STATE OF WASHINGTON

Olmstead Plan

- Department of Social and Health Services
  - *Aging and Long Term Support Administration (ALTSA)*
  - *Behavioral Health Administration (BHA)*
  - *Developmental Disabilities Administration (DDA)*
  - *Economic Services Administration (ESA)*
- Department of Children, Youth, and Families (DCYF)
- Health Care Authority (HCA)

STATE OF WASHINGTON

OLMSTEAD PLAN

Table of Contents

Preamble

Washington is committed to providing choice to consumers who are in need of services and supports. This is evidenced by our rebalancing efforts over the last 25 years. For more than two decades, Washington has been a national leader in the delivery of home and community based services and was ranked in 2017 as number one in the nation by AARP for access, affordability and quality of Long-Term Services and Supports (LTSS). We have built our programs through innovative resource development with a focus on addressing barriers to living in the community. As we identify barriers, we work to resolve those barriers and aggressively seek funding through the Washington Legislature to ensure that we can develop the needed services to provide consumers with additional community living options. Throughout the years, we have developed Assisted Living, Adult Family Home, Supported Living and Enhanced Service Facilities to offer a variety of community based setting for individuals needing 24/7 assistance with personal care or a combination of personal care and behavioral support.

In Assisted Living and Adult Family Home settings, we have added nursing services and delegation. For in-home care we have added nurse delegation services, which allows for assistance with insulin injections (something we identified more than a decade ago as a significant need for nursing home residents), self-directed care, supported living, agency care, environmental modification, assistive technology, home delivered meals, skilled nursing, adult day care and adult day health.

As part of our work in transforming mental health in Washington, we have added specialized contracts that provide behavioral health supports within community residential settings and skilled nursing facilities. We have a specialized dementia care program for individuals living with Alzheimer's or other related dementia residing in contracted Assistive Living Facilities. In addition, we are increasing our number of Supportive Housing providers and wrap around supports to meet the needs of individuals who desire to live independently in their community. We are providing additional training and support to community care providers serving individuals with complex functional and behavioral support needs.

Enhanced Services Facilities began serving people transitioning from the state psychiatric hospitals to the community in 2017. The facilities serve people who no longer need active psychiatric treatment, but still have significant medical and personal care needs related to their behavioral health conditions. The Developmental Disabilities Administration (DDA) offers many support options for individuals who choose to reside in the community. DDA provides these services through five Home and Community Based Waivers, the Medicaid State Plan and state-only funding.

Home and community-based residential support recipients receive a variety of services depending on the individual's assessed need. This includes services ranging from twenty-four hour care to one-on-one care a few times weekly. Individuals living in their own home or with their family are eligible for Medicaid Personal Care to meet their daily living needs. Some individuals receive state-only funded services, employment support and individual and family

support. In the next biennium, there will be 81 new State Operated Living Alternative (SOLA) beds added, new community crisis respite beds and a rate increase for community residential providers such as supported living.

In the spring of 2018, Governor Jay Inslee announced a five-year plan to dramatically reshape how and where the state treats people suffering from acute mental illness. Under the Governor's five year plan for transitioning individuals from the state hospitals, the following items were funded in the Health Care Authority's (HCA) operating budget and Department of Commerce's Behavioral Health Community Capacity capital budget. Under *Community Diversion and Stabilization Services* (services for those living in the community or supportive housing), 2019-2021 funding is provided for eight additional Program of Assertive Community Treatment (PACT) teams statewide. For Fiscal Year (FY) 2020, funding is provided for three full teams and two half teams. FY2021 funding is provided for an additional three teams. Mental Health Drop-in Facilities (24-hour Peer Respite) funding begins in FY2020-2021 and provides for five mental health peer respite centers to divert individuals from crisis services as well as a pilot program to provide Mental Health (MH) Drop-in services. HCA must conduct a survey of peer MH programs and submit reports to the legislature on the results of the survey and the pilot program.

