder/lattice opportunities.
- Increase the number of long-term care professionals across the state.
- The ALTSA workforce development (WD) program staff coordinate and facilitate the meetings and have focused on several topics including:
- Providing information to attendees about WA Cares Fund
- Educating attendees about the LTC Licensed Practical Nurse (LPN) Apprenticeship pilot project managed by DOH
- Obtaining recommendations, via a WDRG subgroup, for the content of a retention toolkit being developed by workforce development program staff
- Upcoming meetings will include:
  - Introductions of new ALTSA WD staff including updates of current development and retention projects/efforts and distribution of information about home care aide training deadlines due to the ending of COVID flexibilities.
  - Polling of the group to identify and discuss strategies used by agency participants to address staffing shortages
  - Reviewing and updating the workgroup charter
  - Identifying additional members to expand the diversity of the group

WD program staff will continue to meet with Tribes to offer support around home care aide training to meet the needs of their tribal elders and provide access to a career path for their jobseekers. We will present at the upcoming Tribal Summit and Indian Policy Advisory Committee (IPAC) meeting. We will continue efforts to develop High School Home Care Aide Training Programs within Tribal communities.

WD management staff have participated in the **WA Resilience Group** (formerly the Washington Recovery Group), a(formerly the Washington Recovery Group), assembled by Gov. Inslee, to create new ideas to stimulate economic recovery in different job sectors hit hard by COVID. The Washington workforce development system leaders also attend, and these meetings help bring awareness to long-term care workforce shortages. New WD management has contacted this group to be added to upcoming meetings.

WD staff contributes to DOH's LTC LPN Apprenticeship pilot by being part of the sub-work groups that will operationalize the pilot. Our new WD Program Specialist, focusing on retention efforts, will be instrumental in building on this work.

Goal 2- Solidify partnerships that create resource support (or funding streams) for long-term care giver job opportunities

A sub-group of the WDRG convened and put together focus groups consisting of direct care workers and supervisors. The sub-group asked the focus groups about their lived experiences with work settings and what support they needed to build retention efforts in their workplace, respectively. An online questionnaire was created that reflected the same questions that were asked of the focus groups to expand the data collection, as the focus groups were small.

From this data, the sub-group identified five elements of importance, providing focal points for developing a toolkit to support agency and facility supervisory staff with their workforce retention efforts. The five elements of the toolkit are listed below—each element of the toolkit will focus on a key aspect that can positively impact the retention of Home Care Aides and other Direct Care Workers in Washington State.

- Recognition
- Well-Being
- Communication
- Onboarding Support
- Navigation Binder

This subgroup has also reviewed draft training materials and provided input for improvements and modifications. Along with the rollout of the toolkit and training recommendations, and to supplement and support toolkit materials, select leadership training courses will be made available for continuing education credits to providers in supervisory roles.

Goal 3 - To implement the High School Home Care Aide course in one to three high schools

Everett High School is our first school to implement the High School Home Care Aide program, which they offered in their second semester of 2022. Approximately 20 students participated in the program, with many choosing to move forward with testing for certification after completing the class. The WD team, in collaboration with the staff from Everett High School, is using this experience to develop best practices and identify improvements to the process to help other school districts implement the program.

Since the beginning of the 2022 school year, our WD high school liaison has concentrated outreach efforts to areas of the state identified as priorities in their need for caregivers. From this outreach, several high schools in the Southwest Washington area have expressed interest in the program and have participated in informational meetings. Many are now meeting with their internal staff and partners to determine the next steps.

Other schools within Washington State interested in the program are in various stages of implementation, from gathering information, determining student interest, and exploring partnerships with nearby schools, to finding teachers and completing the application and contracting process. New regional areas will soon be identified and targeted for outreach.

Supporting a Diverse Workforce of Certified Home Care Aides who work for Medicaid Clients in their own home and in other community-based settings

To support the development of a diverse workforce, the WD team created a website (wacarecareers.org) focused on the following topics: how to become a long-term caregiver; long-term care jobs; training; and wage potential. This website's target audience is individuals interested in careers in healthcare, specifically in becoming long-term caregivers. This website is continually being updated and improved. In the future, translation abilities will enable job seekers to access information in several languages. The website contains an interactive map with contact information for Home Care Agency offices to support job seekers in finding employment. It has a 30-second video that includes information on becoming a long-term caregiver. The video is also on social media and streaming apps. And it directs the viewer back to the website for more details.

