

ROADS TO COMMUNITY LIVING



Washington State's Money Follows the Person Demonstration Project

OPERATIONAL PROTOCOL

Version 1.8

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Project Introduction

Project Introduction

Washington State has a well-developed long-term care system, with more than three quarters of its services and supports provided in community settings. Even with our mature network of community services, we face significant barriers to successfully transitioning individuals with highly complex needs or long histories of institutionalization. Our experience, data from other states and consumers tell us that long periods of institutionalization, whether in a nursing home, Residential Habilitation Center, or psychiatric hospital, make successful transitioning into the community much more difficult.

This demonstration project is particularly timely for Washington State. In nursing homes, intensive and successful efforts are made to transition individuals within the first month to two months of their stay. However, if for any reason the stay is prolonged, barriers to moving back into the community become considerably greater. Our early data shows that approximately 46 percent of those living in nursing homes in Washington State have been there six months or longer. The demonstration will provide the Aging and Disability Services Administration an opportunity to offer additional services and supports to those currently available in hopes that they may be key to helping those longer term residents who choose to move. Within the Division of Developmental Disabilities, increasing numbers of children and adolescents are being placed in Residential Habilitation Centers after many years of seeing these institutional placements decrease dramatically. This will be the focus of the demonstration project for the Division of Developmental Disabilities. Individuals with serious and persistent mental illness also face significant barriers in terms of having the support necessary to move to the community after long institutional stays. The Mental Health Division will focus on children, adolescents, and seniors residing in the State's two psychiatric hospitals.

Washington State's demonstration, entitled Roads to Community Living (RCL), builds upon our experience designing successful community-based service systems. RCL will use state and federal funds to transition as many individuals as possible who are eligible to receive services under the demonstration. Our vision for this demonstration project is twofold. First, we wish to support the demonstration participants who choose to move from institutional settings to the community, and do this in a way that is person-centered and responsive to their individual needs. Second, we wish to identify services and supports that may be modified or added to existing programs to help individuals in the future bypass some of the existing barriers to transition.

The RCL demonstration project is managed by the Department of Social and Health Services (DSHS), Aging and Long-Term Support Administration (AL TSA). We are including older adults, individuals with developmental disabilities, individuals with

physical disabilities, and individuals with mental illness. RCL is designed to assist people who have been in a Nursing Facility, Hospital or Division of Developmental Disabilities (DDA) Residential Habilitation Center for 90 days or longer who want to move to their own homes, apartments or to small (4 beds or less) Adult Family Homes or other residential settings. Participants must receive Medicaid benefits for inpatient services for one day to become eligible to participate in the RCL demonstration.

RCL was approved and funded under the federal “Money Follows the Person” initiative of the 2005 Deficit Reduction Act and renewed in the Affordable Care Act. This initiative has four main objectives for all demonstration projects.

1. Increase the use of home and community-based, rather than institutional, long-term care services:

To plan and design RCL at the outset, the department assembled a vocal advisory group with consumers from all disability groups represented in the demonstration, provider representatives, family members and state staff. With the help of this group, RCL has been designed to be both practical and innovative. One of the outcomes AL TSA is looking for is organized and vocal advocacy from all parts of the system. The RCL demonstration has provided avenues for advocacy and for new advocates to have substantive involvement in long-term care planning. AL TSA considers this positive and essential to our continual rebalancing efforts. As part of the evolution of the project, stakeholder input is now gathered through various existing venues in which the RCL team has the opportunity to both give and receive meaningful information at a more detailed level targeting both local and statewide RCL initiatives. The information gathered through these venues is then reported back to and informs the work of the higher level RCL full staff team meetings and Coordination Committee. This process facilitates an ongoing give and take of information, ideas, and dialogue that utilizes the time and expertise of our stakeholders in a way that the single group could not.

RCL will accomplish this objective for individuals by helping residents of institutions relocate to community settings. Each individual will have a person-centered plan. While the person is still in the institution, a stable and sustainable discharge plan that addresses the person’s goals and needs will be established. The emphasis on person-centered planning in RCL will support more widespread use of self-direction and consumer empowerment – both essential elements for continued rebalancing of the long-term care system. On a system level, RCL is testing a more flexible service package than is currently offered under long-term care programs. This will assist with planning for future HCBS waiver and state plan changes that are responsive to people’s needs and sustainable in the Medicaid system.

2. Eliminate barriers or mechanisms, whether in the State law, the State Medicaid plan, the State budget, or otherwise, that prevent or restrict the flexible use of

Medicaid funds to enable Medicaid-eligible individuals to receive support for appropriate and necessary long-term services in the settings of their choice:

Washington's long-term care services are funded largely through legislative appropriations matched by federal Medicaid monies through the state plan or waivers. There are additional funds through the Older Americans Act and state general revenues.

Medicaid payment is tied to rigid service definitions required in traditional HCBS waivers. This interferes with true individual planning for unique one-time needs. Washington State offers a rich array of services in its waivers and state plan. Consumer and provider feedback for this project has very clearly pointed out that the silos in which these services are offered and their delivery mechanisms are themselves barriers to care. It was striking that in many of the venues in which outreach occurred for this project, consumers and state and local providers often expressed their wish for services that are in fact already offered by the state. This highlights the need for a more streamlined, cohesive offering of services and supports which are more easily accessible to both consumers and those coordinating or providing their care. It is our hope that this demonstration will help move the Washington State system in this direction.

The State has a self-directed waiver in two counties which allows the purchase of individualized services and promotes self-direction of budget. This, in conjunction with the RCL demonstration, will give us important data to continue statewide system planning.

The appropriation for institutional and community-based care in Washington is based upon the number of individuals served in each setting (caseload forecasting) and the per cap (per person) expenditure for each of those settings. When individuals are moved from an institutional to community setting, the appropriation levels at the institution are not automatically moved to the community. However, this is ameliorated by the caseload forecasting process AL TSA participates in for its personal care programs. Caseload forecasting allows the state to identify and/or project a decrease in institutional care and argue for an increase in community spending based upon a caseload or per cap caseload step. The effect of the movement of RCL participants will be reflected in the allocation of resources through the forecasting process.

3. Increase the ability of the State Medicaid program to assure continued provision of home and community-based long-term care services to eligible individuals who choose to transition from an institution to a community setting:

Following the 12-month demonstration period, we anticipate that participants will be served through a combination of existing waivers and State Plan services. Current long-term care services include standard HCBS waivers for aged, blind, and disabled; HCBS waivers for individuals with developmental disabilities, and a New Freedom/Cash & Counseling waiver. As we learn from this demonstration, DSHS may request that these waivers be amended to allow for additional, successful demonstration services.

Over the past two decades, ADSA amended its HCBS waivers to allow for increased capacity and new services, such as medication reminders and community transition.

The enhanced match provided through the MFP demonstration project will be captured and be available for both MFP participants and the larger pool of Medicaid long term care participants as well, depending on need. We estimate this amount to be approximately \$5 million annually. These funds will be used to support rebalancing projects which are not funded through existing budgeted funds.

4. Ensure that a strategy and procedures are in place to provide quality assurance for eligible individuals receiving Medicaid home and community-based long-term care services and to provide for continuous quality improvement in such services:

ALTSA's current quality assurance strategy is a holistic approach to evaluation for all individuals. Continuous Quality Improvement is an internal value and is used throughout the long-term care system. ALTSA uses the same strategies to provide services for persons who are on waivers or receiving State Plan services or state-only-funded services. ALTSA will continue to provide quality services for those who are part of the demonstration project, as well as those continuing to live in institutions. Recognizing that some participants in the demonstration project are high-risk due to complex needs and long-term institutionalization, we will tailor quality assurance protocols to ensure their safety and well-being by utilizing demonstration-specific quality assurance activities in accordance with the national quality assurance requirements. We monitor all RCL clients annually through our QA tool, which is continually revised to meet ongoing needs. The CMS Quality of Life Survey will also create additional check-in points for these clients. ALTSA and DDA will administer the QOL surveys during the specified time framework to all seniors, younger adults with disabilities, and individuals with development disabilities exiting nursing facilities and Residential Habilitation Centers. The only clients whose experience will not be measured using the QOL tool are children exiting from Children's Long-term Inpatient Centers (CLIPs) for whom the tool is not designed or appropriate for.

ALTSA uses the CMS Quality Framework to provide a solid conceptual foundation for all home and community quality assurance processes. Oversight committees provide feedback and remediation mechanisms to cultivate quality assurance for all HCBS programs. Health and safety, as well as the safeguarding of participants' rights and responsibilities, always remain an ALTSA priority.

The Quality Management Strategy is integrated at all levels of administration and service delivery. ALTSA works with other systems such as the Division of Behavioral Health and the Developmental Disabilities Administration to ensure formalized quality assurance processes for people who utilize services across program boundaries.

Outcome and satisfaction measures are collected by specialized Quality Assurance staff at both the local and state level in a systematic way to provide analysis at all levels of the organization and to inform where changes should take place. Staff is well-trained on issues such as waiver eligibility, customer service, technical skills, quality assurance, and policies and procedures. Problems and concerns are identified and are used to determine strategies that will assure continuous improvement. In addition to waiver quality assurance requirements, AL TSA follows the transition of individuals with developmental disabilities into the community and does face-to-face interviews at three intervals during the first year to measure success and satisfaction. This will continue for DDA RCL participants.

Benchmarks

Benchmarks are recorded and updated in the CMS semi-annual report. The following information provides a framework for understanding the way benchmarks for the project are tracked and, with the exception of benchmark 1 which projects transitions, records historical data at the time of this revision (9/2014).

1. Benchmark #1: The projected number of eligible individuals in each target group of eligible individuals to be assisted in transitioning from an inpatient facility to a qualified residence during each fiscal year of the demonstration.

Year 1 - 2008				
Populations to be transitioned	Older Adult	Developmental Disability	Physical Disability	Mental Illness
Number of Individuals Transitioned	9	8	21	0
Year 2 - 2009				
Populations to be transitioned	Older Adult	Developmental Disability	Physical Disability (PD)	Mental Illness (MI)
Number of Individuals Transitioned	135	18	170	2
Year 3 - 2010				
Populations to be transitioned	Older Adult	Developmental Disability	Physical Disability (PD)	Mental Illness (MI)
Number of Individuals Transitioned	296	16	267	0
Year 4 - 2011				
Populations to be transitioned	Older Adult	Developmental Disability	Physical Disability (PD)	Mental Illness (MI)
Number of Individuals Transitioned	414	51	340	2
Year 5 - 2012				

Populations to be transitioned	Older Adult	Developmental Disability	Physical Disability (PD)	Mental Illness (MI)
Number of Individuals Transitioned	416	14	328	18
Year 6 - 2013				
Populations to be transitioned	Older Adult	Developmental Disability	Physical Disability (PD)	Mental Illness (MI)
Number of Individuals Transitioned	450	25	321	31
Year 7 - 2014				
Populations to be transitioned	Older Adult	Developmental Disability	Physical Disability (PD)	Mental Illness (MI)
Estimated number of individuals to be transitioned	381	18	307	18
Year 8 - 2015				
Populations to be transitioned	Older Adult	Developmental Disability	Physical Disability (PD)	Mental Illness (MI)
Estimated number of individuals to be transitioned	381	18	307	18
Year 9 - 2016				
Populations to be transitioned	Older Adult	Developmental Disability	Physical Disability (PD)	Mental Illness (MI)
Estimated number of individuals to be transitioned	381	18	307	18
Year 10 - 2017				
Populations to be transitioned	Older Adult	Developmental Disability	Physical Disability (PD)	Mental Illness (MI)
Estimated number of individuals to be transitioned	381	18	307	18
Year 11 - 2018				
Populations to be transitioned	Older Adult	Developmental Disability	Physical Disability (PD)	Mental Illness (MI)
Estimated number of individuals to be transitioned	381	18	307	18
Year 12 - 2019				
Populations to be transitioned	Older Adult	Developmental Disability	Physical Disability (PD)	Mental Illness (MI)

Estimated number of individuals to be transitioned	381	18	307	18
Year 13 - 2020				
Populations to be transitioned	Older Adult	Developmental Disability	Physical Disability (PD)	Mental Illness (MI)
Estimated number of individuals to be transitioned	0	0	0	0

Effective 2014, data will be reported and updated in the bi-annual web report.

2. Benchmark #2: Qualified expenditures for HCBS during each year of the demonstration program.

Year	Target Level of Spending	% Annual Growth Projected	Total Spending for Calendar Year	% Annual Change (from Previous Year)	% of Target Reached
2006	0	0	0	0	
2007	\$600,529,917.00	8.30	0	0	
2008	\$689,143,127.00	12.86	\$682,609,745.00	0	99.05%
2009	\$767,493,382.00	10.21	\$778,336,362.00	114.02%	101.41%
2010	\$787,992,510.00	2.60	\$841,507,389.00	108.12%	106.79%
2011	\$794,769,660.00	0.85	\$862,981,936.00	102.55%	108.58%
2012	\$879,987,381.00	3.60	\$859,167,918.00	99.56%	97.63%
2013	\$888,787,254.00	3.60	878,457,902	102.25%	98.84%
2014	\$897,675,127.00	3.60			
2015	\$906,651,878.00	3.60			
2016	\$915,718,397.00	3.60			

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3. Benchmark #3 captures rebalancing efforts by measuring annual percent increase in Total HCBS Caseload (with the inclusion of expected counts of RCL participants. NOTE: the table below reflects corrections submitted by WA State to Truven Health via email July 30, 2014).

Year	Measure: Target	Measure: First Period	Measure: Second Period	Measure: Entire Year	% Achieved: First Period	% Achieved: Second Period	% Achieved: Entire Year
2008	3.38	3.60	0.00	3.60	106.51%	0.00%	106.51%
2009	3.27	3.27	2.46	5.73	100.00%	75.23%	175.23%
2010	2.24	2.68	3.18	5.86	119.64%	141.96%	261.61%
2011	1.55	2.97	2.47	5.44	191.61%	159.35%	350.97%
2012	3.60	2.41	2.39	4.80	66.94%	66.39%	133.33%
2013	3.60	1.23	2.54	3.77	34.17%	70.56%	104.72%
2014	3.60	0.00	0.00	0.00	0.00%	0.00%	0.00%
2015	3.60	0.00	0.00	0.00	0.00%	0.00%	0.00%
2016	3.60	0.00	0.00	0.00	0.00%	0.00%	0.00%

Effective 2014, data will be reported and updated in the bi-annual web report.

4. Benchmark #4 changed in 2011 and thus is reported in two different tables.

The percent of institutional care as proportion of total LTC caseload.[REPORTED FROM 2008 - 2011]

Year	Measure: Target	Measure: First Period	Measure: Second Period	Measure: Entire Year	% Achieved: First Period	% Achieved: Second Period	% Achieved: Entire Year
2006	0.00	0.00	0.00	0.00	0.00%	0.00%	0.00%
2007	23.10	0.00	0.00	0.00	0.00%	0.00%	0.00%
2008	22.50	21.87	21.84	43.71	97.20%	97.07%	194.2
2009	21.60	21.70	20.46	42.16	100.46%	94.72%	195.1
2010	20.80	18.59	17.66	36.25	89.38%	84.90%	174.2
2011	20.40	17.66	17.48	35.14	86.57%	85.69%	172.2

The percent of LTC HCBS caseload as a proportion of total LTC caseload (reported starting in 2012).

Year	Measure: Target	Measure: First Period	Measure: Second Period	Measure: Entire Year	% Achieved: First Period	% Achieved: Second Period	% Achieved: Entire Year
2012	83.10	82.97	83.00	165.97	99.84%	99.88%	199.72%
2013	84.10	83.16	83.59	166.75	98.88%	99.39%	198.28%
2014	84.80	0.00	0.00	0.00	0.00%	0.00%	0.00%
2015	85.20	0.00	0.00	0.00%	0.00%	0.00%	0.00%
2016	85.50	0.00	0.00	0.00%	0.00%	0.00%	0.00%

Effective 2014, data will be reported and updated in the bi-annual web report.

5. Benchmark #5 will document baselines for 2 data elements associated with client complexity in the community. Data will be taken from CARE assessment information. Effective 2014, data will be reported and updated in the bi-annual web report.

- The first factor is ‘ADL’ (ADL scores associated with an HCS client's level of care assessment).

Year	Measure: Target	Measure: First Period	Measure: Second Period	Measure: Entire Year	% Achieved: First Period	% Achieved: Second Period	% Achieved: Entire Year
2006	11.20	0.00	0.00	0.00	0.00%	0.00%	0.00%
2007	11.34	0.00	0.00	0.00	0.00%	0.00%	0.00%
2008	11.41	0.00	11.37	11.37	0.00%	99.65%	99.65
2009	11.54	11.54	11.64	23.18	100.00%	100.87%	200.87
2010	11.65	11.87	11.88	23.75	101.89%	101.97%	203.86
2011	11.75	12.16	12.28	24.44	103.49%	104.51%	208.00
2012	11.86	12.35	12.45	24.80	104.13%	104.97%	209.11
2013	11.96	12.62	12.56	25.18	105.52%	105.02%	210.54
2014	12.06	0.00	0.00	0.00	0.00%	0.00%	0.00%
2015	12.16	0.00	0.00	0.00	0.00%	0.00%	0.00%
2016	12.26	0.00	0.00	0.00	0.00%	0.00%	0.00%

Effective 2014, data will be reported and updated in the bi-annual web report.