Funding has also been allocated to *Services for those with Acute or Post-acute Inpatient needs.* This includes long-stay hospitals and serving 90 - 180 day commitments. Services for individuals on 90-day and 180-day commitments are traditionally provided in state hospitals. The 2019-2021 biennial funding provides for 71 new community beds in FY2020 and increasing to 119 new beds by FY2021. The proposed outlook assumes that the number of new community beds will grow to 227 by FY2023. It is assumed that these beds will include a mix of community hospital and Evaluation and Treatment center settings. Under *Services for those Living in an Institutional Home* (those no longer acute and/or with cognitive historic behavioral issues), 2019-2021 biennial funding provides for an Intensive Residential Team to serve individuals in Skilled Nursing Facilities and Adult Family Homes. Funding is proposed for wraparound services for adults discharging or being diverted from state psychiatric hospitals into alternative community placements. HCA is required to consult with DSHS on these efforts fostering a collaborative approach to providing community based options. The 2019-2021 biennial funding also allows for Intensive Behavioral Health (BH) Treatment Facility (Specialty Enhanced Service Facility). This new community facility type would address the need for additional discharge placements for individuals leaving the state psychiatric hospitals. Intensive BH facilities serve individuals who possess higher levels of BH challenges that existing alternative BH facilities cannot accommodate.

The remainder of this document provides additional detail on the work Washington is doing to ensure consumers can choose to live in the community setting of their choice.

Brief History of Olmstead

Olmstead, or Olmstead v. L.C., is the name of the most important civil rights decision for people with disabilities in our country's history. In 1999, based on the Americans with Disabilities Act (ADA), the Supreme Court held that people with disabilities have a qualified right to receive state funded supports and services in the community rather than institutions when:

1. the person's treatment professionals determine that community supports are appropriate;
2. the person does not object to living in the community; and
3. the provision of services in the community would be a reasonable accommodation when balanced with other similarly situated individuals with disabilities.

On June 22, 1999, the United States Supreme Court held in Olmstead v. L.C. that unjustified segregation of persons with disabilities constitutes discrimination in violation of Title II of the Americans with Disabilities Act. The Supreme Court held that public entities must provide community-based services to persons with disabilities, taking into account the resources available to the public entity and the needs of others who are receiving disability services from the entity.

The Olmstead Decision does not require states to stop serving people in institutions if the person is unable to handle or benefit from a community setting.

The Supreme Court suggested that states demonstrate compliance with the ADA by showing that they have comprehensive and effective plans for placing qualified individuals with disabilities in less restrictive settings and waiting lists that move at a reasonable pace, not controlled by the state's endeavors to keep its institutions fully populated.

INSTITUTIONS IN WASHINGTON STATE

Institution types and responsible agencies in the state of Washington include:

Department of Social and Health Services

- State Psychiatric Hospitals
- Special Commitment Center
- Residential Habilitation Centers
- Nursing Facilities

Department of Children, Youth, and Families

- Behavioral Rehabilitation Services (BRS) facility based placement
- Contracted facility based services for dependent children and youth
- Medically fragile facility based care
- Facility based child-specific contracted placements

Department of Veterans Affairs

- State Veterans Homes

Background of Washington State's Olmstead Plan

On March 27, 2000, Governor Gary Locke designated the Department of Social and Health Services (DSHS) as the lead state agency for Olmstead planning in Washington State. Since DSHS has been emphasizing community placement since 1990, Washington's Olmstead Plan is intended to be a living document, subject to continuous planning and change.

Initial planning activities included setting up a workgroup, meeting with consumers and stakeholders, assessing current policies and services and developing budget requests for the 2001 - 2003 biennial budget. DSHS established an Olmstead Workgroup to coordinate planning and accelerate on-going processes and programs.

Washington's Olmstead Plan includes an overview of current services and activities that further the intent of Olmstead, such as housing, transportation, integration, employment and systems change initiatives

Planning and Future Updates

This updated plan is the result of a collaborative effort between the following state agencies:

- Department of Social and Health Services
  - *Aging and Long Term Support Administration (ALTSA)*
  - *Behavioral Health Administration (BHA)*
  - *Developmental Disabilities Administration (DDA)*
  - *Economic Services Administration (ESA)*

- Department of Children, Youth, and Families (DCYF)
- Health Care Authority (HCA)

The Washington State Olmstead workgroup will review this plan and update it as needed each biennium.

Washington State Department of Social and Health Services

In any given month, DSHS provides some type of shelter, care, protection and/or support to 2.4 million of our state's 7.1 million people. DSHS' goal and commitment is to be a national leader in every aspect of client service. DSHS values honesty, integrity, open communication, equity, diversity and inclusion and a commitment to service that will transform lives. DSHS' vision is that people are healthy, safe, supported and that taxpayer resources are guarded. DSHS has a long-standing policy of emphasizing community services and reducing institutional

services. Below is an overview of how DSHS will meet its responsibility to uphold the requirements of Olmstead.

Aging and Long Term Support Administration

Washington has a long and demonstrated history of providing an array of Long-Term Services and Supports (LTSS) that allow individuals to choose among settings and providers that will best meet their needs. This has been accomplished through strong federal and state partnerships to leverage federal funding from Centers for Medicare and Medicaid Services (CMS) and the Administration for Community Living (ACL) in combination with many of the grants used over the years to test models of care.