The workforce development recruiting for long-term care positions within high schools and skills centers potentially adds a needed younger demographic to the workforce. The workforce development program staff also includes an outreach specialist to strengthen our outreach efforts by engaging higher ed, summer programs, and other Community-Based Organizations (CBOs) in conversations to create further awareness of long-term care worker shortages and home care aide training. WFD staff involved in community outreach is working with staff on the military bases to include military retirees and spouses in conversations about the flexible employment opportunities that can be offered by becoming a home care aide. In addition, WFD staff are in the process of collaborating with Refugee & Immigration Services Northwest to provide outreach materials and educational presentations to Ukrainian and Afghan refugees seeking employment in Snohomish, Skagit, and Whatcom counties.
We also contact the employment specialists at International Rescue Committee and World Relief Spokane for Eastern Washington.

The WFD team has also hired a Workforce Development Analyst to consult and collaborate with about the design of reporting tools, pre-post surveys, tracking documents, and other documents used to measure workforce activity outcomes. Most recently, the analyst has been working on a mapping project to assist the team with identifying the locations of training and testing sites and their proximity to the high schools and facilities like ALFs, AFHs, etc. These will be invaluable tools for planning future outreach activities and providing information.

HOME CARE REFERRAL REGISTRY

The Home Care Referral Registry transitioned all recruiting, hiring, and training of independent homecare providers to the Consumer Direct Care Network Washington contract as of April 2022. Consumer Direct Care Network Washington partnered with Carina.org, a website that allows Medicaid clients to search for long-term home healthcare providers using various criteria that meet their needs.

WORKFORCE TRAINING

SUPPORTING THE CONTINUATION OF TRAINING DURING COVID-19 RESTRICTIONS

The State of Washington has some of the most comprehensive training requirements for long-term care workers/home care aides. Before the public health emergency (PHE), the 75-hour home care aide certification training was primarily instructor-led and in an in-person classroom setting. Last year, the Training Oversight and Policy Team (TOP) in the TCD Unit created several processes to support instructors so that training could continue in compliance with the State'sState's COVID-19 guidelines. This support continues, although the Governor rescinded training proclamations effective October 27, 2022.

- Emergency rules – emergency rules were written to establish cohorts and training deadlines for caregiver training. The dates were created to encourage employers and caregivers to return to training, although the PHE was in place. It also provided a "runway" to ensure learners would have ample time to complete their required training, testing, and continuing education (CE) courses. Twelve CEs were granted to caregivers for "on-the-job" learning they experienced in rapid response to PHE protocols, infection control, and COVID-19 protocols, which frequently changed as more became known about the disease and health organizations changed their requirements and recommendations.
- Partnerships – worked with the Department of Health (DOH) to ensure DSHS emergency rules coordinated/worked with DOH rules, e.g., testing and certification deadlines, and nurse delegation training to ensure caregivers could continue to provide care. TOP worked with Residential Community Services (RCS) and DOH to co-host and present updates at regularly scheduled informational meetings.

- Communications – Communication was provided to training instructors and stakeholders related to requirements according to Governor Inslee'sInslee's proclamations for re-opening or continuing business: guidelines classroom infection control and tracking protocols, PPE, social distancing, vaccinations, etc. Caregiver training is considered essential and may fall under requirements set for businesses, private career schools, and/or higher education institutions.

- Virtual classroom learning – The training unit has continued to extend the option to allow virtual/webinars for required training. This accommodation is based on client and family requests to continue virtual training and to support opportunities and accessibility of training to learners. A virtual delivery method allows caregivers to complete core training as well as dementia, mental health, and nurse delegation tasks, all required courses for tailoring services to client needs and to providing person-centered care.

Before COVID-19, the majority of long-term care worker training was delivered in a traditional classroom setting, led by an instructor, per current rules or policy. In 2020, DSHS created a process for already-approved Community Instructors to apply for delivering long-term care worker training (non-skills) using a webinar-type platform. Colleges can also now offer virtual training for the Adult Family Home Administrator course, which is required to own/operate an adult family home.