- The second factor is ‘Diagnoses’ (the number of distinct diagnosis codes listed in an HCS’s client assessment). (2006-2007 are actual baseline scores.)

Year	Measure: Target	Measure: First Period	Measure: Second Period	Measure: Entire Year	% Achieved: First Period	% Achieved: Second Period	% Achieved: Entire Year
2006	7.89	0.00	0.00	0.00	0.00%	0.00%	0.00%
2007	8.25	0.00	0.00	0.00	0.00%	0.00%	0.00%
2008	8.46	0.00	8.45	8.45	0.00%	99.88%	99.88%
2009	8.57	8.58	8.69	17.27	100.12%	101.40%	201.52%
2010	8.68	8.96	8.97	17.93	103.23%	103.34%	206.57%
2011	8.79	9.21	9.26	18.47	104.78%	105.35%	210.13%
2012	9.03	9.58	9.57	19.15	106.09%	105.98%	212.07%
2013	9.20	9.83	9.84	19.67	106.85%	106.96%	213.80%
2014	9.37	0.00	0.00	0.00	0.00%	0.00%	0.00%
2015	9.54	0.00	0.00	0.00	0.00%	0.00%	0.00%
2016	9.71	0.00	0.00	0.00	0.00%	0.00%	0.00%

Effective 2014, data will be reported and updated in the bi-annual web report.

Demonstration Policies and Procedures

Participant Recruitment and Enrollment

I. Target Populations

Targeting and recruitment strategies vary by population; this section is organized according to specific Home and Community Services, Division of Developmental Disabilities, and Behavioral Health Division systems of care.

Home and Community Services (HCS)

The key targeting and recruitment strategies for Roads to Community Living are face-to-face interviews, data analysis, consultation with staff, and technical assistance as needed. Education and outreach, and the ability to accept self-referrals will also play an important role in our strategy.

Within nursing facilities, Washington takes a proactive stance, seeing each newly admitted Medicaid eligible individual within the first seven days of admission or conversion. AL TSA assigns case managers to each nursing home to work with residents. Each case manager is responsible for working with residents in 2-3 facilities. There is no recommended case load per case manager. Work is distributed utilizing the following considerations:

- Turnover rate of Medicaid residents in each facility,
- Medicaid census in each nursing facility
- Medicare census in each facility,
- Geography: distance between sites

The census and history of turnover at each site determines the number of visits per site and the number of staff assigned to each site.

Case managers, who may be social workers or registered nurses, contact residents to inform them of their right to decide where they will live. They will then discuss their preferences, identify barriers to discharge and likely care needs, and review the supports that are available in the community and other possible service options. A comprehensive assessment is completed when the consumer indicates an interest in relocation, and a transition plan is developed jointly. The individual's desire to relocate and available community options are reviewed at this time.

We use reports using the Minimum Data Set information collected through the Resident Assessment Instrument for nursing home residents in conjunction with the data collected through the long-term care assessment process to identify potential participants. We will initiate face-to-face interviews with residents at this point. In state hospitals, children and young adults through age 21 will be identified by

consulting with clinical staff. Reports using the MDS will be utilized from the start of the project as one tool to help identify all eligible nursing facility residents. These individuals will be contacted briefly by the Nursing Facility Case Manager assigned to that facility, and if they express interest in the project, they will receive further contact according to their needs and wishes and the Case Manager will complete the CARE assessment.

RCL will re-enroll individuals after a 30 day institutional stay if they are interested in doing so, and will provide services for the balance of the 365 days of the demonstration allowed.

Long-term care Ombudsman, Nursing Facility Case Managers, and Independent Living Centers all visit Medicaid nursing facilities in our current system of care. During this demonstration, we anticipate using this well-developed system to aim for contact being made with nursing home residents at regular intervals. We will have written information available to all facilities about the demonstration project.

Developmental Disabilities Administration (DDA)

The Developmental Disabilities Administration is focusing on moving individuals currently residing in four State Residential Habilitation Centers (RHCs) across the State, and effective July 2014 will also include nursing facility residents with developmental disability diagnoses in their transition counts. In the RHCs, particular attention will be focused on the rising number of children and adolescents being placed in these facilities because of lack of community resources to handle their needs. RCL demonstration services for DDA have been developed to help address these gaps in services.

Information is routinely provided to individuals and their families about alternative community based services that can be made available. Help is available to assist them to explore possibilities for this in order to support informed choice. This often includes providing information about qualified service providers in the person's geographical area of interest, and arranging visits to see actual homes where other people are living upon request.

For the purposes of this grant, DDA has developed information that will be sent to all potential participants and guardians of people residing in our Centers informing them of this opportunity, how to get more information if they have questions, and how to apply if they have interest. In conjunction with this, DDA will also develop information for RHC and Field Services staff that will be given to the Regional Administrators and Superintendents to distribute to staff. Each RHC in each DDA region has a designated RCL liaison to help coordinate RCL activities within their respective areas who works directly with the RCL planning team at the State level. In addition, at each yearly Individual Habilitation Plan meeting, DDA field and RHC staff provides information on the RCL grant opportunity and if the person and/or their family or legal guardian has interest, connects them with the RCL coordinator.

In nursing facilities, RCL staff will use MDS data, resident and family referrals, and nursing facility and HCS staff referrals to identify participants. Because they are moving from nursing facilities, HCS staff will also be involved in the discharge planning process in the pre-transition phase.

Assigned RCL staff will conduct the initial interview to determine the level of potential participant's interest. RCL eligibility according to statute and the desire to relocate and participate will determine their eligibility for the project. DDA will be offering all eligible individuals in the RHCs and nursing facilities the opportunity to participate and will not be using any additional data sources or tools to identify and screen potential participants.

One of the RCL demonstration services is family services, including counseling and training. These services will be offered in the event that the prospective participant is interested in transition back into the family home. The family has the right to accept or refuse these services. These added services are focused on families with children whom they want to bring back home but need additional counseling or training in order to do so.

A DDA assessment and person centered plan will then be developed. This plan will lead to the identification of potential qualified service providers with whom the person has interest in considering as a new service provider in the community. With a signed consent/release of information form, the RCL Coordinator and the appropriate DDA Resource Manager work together to initiate sending a referral packet to the person's agency of choice. This packet will include overview written information from the person's records as well as names and phone numbers of a contact person so the new providers can meet and spend time with the person and also establish contact with support staff. Information packets will include assessments and evaluations by involved professional staff and detailed medical and health care assessments and information. If the community service provider has interest in providing services to the person (and their family/guardian continues to be interested in receiving community services from this agency), the Regional Resource Manager and RCL Coordinator will continue to work together. They will request and review an individualized services plan/budget proposal from the agency, and negotiate approved payment for the person's new services in the community mirroring the appropriate waiver.

Once an accepted plan has been developed, the regional Resource Manager and RCL coordinator will again work together to submit the appropriate enrollment and proviso funding requests for review and approval, following DDA protocols that have been established for this. After the RCL funding has been approved, the person planning to move, along with their support team, family or guardian, and new community residential staff share information with one another and develop the services and supports that will be needed in the community. Working collaboratively with the RCL liaisons and the appropriate regional DDA case/resource managers, this process typically involves hiring and training new support staff, locating desirable and affordable housing, having the

new community support staff spend time with the person (and their support team) and supporting the person to begin visiting at their new home in the community. Regional DDA staff will coordinate efforts with local housing authorities as appropriate to develop individual and project based housing opportunities as appropriate. The planning team will also identify and finalize other supports that may be needed by the person, e.g. doctors, dentists, occupational therapists, physical therapists, communication and behavior support specialists, delegating nurses etc. and will begin exchanging information with these individuals as well, with a signed release. Considering how transportation will be provided will also be routinely addressed. Back-up plans in case of emergencies and crisis situations are also incorporated into this planning, which may sometimes include the development of a more formalized “cross systems crisis support plan” if this is deemed appropriate. In conjunction with this process the person’s receiving DDA case manager will also coordinate the implementation of the DDA assessment, which includes the development of an individual support plan for the person’s new services in the community.

Once the identified services and supports are in place, a target moving date is set and a final placement planning meeting is scheduled, which is attended by the person, their family or guardian, and DDA Field staff and the new community service providers. The person moves to their new home as negotiated during their individualized planning process in accordance with decisions made at this meeting. The methods by which actual placements occur can be a very flexible process that is individually tailored to meet the needs and desires of the person moving, and their families and guardians, on a case by case basis. As people actually move, the receiving DDA Case Manager will finalize RCL enrollment and authorize services in accordance to the person’s DDA assessment and the individual support plan that has been developed.

The person’s new support team in the community can contact the RHC or regional RCL liaison and/or their DDA Case Manager at any time (no time limit) after the person has moved if they have questions, concerns or require additional information about the person. Additional support, technical assistance and training can be provided as needed and as authorized by the person’s Case Manager. In addition, the Division facilitates independent follow along quality assurance visits within 30 days, 90 days and one year after the person has moved, to help assure that they are safe and successful in their new homes and lives in the community.

All transition plans are created well before they leave the institution. Everyone involved must have a comfort level that support to be provided will be sufficient to meet the person’s need, or the plan will not be carried out. All DDA RCL participants will be guaranteed continued funding at the waiver level before the conclusion of the demonstration year.

Every year the person is reassessed using the DDA Assessment and the Individual Support Plan is updated to ensure that all current programs and services are current and in place and that the person’s health and safety needs are adequately addressed.

Division of Behavioral Health and Recovery (DBHR)

DBHR is focusing on moving children and adolescents currently residing in qualified institutional settings. We will transition from nursing facilities, Residential Habilitation Centers, and psychiatric hospitals where Medicaid is available. All institutions are licensed, certified, and monitored and clearly meet the statutory requirements of an eligible institution. Children and adolescents with a DDA diagnosis will use the DDA system of care for treatment coordination.

In order to recruit individuals for the project, hospital liaisons and the inpatient treatment teams will provide eligibility information to the Mental Health Regional Support Networks (Networks). Eligibility requirements for RCL shall include significant barriers to successful discharge that could be addressed through provision of the enhanced services, and co-occurring physical or developmental disability and/or personal care needs in addition to the broader RCL requirements.

II. Qualified Institutional Settings

Washington State is using the Deficit Reduction Act statutory guidelines for qualified institutional settings. The demonstration will be statewide. Any eligible individual (section 6071(b)(2) of the Deficit Reduction Act) wanting to move from a qualified institution (section 6071(b)(3) of the Deficit Reduction Act) will be assessed for relocation during the course of the project.

Washington will be transitioning residents of nursing facilities, ICF-IDs (Residential Habilitation Centers), and state psychiatric hospitals (to the extent Medicaid is available). These are the types of facilities called out in the statute.

III. Minimum Residency Period

Individuals must reside for a minimum of three months in a qualified institutional setting. Case managers will be responsible for verifying institutional tenure.

IV. Eligibility Assurances

The Case Manager verifies Medicaid eligibility in the State's Automated Client Eligibility System. This will be done at the time of referral.

V. The State's policy regarding re-enrollment into the demonstration. That is, if a participant completes 12 months of demonstration services and is readmitted to an institution including a hospital, is that participant a candidate for another 12 months of demonstration services? If so, describe the provisions that will

be taken to identify and address any existing conditions that lead to re-institutionalization in order to assure a sustainable transition.

Individuals will be eligible for RCL services after each 3-month period of institutional residency. Given the time frames for RCL, it is possible that an individual could be admitted to the program on two separate occasions. A new Comprehensive Assessment Reporting Evaluation will be conducted and plan of care developed. This assessment will identify and address existing conditions that led to re-institutionalization per CMS guidance on second RCL demonstration years for individuals.

VI. Information for participants

Washington State employs strict protocols regarding the reporting of abuse, neglect, and exploitation. The following resources illustrate ways that participants, family members, caregivers and/or legal representatives are provided information about protections from mistreatment and told how to report concerns or incidents of abuse, neglect, and exploitation:

- Comprehensive Assessment Reporting Evaluations address potential abuse, neglect and exploitation;
- Participants review and sign a form entitled “Your Rights and Responsibilities”(including the right to be free from abuse...) at the time they accept services;
- The participant financial eligibility process also includes a review of funds and information on consumer financial rights;
- AL TSA publications (e.g., Medicaid and Options for Long-Term Care Services for Adults);
- Provider training (e.g., Caregiver Orientation, and Revised Fundamentals of Caregiving and Safety Training);
- AL TSA, DBHR, and DSHS internet websites;
- Eldercare Locator (Administration on Aging);
- DSHS End Harm campaign and the activities associated with the annual statewide July Adult Abuse Prevention month;
- DDA consumers receive the Consumer complaint policy brochure;
- DBHR consumers receive information on the Behavioral Health ombudsman service.

Training regarding abuse assessment and reporting is also found in the basic training for caregivers in Washington, called the “Revised Fundamentals of Caregiving.” This is a 75-hour classroom course in caregiving. The class focuses on correctly performing basic caregiving personal care tasks, consumer rights, important communication and problem solving skills in caregiving, and protecting the health and safety of the consumer.

VII. Training and education

- State and Area Agency on Aging case managers provide direct information to participants at a minimum on a yearly basis.
- The State is responsible for all caregiver training content including the obligations of mandatory reporters per statute.

Informed Consent and Guardianship

Washington has several mechanisms for assuring that individuals, their legal representatives and families are informed of choices and rights regarding home and community-based services. The current practices summarized below will continue with RCL:

- Individuals participate in a standardized assessment process that always includes an in-person interview with the participant, family, legal representative and others of the individual's choosing. Together the assessor, the participant and any others listed above, document needs, goals, strengths, limitations, resources, preferences, and level of care requirements using a uniform, comprehensive system.
- By policy, the assessment process leads to the development of a plan of care encompassing services needed by the individual without minimizing or undermining existing supports provided by the family and other significant individuals in the participant's life or community. Family or legal representatives and other natural supports are always included to the extent possible as agreed to by the person.
- The plan of care includes both formal and informal providers of support and personal goals identified by the individual.

Case managers review the "Client's Rights and Responsibilities (DSHS 16-172)" document with consumers that outlines their right to participate in the development of their plan of care and ensure that their preferences and the available services they wish to receive are included in their plan of care. The Client's Rights specify that, as a consumer of DSHS services, individuals have a right to:

- Be treated with dignity, respect and without discrimination;
- Not be abused, neglected, financially exploited, or abandoned;
- Have your property treated with respect;
- Not answer questions, turn down services, and not accept case management services you do not want to receive. However, it may not be possible to offer some services if you do not give enough information;
- Be told about all services you can receive and make choices about services you want or don't want;

- Have information about you kept private within the limits of the laws and DSHS regulations;
- Be told in writing of agency decisions and receive a copy of your care plan;
- Not be forced to answer questions or do something you don't want to;
- Talk with your social service worker's supervisor if you and your social service worker do not agree;
- Request a fair hearing;
- Have interpreter services provided to you free of charge if you cannot speak or understand English well;
- Take part in and have your wishes included in planning your care;
- Choose, fire, or change a qualified provider you want; and
- Receive the results of the background check for any individual provider you choose.

The plan of care includes the person's choice of living situation, what services the individual is eligible for, limits on authorized hours and any additional supports needed as identified in the assessment. The individual or their legal representative signs and receives a copy of the plan of care.

Informed consent is always obtained directly from the person unless he/she is legally not competent to consent. In that event, state statute ([RCW 7.70.065](#)) allows the following in order of priority to give informed consent for adults: legal guardian, Durable Power of Attorney, spouse or state registered domestic partner, adult children, parents and adult siblings. For children, custodial parents provide informed consent unless there is a court appointed guardian.

For consumers of the Developmental Disabilities Administration, a further step is added. Case resource managers are required to make sure that each person has a necessary supplemental accommodation (NSA) to and ensure that the person understands any action the division is taking concerning them. If a person does not have a necessary supplemental accommodation, and needs a guardian, then guardianship will be pursued. Clients who have a mental, neurological, physical, or sensory impairment or other problems that prevent them from getting program benefits in the same way as those who are not impaired are considered in need of necessary supplemental accommodation.

An NSA is involved to ensure that a participant who may have difficult accessing program benefits for any reason (disability, language) will get help in doing so. In AL TSA, we ask whether consumers need this service. In DDA, it is provided to all applicants.

An "Acknowledgement of Services" form (DSHS 14-225) is used to document the person's freedom to choose between institutional and home and community-based

services. The choice is explained to the person and their legal representative if appropriate, and a signature is obtained stating that the individual understands they have a choice in the type of services received, where the services are provided as well as the right to a fair hearing. The individual signs this form to designate the service choice.

In addition to all of the above, Washington has developed a specific form and process for obtaining consent to participate in the demonstration. It includes the elements specific to the demonstration. As part of initial project development, feedback from Key Informants regarding informed consent was included as a topic area on our widely distributed questionnaire. The results were interesting and instructive. What became clear is that consumers see the procedures typically associated with “informed consent” as only one aspect of the discussion. The majority of the comments we received had more to do with the subjective experience of risk. The fear and uncertainty that may be associated with transitioning from an institutional to a community setting varies both in intensity and content from person to person.