According to the national LTSS Scorecard of States, Washington is currently ranked first in the nation for its high performance while at the same time ranking 32nd in total Medicaid LTSS cost. Assisting individuals to receive services in community-based settings remains a priority for ALTSA. A commitment to innovation, providing high quality services, addressing the changing needs and preferences of individuals served and delivering services and supports in a cost effective way is at the core of ALTSA's and Area Agencies on Aging approach to delivery of LTSS.

The state of Washington is among the nation's leaders in rebalancing away from a reliance on institutional settings and supporting individual and family preferences to be served in home and community-based settings. The Washington state legislature recognized the desire of most people is to maintain as much independence as possible and to receive services in their own homes and in home-like residential settings that are located in local communities. As a result, the legislature directed the DSHS to expand community options that provide opportunities for individuals to divert and relocate from nursing home, hospital and residential habilitation settings.

Home and Community Services provides and administers long-term care services to eligible individuals and collaborates with Area Agencies on Aging to share community service options. ALTSA embraces the belief that clients with very high care needs can be cared for and supported in a variety of settings through the implementation of waivers and state plan services that provide alternatives to nursing facility and state hospital care. Over the last twenty-five years, ALTSA has developed alternatives to nursing facility placement for the people they serve, including people over the age of 18 with functional disabilities. ALTSA's mission has been, and continues to be, to provide an array of long-term care options from which clients and their families can choose.

Area Agencies on Aging (AAAs) were established under the Older Americans Act (OAA) in 1973 to respond to the needs of Americans ages 60 and over in every local community. AAAs are responsible to plan, coordinate and advocate for the development of a comprehensive service delivery system at local levels to meet both the short and long-term needs of older adults. AAAs

develop and promote services and options to maximize independence for elders, adults with disabilities and family caregivers in their Planning and Service Area (PSA).

The Aging and Long-Term Support Administration has designated thirteen Planning and Service Areas, also referred to as Area Agencies on Aging.

AAAs utilize a variety of federal, state and local funding sources to provide a network of in-home and community services, support programs and assistance to older adults, adults with disabilities and family caregivers. The specific services funded by each AAA are determined through local planning activities and delineated in a 4-year Area Plan. A broad spectrum of services are offered in the areas of access services, in-home services, nutrition services, family caregiver support, social and health services, legal services and other activities. AAAs also provide case management for Medicaid and state funded in-home care participants.

For more information on ALTSA's/AAA's full range of services, visit https://www.dshs.wa.gov/altsa

Community Living Connections (CLC) can connect people with the right kind of help, when and where you need it. Older adults, adults with disabilities, caregivers, family members and professionals can call CLC at **1-844-348-5464** to get objective, confidential information about community resources and service options, or visit https://www.communitylivingconnections.org/

ALTSA Programs that Further the Intent of Olmstead

In 2004, less than 12,500 clients lived in nursing facilities statewide (down from 17,500 in 1994) and approximately 34,000 clients were served in a community setting. In 2019, less than 9,500 clients live in nursing facilities statewide and approximately 59,000 are served in the community. ALTSA is striving to develop programs that optimize choice and increase independence for people with disabilities. Programs include:

COMMUNITY FIRST CHOICE (CFC)

CFC personal assistance services can be provided outside the home setting, which allows individuals with disabilities to receive services at school, the workplace and during recreational outings. A planning and implementation workgroup of stakeholders helped design this program. CFC is an optional state plan program, which was implemented in July 2015.

CFC provides services to more than 55,000 individuals served by ALTSA in their own homes, Assisted Living Facilities (ALFs) and Adult Family Homes (AFHs). Services include:

- personal care
- nurse delegation, skills acquisition training
- Personal Emergency Response Systems (PERS)
- relief care
- caregiver management training
- community transition services

- assistive technology

COMMUNITY OPTIONS PROGRAM ENTRY SYSTEM (COPES) WAIVER

The COPES waiver provides services to over 39,000 individuals. In addition to the personal care services received through CFC, services available to individuals on the COPES waiver include:

- client support training
- wellness education
- skilled nursing
- home delivered meals
- environmental modifications
- specialized equipment and supplies
- transportation
- adult day health
- community choice guiding
- community support, goods and services.

This waiver was implemented in 1983 and in addition to providing the supportive wrap around services listed above, it provides the ability for individuals who have incomes up to 300 percent of the federal benefit level to qualify for needed services.