On the Job Training (OJT) – Currently, 140 facilities are participating in the OJT program. While OJT has long been an option for facilities, the PHE provided an opportunity to update forms and re-introduce the program to facilities. DSHS collaborated with the Washington Healthcare Association, Adult Family Home Council, and Leading Age to create the process, which includes an application, training plan, and skills procedures checklist. This process allows facilities to count OJT towards the required caregiver training, provides oversight as caregivers learn new, person-centered skills, and supports the skills training needed for home care aide testing and certification.

Remote skills training pilot – In late 2020, a remote skills training pilot was implemented. Since the pilot began, 458 students graduated and became certified, many of whom would not have been able to do so because of the PHE restrictions. The skills exam test scores for students participating in the remote skills training pilot are comparable to those who completed in-person skills training.

Emergency rules were created to define and allow for remote skills training. This supports our goals to help the caregiver workforce and our Equity, Diversity, Accessibility, and Inclusion (EDAI) goals. Virtual training and remote skills training provides training access for those who find travel to be a barrier. The remote skills lab requirements are rigorous to ensure off-site training does not decrease the quality of the skills training or the learning experience or negatively affect the learner'slearner's ability to pass the required skills examination. Components of the remote skills training requirements include:

- Virtual classroom or videos of each skill
- Access to all supplies and materials required for practice.
- Clear guidelines and evaluation feedback loops for skills learners performance.
- Instructional support via phone, chat, text, and email.
- Technical support to assist students in recording videos.
- Study guides.
- Access to instructors one-on-one
- Reporting exam pass rates to DSHS

DSHS must approve remote skills training program.

ADVANCED HOME CARE AIDE SPECIALIST TRAINING

HCS and DDA continue to work with Service Employees International Union 775 (SEIU) and the Training Partnership (TP) to create a revised and expanded permanent release of the Advanced Home Care Aid Specialist (AHCAS) training. This 70-hour person-centered advanced skills training will now include a core (5 weeks) and one of two possible specialized learning tracks (3 weeks).
The holistic health learning track will be designed for independent providers caring for clients with multiple chronic conditions and high service levels. The all-new behavioral health track will better serve independent providers caring for clients with complex behavioral needs. The online portion of the hybrid curriculum will be released on a brand-new learning management system that will provide better tracking, more proactive communication models, and a more pleasant user experience.

To date, 2,114 providers have successfully graduated from the AHCAS program and received a pay differential for advanced training.

Before putting this new development on hold due to Covid-19 priorities (beginning March of 2020), DSHS reviewed, helped revise, and approved the Training Partnership's:

- Curriculum Outline
- Skillsets and Practice Standards (pre-work for curriculum development
- Program Design
- Instructional Design Plan

In September 2022, DDA began an additional independent review. Regular development and review cycles will restart in January 2023, beginning with a review of the revised Assessment Plan and including Storyboards for video content.

The Development phase (Phase 3) is currently slated for completion in 2023.
The Pilot phase (Phase 4) is expected by Winter of 2024. Full-Scale Implementation TBD.

SPECIALTY CURRICULUM FOR CAPABLE CAREGIVING

A new Diabetes, Level 1, Capable Caregiving for Diabetes expanded specialty curriculum was completed and made available to instructors. This new curriculum was developed to implement SSB 5630, which enacts recommendations for Adult Family Homes and Assisted Living facilities. Diabetes adds significantly to the complexity of caregiving in long-term care settings, with ramifications related to insulin management, nutrition, exercise, and skin care, among other concerns. Having specialty training for diabetes may not simply be about disease management. Still, it may also be about disease prevention in high-risk populations. Ten subject matter experts collaborated to identify learning objectives and provide a thorough review of content. Internal reviews and pilot testing drove the finalization of the course which was rolled out to 82 instructors in July 2021.

The start of a new substance use disorder (SUD), Level 1, Capable Caregiving course began through the same recommendations. Stakeholders recommended that Substance abuse [substance use disorder] is often comorbid with other conditions and presents challenges for caregivers who must balance patient rights and the safety of the client and the other residents. "Possible specialty is a dual diagnosis of mental health and substance abuse. We often have clients that are also substance abusers—whether that is medications or illicit drugs. They may [also] be abusing their regular medications."
Collaboration with nine subject matter experts and seven internal reviewers began in February 2022. Final draft of the textbooks is at the design stage with visual communications as of October 2022 with anticipation for pilot and roll out in 2023.