The person-centered planning approach will give voice to the specific fears and concerns that surround the particulars of each person’s situation and will address these in a realistic and concrete way. Training for Community Choice Guides and Case Management staff will include information on how to solicit this important aspect of transition from individuals as part of the process.

a. Complaint System

Consumers have several avenues for registering complaints about services or any other aspect of their care. Participants may register complaints about anything the Department does or is responsible for that they perceive as affecting them negatively in any way. The complaint system is operated by each administration.

To protect participant rights, some types of complaints are immediately directed to other formal systems rather than being addressed through the grievance process. Complaints not handled through the grievance process include the following:

1. Complaints of abuse, neglect or financial exploitation of a vulnerable adult or child - referred to formal protective systems
2. Consumer disputes about services that have been Denied, Reduced, Suspended, or Terminated - consumer is informed of their rights and referred to the administrative hearing process
3. Complaints about possible Medicaid fraud - referred to the Medicaid Fraud Control Unit

Complaints or disputes about services can be received and addressed at any level of the organization. However, DSHS always strives to address grievances/complaints at the lowest level possible. Upon receipt at any level, all DSHS employees are required to respond to in-person or telephone complaints within one business day. Written

complaint must receive a response within seven business days. Complaints are referred to the case manager for action unless the complainant requests it not be. If the case manager is unable to resolve the complaint, the person is referred to the case manager's supervisor. The supervisor has ten working days from the date of receipt to attempt to resolve the issue. If the person feels their complaint is not resolved they are referred to the Regional Manager. The Manager/Director has ten working days to seek resolution. If the person continues to feel their complaint is not resolved, they are referred to the state level ADS headquarters. ADS has ten working days to resolve the complaint and must notify the person in writing of the outcome. All steps in this process are logged.

Mechanisms that are used as appropriate to the type of complaint may include record review and correction of any errors; case conferences with the consumer; a change of providers; information and referral; additional information on program policies, statutes, administrative rules; and adjustment to the plan of care.

References:

- (1) ADS Complaint/Grievance Policy for Home and Community Services Division and the Developmental Disabilities [DDA Policy 5.03 Client Complaints](#)
- (2) Management Bulletin H05-018 – Policy/Procedure Client Grievance Policy March 2005 [Client Grievance Policy](#)
- (3) DSHS Administrative Policy No. 8.11 [Complaint Resolution and Response Standards](#)

In addition to the complaint/grievance system operated by DSHS, consumers have access to local mental health ombudsman services operated out of the Regional Support Networks. Complaints may be filed with a community mental health agency, the regional support network/prepaid inpatient health plan or the Ombudsman services. All Medicaid recipients are informed of their rights in a Medicaid benefits booklet. [MH Medicaid Benefits](#) The State also has an independent long term care Ombudsman who responds to complaints in Adult Family Homes, Boarding Homes and Nursing Facilities.

b. Guardianship Policy

Facility administrators are not permitted to serve as guardians for residents of their facilities. Per state statute [RCW 11.92.043](#) , guardians have the following among their duties:

“Consistent with the powers granted by the court, to care for and maintain the incapacitated person in the setting least restrictive to the incapacitated person's freedom and appropriate to the incapacitated person's personal care needs, assert the incapacitated person's rights and best interests, and if the incapacitated person is a minor or where otherwise appropriate, to see that the incapacitated person receives appropriate training and education and that the incapacitated person has the opportunity to learn a trade, occupation, or profession.”

Guardians are always asked to participate in care planning that occurs yearly and at other times as needs change. For individuals who have court appointed guardians,

no transitions will be made under RCL without the consent of the guardian. Guardians are required by statute to file an annual report which includes:

- (a) The address and name of the incapacitated person and all residential changes during the period;
- (b) The services or programs which the incapacitated person receives;
- (c) The medical status of the incapacitated person;
- (d) The mental status of the incapacitated person;
- (e) Changes in the functional abilities of the incapacitated person;
- (f) Activities of the guardian for the period;
- (g) Any recommended changes in the scope of the authority of the guardian or legal representative;
- (h) The identity of any professionals who have assisted the incapacitated person during the period.

Just as is done under current programs, RCL will involve guardians throughout the process and involve them to the extent possible. Guardians are included in the assessment process and have input into the development of the plan. Guardians will be informed about the demonstration process at the time the assessment is being developed. As the legally appointed representatives of the consumer, guardians are an integral, mandatory part of the institutional interdisciplinary teams for everyone residing at our DDA RHCs, nursing homes, and hospitals. As such they are routinely involved in the development of “Individual Habilitation Plans” (DDA) or “Plans of Care” (HCS) for people for whom they are guardian. All the information that is a part of the normal assessment – decision making, memory, overall cognition, risks, etc. – will be discussed with the guardian. The IHP’s and POC’s very thoroughly review client needs in a very comprehensive way, as well as indicating how prioritized needs will be addressed in the coming year. Guardians are routinely included in the review and development of individual plans that are developed and routinely receive copies of these documents by mail in those rare instances where they are not able to participate in person at the time.

Client needs, and how these will be addressed in the community are a routine part of the initial conversations that occur with guardians as they are making an informed decision about whether or not to participate in RCL demonstration activities. We will formalize this with an additional reference to it on the mandatory signature line on the Informed Consent form.

Corporate guardians or guardians who might not be interested in a high level of involvement will, at a minimum, be responsible for providing informed consent per statute. If we have reason to believe that the guardian is not attending to the health, safety and welfare of the individual, we will go to the court and request a re-assignment.

Outreach/Marketing/Education

a. Enrollee Information: Outreach at start-up

During the months of March through September 2007, the Project Director held a series of meetings to describe the Money Follows the Person demonstration and the particular objectives of Washington State's Road to Community Living project. Eligibility for the project and the opportunities afforded by the demonstration were discussed. A website (www.adsa.dshs.wa.gov/professional/roads) was set up and used to post project information. The website was also used as a communications tool for information to flow back to the project, with an online survey and more in-depth questionnaire available for download. These are both available to view on the website. Additionally, an informational PowerPoint presentation was developed explaining the demonstration project.

Within the State system, the Project Director met with representatives of Home and Community Services, the Developmental Disability Administration, DBHR, the State Independent Living Council, the Division of Vocational Rehabilitation, Division of Employment and Assistance Programs, the Indian Policy Advisory Committee, and the Home Care Quality Authority. State supervisors and staff were reached through management and supervisory team meetings in each region of the State.

In the community, outreach occurred with the Senior Lobby; Housing Authorities, including the largest located in King County; The Washington Health Care Association and the Washington Association of Housing and Services for the Aging, Washington State's two professional associations for nursing homes and residential services; Independent Living Centers, including the Association of Centers for Independent Living of Washington Executive Committee and the Independent Living Center Regional Conference; the Ombudsman statewide supervisory team; the professional association for Homecare Agencies; Service Employees International Union; County Vocational Rehabilitation providers; and the statewide Area Agency on Aging Executive Committee. Outreach was also done with existing stakeholder groups in Mental Health and the DDA community.

Staff training will be approached by developing expertise in RCL in each Department Of Social and Health Services region. Each region will have contacts established who will be the conduit for information about the program as well as for training about how to access and utilize its benefits. Information channels have been established through the Collaborative Team and key informant process. Training of key staff occurred prior to project implementation and re-occurs as needed both statewide and regionally. Among the tools used are brief, easy to read informational flyers with contact information that can be used in a variety of places, including within the institutional settings and community locations which reach a large audience (medical clinics, community centers, etc.). We created and regularly use a transition handbook, which takes someone step-by-step through the RCL process. In addition to the demonstration

project details, the areas covered are: who can provide help; personal finances and resources; funding and benefit programs; housing options; independent living supports; health services; supplies and equipment; transportation options; social and recreational resources; and information on work. Materials are tailored to address the particulars of local communities. We leverage existing mailings and communication loops to aid in dissemination of information. Drafts of the model forms and pamphlet are attached.

Initially, as part of quality assurance activities the ALTSA Quality Assurance team performed a focused quality improvement activity related to ensuring client choice. Staff spoke directly to over 800 clients in nursing facilities to assess whether they were aware of community options and their interest in discharge. The process produced valuable data for RCL to use in planning our outreach and engagement strategy. Interviews were conducted in all regions of the state in a total of 120 nursing facilities. The process identified types of barriers to discharge and the occurrence of each type both state wide and by region. Barriers are grouped into the following categories: accessibility issues; client declines discharge; complex medical needs; financial; housing; no informal support; and unstable medical condition. This data will assist ADSA with person specific identification as well as with targeted planning for regional resource and service deficits.

b. Types of media to be used:

Written information including flyers, brochures, and pamphlets will be widely available. We will leverage existing mailings to include RCL information. The project website (<http://www.adsa.dshs.wa.gov/professional/roads/>) has already been an invaluable tool for information sharing and gathering of feedback and will continue to be used in both of these capacities. In addition, we will explore the use of videos and/or web-based media to communicate both project information and success stories.

c. Specific geographical areas to be targeted:

The RCL demonstration is statewide. Outreach includes targeted outreach to Tribes.

d. Locations where such information will be disseminated:

- Long term care providers, Area Agencies on Aging, and counties.
- HCS and DDA Regional staff to share with consumers and stakeholder groups.
- Making materials available on the RCL website.
- Leveraging existing relationships with various stakeholder groups to distribute educational information to consumers.
- Hosting educational workshops for providers on consumer eligibility.
- Tribal representative meetings
- Institutional Settings

e. Staff training schedules, schedules for State forums or seminars to educate the public:

The following are ongoing, regularly scheduled meetings that are used to provide staff and community education specifically about the RCL demonstration, as well as collect feedback about the project's progress. Staff training on the specifics of RCL implementation will occur from October through December 2007 in anticipation of the January 2008 start up and regularly after that. Future meetings will be scheduled according to the needs of the particular groups:

ONGOING MEETINGS	MEETING FREQUENCY
DDA and HCS Field Service Administrators	Monthly
DDA and HCS Regional Administrators	Monthly
DDA and HCS Full Management Team	Quarterly
DDA and HCS Quality Programs & Services Unit	Monthly
DDA Field Services Support Unit	Monthly
HCS Headquarters All Staff	Bi-monthly
HCS State Unit on Aging	Monthly
HCS Home and Community Programs	Monthly
Washington Area Agencies on Aging Executive Team	Monthly
State Council on Aging	Monthly
Senior Lobby	Monthly
Association of Centers for Independent Living	Quarterly
Indian Policy Advisory Committee	Quarterly
Regional Ombudsman Meetings	As Scheduled
Homecare Agency Meetings	Quarterly
Mental Health Planning and Advisory Council	Quarterly
Regional NF/RCL Field Service Administrators	Quarterly or as needed

f. The availability of bilingual materials/interpretation services and services for individuals with special needs:

The policy of DSHS is to provide fully translated written materials in the person's primary language. Written materials covered in this policy include informational materials about Department services, consumer rights and responsibilities and Department forms that require a consumer signature. Certified Interpreters and accommodations for individuals with special needs are also required.

The following statutes and policies govern services and materials available for people with Limited English Proficiency and people with special needs:

Statute and Administrative Code

[RCW 74.04.025](#): Bilingual services for non-English speaking applicants and recipients and bilingual personnel: Primary language pamphlets and written materials.

[WAC 388-03](#): Rules and regulations for the certification of DSHS spoken language: interpreters and translators.

[WAC 388-271](#): Limited English proficient services.

DSHS Administrative Policies

7.20 Communication Access for Persons who are Deaf, Deaf/Blind and Hard of Hearing

7.21 Access to Services for Clients who are Limited English Proficient

The Department of Social and Health Services and its contractors are required by statute, administrative code and department policy to deliver services that recognize individual and cultural differences. All consumers must be given equal access to services, information, and programs whether the department or contracted vendors deliver services. The following are summaries of requirements:

1. Interpreters are used when the consumer requests interpreter services, when necessary to determine a consumer's eligibility for services, or when necessary for the consumer to access services.
2. Limited English Proficiency and Sensory Impaired consumers are informed of their right to request an interpreter or auxiliary aide and are offered interpreter services or auxiliary aids at no cost to them and without significant delay. Children under age 18 are not allowed to serve as interpreters. Limited English Proficiency Interpreters and Translators for spoken language must be certified and/or qualified by DSHS and comply with the DSHS code of professional conduct.
3. To assure access and quality, DSHS maintains a statewide translation contract, American Sign Language contract and Interpreter Brokerage contract for Spoken Languages.
4. If the listed contractors cannot meet the need, or there is an emergency, which requires the immediate attention, staff can access the Language Line.
5. Procedures are in place to obtain translation of official publications, forms and records as well as consumer specific requests for translations.

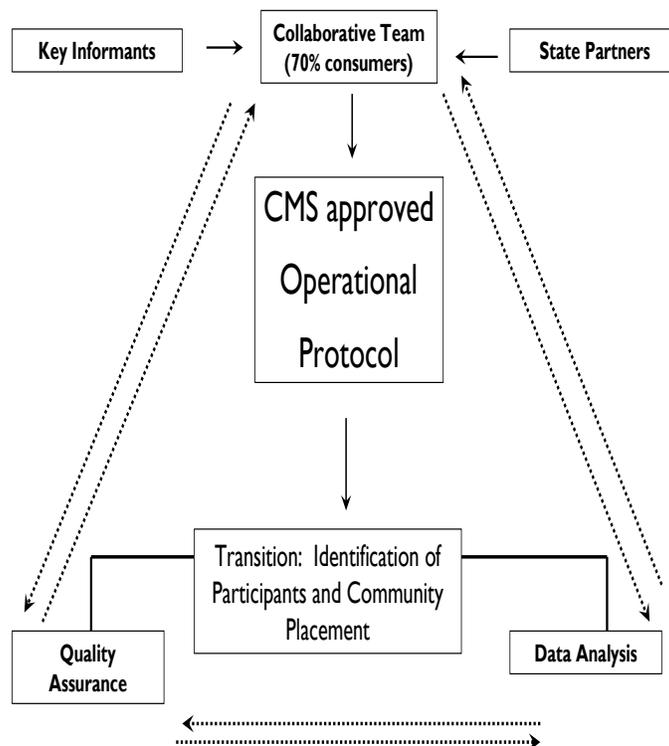
g. A description of how eligible individuals will be informed of cost sharing responsibilities.

During the process of assessment and establishing eligibility, case managers discuss any responsibilities related to cost sharing with the participant so they are fully informed.

Eligible individuals are also informed of cost sharing responsibilities in their Medicaid award letter. Award letters are auto generated by the Automated Client Eligibility System. This is the state’s electronic financial eligibility and tracking system. The award letters explain what consumer participation is and how much the consumer is responsible for. The award letters are Automated Client Eligibility System (ACES) form 0002-16 Approval for Medical/Waivered Services and ACES form 0018-01 Change in Participation Amount. If cost sharing responsibilities changed as a result of moving from an institution to the community the person would receive a new letter.

Stakeholder Involvement

a. A chart that reflects how the stakeholders relate to the organizational structure of the grant and how they influence the project.



b. A brief description of consumers’ involvement in the demonstration.

Washington State has taken the opportunity offered by the RCL Demonstration Project to do thoughtful and meaningful planning in advance of any placements, and actually began the process during the grant application process. Because of the extent of institutional transitions that already occur as part of our long term care system, it was important to ensure that we would have good collaboration between state agencies as well as with community partners and consumers. To help determine the direction of the application, a survey was widely distributed asking for feedback about what was necessary to further our rebalancing efforts. After receiving the award, an initial planning meeting was held in March of 2007 to determine the best way to ensure stakeholder participation. The following key decisions were reached that then shaped the course of the process:

- Community providers, State staff, institutional representatives, contracted agencies, advocacy organizations, and local housing authorities were considered Key Informants for the project. These providers and staff would provide essential information necessary to understand local resources and gaps, and will implement components of service delivery and quality measures.
- A consumer-based **Collaborative Team** made up of individuals across disabilities and representatives from multiple state agencies would be formed to analyze and prioritize the feedback gathered from key informants, and participate in making decisions about the Operational Protocol.
 - The Collaborative Team would be comprised of at least 51% consumers, and would have specific populations identified to get a cross section of all populations targeted in the demonstration. An application process was established to ensure that the desired mix of representatives would be obtained.
 - The Collaborative Team would be staffed by a host of state partners representing the various State stakeholder groups. The state partners would advise and inform the process but NOT be part of the decision making process of the group.
 - The Collaborative Team would be formed only for the duration of the development of the Operational Protocol. It would then have as one of its tasks the responsibility for determining the method of ongoing stakeholder participation in the project.
 - The Collaborative Team would NOT include any individual or leadership from groups who might be in a position to contract for RCL services.

Applications were collected and reviewed and the Collaborative Team met for the first time in May. The Team is 70% consumer based and is comprised of the following members:

- Senior advocate for adults with dementia

- Adult diagnosed with a mental illness, working with the Division of Vocational Rehabilitation and Mental Health Clubhouse
- Adult with a physical and a developmental disability
- Adult with a developmental disability
- Parent of a child with a development disability
- Adult with a physical disability and Independent Living Center staff
- Tribal elder
- Adult with traumatic brain injury and Independent Living Center staff
- Adult in a nursing facility
- Advocate in the disability rights movement
- Case management representative for DDA
- Case management representative for HCS
- Representative of County services
- Area Agency on Aging representative

It was staffed by representatives of the following State agencies:

- Division of Developmental Disabilities
- Home and Community Services
- Mental Health Division
- Indian Policy Support Services
- Department of Vocational Rehabilitation
- DSHS Housing Coordinator
- Division of Alcohol and Substance Abuse

The team met six times during the months of May through September while the Operational Protocol was discussed and written. During its first meeting, the Team re-named the project from “Roads to Independence” to its current “Roads to Community Living” to better represent the interpretation of the project by the participant populations. At one of the last Team meetings, the group decided to continue its participation beyond development of the Operational Protocol, and met for an additional year after Project implementation began.