RESIDENTIAL SUPPORT WAIVER

The Residential Support Waiver provides services to more than 1,400 individuals with complex behavioral health needs. Services include:

- personal care
- supervision
- support and twenty-four hour on-site response staff
- the development of an individualized behavior support plan
- medication management
- coordination with a behavior support provider;
- Expanded Community Services, which includes training and support by community behavioral support providers
- Specialized Behavior Support, which includes increased staffing in residential settings along with training and support by community behavioral support providers.

Additional services include nurse delegation, client training, specialized medical equipment, adult day health and skilled nursing.

This waiver was implemented in 2014. In addition to the services provided, it creates the ability for individuals who have incomes up to 300 percent of the federal benefit level to qualify for needed services.

NEW FREEDOM

New Freedom is a voluntary option that is a budget-based waiver and provides approximately 450 individuals the opportunity have increased choice and control over their services and supports. New Freedom provides participants a choice from an array of services to meet their needs within a set monthly budget. This program allows flexibility to adjust services and participants can exercise more decision-making authority to take primary responsibility for obtaining services.

Participants in New Freedom decide:

- what services, goods and supports they need within their budget
- when and how their services and supports are to be delivered
- who will provide those services and supports.

Service categories include:

- personal assistance
- treatment and health maintenance supports
- individual directed goods, services and supports
- vehicle modifications and training and educational supports.

This waiver was implemented in 2006. In addition to the increased control and autonomy it provides, the waiver creates the ability for individuals who have incomes up to 300 percent of the federal benefit level to qualify for needed services.

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

The Program of All-Inclusive Care for the Elderly is currently provided by Providence ElderPlace to approximately 700 King County residents who require nursing facility level of care. The PACE team delivers a comprehensive service package which includes all medical and long-term care services. Most of these services are provided in the PACE day center or in the client's home.

This state plan option was first implemented in 1995. This program will expand to a second contractor in King County in May 2019 and to Spokane in late 2019-early 2020.

MEDICAID PERSONAL CARE (MPC)

Medicaid Personal Care is a Medicaid State Plan program that provides personal care for approximately 700 individuals who need some assistance with personal care, but do not meet the institutional level of care required by the other programs. This program began in 1989.

MEDICAID ALTERNATIVE CARE (MAC)

Medicaid Alternative Care provides supports to unpaid family caregivers who are caring for a loved one who meets nursing facility level of care and is eligible for Medicaid Apple Health. Some of the services available include training, consultation, home delivered meals, respite, environmental modifications, specialized equipment and supplies, personal emergency response system and adult day health. Eligible individuals can choose this program to support their caregiver instead of receiving the traditional LTSS programs listed.

This program is part of a five year federal demonstration waiver that is operational calendar years 2017-2021.

TAILORED SUPPORTS FOR OLDER ADULTS (TSOA)

Tailored Supports for Older Adults provides a limited set of services and supports to help individuals avoid or delay the need for Medicaid-funded LTSS programs. These individuals are not financially eligible for Medicaid Apple Health, but meet nursing facility level of care. Individuals eligible for TSOA can choose supports for their unpaid family member, or if no caregiver is available, they can receive services such as personal care, adult day services, environmental modifications, specialized equipment and supplies, personal emergency response system and home delivered meals.

This program is part of a five year federal demonstration waiver that is operational calendar years 2017-2021.

ROADS TO COMMUNITY LIVING (RCL)

In 2007, the Money Follows the Person (MFP) grant was awarded to Washington State from the federal Centers for Medicare and Medicaid Services. The following year, ALTSA began using demonstration dollars to transition individuals out of institutional settings. The purpose of the RCL demonstration project was to investigate what services and supports would successfully help people with complex, long-term care needs transition from an institution to a community setting.

Services and supports from the RCL demonstration project that proved successful were transitioned into the state's COPES waiver in 2019. Dedicated staff that had worked on housing, resource development and nursing home transition during the demonstration period were maintained to continue working on these core strategies.

HCS Services that Further the Intent of Olmstead

ALTSA's continued commitment to innovation ensures we provide high quality services, continue to meet the needs and preferences of individuals served and are delivered in cost effective ways. Services include, but are not limited to:

PERSONAL ASSISTANCE SERVICES

Personal assistance services are provided through agencies or individual providers. The individual provider services are flexible. People with disabilities have the ability to hire, fire and provide daily supervision of the provider. Family members may be paid as individual providers. Trainings are mandatory for all providers, including a two-hour orientation training, three hour safety training and additional hours as required by state statute that must be completed within the first 120 days of employment and 12 hours of annual continuing education. Background checks are mandatory for all providers. There are approximately 15,890 clients using home care agencies and 28,675 clients using individual providers.