BUILDING A NETWORK OF QUALIFIED COMMUNITY TRAINERS IN LONG-TERM CARE SERVICES AND SUPPORTS

Community Instructors are individuals, businesses, private vocational schools, and community colleges that contract with the DSHS to train long-term care workers. The department currently has 314 contracted Community Instructors who support our mission of transforming lives by training and supporting our caregivers all over Washington. In our effort to build a large-scale network of Community Instructors, the Home and Community Services Training, Communications, and Development unit has continued to approve newly qualified trainers steadily. While we did lose some instructors at the onset of the PHE, we have seen an increase of 29 instructors from last year.

In 2022, the training unit completed 786 applications to approve instructors and training curriculum: 301 community instructor applications; 485 facility applications for facility-based instructors working in adult family homes and assisted living facilities. During the Public Health Emergency, instructors continued to provide training by applying to resume in-person training using Safe Start guidelines and applying to provide virtual, synchronous training for non-skills-related learning.

ADULT PROTECTIVE SERVICES & ELDER RIGHTS ACTIVITIES

ADVANCING STATES EVALUATION OF SELF-NEGLECT

Adult Protective Services (APS) contracted with ADvancing States to evaluate self-neglect related to investigations and service delivery. The evaluation assessed national data trends for self-neglect and program variations in other states. The evaluation included surveys and interviews of staff and stakeholders to understand better the complexity of self-neglect investigations, and a national workgroup meeting was held during the Home and Community-Based Services conference in August 2022. The report provided recommendations and best practices for addressing self-neglect.

CONTRACTED SERVICES

APS contracted with a third party to assist with closing investigations open beyond 90 days based on staffing shortages. This project aims to reduce the caseload sizes throughout the state, reduce the number of open investigations, reduce cases open beyond 90 days, and eliminate caseloads assigned to positions that are not typically case-carrying. This allows for timely responses to new reports and will enable investigators to prioritize field work, protective services, and complex investigations requiring legal or multidisciplinary support.

QUALITY ASSURANCE REVIEWS FOR QUALITY INDICATORS

As part of ongoing efforts to review quality indicators, APS hired two Quality Assurance Program Managers to conduct quality indicator reviews for investigations completed in 2019, 2020, and 2021. Quality indicator reviews go beyond compliance and look to the overall quality of performance and outcomes. The reviews allow the program to assess training opportunities, overall performance, and trends throughout Washington State to support staff and investigations better.

MULTI-STATE CONFERENCE

In May 2022, Washington State Adult Protective Services (APS) hosted the APS multi-state conference in Vancouver, WA. APS staff from Washington, Oregon, Idaho, Montana, Alaska, and Washington Indian Tribes were invited to attend. Guest speakers presented on ethics, self-neglect, enhanced cognitive interviewing, Veterans Affairs, and bias busting.

TRAINING AND CURRICULUM DEVELOPMENT

APS implemented several new training initiatives for staff throughout 2022. The Intake Training for Investigators is now required for all investigative staff to support consistency with completing and screening intake reports. We offered in-person safety training to increase safety measures and awareness for staff conducting fieldwork. We trained all staff on statute changes under chapter 74.34 RCW related to the definition of abuse. APS initiated the Revisions to the Supervisor Academy to support supervisors managing remote employees, increase coaching and mentorship, and improve training support for new and existing staff. In collaboration with the University of Washington, the headquarters training unit developed forensic interviewing training and two training videos to demonstrate an effective forensic interview in the field.

WORKFORCE DEVELOPMENT

As part of ongoing efforts to address retention and recruitment, APS worked closely with Human Resources Department (HRD) Class and Compensation to identify opportunities to increase applicants for vacant positions and increase staff retention. HRD and APS are piloting qualification changes for Social Service Specialist positions to allow hiring practices to consider the experience in place of formal education when the experience relates to APS work. APS also streamlined multiple postings to make it easier for applicants to connect with positions in their area without applying numerous times.

UNIVERSITY OF WASHINGTON PROGRAM EVALUATION

APS began work with the UW Center for Health Innovation and Policy Science to complete an overall evaluation of the APS program. The evaluation includes multi-state interviews, staff, and stakeholder surveys, interviews of APS staff, and an assessment of APS policies and practices. The evaluation will assist APS in identifying efficient and effective policies, practices, and workflows to serve vulnerable adults in Washington State better.

This resource was last updated May 2023