Two main ways of collecting information from the community were developed. A brief online survey was posted on the Project’s website early in the project which allowed individuals to weigh in with their opinion of the services and supports necessary for successful transitions. This proved to be a very popular option; 275 people responded, indicating a high level of interest in the project as well as providing valuable feedback for the Collaborative Team as services for RCL was developed. The other tool that was developed was a Key Informant questionnaire, which allowed individuals or groups to provide more in-depth feedback on the project. In addition to services and supports, the questionnaire collected information about informed consent, participant recruitment and enrollment, and elements of successful and unsuccessful transitions. 58 Key Informant questionnaires were completed.

Current stakeholder involvement is documented in the bi-annual web report.

c. A brief description of the institutional providers' involvement in the demonstration.

Institutional providers from the nursing home industry were included in the very first organizational meeting for the project, as mentioned above. The Project Director has met with both of the major professional associations of nursing homes, and has also presented an informational session at their annual state-wide conference. Since many of the nursing homes also have assisted and independent living residences on the grounds, it is hoped that these providers will be a resource for potential placements as well. As key informants for the project, they gave input on the individuals and populations they are seeing having difficulty exiting the nursing facilities.

Nursing Facility Case Managers are assigned to Medicaid Nursing Facilities in WA State and have relationships with discharge planners. Relocation and transition are planned for and worked on jointly. These well established relationships will be integral during demonstration implementation.

In Washington, Residential Habilitation Facilities are operated by the Developmental Disabilities Administration. Staff from the DDA whose area of expertise is helping people who want to move from institutions to the community are involved in the planning and the managing of grant activities.

d. A description of the consumers' and institutional providers' roles and responsibilities throughout the demonstration.

Institutional providers of the nursing home industry are key informants for the project. Consumers comprise the majority (70%) of the Collaborative Team, which informs project development, the planned provision of services, and project evaluation. The project emphasizes peer support, self-direction and participation in person-centered planning. The Collaborative Team originally made a commitment to see the Project through to completion of the Operational Protocol. Since that time, the group has decided to continue operating through the life of the project to contribute to evaluation and process improvement strategies. Institutional providers are already an integral part of the discharge planning process and have opportunities to provide substantive input to the project on a case by case basis as people choose to move under the grant. Within DDA there will also be a designated RCL liaison within each DDA institutional facility. These collaborative relationships will continue throughout the RCL project. The Mental Health Division which operates the State psychiatric hospitals is represented on the Collaborative Team.

Current stakeholder involvement is documented in the bi-annual web report.

e. The operational activities in which the consumers and institutional providers are involved.

Consumers and institutional providers have had the opportunity to take part in the process of completing online surveys and Key Informant Questionnaires, both giving input themselves and conducting the interviews.

Institutional providers will assist in identifying potential enrollees. Consumer and institutional providers will assist with disseminating information about the project in institutional and community settings. Consumers will assist in recruiting providers and providing service. Consumers will identify system gaps to ensure a comprehensive approach to service delivery based on individualized needs. Both groups will be part of ongoing evaluation efforts and improving the process as we move forward.

As part of the Roads to Community Living demonstration, Washington will increase its capacity to engage local experts to address intensive transition support for participants with complex medical, behavioral, and/or psychosocial needs. The State will engage and learn from local institutional and community leaders and individuals with disabilities who know their communities well and have personal experience finding and using available resources to support successful community living.

Consumer groups are instrumental in RCL training efforts and consultation regarding accessibility and other areas of implementation under the grant.

Benefits and Services

DESCRIPTION OF CURRENT SYSTEMS OF CARE UTILIZED TO PROVIDE HCB SUPPORTS AND SERVICES

Home and Community Based Services and supports are provided under the Medicaid State Plan and waivers, a Mental Health managed care waiver, state-funded programs, and the Older Americans Act. ADOSA currently administers eight Home and Community Based waivers that were created under section 1915(c) of the Social Security Act. Listed below is a brief description of Washington's systems of care that provide Home and Community Based supports. These systems will be available to RCL participants who are otherwise eligible at the end of the demonstration period.

Behavioral Health: Medicaid mental health services in Washington State are provided through a managed care model approved by the Center for Medicare and Medicaid Services under 1915(b) authority. The State contracts with local Regional Support Networks to operate pre-paid health plans that cover a full spectrum of inpatient and outpatient mental health services. All Medicaid recipients are automatically enrolled in their local mental health managed care plan operated by the Networks. For RCL

anyone who may need mental health services can schedule an intake assessment. The assessment can occur prior to transition or after relocation depending on the needs and goals of the person. The assessment helps to determine if ongoing mental health services are necessary. The Medicaid mental health benefit will continue after the transition year as long as the person is otherwise eligible.

Each Medicaid recipient who meets access standards for mental health treatment has an individual plan of care. Treatment activities are designed to support consumer goals as documented in the consumer's individual plan. These services must be congruent with the age and cultural framework of the individual and may be conducted with the consumer, their family or guardian, or others who play a necessary role in assisting the consumer to maintain stability in living, work or educational environments. Individual plans recognize the person's skills and goals and support quality of life through access to health services, counseling and psychotherapy and peer support services. The initial assessment -or intake evaluation- of each individual is critical to developing a supportive recovery plan.

Based on eligibility and individual assessment, mental health services may include:

- Brief Intervention Treatment;
- Crisis services;
- Day Support;
- Family treatment;
- Freestanding Evaluation and Treatment;
- Group treatment services;
- High Intensity Treatment;
- Individual Treatment Services;
- Intake evaluation;
- Medication Management;
- Medication Monitoring;
- Mental Health Services provided in Residential settings;
- Peer Support;
- Psychological Assessment;
- Rehabilitation Case Management;
- Special population evaluation;
- Stabilization Services;
- Therapeutic psycho-education; and
- Program for Assertive Community Treatment.

State Plan Programs

- a. **Medicaid Personal Care (MPC)** is Washington's State Plan entitlement program. Personal care is authorized for individuals meeting functional and financial criteria as opposed to diagnostic category. Personal care assistance is provided either by an Individual Provider (IP) who is hired directly by the person

needing assistance or by a caregiver who works for a licensed and contracted home care agency.

- b. **Program of All-Inclusive Care of the Elderly (PACE)** is a fully capitated Medicaid/Medicare managed care program in King County (Washington's largest county, home to 25% of the Medicaid caseload) providing all medical, dental, vision, long-term care, mental health and substance abuse services.
- c. **Private Duty Nursing** provides in-home nursing services to medically complex children and adults who require at least four hours of continuous skilled nursing care daily which can be safely provided outside an institution.
- d. **Adult Day Health** provides skilled outpatient services in a day program setting.

Home & Community-Based Waivers available to aged, blind and disabled

- a. **Community Options Program Entry System Waiver (COPES)** provides in-home and residential options to adults who meet nursing facility level of care. COPES services include self-directed personal care, agency personal care, Adult Family Homes, home health aides, environmental accessibility adaptations, skilled nursing, transportation, specialized medical equipment and supplies, personal emergency response systems, adult day care, caregiver/recipient training, home-delivered meals, in-home nurse delegation and community transition services.
- b. **New Freedom Waiver** provides full self-direction of HCB services, including both employer and budget authority. A cash value is assigned to the long-term care benefit and the participant directs use to meet their individualized needs. A contracted fiscal management agency works with the participant to develop an individualized spending plan. Mechanisms are in place ensuring that services are provided and meet the individual's needs.

Home and Community-Based Waivers for individuals with developmental disabilities

- a. **Basic Plus Waiver** provides services for individuals with development disabilities. Services include: Behavior Management and Consultation, Community Access and Guides, Emergency Assistance, Environmental Accessibility Adaptations, OT/PT and other therapies, Person-to-Person, Personal Care, Prevocational Services, Respite Care, Specialized Medical Equipment & Supplies, Staff/Family Consultation and Training, Supported Employment, and Transportation, skilled nursing and limited residential options.
- b. **Core Waiver** services include residential habilitation and all of the BASIC PLUS waiver services and more comprehensive residential options.
- c. **Community Protection Waiver** services include all CORE waiver services and comprehensive residential services with exceptional supervision.

Other Services

- A Referral Registry exists to connect those who need in-home services with providers who are willing and eligible to work. Staff are available in-person, by telephone or e-mail to help individuals learn more about becoming a provider or to assist individuals to find a qualified provider, substitute provider or access employer skills training.
- **Family Caregiver Support** is funded under State-only and Older Americans Act to provide respite, information and assistance, and training and support services to individuals who provide informal family care.
- **DD Family Support** is offered to families needing additional support to keep a child home.
- **Assistive Technology Funds** are state general revenues used to pay for assistive, adaptive or durable medical equipment, evaluations and consultations by therapists or other professionals, training, or minor home modifications as a payer of last resort. Funds are subject to availability and are used only if there is a denial from Medicare/Medicaid or if the service/device is not a covered item under the State Plan.

Service Package Introduction:

Washington engaged in an extensive stakeholder involvement process in the course of developing this Protocol. The demonstration and supplemental services are purposefully broad and are designed in accordance with stakeholder feedback that services which are very narrowly defined are sometimes a barrier to care. This is especially evident in rural areas where resources are sometimes limited.

The care plans offered through RCL will encompass home and community based services tailored to the circumstances and needs of individual participants. RCL care plans will be coordinated with allied systems including primary care, mental health, substance abuse, vocational rehabilitation and housing.

Decisions to include or not include demonstration and supplemental services in current waiver and state plan services during or after the conclusion of the demonstration period will be made by collecting information about the following:

- overall cost analysis to determine savings or budget neutrality;
- frequency of particular service needs for this population under the demonstration; and
- determination of which services are essential to living independently

We will then use this information to decide which policy level budget decisions to bring forward to legislators and the governor.

Washington State's current transition system includes nursing facility case managers, residential case managers, DDA case managers, mental health community liaisons, and in-home Area Agency on Aging case managers. This system, however, focuses largely

on transitioning individuals early in their institutional stay. Further, community feedback and national transition data highlight that some consumers with complex needs require intensive transition assistance.

Therefore, the transition system we propose for MFP will address these gaps and includes two possible components, one of which is optional depending upon need. The first service is a specialized “Transition Specialist”, which is a state position, that provides outreach and transition coordination exclusively for longer stay nursing facility participants. The Transition Specialist is the only position with the authority to do the MDS based outreach crucial to find those participants who have fallen through the cracks of our existing transition system. Further, each Transition Specialist is responsible for assuring there is no duplication of services in the care plan.

The second service is a Community Choice Guide which is optional. When necessary, the Community Choice Guide deals with time-consuming components of the transition plan for consumers with complex needs. Such tasks are delegated by a Transition Specialist to the Community Choice Guide. The tasks performed by the Community Choice Guide depend on the intensity of the participant’s needs and the necessity for longer, more in-depth involvement for a successful transition. The Community Choice Guide is a contracted option authorized by the Transition Specialist.

The Community Choice Housing Specialist was developed to provide a much needed gap in services related to the challenge of finding, setting up, and maintaining community housing for participants in the demonstration project.

Life skills coordination impacts directly on consumer’s ability to access community settings or health services. It also helps individuals and their caregivers with personal skill development related to the individual’s care plan. If indicated in CARE or the Transition Plan, less formal or atypical daily activities may be supported through this category, such as those that might be found through local YMCA-type organizations, Senior or Community Centers, etc. These are services that may be accomplished by Peer Coach.

Support for families and informal caregivers rated high on the list of suggested additions to our system of care. In home respite care for informal caregivers; support groups focusing on self-care and stress management; training; assistance with challenging behavior management; and brief solution focused therapy were all mentioned as components of this service category.

Professional therapies, transitional mental health, and substance abuse demonstration services covers a range of services for participants whose needs are not otherwise covered by Medicaid. It will allow participants who do not meet current Mental Health Access to Care standards, such as someone experiencing mild depression or anxiety related to their transition, or instances in which the authorized level of service does not meet the individual’s needs, to have access to these services. Similarly, substance

abuse services will be offered to those participants who have not been able to access these services through traditional means. It also covers additional necessary supports and services such as Physical, Occupational, and Cognitive Therapy. The amount, duration and scope of each service are specified within each plan of care and parameters are embedded in the payment system, requiring an additional level of authorization when services differ from established levels.

Challenging Behavior Consultation was highlighted by stakeholders for individuals with traumatic brain injury as well as those with mental illness diagnoses. This option will allow us to target direct interventions to decrease aggressive, destructive, and sexually inappropriate or other behaviors that compromise some participant's ability to remain in the community. It will include specialized cognitive counseling, and be flexible enough that services can be provided in home or in common community settings that the person needs to navigate (i.e. stores, offices, parks etc.).

Purchase and training of certified service animals, and services which modify a participant's residence or vehicle to accommodate the participant's disability and promote functional independence, health, safety and welfare, will also be included in the demonstration. Demonstration services will cover items that are beyond the scope of what we typically cover under current HCBS waivers, such as computers and upgraded wheelchairs.

Bed Holds refer to payments made to an Adult Family Home or Assisted Living Facility to allow an individual who needs to return to an institutional setting for a short term stay. This ensures that the participant will have a place to return to, lessening the likelihood of a protracted stay.

Personal Emergency Response System (PERS) has long been a waived service in Home and Community Services. Putting this option in the demonstration service category will allow us to explore other options now offered through these providers such as enhanced monitoring of in-home settings for those participants who wish it.

The RCL service packages are listed in three tables below. Note that RCL mental health consumers may receive HCB services in any of the three program categories depending on their needs. The tables are organized as follows:

Table 1

This table lists home and community services for older adults and people with physical disabilities. People with mental illness who are older adults or who have a physical disability may be served under this category.

Table 2

This table lists home and community services for people with Developmental Disabilities. People with mental illness who also have developmental disabilities may be served under this category.

Table 3

This table lists Home and Community Services for people with developmental disabilities who meet the Developmental Disabilities Administration criteria for Community Protection. Individuals in this service category require 24-hour, on-site staff supervision to ensure the safety of others ([DDA Community Protection Criteria](#)). People with mental illness who also have developmental disability may be served under this category.

TABLE 1

Roads to Community Living Category		Home and Community Services: Older Adults, Adults with Disabilities, Mental Illness
Qualified (offered under current programs)		<ul style="list-style-type: none"> • Personal Care • Skilled Nursing • Home Health Aide • Adult Day Care • Caregiver/recipient Training • Environmental Accessibility Adaptations • Home Delivered Meals • Transportation • In-home nurse delegation • Specialized Medical Equipment and Supplies • Personal Emergency Response Systems • Community Transition Services • New Freedom Waiver Services (available in King and Pierce Counties) • Adult Day Health
RCL Additional Services		Qualified Providers
Demonstration (Available for the first year and may be continued if approved under waivers or state plan programs)	<i>RCL Life Skills Coordination:</i> Accessing community settings, health services, and personal skill development related to the care plan	<ul style="list-style-type: none"> ▪ Registered Nurse/Licensed Practical Nurse ▪ Dietician/nutritionist ▪ Physical. Occupational, Speech Therapist ▪ Home Health/Care Agency ▪ Independent Living Centers ▪ Weight loss provider ▪ 501(c)(3) serving TBI, Dementia, DDA, MH ▪ Adult Day Center ▪ Fitness Centers ▪ Certified Therapist (Music, Recreation) ▪ Local government ▪ Tribal Government ▪ Housing Providers/consultants ▪ Institutions for Higher Learning ▪ Individual Entrepreneurs (as defined in New Freedom waiver) ▪ Transportation Service Provider
	<i>RCL Informal Caregiver Support Services:</i> Support groups,	<ul style="list-style-type: none"> ▪ Home Care/Health Agency ▪ Joint Commission on Accreditation of Healthcare Organizations (JCAHO) Accredited

	<p>self-care, stress management, training, or brief solution focused therapy for informal caregivers</p> <p>RCL IP Respite Services: Respite for informal caregivers</p>	<p>Agency</p> <ul style="list-style-type: none"> ▪ Community Mental Health Center ▪ Non-profit agency (501(c)(3)) serving TBI, Dementia, DDA, MH ▪ Local Government ▪ Individual Providers (respite only) ▪ Local Government ▪ Tribal Government ▪ Educational and Health Programs ▪ Individual Entrepreneurs (as defined in New Freedom waiver)
	<p>RCL Transitional Mental Health Services: MH services for participants whose needs are not otherwise covered by Medicaid</p> <p>RCL Professional Therapies Plus: Services (physical or occupational therapy, etc.) for participants whose needs are not otherwise covered by Medicaid</p> <p>RCL Substance Abuse Services: Substance Abuse services for participants whose needs are not otherwise covered by Medicaid</p>	<ul style="list-style-type: none"> ▪ Registered Nurse/Licensed Practical Nurse ▪ Physical Therapist ▪ Occupational Therapist ▪ Speech Therapist ▪ Home Health/Care Agency ▪ Community Mental Health or Substance Abuse Services Agency ▪ JCAHO Accredited Agency ▪ Sex Offender Treatment Providers ▪ 501(c)(3) serving TBI, Dementia, DDA, MH, Mental Health ▪ Individual Entrepreneurs (as defined in New Freedom waiver)