ASSISTIVE TECHNOLOGY SERVICE

The Community First Choice program was implemented in 2015 and includes an option to receive Assistive Technology (AT). These are devices and supports that enhance independence or substitute for human assistance. This service may include training on the item or maintenance and upkeep of an item purchased under this service.

In addition, ALTSA has a limited state funded Assistive Technology program to assist clients who have no other funding source to obtain these items. This program funds evaluations, short-term training and assistive technology services and devices.

IN-HOME CARE SERVICE AGENCIES

In-home care service agencies are licensed to administer or provide home health, home care, hospice or hospice care center services directly or through a contract arrangement to patients in a place of temporary or permanent residence.

Home health services: This may include nursing services, home health aide services, physical therapy services, occupational therapy services, speech therapy services, respiratory therapy services, nutritional services, medical social services, home medical supplies or equipment services and professional medical equipment assessment services.

Home care or non-medical services: This may include personal care such as assistance with dressing, feeding and personal hygiene to facilitate self-care; assistance with household tasks, such as housekeeping, shopping, meal planning and preparation, and transportation; respite care assistance and support provided to the family; or other nonmedical tasks, or delegated tasks of nursing.

In-home care hospice services: This may include symptom and pain management provided to a terminally ill patient and emotional, spiritual and bereavement support for the patient and family. Services are made available in a temporary or permanent residence, including hospice care centers, and may include the provision of home health and home care services for the terminally ill patient through an in-home services agency licensed to provide hospice or hospice care center services.

Hospice care center: Provided in a homelike non-institutional facility, services may include continuous care, general inpatient care, inpatient respite care and routine home care.

INDEPENDENT OR INDIVIDUAL PROVIDER

Independent or Individuals Living Providers provide personal care or respite services in the home. The individual who requires care hires the Independent or Individuals Living Provider; providers are paid privately or through DSHS.

DAY CENTERS

Adult Day Care (ADC) is a supervised daytime program providing core services for adults with medical or disabling conditions that do not require the intervention or services of a registered nurse or licensed rehabilitative therapist acting under the supervision of the client's authorizing

practitioner. Services may include personal care, routine health monitoring, health education, nutritious meals and supervision or protection.

Adult Day Health (ADH) is a supervised daytime program providing skilled nursing and/or rehabilitative therapy services in addition to the core services of adult day care. Adult day health services may also include physical therapy, speech-language pathology, audiology, or counseling services.

CONTINUING CARE RETIREMENT COMMUNITIES (CCRCS)

CCRCs give older adults the option of living in one location for the duration of their life while guaranteeing that additional care will be provided when needed. Individuals can move into a CCRC when they are fully independent and access assisted living, personal care and skilled nursing as their needs change.

CCRCs have various levels of contract types. Individuals may enter into CCRCs with different levels of financial commitment and service level agreements. Entry fees and monthly fees are typically included in the service agreement.

PERSONAL EMERGENCY RESPONSE SYSTEMS (PERS)

Although there are a wide variety of personal emergency response products, PERS (also called Medical Alert Systems) typically consist of a small button-sized transmitter that may be carried or worn, a receiving console that is connected to a telephone and a monitoring center which may be nationally or locally based.

Numerous companies offer this service with differences in contract terms, technology, level of service and cost that the user should be aware of. Companies provide this service by selling devices, renting devices and providing paid monthly services. In some cases, the cost of the device may be subsidized by another program.

Depending on the type of system used, service provided may include storing relevant medical information with a monitoring center, GPS location, 24/7 monitoring, direct communication with an monitoring center dispatcher, fall detection, an auto call to the identified the emergency contact and an auto call to 911.

NURSE DELEGATION

Nurse delegation provides nursing services in a community setting. Registered Nurse Delegators can delegate nursing care tasks to nursing assistants and home care aides, registered or certified, who provide care in adult family homes, assisted living facilities, boarding homes and in-home settings.

TRANSITION ASSISTANCE FROM NURSING HOMES

To facilitate assistance to individuals in nursing facilities in transitioning back to community settings, specialized transition assistance is available through dedicated state staff that can also be augmented through contracted providers when directed by the state entity.

ALTSA works actively with individuals from the point of admission to a nursing facility to achieve the client's discharge goals. This includes meeting face-to-face with clients early in their admission, working with families and staff at the facility to advocate for therapies, treatments and teaching is provided. The goal is for clients to receive services in the least restrictive, most appropriate setting that meets their care needs while honoring client choice and preference.