	<p>RCL Transition Specialist: Outreach and transition plan coordination</p>	<ul style="list-style-type: none"> ▪ State government
	<p>RCL Community Choice Guide: Intensive, individualized relocation help</p> <p>RCL Community Choice Housing Specialist: Locating, setting up, maintaining affordable housing</p>	<ul style="list-style-type: none"> ▪ Independent Living Center ▪ 501(c)(3) serving TBI, Dementia, DDA, MH ▪ PCP Consultant ▪ Housing Provider ▪ Housing consultant ▪ Peer Support provider ▪ Local government ▪ Tribal government ▪ Care Management Provider ▪ Individual Entrepreneurs (as defined in New Freedom waiver)
	<p>RCL Challenging Behavior Consultation: Interventions to decrease behaviors that compromise a participant's ability to remain in the community</p>	<ul style="list-style-type: none"> ▪ JCAHO Certified Agency ▪ Community Mental health Center ▪ Psych Assistant ▪ Psychologist ▪ ARNP ▪ Licensed Marriage Family Therapist/Masters of Social Work, Mental Health Counselor ▪ 501(c)(3) serving TBI, Dementia, DDA, MH, Substance Abuse ▪ Individual Entrepreneurs (as defined in New Freedom waiver)
	<p>Bed Holds</p>	<ul style="list-style-type: none"> ▪ N/A
	<p>PERS expansion: Additional services to monitor safety and well-being of participant.</p>	<ul style="list-style-type: none"> ▪ Personal Emergency Services provider
<p>Supplemental (Available for the first year)</p>	<p>RCL Service Animal: The provision of a</p>	<ul style="list-style-type: none"> ▪ Org. providing certified service animals ▪ Org. providing related training

and may not be continued)	trained service animal and related training	
	RCL Assistive Technology, Home and Vehicle Adaptations: Items not currently paid for through waivers	<ul style="list-style-type: none"> ▪ business license/expertise
	RCL Residential Environmental Modifications: Modifications to AFHs or another qualified, residential community setting to allow for placement of the RCL participant	<ul style="list-style-type: none"> ▪ business license/expertise
	RCL Adult Day Trial Services: Adult Day Care or Health services while in the nursing home on a trial basis	<ul style="list-style-type: none"> ▪ Adult Day Services provider
	RCL Demonstration Transition Goods: Items not currently paid for through waivers	<ul style="list-style-type: none"> ▪ N/A

Table 2

Roads to Community Living Category	Developmental Disability	
<p>Qualified (offered under current programs)</p>	<ul style="list-style-type: none"> • Behavior Management and Consultation • Community Guide • Environmental Accessibility Adaptations • Occupational Therapy • Physical Therapy • Specialized Medical Equipment/ Supplies • Specialized Psychiatric Services • Speech, Hearing and Language Services • Staff/Family Consultation & Training • Skilled Nursing • Adult Day Health 	<ul style="list-style-type: none"> • Respite Care • MH Stabilization Services: <ul style="list-style-type: none"> ○ Behavior management and consultation ○ MH Crisis Diversion Bed Services ○ Specialized Psychiatric Services ○ Skilled Nursing • Residential Habilitation • Community Transition • Transportation • Employment/ Day Program Services: <ul style="list-style-type: none"> ○ Person to Person ○ Supported Employment ○ Community Access ○ Pre-vocational Services • Personal Care • Sexual Deviancy Evaluation
	RCL Additional Services	Qualified Provider
<p>Demonstration (Available for the first year and may be continued if approved under waivers or state plan programs)</p>	<p><i>Personal Emergency Response System (PERS)</i></p>	<p>Personal Emergency Response System Provider</p>
	<p><i>Personal Agent:</i> Individualized relocation help</p>	<ul style="list-style-type: none"> ▪ Contracted Personal Agent
	<p><i>Community Activities:</i> Help with accessing community settings, health services, and personal skill development related to the care plan</p>	<ul style="list-style-type: none"> ▪ Contracted Community Access Provider

Supplemental (Available for the first year and may not be continued)	Service Animals/Training: The provision of a trained service animal and related training	<ul style="list-style-type: none"> ▪ Org. providing certified service animals ▪ Org. providing related training
	Adaptive Equipment: Items not currently paid for through waivers	<ul style="list-style-type: none"> ▪ Business license/expertise
	Vehicle Modifications: Items not currently paid for through waivers	<ul style="list-style-type: none"> ▪ Business license/expertise
	Family/Provider Assistance and Counseling: Assistance to families and caregivers in the client's home to maintain a positive and supportive home environment	<ul style="list-style-type: none"> ▪ MFT/MHC ▪ Psychologist ▪ Sex Offender Treatment Provider ▪ Social Worker ▪ Psychiatrist ▪ Psychiatric Advanced Registered Nurse Practitioner ▪ Registered Counselor ▪ Family Counselor ▪ Family Counseling Agency Provider

Table 3

RCL Category	Developmental Disability Community Protection*	
Qualified (offered under current programs)	<ul style="list-style-type: none"> • Behavior Management and Consultation • Environmental Accessibility Adaptations • Occupational Therapy • Physical Therapy • Specialized Medical Equipment/Supplies • Specialized Psychiatric Services • Speech, Hearing and Language Services • Staff/Family Consultation & Training 	<ul style="list-style-type: none"> • Sexual Deviancy Evaluation • MH Stabilization Services: <ul style="list-style-type: none"> ○ Behavior management and consultation ○ MH Crisis Diversion Bed Services ○ Specialized Psychiatric Services ○ Skilled Nursing • Residential Habilitation • Community Transition

	<ul style="list-style-type: none"> • Transportation • Employment/ Day Program Services: <ul style="list-style-type: none"> ▪ Person to Person ▪ Supported Employment ▪ Pre-vocational Services • Skilled Nursing 	*Note that some service definitions differ on this waiver and participants must agree to a community protection care plan.
RCL Additional Services		Qualified Provider
Demonstration (Available for the first year and may be continued if approved under waivers or state plan programs)	Mental Health services Plus (Does not meet Access to Care standards under the 1915(b) Waiver)	<ul style="list-style-type: none"> • Community Mental Health Agency
Supplemental (Available for the first year and may not be continued)	Service Animals/related training	<ul style="list-style-type: none"> • Org. providing certified service animals • Org. providing related training
	Assistive technology	<ul style="list-style-type: none"> • Business license/ • expertise
	Vehicle Adaptations	<ul style="list-style-type: none"> • Business license/expertise

Consumer Supports

Case Management: Each participant will have a case manager appointed prior to transition. The case manager ensures that the participants have access to the assistance and support that will be available under the demonstration. Case managers are either employees of the state or contracted with the Area Agency on Aging. Case managers help the consumers through a detailed assessment, provide all available options including RCL, discuss risks and benefits of leaving the institution, and work with the individual to create their own back-up and support plan. Care plans are not considered complete until an individualized back-up plan is in place for critical services.

Back-up plans can include the use of a home care agency which can provide back-up support when needed, several Individual Providers who back each other up, and the use of informal supports that can be called in when needed. Individual Providers can also be obtained through the Individual Provider registry which is in place state-wide. Consumers who have difficulty with transportation or with repair and replacement of their Durable Medical Equipment can call their case manager for assistance with the immediate problem. Community Choice Guides may be available to assist with problem solving during the initial intensive transition process.

Case managers will be able to authorize supplemental and demonstration services as approved in the Operational Protocol using current systems and coding. This is the same process used for authorization of all ADS services so case managers will have a high degree of familiarity with the system. RCL specific codes will be established. Sample copies of education and outreach materials are attached.

Back-up resources: There are 24-hour crisis lines available across the state for MH emergencies.

For Home and Community Based Services, back-up plans are individualized. Each participant will have a case manager appointed prior to transition. The case manager ensures that the participants have access to the assistance and support that will be available under the demonstration. Care plans are not considered complete until an individualized back-up plan is in place. Prior to transition, primary care providers will be identified and initial appointments will be set up in advance to ensure appropriate linkages are made.

Back-up plans can include the use of an agency which can provide back up support when needed, several Individual Providers who back each other up, and the use of informal supports that can be called in when needed. They can also be obtained through the registry which is in place state-wide. Consumers who have difficulty with transportation or with repair and replacement of their durable medical equipment can call their case manager for assistance with the immediate problem. Transportation can also be arranged through the personal care provider.

Back-up plans are discussed, planned for, and documented during the assessment process. This multi-tiered approach includes individualized supports, additional agency or contracted back up as needed, and statewide emergency response systems.

- Informal supports as identified by participant and team: Emergency contacts are documented in the CARE plan.
- Personal Emergency Response System (PERS) is an electronic system whereby an individual can secure help in an emergency through an electronic device that is connected to the individual's phone and programmed to signal a response center, staffed by trained professionals who will immediately summon help for the client. This is already a qualified service in WA's waivers and will be available to all RCL clients as needed.
- IP back up: the Statewide Referral Registry is a resource available to help identify local IP back up as part of the plan of care. These resources are documented in the plan of care. There is a 24 hour statewide hotline to access this service.
- Provider Agency back up: Agency back-up may be required for some RCL participants if indicated in the assessment. Agencies are required to have a means by which clients can contact them during the hours of care provided by that Agency. This is always noted in the plan of care. If an agency needs to be assigned for back-up purposes for health and safety reasons, the particular agency is decided by factors of availability, geography, and client choice.
- Case Managers: Every consumer has a case manager assigned to them for the duration they receive Medicaid services. Detailed notes are kept monitoring all contacts and these receive review through ongoing QA processes.
- RCL contracted resources: Contracted individuals and agencies will be asked about their ability to provide 24 hour backup in cases where there are limited or no informal supports. This will be documented in the plan of care.
- MH statewide 24 hour hotlines: All RCL participants will have access to this 24 hour support regardless of diagnosis. It is available through Regional Support Networks which operate all mental health services. The local access number will be given to all participants at the time of enrollment.
- Adult Abuse 800 line: This is another resource available to all RCL participants and their teams.
- 911: Average statewide response time is 6 minutes. Records are kept of all of these calls.

Additionally, every plan of care must include an evacuation plan. Appendix D-1 “Participant-Centered Planning and Service Delivery” specifies, “If evacuation without assistance is difficult or impossible the case manager and client discuss the risks involved and possible outcomes. The case manager discusses long term care settings that may meet the individual’s need and reduce risk. If the individual chooses to stay at home, the case manager documents the client’s decision.”

In a true person centered planning environment, the state recognizes that there is inevitably some level of risk inherent in community living. While crisis and back-up plans will be in place, we are committed to the principle that RCL participants must be accorded the dignity of risk.

Complaint and resolution process:

Consumers have several avenues for registering complaints about services or any other aspect of their care, including back-up systems and supports. Reassessment is often offered as an alternative to pursuit of a formal complaint. Participants may register complaints about anything the Department does or is responsible for that they perceive as affecting them negatively in any way. The complaint system is operated by Aging and Disability Services.

To protect participant rights, some types of complaints are immediately directed to other formal systems rather than being addressed through the grievance process. Complaints not handled through the grievance process include the following:

- Complaints of abuse, neglect or financial exploitation of a vulnerable adult or child - referred to formal protective systems
- Consumer disputes about services that have been denied, reduced, suspended, or terminated – the consumer is informed of their rights and referred to the fair hearing process
- Complaints about possible Medicaid fraud are referred to the Medicaid Fraud Control Unit

Complaints can be received and addressed at any level of the organization. However, ADS always strives to address grievances/complaints at the lowest level possible. Upon receipt at any level, all DSHS employees are required to respond to in-person or telephone complaints within one business day. Written complaint must receive a response within seven business days or sooner if the issue is critical to health and safety.

Complaints are referred to the case manager for action unless the complainant requests it not be. The case manager will reassess and provide care planning specific to the identified problem, including back-up plans. If the case manager is unable to resolve

the complaint, the person is referred to the case manager's supervisor. The supervisor has ten working days from the date of receipt to attempt to resolve the issue. If the person feels their complaint is not resolved they are referred to the Regional Manager or Area Agency on Aging Director. The Manager or Director has ten working days to seek resolution. If the person continues to feel their complaint is not resolved, they are referred to the state level ADS headquarters. In the case of RCL, the Project Director will work with the appropriate providers including transportation, direct service workers, and medical equipment and supply companies. ADS has ten working days to resolve the complaint and must notify the person in writing of the outcome. All steps in this process are logged.

In addition to the complaint/grievance system operated by ADS, Mental Health consumers have access to local Ombudsman services operated out of the Regional Support Networks. Complaints may be filed with a community mental health agency, the regional support network/prepaid inpatient health plan or the Ombudsman services. All Medicaid recipients are informed of their rights in a Medicaid benefits booklet. [MH Medicaid Benefits](#) Finally, Washington has an independent long-term care ombudsman service that responds to complaints originating from Adult Family Homes, Boarding Homes and Nursing Facilities.

Self-Direction

Self-Direction has long been recognized as an important tool to promote independence and community care. It is governed through the broad authority of RCW 74.39.050.

Individuals with functional disabilities -- Self-directed care.

(1) An adult person with a functional disability living in his or her own home may direct and supervise a paid personal aide in the performance of a health care task.

(2) The following requirements shall guide the provision of self-directed care under chapter 336, Laws of 1999:

(a) Health care tasks are those medical, nursing, or home health services that enable the person to maintain independence, personal hygiene, and safety in his or her own home, and that are services that a person without a functional disability would customarily and personally perform without the assistance of a licensed health care provider.

(b) The individual who chooses to self-direct a health care task is responsible for initiating self-direction by informing the health care professional who has ordered the treatment which involves that task of the individual's intent to perform that task through self-direction.

(c) When state funds are used to pay for self-directed tasks, a description of those tasks will be included in the client's comprehensive assessment, and subject to review with each annual reassessment.

(d) When a licensed health care provider orders treatment involving a health care task to be performed through self-directed care, the responsibility to ascertain that the patient understands the treatment and will be able to follow through on the self-directed care task is the same as it would be for a patient who performs the health care task for himself or herself, and the licensed health care provider incurs no additional liability when ordering a health care task which is to be performed through self-directed care.

(e) The role of the personal aide in self-directed care is limited to performing the physical aspect of health care tasks under the direction of the person for whom the tasks are being done. This shall not affect the ability of a personal aide to provide other home care services, such as personal care or homemaker services, which enable the client to remain at home.

(f) The responsibility to initiate self-directed health care tasks, to possess the necessary knowledge and training for those tasks, and to exercise judgment regarding the manner of their performance rests and remains with the person who has chosen to self-direct those tasks, including the decision to employ and dismiss a personal aide.

A. Voluntary Termination of Participant Direction

Participants are able to switch to and from agency/individual provided personal care at any time. The Case Manager facilitates the transition and assures continuity of care from one provider to the next.

B. Involuntary Termination of Participant Direction.

The state does not have a mechanism for involuntary termination of participant direction. The state may terminate payment to an individual provider or agency for cause. In this case the Case Manager assures continuity of care

By statute, we can deny a client's choice of provider when the health, safety, and welfare of the client are in jeopardy. HCS has also established a "challenging cases" protocol, which gives us a mechanism for bringing the care team together to resolve issues of concern. This process can result in a termination of participant self-direction.

The challenging case protocol is used in less than 1% of WA's Medicaid caseload and occurs when all case management options/activities have been exhausted and the client is still at risk due to poor decision making capability, cognitive issues, and/or safety to self. In most instances the transition from self-directed to traditional service delivery occurs when a client has proven themselves not fully capable of hiring and supervising their own employee. In these cases we discuss their choice of provider and

suggest agency care instead of hiring an individual provider. This transition is usually made voluntarily with minimal disruption to services.

Data regarding the number of individuals using self-directed (individual provider) services are documented twice per year in the bi-annual web report located at dehpg.net.

Quality

For purposes of quality management, the State integrates the demonstration into existing 1915(c) and state plan quality strategy. The State has an extensive, approved quality strategy for HCBS waivers. State plan personal care monitoring and improvement is integrated into the approved strategy. RCL will have the same level of quality oversight as existing programs including all assurances and activities required in Appendix H of the 1915(c) HCBS waiver application (see section (c) below). Washington's Quality Management Strategy covers all HCB recipients including those served under the State Plan.

For some participants, Washington will use the Community Choice Guide demonstration service to ensure early and frequent contact with prior to transition and during the year following transition. Individual issues will be addressed and problems will be reported to the project director so that system level issues can be identified and resolved.

Following the first year we anticipate that most RCL participants will be served through one of the Department's 1915(c) waivers or state plan, and that the QMS will continue to address the required assurances. It is possible that state plan personal care could meet the needs of an individual recipient after the first year. As noted above, the approved QMS encompasses both waiver and state plan services including the standard assurances in section c below.

ASSURANCE #1 – Level of Care Determinations

Washington uses an automated assessment system called the Comprehensive Assessment Reporting Evaluation (CARE) tool to evaluate and reevaluate level of care. This assessment is the only assessment tool used to determine level of care. A level of care determination is provided to all applicants for whom there is reasonable indication that services may be needed in the future. All RCL participants will receive a Comprehensive Assessment Reporting Evaluation. Participants are reevaluated at least annually or in response to a significant change. The timeliness of evaluations and re-evaluations is monitored through establishes Quality Management System processes.

Washington monitors level of care decisions and takes action to address inappropriate determinations. CARE, Quality Assurance, and payment reports are reviewed and corrective action taken on an on-going basis by Home and Community Services supervisors and field managers. Case managers are required to take action within

specified time frames to address all inappropriate level of care determinations identified during supervisory and the Quality Assurance unit monitoring.

CARE Management Reports include data elements such as: intake date, first assigned date, primary Case Manager, date assessment created, date moved from pending to current (make payment), setting and transfer dates.

Quality Assurance Proficiency and Follow-up Reports, which outline level of care decisions and corrective actions taken, include documentation of prompt assessment and eligibility determination. Quality Assurance roll up reports are reviewed at all levels of the system. Case managers receive individualized proficiency reports, supervisors receive unit reports, Regional Administrators and Area Agency on Aging Directors receive regional reports, and ADSA Headquarters reviews aggregate data.

ASSURANCE #2 – Plan of Care

Washington has designed and implemented an effective system for reviewing the adequacy of service plans for demonstration participants. Plans of Care are reviewed on a regular monitoring schedule, when transferring to another office, or as needed. Together the case manager and consumer develops and reviews the plan of care to ensure that the needs (including health and safety risk factors), goals, and preferences of the consumer have been addressed. The case manager will review the plan of care with the provider prior to service implementation to ensure full participation with the plan of care.

Monitoring ensures that services are delivered in accordance with the amount, duration, and frequency specified in the plan of care and that individual plans identify and address all the participant's needs. CARE allows the assessor to document potential safety issues for demonstration participants such as: access to an emergency response system, evacuation in an emergency, necessary environmental modifications, consumer training needs, risk indicators that may affect health status such as the potential for skin break down, durable medical equipment needs, cognitive deficits, person(s) responsible for supervising caregivers, any recent history of falls, Drug/Alcohol assessments, signs of depression, caregiver burnout, suicide risk, and other high-risk indicators. CARE includes a specific section for transition in the plan of care. The transition section will be included in all monitoring for RCL participants.

Case managers are required to take action within specified time frames if inadequacies are identified in the plan of care development and/or implementation. These plans are updated at least annually or when warranted by changes in participant needs. In addition to established Quality Management System measures, for RCL participants the state will include a review of the plan of care prior to transition to assure that necessary services are in place. Contact between institutional and community providers will be arranged to assure continuity of care and there will be routine contact during the demonstration year to assure that transition is successful and that the person's needs are being met.

The following elements are documented in Quality Assurance Application and CARE Reports:

- Needs identified in the level of care are adequately addressed in the participants' Plan of Care
- The Plan of Care is consumer directed and plans are completed in required time frame
- Participants receive the services identified in the plan of care
- Participants are provided a free choice of providers
- Plans are reviewed and revised in response to participant direction or change in needs

Quality Assurance Monitoring Process Overview:

1. A statistically valid sample is pulled statewide per program;
2. The area sample is pulled based on the percent of population for each program in each geographical area;
3. The calendar is developed and distributed;
4. QA unit provides training;
5. An Entrance Conference is conducted by webinar for each area;
6. Monitoring occurs; three day issues are addressed; and
7. An Exit Conference is conducted in person at the completion of the review.
8. Areas have 30 calendar days to make required corrections and QA document remediation.

Local case management supervisors/managers complete a review of four records per worker per year, and case managers provide ongoing review of the client's service plan and services provided several times throughout the year. In DDA, a statistically valid audit of files is done yearly as well as a monthly supervisory review of files. DDA Quality Review Managers also review files as least yearly as well as on an ongoing basis as needed.

ASSURANCE #3 – Qualified Providers

Monitoring assures that providers are contracted appropriately and qualified to provide services. The Quality Management System requires that a statistically valid sample of provider files are monitored to assure that verification of licensing, certification or any other required qualification is provided prior to execution of the contract. Payment cannot be made without a valid contract.

The State has a highly developed provider contract monitoring system as outlined in the approved Quality Management System. This includes monitoring of a statistically valid sample of existing providers to assure that qualifications continue to be met.

Washington re-verifies licensing or certification at the time of contract renewal and per individual licensing or certification schedule. If licensing and/or certification is not required, the State monitors based on qualifications in approved waivers and the state plan. We will use the existing system for providers under RCL.

If a provider is found to not meet qualifications, appropriate action is taken to rectify the situation. This may include termination of the contract if qualifications cannot be met.

Individuals in RCL (and in existing programs) can choose to self-direct their personal care. This means they hire, fire, train and supervise their own providers. To support adequate protections for consumers the state provides regulation, background checks, contracting and continuing education of individual providers. Specific and extensive requirements are noted in Washington Administrative Code ([WAC 388-71](#)). The Quality Management system monitors individual provider files to assure that these requirements are met. Providers who fail to meet requirements are not offered a contract or, for existing provider, the contract is terminated.

The Quality Management System specifies response times for errors related to provider qualifications and conduct. Those requiring immediate response include payment errors; indications of abuse, neglect, and exploitation; consumer safety risks; consumer rights violations; poor quality of care with no indication that a referral, investigation, and/or action occurred. Policy also specifies the response time required to address the provider contracting/training problem that has been identified.

ASSURANCE #4 – Health & Welfare

ADS has strong systems in place to protect vulnerable adults in home and community settings from critical incidents and other life-endangering situations. The Quality Management Strategy for ensuring compliance with this assurance includes a required schedule of face to face contact with the consumer in their own environment, abuse/neglect prevention training; community education; increased monitoring when indications of abuse, neglect, abandonment or exploitation are found; and protocols for mandatory and timely referral to adult protective services, residential care services, child protective services and law enforcement for allegations of abuse, neglect, abandonment or exploitation.

Protective service activity is organized into standard reports and made available to all of ADS. Self-serve, customized reports are available on demand through the Adult Protective Services automated system. These reports are available based on a three level hierarchy of access: an individual worker may access reports about their own

cases; a supervisor/program manager may access reports about their own region, units and workers; and upper management may access reports about all individual workers, units, regions, and statewide. These reports are used for on-going evaluation to ensure that appropriate actions are taken, that analysis of abuse, neglect and exploitation trends occurs and to facilitate day-to-day workload management.

As noted under the Plan of Care assurance, CARE facilitates documentation of potential safety issues for participants. The Plan of Care addresses identified safety concerns.

ASSURANCE #5 – Administrative Authority

RCL is operated by Aging and Disability Services (ADS), a separate administration within the Department of Social and Health Services (DSHS). DSHS exercises administrative discretion, oversight and supervision of RCL by issuing policies, rules and regulations related to Home and community based services. DSHS contracts with Area Agencies on Aging to perform certain waiver functions. Copies of these contracts are on file at the Medicaid agency. On-site contract monitoring of Area Agencies on Aging is performed on a two year rotation schedule, and more frequently at the discretion of the State. Performance is measured as per the terms of the contract, the waiver and identified delegated functions.

ASSURANCE #6 – Financial Accountability

State financial oversight exists to assure that claims are coded and paid in accordance with the reimbursement methodology specified in approved programs. The same methodology will be used for RCL. ADS is meeting this assurance through established Quality Improvement strategy that embeds monitoring of financial accountability and integrity. Monitoring is performed by ADS Headquarter managers responsible for ensuring compliance with financial management policy and procedures.

Quality assurance monitoring related to financial integrity occurs at local, regional and statewide level using a variety of financial data and reports and includes analyzing aggregate data to discover statewide and/or regional trends. Financial irregularities or errors/adjustments made by the state and/or providers are identified, addressed, and corrected.

Financial records are maintained by the state, regional managing entities, and providers, as specified. CARE payments from the Social Services Payment System (SSPS) are entered through electronic interface and a history of payment is maintained. Errors are corrected when identified within the initial monitoring review and follow up review occurs to assure that corrections are complete.

The Quality Assurance Unit develops initial, 30 day, and follow-up proficiency Quality Assurance monitoring reports and approves corrective action plans. Social Services Supervisors are responsible for reviewing four records per case manager per year in addition to all records being transferred between offices. Supervisors/local managers have the ability to perform targeted or additional reviews if concerns arise.

Two Payment Review Program workgroups meet on a monthly basis to review payment data. The Payment Review Program runs algorithms to identify errors in service authorization and ensure that duplicate payments are not occurring. Continuous automated data systems that track waiver status and provider payments are utilized. These reports may identify overpayments and result in recovery actions.

In addition to embedded Quality Assurance activities that monitor financial functions, ADS also audits yearly a random sample of waiver consumer plans of care for financial integrity. The state Social Service Payment System (SSPS) is used to pay providers is continuously monitored for promptness and accuracy utilizing live data. An ADS Headquarters committee reviews all SSPS data when an exceptional rate is requested to ensure compliance. Supervisory review of payment authorization occurs twice a month.

Program Managers review payment data for their programs, address as appropriate, and follow-up to ensure payment corrections are made. WA maintains documentation showing the results of its financial monitoring process.

Supplemental demonstration services

Monitoring of RCL services will be integrated into the existing Quality Management System. Washington will use the same monitoring process for evaluating the adequacy of services including demonstration and supplemental services. The approved system includes remediation and improvement processes. Additional monitoring will evaluate whether transition plans meets Quality Assurance standards.

Housing

The CARE electronic assessment tool documents the type of residence for each participant. All RCL participants will be entered in the CARE system. Case Managers will have an information screen which alerts them to all RCL eligibility requirements including qualified institutional settings as well as qualified community residences.

The Washington State Administrative Code defines housing that is owned or rented by an individual as the present or intended place of residence:

- (a) In a building that you rent and the rental is not contingent upon the purchase of personal care services;
- (b) In a building that you own;
- (c) In a relative's established residence; or
- (d) In the home of another where rent is not charged and residence is not contingent upon the purchase of personal care services.

An Adult Family Home is a residential home in which a person or persons provide personal care to more than one but not more than six adults who are not related by blood or marriage to the person or persons providing the services. For RCL purposes, we will need to utilize only those Adult Family Homes that serve four adults. Adult Family Homes are licensed for a specific number of beds and inspected by the Residential Care Services. A contract with DSHS – ADS is necessary to provide services (and receive payment) to Medicaid consumers.

In the Washington Administrative Code, the category of Assisted Living includes Assisted Living, Enhanced Adult Residential Care, and Residential Care. It refers to any home or other institution providing housing, basic services, and assuming general responsibility for the safety and well-being of the residents. Boarding Homes are licensed and inspected by the Residential Care Services A contract with DSHS – ADS is necessary to provide services (and receive payment) to Medicaid consumers. Some boarding homes provide specialized dementia care.

Individuals receiving services through DDA may live in homes that they rent or own, with agencies providing the level of needed support. Individuals receiving services from DDA also have the option of companion homes (one person living with a provider); alternative living – habilitation services in own home; or supports in the family home by an individual or an agency.

ADS has staff dedicated to working with providers to develop community housing and assisted and supportive living opportunities throughout the state including in rural areas and tribal lands which have been historically difficult to reach. Staff works with local public housing authorities and providers to identify appropriate units of housing for eligible individuals as they are preparing for discharge. This will include identifying options for accessibility and affordability on an individual basis. For example, when an eligible individual is planning to discharge to a specific community and utilizes an electric wheelchair, staff will work with the housing provider to ensure that the available unit is completely accessible to that specific person's needs, including subsidized rental voucher assistance when needed.

We always seek additional affordable housing options. Since implementing the RCL project we have added 215 NED 2 vouchers, and 275 units of HUD 811 housing. Housing Specialist have implemented a Bridge Subsidy pilot, financed through rebalancing funds, to give individuals an opportunity to obtain independent housing while waiting for permanent subsidies. Outreach to Housing Authorities, the Department of Commerce, and independent landlords have resulted in new connections and expanded access to permanent, affordable housing statewide. We educate prospective Adult Family Home owners about the RCL project and begin to examine ways to support them in serving the complex arrays of needs we currently see.

The Developmental Disabilities Administration has a “set-aside” in the State Housing Trust Fund every biennium. These funds are made available to non-profit housing builders who identify individuals with developmental disabilities in need.

As part of the person centered plan of care, each individual will identify their own needs and desires for housing. It is likely that after an institutional stay of at least 3 months, many people will have lost their housing. If not, efforts will be made to place them back into the setting they left. For those instances where that is not the case, the housing resources will vary greatly according to what geographic area they live in.

Staff will work closely with the public housing authorities and local providers in each community where eligible individuals will be living. This work will involve long-term and short-term strategies, where stakeholder work with potential developers of new units of housing will be addressed, as well as addressing the needs of providers and landlords to ensure the availability of immediate accessible and affordable units to eligible discharging individuals.

DDA staff will make sure that people leaving the institutions are aware of this possible funding opportunity for housing and help to facilitate looking at the possibility of using these dollars.

Washington State partners with the Department of Commerce and the Washington State Housing Finance Commission, state Housing Trust Fund, community action groups and local public housing authorities on many initiatives that fund housing and services combinations. These partnerships include packages of funding for local proposals between housing and services providers that include supportive housing options such as project managers on site and referrals to mental health, drug/alcohol treatment, health care and other services as needed.

Public housing authorities throughout Washington are actively providing Section 8 (HUD), HOME funds (federal), local tax funding sources and other rental assistance subsidies, and technical assistance providers are providing forums for the development of proposals between housing and service providers.

RCL funding will be used to supplement our system to cover one-time relocation costs, find accessible and affordable housing, pay for tailored employment opportunities, community transportation, intensive relocation and resource development, peer mentoring, adaptive equipment and assistive technology. RCL services offer strong incentives to those providers with accessible and affordable housing that eligible individuals need to relocate in communities throughout Washington State. DDA will continue to work with the Housing Trust Fund to set goals for availability of Housing Trust Fund dollars to RCL participants.

Continuity of Care Post Demonstration

The state anticipates that most participants in RCL who continue to be otherwise eligible after the one year demonstration will receive services through one of several HCBS waivers. It is also possible that a participant could receive only state plan Medicaid Personal Care (MPC) if that program was adequate to meet identified needs.

Home and Community Services Waivers:

Given the complex needs of these participants, we anticipate they may utilize more than average amounts of long-term care services. We have an exception process in place that will be used to authorize and meet this greater level of need at the end of the demonstration year for participants who need it. In the Exception to Rule (ETR) process, requests may be submitted if the hours/daily rate generated by the CARE algorithm does not meet the participant's care needs. ETR approvals are based on the clinical characteristics and specific care needs of the individual. This process will apply to RCL participants and will be available as they move to ongoing services so that participants will not experience an unanticipated loss of service. There is currently no money or people cap on ETR services.

Medicaid Personal Care (MPC) is Washington's State Plan entitlement program. Personal care is authorized for individuals meeting functional and financial criteria as opposed to diagnostic category. Personal care assistance is provided either by an Individual Provider (IP) who is hired directly by the person needing assistance or by a caregiver who works for a licensed and contracted home care agency. Washington has never had waiting lists for this program and we do not anticipate any problems with obtaining access for RCL participants post demonstration.

Community Options Program Entry System Waiver (COPES) provides in-home and residential options to adults who meet nursing facility level of care. We anticipate that the majority of RCL participants who are transitioned from nursing facilities and hospitals will be enrolled in the COPES waiver at the end of their demonstration year. We do not anticipate needing a waiver amendment to accommodate RCL. For the last five years unduplicated recipients on this waiver average 1500-2000 under the approved capacity. For the most recent waiver reporting year COPES is authorized to serve 32,772 and total unduplicated participants were 30,790.

New Freedom Waiver provides full self-direction of HCB services, including both employer and budget authority. A cash value is assigned to the long-term care benefit and the participant directs use to meet their individualized needs. A contracted fiscal management agency works with the participant to develop an individualized spending plan. Mechanisms are in place ensuring that services are provided and meet the individual's needs. This waiver is currently limited to King and Pierce Counties.

HCBS Waivers for individuals with developmental disabilities:

People with developmental disabilities who are transitioned from the state's Residential Habilitation Centers (ICF-IDs) will be enrolled in one of four DDA waivers on the day they move to a community setting.

The four waivers are described below. It is anticipated that most DDA RCL participants will be enrolled in the CORE waiver. A few will be enrolled in the Community Protection waiver. The state will request waiver amendments as needed to accommodate RCL participants.

BASIC Plus Waiver provides services for individuals with development disabilities. Services include: Behavior Management and Consultation, Community Access and Guides, Emergency Assistance, Environmental Accessibility Adaptations, OT/PT and other therapies, Person-to-Person, Personal Care, Prevocational Services, Respite Care, Specialized Medical Equipment & Supplies, Staff/Family Consultation and Training, Supported Employment, and Transportation, skilled nursing and limited residential options.

CORE Waiver services include residential habilitation and all of the BASIC PLUS waiver services and more comprehensive residential options.

COMMUNITY PROTECTION Waiver services include all CORE waiver services and comprehensive residential services with exceptional supervision.

Other services in place to ensure continuity of care:

A Referral Registry connects those who need in-home services with providers who are willing and eligible to work. Staff is available in-person, by telephone or e-mail to help individuals learn more about becoming a provider or to assist individuals to find a qualified provider, substitute provider or access employer skills training.

Family Caregiver Support is funded under State-only and Older Americans Act to provide respite, information and assistance, and training and support services to individuals who provide informal family care.