SELF-DIRECTED CARE

This service provides an opportunity for people with functional disabilities who live in their own homes to direct health-related tasks they could do for themselves if they were physically able. Implemented in home settings in 2000, case management staff inform clients, regardless of their current living setting, of this option during assessments and reassessments. This gives the client and the social worker the opportunity to put a plan together for the client to stay in, or transition back to, his/her own home.

SPECIALIZED DEMENTIA CARE

Specialized dementia care provides services and supports in an assisted living facility dedicated solely to the care of individuals with dementia, or in a designated, separate unit/wing dedicated solely to the care of individuals with dementia. The Specialized Dementia Care Program allows residents with dementia to 'age in place' instead of requiring nursing facility care.

Specialized Dementia Care services include:

- Intermittent nursing services;
- medication administration;
- personal care services, including assistance with eating;
- supportive services that promote independence and self-sufficiency;
- awake staff 24 hours a day;
- daily activities consistent with functional abilities and interests in the form of independent, self-directed, individual and group activities; and
- Access to a secure outdoor space with walking paths and protected areas with outdoor furniture.

SPECIALIZED BEHAVIOR SUPPORT

Specialized behavior support provides an enhanced staff ratio for each individual served. Staff providing this service receive additional training.

Specialized behavior support services include:

- A behavior support plan developed with the individual;
- recreational opportunities designed and provided to meet behavioral challenges;
- an individually developed crisis prevention strategy; and
- additional support coordination and supervision with a behavioral support provider.

PUBLIC COMMUNITY BASED LTSS MATRIX

Public Funded
Service Matrix_2018.

SERVICE SETTINGS

ALTSA offers services that empower older adults and people with disabilities to remain independent and supported in the setting of their choice.

Independent Housing

Individuals may choose to receive services in their homes.

ADULT FAMILY HOMES (AFH)

Adult Family Homes are licensed to care for up to six people in a private home setting with staff available 24 hours a day. These homes provide room, board, laundry, necessary supervision, personal care, social services and assistance with activities of daily living. Some also provide nursing care. There are approximately 6,650 clients statewide in adult family homes.

ASSISTED LIVING FACILITIES

Assisted living facilities are licensed to care for seven or more people. They provide room and board, assistance with activities of daily living and supervision and may also provide limited nursing care. There are three distinct Medicaid contracts used in Assisted Living Facilities.

ADULT RESIDENTIAL CARE (ARC)

Adult residential care (ARC) provide room and board and help with medications and personal care.

ENHANCED RESIDENTIAL CARE (EARC)

Enhanced Adult Residential Care (EARC) facilities offer services provided in an ARC as well as limited nursing care. Approximately 2,508 clients reside in Adult Residential Care facilities.

ASSISTED LIVING FACILITIES (ALF)

Assisted living facilities with an assisted living Medicaid contract are small studio-like apartments with a private bath and small kitchenette. Congregate meals, laundry, personal assistance services, and limited nursing services are offered. There are approximately 3,946 clients receiving services in licensed assisted living facilities.

ENHANCED SERVICES FACILITIES (ESF)

Enhanced services facilities serve adults coming out of state and community psychiatric hospitals or who have no other placement option due to their complex behavior, medical, chemical dependency and/or mental health needs. These facilities are required to have a

licensed or registered nurse on site at all times, as well as a mental health professional on site eight hours each day.

CONSUMER EXPERIENCE SURVEY

In 2018, ALTSA implemented the National Core Indicator-Aging and Disabilities (NCI-AD) consumer survey. The NCI-AD is a consumer satisfaction survey used to assess the performance of the Long Term Care (LTC) programs and delivery system in order to make improvements. The primary aim of the NCI-AD is to collect and maintain valid and reliable data that gives a broad view of how publicly funded services impact the quality of life and outcomes of service recipients.

CASE MANAGEMENT AND CARE COORDINATION

Individuals who receive Medicaid-funded long-term services and supports receive case management services that assist with eligibility determination, assessment, service planning, authorization of services and ongoing case management targeted to assist individuals with understanding their options and accessing services needed for health and well-being.

The Health Home program is a Medicaid service that promotes person-centered health action planning to empower clients to take charge of their own health care. This is accomplished through better coordination between the client and all of their health care providers which encourages involvement and independence. The Health Home program is designed to ensure clients receive the right care, at the right time, with the right provider.