DD Family Support is offered to families needing additional support to keep a child home.

Assistive Technology Funds are state general revenues used to pay for assistive, adaptive or durable medical equipment, evaluations and consultations by therapists or other professionals, training, or minor home modifications as a payer of last resort. This fund is used only if there is a denial from Medicare/Medicaid or if the service/device is not a covered item under the State Plan.

Billing and Reimbursement Procedures

Billing and reimbursement will be managed through the systems currently used for waiver and state plan services. Washington has extensive fraud control and financial monitoring systems in place.

The process for validating provider billings is as follows:

- (a) The individual was eligible for Medicaid waiver payment on the date of service.

Aging and Disability Services social workers, community nurse consultants and Area Agency on Aging direct service and contracted case manager will authorize waiver program services (as listed on the individual service plan) effective on the date all the following program factors constituting Medicaid eligibility for waiver services are satisfied:

1. Categorical relatedness and financial eligibility are approved.
2. The assessed applicant/recipient is eligible for nursing facility level care and is, or likely to be, institutionalized.
3. The individual service plan is developed and approved by the Aging and Disabilities Services social worker/case manager, community nurse consultant or the Area Agency on Aging direct service or contracted case manager.
4. The recipient has approved the service plan.
5. The provider is qualified for payment.
6. The provider contract procedures are completed.

- (b) The service was included in the participant's approved service plan.

The services in the approved plans are not authorized until steps in the description of the mechanism for assuring payments are made only for eligible service recipients are completed. Claims for payments can be made only after Aging and Disability Services staff or Area Agency on Aging direct service or contracted case managers have authorized the payment. The only services authorized are those services listed in the consumer's plan of care.

- (c) Verification that the services were provided:

1. Verification is obtained during face to face annual and significant change reviews with the recipient/legal representative.
2. Verification is obtained via quality management record reviews which may include face to face contact or survey style responses gathered annually.

3. Verification may be obtained through the ADS consumer grievance process -
The policy and procedure for this process was updated and disseminated in 2005 (MB H05-018 – Policy/Procedure)

If billing problems are identified via the consumer, the Quality Assurance process or the grievance process ADS corrects the payment and adjusts the claim for Federal Financial Participation accordingly.

Payment Procedures

Washington uses two systems to process claims pertaining to the services provided to waiver recipients. The same systems will be used for RCL claims processing will use the same payment processing system as all other waiver and state plan services. . State plan services are processed through the Medicaid Management Information System. Payments are currently in the process of being converted from our current system (the Social Service Payment System (SSPS) to a new payment system, ProviderOne. The SSPS system is described briefly here; the new system will have several additional benefits and will retain the same accountability features that our current system provides.

SSPS has unique code sets for each program. RCL has an assigned code series and within that series, each service has unique codes. Services for consumers in RCL can only be authorized using RCL SSPS codes.

The SSPS maintains data on waiver recipients including recipient name, birth date, social security number and case number. The recipient data is associated with the provider name, provider payment identification number, waiver service begin and end dates, unit rate, authorized service charge code, amount paid, date paid, etc.

Aging and Disability Services Administration (ADS) social workers, community nurse consultants and Area Agency on Aging direct service and contracted case managers authorize waiver service payments for applicant/recipients meeting financial and service eligibility factors using a DSHS 14-154, Service Authorization form. Information on the form is used to update the SSPS computer database. A copy of the completed form is retained in the recipient's case record and the service provider receives a notice of payment authorization from SSPS. The computer generates a Change of Service Authorization form (DSHS 14-159) after the first authorization is processed. ADS and the Area Agency on Aging direct service and contracted case manager staff use this Change of Service form to add, change, or terminate services.

The Service Invoice is the basis for payment of authorized waiver services, which have been provided. Each service is shown on an invoice one time for each month it was authorized as that month ends. Even if a service has not been billed or paid for, it will not be shown on an invoice a second time unless ADS or Area Agency on Aging direct service or contracted case manager staff re-authorize payment. The provider signs the

invoice and returns it to the department. Payments are made directly to the service provider. Historical records of all payments are maintained.

Financial Integrity and Accountability

(a) Requirements concerning the independent audit of provider agencies.

Home Care Agencies are required to have an independent financial audit without findings covering the two year period prior to contracting. The audit must be conducted by a licensed CPA or a recognized financial firm.

Federal rules are followed for agencies that have non-profit status per the Single Audit Act and OMB CIRCULAR A-133. A single or program specific audit is required for the AAA and other subcontractors who expend more than \$300,000 in federal assistance in a year. If the subcontractor is a for-profit organization, it may be a sub recipient, but it will not fall under the OMB CIRCULAR A-133 requirements for a federal single or program-specific audit. In this unique case, the for-profit is monitored annually as follows:

1. By performing a desk review of the vendor's annual audit,
2. By on-site monitoring and completion of the monitoring worksheet. AAAs are required to use the following risk factors to help determine if on-site monitoring should be done:
 - a. Frequency of outside audits
 - b. Prior audit findings
 - c. Type of Contract
 - d. Dollar amount of contract
 - e. Internal control structure of subcontractor
 - f. Abnormal frequency of personnel turnover
 - g. Length of time as a subcontractor
 - h. History of marginal performance
 - i. Has not conformed to conditions of previous contracts

3. Review of subcontractor's relevant cost information when contract is renewed. The State Auditor's Office conducts the periodic independent audit of the waiver program as required by the single audit act.

(b) The financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits.

Area Agencies on Aging are responsible for monitoring Home Care Agency service contractors with whom they have executed contracts. Full on-site monitoring occurs every two years. A new subcontractor must receive a full monitoring for each of the first two years they are under contract. Abbreviated monitoring occurs in each year when full

on-site monitoring does not occur. Desk monitoring occurs semi-annually. Review tools and policies are available through ADS.

In addition to administrative review, consumer record and plan of care review, full on-site monitoring includes a fiscal review. The fiscal review consists of a comparison of a sample of contractor billings/SSPS reports to contractor maintained documentation of work performed. A review of individual employee time records is part of this responsibility. The minimum sample size is 5% of current authorizations. The monitoring activity verifies that work billed for was performed, that the contractor is maintaining documentation of work performed and, that employees are paid for work performed.

An abbreviated review consists of a review of complaints and review of any items where compliance was not met during the full review. The abbreviated monitoring must be expanded to full when a subcontractor exhibits significant problems that are not corrected as required by corrective action.

Desk monitoring consists of a review of program and financial reports to compare level of service provided to the level of service authorized. Area Agencies on Aging's verification of a sample of time keeping records is required for home care agencies that exceed a ratio of provided versus authorized hours of 92% or above for the quarter reviewed. AAAs must require a written response from home care agencies that have a quarterly ratio of provided versus authorized hours that are equal to or less than 75%. If the reason for the underserved hours is primarily due to an agency's inability to appropriately respond to referrals or provide adequate staffing levels, a corrective action must be submitted by the agency.

DSHS Payment Review Program

DSHS launched the Payment Review Program in 1999 to employ new technology to assist with the regular DSHS review of Medicaid billings for accuracy. The focus of the Payment Review Program is to identify and prevent billing and payment errors. Originally, the Payment Review Program only looked at claims through the Medicaid Management Information System. Social Service Payment System billings were added to the Payment Review Program in 2002.

The Payment Review Program employs algorithms to detect patterns and occurrences that may indicate problem billings. DSHS has an extensive internal algorithm development and review process. To keep providers informed about finalized algorithms, the Payment Review Program has posted the algorithm descriptions on the DSHS Internet site. Teams of DSHS clinical, program and policy experts rigorously review all data analysis results from PRP reports to ensure accuracy.

Adult Day Care providers are reviewed at least annually per WAC 388-71-0724. Review includes administrative procedures and a required audited financial statement. Monitoring for other waiver service contractors is conducted at a minimum every two years. Area Agencies on Aging may conduct either a full or abbreviated monitoring based on a usage/risk threshold. Triggers for a full monitoring are within a two year

period, and consist of: five or more authorizations; one complaint concerning quality of care or consumer safety; or, \$5000 or more in payments or any other reason the AAA thinks a contractor needs to be monitored.

Full monitoring of other waiver service contractors includes a comparison of contractor billings to contractor-maintained documentation of work performed. Verification that the work was performed should also be obtained from the consumer if possible. There is a minimum of 5% of the total consumers served in the previous two years which is the sample size for short term or one time services such as environmental modifications or specialized medical equipment. The minimum sample size for services that are generally ongoing such as skilled nursing or Personal Emergency Response Systems is 5% of current authorizations. Monitoring includes review of individual files where they exist for services such as skilled nursing, consumer training, adult day care, home delivered meals and home health aide services.

(c) The agency (or agencies) responsible for conducting the financial audit program.

State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable). The Medicaid Agency is responsible for conducting the financial review program of Area Agencies on Aging. AAAs are responsible for conducting financial review activities of subcontracted providers. The State Auditor’s Office conducts the periodic independent audit of the waiver program as required by the single audit act.

Staffing Plan

The Project Director works full time planning, organizing, and directing the implementation and operation of the Roads to Community Living RCL demonstration project. Participant and stakeholder involvement in the planning, design, implementation and evaluation of the project is a key objective of the position. Successful project direction includes coordination, organization, development of partnerships and resources, data collection, and outreach activities, both within the state system as well as private entities that are components of these objectives. In addition the Project Director is responsible for providing analysis and guidance to Home and Community Services upper management on rebalancing and RCL issues as they affect DSHS. The Project Director’s resume has been submitted to and approved by the Center for Medicare and Medicaid Services.

Dedicated Positions			
#	Title	% of Time	Role/Responsibility
1	Project Director	100	Plans, organizes, and directs the implementation of the RCL project.
1	Program Manager, Data Coordinator, Decision Support	50	Coordinates and manages data systems for grant
1	Fiscal Analyst	50	Develops budget, payment systems and fiscal reporting

Descriptions of additional approved full time State positions working on the grant may be found in APPENDIX A: Resource Initiative 2010.

Positions Providing In-Kind Support			
#	Title	% of Time	Role/Responsibility
3	Office Chief, Community Living and System Support	5	Supervise the Director, provide direction for the project. Responsible for the assessment of performance of the staff involved in the demonstration.
	Office Chief – Training Unit	5	Implement Quality assurance and improvement processes
	Office Chief – DDA	5	Develop QA/QI program and processes, data collection methodologies, and analysis
1	HCS Waiver Program Manager	15	Manager HCBS and waivers. Submit SPA or Waiver amendments as needed
2	Assessment/Case Management Program Manager	15	Develop and implement any assessment or case management changes
1	Quality Assurance Program Manager	20	Develop QA/QI program and processes, data collection methodologies, and analysis
3	Quality Assurance Specialists	10	State evaluation & analysis of the RCL project

a. Number of contracted individuals supporting the grant.

There are no contracted individuals directly supporting the management of the grant. Those functions are being performed by state staff as outlined above. The services and supports for the Roads to Community Living demonstration project will be provided by contracted agencies and individuals including contractors for our existing waivers and state plan services.

Staff involved in the demonstration are assigned to Aging and Disability services. Within that administration, the Office Chief of the Community Living and Support Services unit will assess the performance of the Project Director. The Office Chief of Decision Support will assess the performance of the Data Coordinator for RCL. The Budget Manager will assess the performance of the Fiscal Analyst.

Other administrative aspects of the program:

BUDGET: All MFP budget, MOE, and financial documentation is submitted, approved and recorded on the online GrantSolutions.gov website.

REPORTING REQUIREMENTS: Grant budget and reporting requirements are documented on the online GrantSolutions.gov website. Additional budget, benchmark, rebalancing, and programmatic data are documented on the online semi-annual web reports located under “MFP” on the dehpg.net website.

APPENDIX A: HCS Resource Initiative 2010

Introduction – May, 2010

It has been approximately two years since Washington began transitioning people through the MFP demonstration. During these first years of the grant we have been learning about, adding to, and refining our existing transition infrastructure to meet the needs of our longer stay Nursing Facility (NF) residents. The current package of demonstration services and staff to support these transition efforts are allowing us to successfully reach out benchmarks. Existing community resources including providers, qualified community settings and affordable/accessible housing options will not sustain our projected growth. We are struggling to find providers who are willing and able to serve our most complex NF residents who wish to live in the community.

In order to meet and later exceed our goals, we shall use the current opportunity to use increased federal investment to make a concerted effort to increase our capacity in these areas. Our goals include:

- Provide policy level support to help coordinate and provide sustainable direction and infrastructure;
- Train the workforce (state staff and community providers) to meet the demands of the increasingly complex NF population now transitioning to the community; and
- Create new resources to accommodate our growing community caseload.

Four new policy level positions and six resource specialists as well as additional training and outreach efforts will be added to support this effort state-wide. Brief descriptions of these positions follow.

Policy Level Positions

To oversee and coordinate training efforts, we are adding a policy level *Training Curriculum Developer*. Hand in hand with training is the need for a *Quality Improvement Specialist*, tasked with analyzing, reviewing and suggesting areas of improvement regarding our transition work. We will find out and document from both clients, their families AND providers: when transition is successful, what's working? And when it is unsuccessful, why? A Quality Improvement Specialist can further best practices by working with the Training Curriculum Developer to tailor trainings to meet needs identified by those in transition, those housed in the community, staff and providers.

As part of our MFP efforts, we have actively sought out expertise from the community to expand the depth and breadth of the transition services we can offer our clients. A large part of our demonstration services are provided through this newly developing cadre of community providers. This has proven to be a very successful part of our demonstration.

Community Choice Guides and Housing Specialists are contracted direct service providers supported through the demonstration's enhanced match. Contracts have also been established for Life Skills and Challenging Behavior Consultants and Transitional Mental Health Consultants. In all, approximately 85 new contracts have been created as a result of the RCL grant. These are new roles within our system; as more people transition, the need for these providers' increases. The development of contracts, the necessity for contract monitoring, and consistent development of rates for transition services leads us to propose a *RCL Systems Change Specialist*. As the number of providers increase, the need for systemic change in our contracting procedures and quality assurance also increases. This position will handle the systemic issues that arise as we bring providers in through a network of complicated individual, agency, city, county, and state contracts. In Washington State, our community contracts are typically handled through our AAAs. They have not historically managed contracts for services provided in NFs, leaving the burden of bringing in these new providers to our HCS offices. We identify a pressing need to resolve the time consuming systemic issues that have arisen because of this new set of circumstances. Provider rates have also proven to be a complicated system to standardize and manage. The RCL Systems Change Specialist will analyze, review and make recommendations regarding policies and procedures to determine best practices for contracts acquisition and rates determination, as well as the most effective use of RCL Reinvestment funds.

A recurring theme as we rebalance our system is the need to develop policy expertise at the headquarters level around how to successfully serve individuals with significant behavioral issues. When we look at recidivism and care planning it is clear that we need to develop the expertise of our social workers and providers about how to serve individuals in the long term care system who have behaviors due to dementia, mental illness, traumatic brain injury, substance abuse, etc. Although we have some real success stories we have been unable to systemically address this need. We are adding a *Behavior Specialist* to develop policy guidelines and provide consultation to the field as necessary regarding working with clients with challenging behaviors.

Housing and Resource Specialists: System Centered Community Relationship Building

Affordable, independent, community housing options for our RCL clients is a pressing need. The proportion of younger adults with disabilities coming through our program is much higher than anticipated. Not surprisingly, their need and preference is for subsidized housing with supports, currently in short supply. In preparing for the new Housing Choice Vouchers offered through HUD we are increasing our efforts to connect local HCS offices to work with the housing authorities in their area to combine efforts to help address this housing gap.

Our goal is to support the options that our contracted housing specialists find for individuals and transform them into long term relationships which foster new development and better utilization of existing housing resources. Having a presence at local planning meetings and making connections with local CDBG and HUD projects is necessary to move forward. Sustained contact with them is necessary for ongoing

inclusion of the NF relocation population. We will be looking more intensively at cluster care, Supportive Housing, Shelter plus Care, and Single Room Occupancy (SRO) units.

We are fortunate in Washington to have a network of Adult Family Homes and Assisted Living Facilities that also accommodate people transitioning out of NFs. For many people, these independent community options with a communal element fit their needs very well. We would like to increase both the capacity of these settings available to Medicaid clients, and work with these providers to accommodate clients with increasingly complex needs.

Housing Specialists (3: one for every two regions): These individuals will provide local focus on opportunities to increase the availability of qualified community settings for individuals transitioning from NFs. The goal of these positions is to work with Housing Authorities, senior housing providers, and other community providers to create new housing options.

Resource developers (3: one for every two regions): These individuals will identify local resource needs, and develop local services and contracts to meet these needs. They will assess and develop community providers (individual and agency) for services other than personal care, and work with professional organizations and other local resources to recruit contractors to meet identified needs. They will also assist the Systems Change Specialist with developing rates and contract terms for caregiver/recipient training and other providers. As local resources, they will also assist with field training in conjunction with the Training Curriculum Developer, and contract monitoring as directed by the Systems Change Specialist.