The centerpiece of the Health Action Plan (HAP) is the clients' self-identified short- and long-term health-related goals, including what action steps the client and others will do to help improve his or her health. With client consent, the HAP can be shared with care providers in order to foster open communication, support and encouragement to reach their health goals. To be eligible, a person must:

- have at least one chronic condition and are at risk for another;
- have a PRISM predictive risk score of 1.5 (per WAC 182-557-0225); and
- meet Apple Health (Medicaid) eligibility criteria.

STAKEHOLDER INTERACTION

The Service Experience Team (SET) works in partnership with HCS to promote choice, quality of life, independence, safety and active engagement to programs developed and operated by the division. The SET membership includes clients representing a diverse cross-section of geography, gender and programs. Other participants include Advocacy Representatives, a Tribal Representative and the HCS Director. They are responsible to:

- provide feedback and input into ongoing HCS programs and services;
- review and provide input regarding new programs being developed;
- help identify opportunities to improve the quality of services and the client experience; and
- promote community involvement in the support of our mission and vision.

STATE HOSPITAL DISCHARGE AND DIVERSION

The Aging and Long Term Support Administration partners with the state psychiatric hospitals to assess eligibility for long-term services and supports for patients who are transitioning to community settings. ALTSA is dedicated to problem-solving and increasing cross-collaboration with the DSHS Behavioral Health Administration, the Health Care Authority, Behavioral Health Administrative Service Organizations and Managed Care Organizations in an effort to support clients to transition safely to a community setting of their choice. The focus of the collaboration includes:

- increasing discharges and diversions from state hospitals;
- serving clients who meet eligibility requirements for personal care services; and
- increasing the stability of ALTSA clients in the community once they have discharged or diverted from state hospitals.

HOUSING

DSHS recognizes that lack of availability to affordable and accessible housing can be a barrier to individuals who desire to live in a community setting. This is an issue that many Washingtonians face as housing becomes more expensive and out of reach for low-income individuals. ALTSA has invested in strategies designed to create opportunities to partner with private and public entities to significantly increase statewide federal, local and state paid subsidized options by partnering with the Department of Commerce, housing authorities, Housing and Urban Development, and private landlords.

DSHS is also partnering with the Health Care Authority to expand supportive housing services, which are available to individuals who meet eligibility criteria and need additional assistance finding and maintaining housing.

EMPLOYMENT

Supported employment services are available through the Administration for individuals that are Medicaid-eligible and have long-term service needs that make it difficult to gain and retain employment in the community. These services are person-centered and individualized and last as long as needed to support individuals through pre-vocational assessment, job placement, job coaching and long-term follow-along supports. The supported employment services are funded through a Medicaid Waiver and became available to Administration clients in January 2018.

DSHS recognizes the importance of supporting employment participation in the community to achieve Olmstead Plan goals. The Department offers a range of employment supports and programs through a number of different agencies. The Aging and Long Term Support Administration (ALTSA) and Developmental Disabilities Administration (DDA) offer Medicaid-funded supported employment services to their respective clients that meet the eligibility requirements and can access the Medicaid waivers that offer the supported employment services. Clients in the Economic Services Administration (ESA) may also access Medicaid-funded supported employment services under certain circumstances and if they meet the eligibility criteria. The Division of Vocational Rehabilitation's mission is to enable people with disabilities to obtain and keep paid employment in the community. They offer a broad range of

employment and employment support services to the individuals who meet their criteria and are enrolled in their programs.

DSHS also implements the state's Medicaid buy-in program to support individuals with disabilities engaged in completive employment. Under Healthcare for Workers with Disabilities (HWD), employed individuals with disabilities are able to purchase Medicaid, which may afford them access to the Medicaid-funded supported employment services. Employed individuals with disabilities can earn and save more money and purchase their healthcare coverage for an amount based on a sliding income scale. Additionally, Social Security Administration's Ticket to Work and the employment services afforded through the Workforce Innovation and Opportunity Act (WIOA) are available to individuals served by DSHS and may be utilized in support of the Olmstead Plan employment goals.

Residential Care Services: Residential Care Services (RCS) is responsible for the licensing and oversight of adult family homes, assisted living facilities, nursing facilities and intermediate care facilities for individuals with intellectual disabilities, and certified community residential services and supports. The mission is to promote and protect the rights, security and well-being of individuals living in these licensed or certified residential settings. Through the licensing and certification process, RCS ensures facilities are meeting the local, state and federal laws and regulations, including regulations that uphold client choice and rights to live in community settings.