Training: Expertise to Staff and Providers Reinforcing Best Practices

As we are demonstrating in our benchmarks, measures of acuity in our nursing facilities demonstrate that the complexity of needs of NF residents and those we serve in the community increases as we continue to rebalance. On a case by case basis, however, we often see clients in the NF whose care needs are far less complex than many of the individuals we see living in the community. We are in the process of trying to understand why that is, and develop successful strategies to engage LTC clients in goal setting and taking an active role in their own health care decisions and managing their quality of life. How to help people become actively engaged in their own health care and well-being while managing their numerous chronic conditions often exacerbated by depression and anxiety requires an increased level of skill that is new to many of our social workers and providers. We would like to understand the way people look at and make important changes, in this case, regarding their health and long term care choices. The relatively new area of motivational interviewing can help us understand this process better in our clients and their family members. It has proven to be very effective in our chronic care management pilots and in other healthcare settings.

We will also focus on the use of assistive technology. Although we are seeing effective, sustainable care plans being implemented with our MFP clients, we are not seeing frequent usage of some of the technology that is becoming more readily available on

the market. These are new tools, which require training to understand what they are as well as how they are best used and where they can be obtained. When appropriately used, assistive technology can increase the ability to manage more independently and integrate more fully into the community.

Our providers also need training to serve individuals with a host of complex needs in the community. Making sure that providers in qualified settings have specialty training in dementia, mental illness and recovery, behavior management, chronic care management and what is necessary to provide safe and effective care to individuals who are obese are examples of the training we believe is critical to increase both capacity and confidence of our provider networks.

These efforts will be supported by additional funding for travel, outreach and marketing.

Measurable Outcomes

Our original benchmark transition goal was **580** Home and Community Services (HCS) transitions over the course of the five year demonstration. We are now projecting an additional **600** transitions through December 2012. This would bring the total number of HCS transitions to **1,180** for the entire MFP demonstration, more than doubling our original number of transitions. These changes have been made to Benchmark #1.

DDA Resource Initiative 2010

Introduction

Washington currently has about 900 individuals residing in their five residential habilitation centers (RHCs) and many of those individuals have lived there most of their lives. In addition, there are a growing number of youths whose parents have demanded placement in the RHCs because of behavioral issues the young person has and the lack of resources in the community.

DDA originally proposed to move approximately 80 individuals over the five year grant period, with focus on the young people who have been in the institutions for six months or more. This has proven to be difficult. Letting people know about the opportunity, securing their interest and then preparing for moves is taking considerably longer than anticipated and require additional resources to accomplish. We have established the need to have additional administrative staff that can be ready to act on the opportunity to offer choice of community living to individuals who now reside at the RHCs and whose guardians might be more receptive to considering community options. Additional time and energy needs to be focused on developing community alternatives for young people before they and their families become accustomed to institutional care.

Policy Level Positions

Three new positions are being added that can focus on MFP transitions exclusively.

DDA Transition Coordinator: will provide support, focus, and guidance to field staff responsible for transitioning individuals out of the RHC's. Work with individuals and their families is very intensive. Coordination of resources statewide will streamline the

process and maximize the time available to regional staff. The Transition Coordinator would focus on helping individuals and families think about what the community has to offer, as well as enabling DDA staff to learn about options that are available.

Behavior Specialist: will develop policy guidelines and provide consultation to the field as necessary regarding working with clients with challenging behaviors including mental health, substance abuse and TBI. Many of the individuals currently residing in our RHCs have been placed there because of behavioral issues. Having a specialist who can analyze and help find the proper setting, identify training needs for staff and follow-up on the well-being of the persons moving will substantially enhance the success of community placements.

Quality Improvement Specialist: shall meet with clients, families, providers and state staff in order to analyze, review and suggest areas of improvement regarding transition from RHCs to the community. This is a function that will impact our ability to provide successful interventions for RHC clients and to proactively deal with challenges that might arise.

Contractors

We will also purchase technical assistance from contractors with specialized support knowledge and expertise in the following areas:

- Providing supports to clients who are difficult to serve;
- Assistive technology necessary to community living;
- Housing modifications and development; and
- Training of providers on supporting clients to transition from institutional living to community living.

Measurable Outcomes

Our original benchmark transition goal was **80** Division of Developmental Disabilities (DDA) transitions over the course of the five year demonstration. These additional resources are being added in order to reach that goal by December 2012.

APPENDIX B: ADRC Resource Database

Washington State has initiated work creating a vision and methodology to achieve information technology that informs and assists Washington's Aging & Disability network to optimally serve consumers of all backgrounds and economic circumstances plan and easily access both public and private long term supports and services.

Aging & Disability Services Administration's (ADSAs) is purchasing a configurable, off the shelf vendor hosted Application Service Provider (ASP) that can deliver four functionally essential elements:

- Client management functionality (demographics, intake/screening, referrals, case notes)
- An AIRS Standards/211 LA County compliant resource database that is consumer friendly
- State and NAPIS reporting functionality
- Public "self-service" access capabilities and secure client document "self-storage"

The goal of the project is to enhance the ADRC infrastructure in Washington State and expand access to pre-Medicaid individuals transitioning from institution to community care. The objectives are: 1) leverage and create links with diverse state partners to facilitate use of the resource database; 2) create access to the ASP and create partnerships that support implementation of MDS 3.0 Section Q; 3) increase access through the use of self-service portals to educate and inform consumers. The expected outcomes are: 1.) increased coordination of efforts between HCS, the AAA's, and the ADRC for pre-Medicaid individuals transitioning to community care; 2) self-service access to resources to assist pre-Medicaid individuals transitioning to community care; 3) a system of consumer driven menu options. The products are: a final report, a robust public resource database, a self-service portal website with three videos.

ADRC project staff will coordinate efforts between Home and Community Services (the MFP) and Area Agencies on Aging for pre-Medicaid individuals transitioning to community care. The ADRC project staff will assist in the development and enhancement of protocols to execute the ASP resource database. The MFP and ADRC program staff will collaborate to provide cross training to their prospective field staff on the MFP programs and use of the ADRC resource database. The project staff will develop and coordinate partnerships with nursing facilities who have identified pre-Medicaid individuals interested in discharge from the facility to the community. In addition, project staff will provide technical expert assistance to staff with the Washington State Department of Informational Services (DIS) to assist in developing three educational video resources that will be utilized on the website and in the self-service portals.

Budget Narrative/Justification Year 1:

2010 ADRC Nursing Home Transition and Diversion Program Grant

Object Class Category	Federal Funds	Non-Federal Cash	Non-Federal In-Kind	TOTAL	Justification
Personnel					
Fringe Benefits					
Travel					
Equipment					
Supplies					
Contractual	\$325,000	\$0	\$0	\$325,000	Grant funding will be combined with Title 3B Administrative funds to purchase ASP Statewide Information System and Resource Database (Year One Cost Estimates - \$500,000-\$1,000,000)
Other					
Indirect Charges					
TOTAL	\$325,000			\$325,000	

Budget Narrative/Justification Year 2

2010 ADRC Nursing Home Transition and Diversion Program Grant

Object Class Category	Federal Funds	Non-Federal Cash	Non-Federal In-Kind	TOTAL	Justification
Personnel					
Fringe Benefits					
Travel					
Equipment					
Supplies					
Contractual	\$75,000	\$0	\$0	\$75,000	Washington State Department of Information Services (DIS): Contract with DIS to develop educational video resources: Three 20 minute DVD/videos @ \$25,000 = \$75,000 A detailed evaluation plan and budget will be submitted when contract is finalized.
Other					
Indirect Charges					
TOTAL	\$75,000			\$75,000	

Appendix C: Integrated Client Protection System

Introduction

Roads to Community Living (RCL), Washington's Money Follows the Person (MFP) project, has provided an opportunity to move forward with our rebalancing and transition work despite difficult state budget challenges. We continue to learn about best practices in terms of safely moving and maintaining individuals in the community. In our original Operational Protocol (OP), Washington integrated the RCL demonstration project into existing 1915(c) and state plan quality programs and added quality of life surveys and reporting required in the grant application. Washington has a rigorous quality assurance program that monitors and tracks our progress as a system, as well as protects the ongoing safety and well-being of individuals in residential and home and community based settings. The same quality assurance standards are used across the 1915(c) and state plan services that provide personal care. As our system grows and changes to meet current needs, however, outdated computer systems hamper our ability to link the important information that comes in from different silos within our internal systems. The ability to connect our existing separate systems becomes particularly critical in regard to incidents of abuse, neglect and exploitation.

We are moving far more people through RCL than we had originally projected. Adding a new client protection system to our systems P will better provide safety assurances for the individuals with complex needs who are successfully relocating to HCBS settings. By developing this system within the auspices of MFP, we are assuring better quality management for MFP and all waiver clients.

Washington parallels national trends with the predicted increase in the 65+ population and younger adults with disabilities, the fastest growing segment of our nursing home population. The older adult population alone is forecasted to represent one-fifth of Washington State's total population in 2030. Washington State's adult abuse and neglect response system must be able to quickly and efficiently identify and meet the needs of those adults who are vulnerable to abuse, neglect and exploitation.

Recognizing that identification, prevention, and response to abuse and neglect against older adults or people with disabilities is dependent upon community partnerships, Susan Dreyfus, Secretary of the Washington Department of Social and Health Services (DSHS), convened a group of community advocates and state agency staff to address the need for continuous improvement of the abuse and neglect response system for adults who are vulnerable in Washington State. The group included representatives from law enforcement, Tribal governments, Protection & Advocacy, the Long Term Care Ombudsman, Area Agencies on Aging, the Developmental Disabilities Council, The ARC of Washington, Self-Advocates In Leadership, the State Council on Aging, the Attorney General's Office, the Medicaid Fraud Control Unit, AARP, the Governor's Committee on Disability issues and state staff involved in long term care and disability programs. The study group's final report was submitted on Sept. 15, 2010:

After an intensive study of system capacity and gaps, the number one recommendation made by the Vulnerable Adults Study Group is to replace and

integrate antiquated protective services databases for both in-home and residential settings to improve accuracy, accountability, program and individual outcome tracking and information sharing. (Improving Washington State's Adult Abuse Response System, pg. 8)

In review of state waiver and MFP programs the Centers for Medicare and Medicaid Services (CMS) also strongly suggested that the state invest serious effort in this area. We believe that strengthening the State's ability to track, trend and report abuse/neglect data across settings and programs is vital to the continued success of rebalancing given the State's current success and our projected growth in both general population and MFP participants.

The need for developing a more efficient system for managing critical incidents was confirmed during the gap analysis conducted by the state with National Quality Enterprise (NQE) in late 2010.

The TIVA system went live in May of 2014. Below is the final budget for the project, including projected costs through March of 2015 to wrap up all training and implementation follow-up.

Budgeted	Expenditures through July 31, 2014	Obligated through 3/31/15	Total estimated expenditures for TIVA project
Salaries	983,522	520,000	1,503,522
Benefits	279,123	130,000	409,123
Personal Services Contract	10,476,959	567,975	11,044,934
Goods & Serv	23,336	5,250	28,586
Travel	6,738	2,000	8,738
Equipment	337,243	50,000	387,243
Quality Assurance Contract	83,272	29,232	112,504
TOTAL Budgeted	12,190,192	1,304,457	13,494,649
State	1,200,278	127,523	1,327,800
Federal	10,989,914	1,176,935	12,166,849
Total	12,190,192	1,304,457	13,494,649
			-

APPENDIX D: Tribal Initiative 2014

Project Narrative: For the first time, with the passage of the Affordable Care Act and its conjoined American Indian Health Improvement Act, long term services and supports (LTSS) can be developed and supported through Indian Health Service resources. This provides an opportunity for Washington State, Tribes, Urban Indian Organizations and allied long term care organizations to utilize existing strong partnerships as a base to plan and develop community-based services which meet the needs of Tribal people in culturally appropriate ways. The partners will seek to identify pertinent tribal characteristics through surveys, assessments and broad input to determine respective roles for Medicaid administrative functions at the tribal level. This process will ensure that native services will be of high quality and ready to accept tribal members discharged from skilled nursing facilities and other institutional settings. Key partners and existing formal relationships that support cooperative relationships for the continued improvement of services and service delivery for tribal members will provide a strong base.

State/Tribal Partners and Partnerships: The **Primary Partners¹** will include the Indian Policy Advisory Committee (IPAC), the Washington American Indian Health Commission (AIHC), the Department of Social and Health Services (DSHS), Aging and Long Term Support Administration (AL TSA) and the Health Care Authority (HCA). This partnership will provide leadership throughout the Initiative.

The **Indian Policy Advisory Committee²** is the oldest tribal advisory committee in the state, established in 1977. The IPAC is an advisory body to the Secretary of the Department of Social and Health Services, the largest state agency in Washington State. Membership is the 29 Federally Recognized Tribes in Washington State as well as 6 Recognized American Indian Organizations. The **Office of Indian Policy³** (OIP), DSHS will continue to provide administrative support and technical assistance to the grant. This will be done through the monthly IPAC subcommittee meetings. The **Washington State American Indian Health Commission⁴** was created in 1994 by federally recognized tribes, urban Indian health organizations, and other Indian organizations to improve the health of AI/AN people through collaboration on health policies and programs that will help decrease disparities, which are contained within the American Indian Health Care Delivery Plan. The **Department of Social and Health Services**, through a memorandum of agreement with the **Health Care Authority⁵**, administers long-term services and supports for Medicaid recipients. Both State agencies will participate in the initiative with DSHS/AL TSA as the designated MFP lead.

A number of formal agreements⁶ currently exist between Washington and the Federally Recognized Tribes and/or Recognized American Indian Organizations. Additional supports for a strong working relationship include formal consultation policies for both DSHS and HCA. Through decades of planning, trial, and continuous quality improvement, Washington State's LTSS system is of high quality and reasonable cost. It is likely that the lessons learned in Washington's development of home and

community-based services will provide an excellent foundation and starting point for the development of services in tribal communities.

Relevant tribal characteristics in the state: The AI/AN population in Washington is diverse, geographically dispersed, and economically disadvantaged. AI/ANs are more likely to live in poverty than any other racial or ethnic group in Washington. They also experience disproportionately high mortality and morbidity burden compared to the general population. Recent Washington State Department of Health statistics (from BRFSS and other community data sets) establish that AI/ANs have the highest rates of most diseases and chronic conditions, self-reported poor mental health, heart disease, diabetes, binge drinking, drug abuse, traumatic brain injury, motor vehicle accidents, and disability when compared with other ethnic groups in our state. These health disparities⁷ indicate a population at high risk and need for support with activities of daily living. Developing services to support them is imperative.

Activities to develop State-Tribal Partnership Commitment Agreement

Based on the solid groundwork of the existing partnerships, agreements, and the March 2013 preliminary letter of commitment⁸, the primary partners will:

- Expand and improve the government-to-government relationship between DSHS Aging and Long Term Services Administration (AL TSA), HCA, Department of Health (DOH) and Tribes/Tribal Organizations to develop appropriate policies and delivery systems for providing home and community based services to Tribal elders and adults with disabilities.
- Identify areas on which to partner with sister agencies to address any barriers associated with licensure and/or payment processes for long-term services and supports.
- Create and finalize a concept paper, proposing the pathways Tribes/Tribal Organizations and Washington will work together on the Money Follows the Person Tribal Initiative and
- Enter into a signed commitment agreement, based upon the March 2013 preliminary letter of commitment to expand the capacity of Medicaid LTSS in tribal areas, enhance the leadership roles of tribes in the design and operations of these programs, and rebalance the LTSS system by transitioning eligible and interested tribal members to their communities of choice.

Activities to assess relevant tribal characteristics in the state: A priority in establishing the need for services in Indian Country is the need for **tribal assessment**. The National Resource Center on Native American Aging (NRCNAA) has been asked to consider adding some Washington-specific questions to their survey tool, 'Identifying Our Needs: A Survey of Elders IV' to use for this purpose. Using this survey process will accomplish two goals, one tribal data will be available for each Washington tribe to compare their information with those of the US All-tribes data and secondly, it will

provide opportunity for the NRCNAA to determine questions for other tribes seeking to establish LTSS. Additional direct input from Tribes will be sought to gather specific population details and identify when and why decisions have been made to seek services in an institutional environment. DSHS/ALTSA will contract with the American Indian Health Commission to provide face-to-face needs assessment for the tribes of Washington to draft the Concept paper.” Specific activities to assess relevant tribal characteristics in the state will include:

- Collect and analyze data, population projections of vulnerable AI/AN adults to enable planning for long-term service and support (LTSS) needs.
- Identify existing “promising” LTSS practices and service delivery methods provided in Tribal communities.
- Identify challenges and barriers in providing local Tribal LTSS.
- Educate Tribal programs on all LTSS funding resources available and develop a matrix for local tribal planning purposes.
- Implement strategies to address regulatory and policy barriers for Tribes to provide and be reimbursed for state-funded LTSS in their own communities, including State licensing/certification challenges and coordination issues with Area Agencies on Aging.
- Identify LTSS ‘train-the-trainer’ opportunities, such as Statewide Health Insurance Benefits Advisors (SHIBA) for Tribes to build internal expertise for assisting elders with their needs.

The combined data collection of tribal characteristics, evaluation of promising practices, and continued exploration of government to government relations will result in a concept paper to enter into Phases Two through Four and a signed commitment letter between Washington and the Federally Recognized Tribes to expand the capacity of Medicaid LTSS in tribal areas, enhance the leadership roles of tribes in the design and operations of these programs, and rebalance the LTSS system by transitioning eligible and interested tribal members to their communities of choice.

Approved Phase I budget: \$300,000