To assist clients with remaining in community settings, rather than returning to more restrictive environments, Residential Care Services (RCS) developed a new Behavioral Health Support Team (BHST). This team offers technical assistance and training to our community residential providers who give services and supports to those individuals transitioning from state psychiatric hospitals or those providers who currently serve individuals with behavioral health challenges.

The objectives of the Behavioral Health Support Team include:

- Assisting in the success of those individuals in transition to a new living arrangement;
- Offering services that will lead to long-term success for people with behavioral challenges in home and community-based settings;
- Success for providers within the regulatory structure, by promoting expertise within community settings and assisting them in meeting unique and complex needs in an individualized and person-centered approach;
- Robust coordination across agencies for system success in transitioning individuals from state and community psychiatric hospitals into community settings;
- Supports for providers in giving high-quality care to individuals with complex needs who are able to relocate out of institutional settings; and
- Proactively providing the necessary training and consulting education on behavioral health topics that assist providers in being successful in serving this population.

Office of the Deaf and Hard of Hearing: There are approximately 529,686 individuals with a hearing loss in Washington. The Office of the Deaf and Hard of Hearing (ODHH) provides an array of services to the deaf, hard of hearing and deafblind communities throughout Washington State. With a history of serving the deaf, hard of hearing and deafblind communities for more than thirty years, ODHH promotes equal access opportunities to effective communication methods. The office operates in accordance to the law and plans for the future and state budget, which funds ODHH services. ODHH holds themselves accountable to the people they serve and partners closely with stakeholders to address gaps in services.

PROGRAM DESCRIPTION

TELECOMMUNICATION EQUIPMENT DISTRIBUTION (TED)
Per regulations, eligible consumers apply to receive specialized telecommunication equipment and receive training to effectively utilize the equipment. Specialized telecommunication equipment distributed matches the consumers' degree of hearing loss or speech disability and preferred communication method. The equipment enables the consumer to make direct telephone calls independently through the telecommunication relay services.

SOCIAL AND HUMAN SERVICES
Social and Human Services contracts with several Regional Service Centers on Deaf and Hard of Hearing throughout the state to provide an array of social and human services. Currently the scope of services includes:

- information and referral;
- outreach, education and training; and
- advocacy for communication access that focuses on access to products, services and employment, education, health and legal aid in the private, public and nonprofit sectors.

The centers play a vital role in providing educational, cultural, recreational and social opportunities and making their facilities available to local and regional grassroots community-based nonprofit organizations.

ASSISTIVE COMMUNICATION TECHNOLOGY
This program benefits the deaf, hard of hearing, deafblind and late deafened communities. The Assistive Communication Technology (ACT) program provides communication access for services offered through DSHS. ACT equipment works well for people who wear a hearing aid or cochlear implant with a t-coil switch. ACT equipment includes devices such as Portable Loop systems, FM kits, captioning and other assistive technology. The provision of existing and emerging technologies will fulfill the reasonable accommodations mandate to ensure equal communication access to DSHS agencies, programs and services.

COMMUNITY OUTREACH PROGRAM
Outreach and training are designed toward different target audiences including professionals, organizations, and deaf, hard of hearing and deafblind communities. Activities such as exhibits

at community events and conferences, publications and presentations heighten the public profile and awareness of ODHH programs, deaf culture and other issues pertaining to hearing loss. Training activities instill sensitivity awareness to DSHS staff, interested agencies and vendors serving deaf, hard of hearing and deafblind individuals. The training curriculum includes deaf culture awareness and legal reasonable accommodation obligations.

SIGN LANGUAGE INTERPRETER CONTRACTS AND RESOURCES
This program administers the statewide contract to purchase sign language interpreter services. State of Washington agencies are obligated to provide sign language interpreters upon request to deaf, deafblind, hard of hearing or late deafened individuals who are seeking accessible government services. The program monitors contractual compliance including quality of services, certification of interpreters and best practices.

COMMUNCIATION ACCESS PROGRAM
This program provides training, consultation and environment assessments to service providers of all various DSHS entities who have deaf, deafblind, hard of hearing or late deafened clients on their caseloads. The mission of this program is to support service providers' communication and resources for their clients.

TRAINING AND PRESENTATION PROGRAM
This program provides a wide array of trainings and presentations on skill-building, cultural awareness, diversity initiatives and self-advocacy skills for the deaf, hard of hearing, deafblind and late deafened stakeholders.

Behavioral Health Administration (BHA)

The Department of Social and Health Services' Behavioral Health Administration (BHA) transforms lives through dedication to the wellness of individuals, their families and the community through behavioral health intervention, treatment and education. BHA operates three state psychiatric hospitals, the Special Commitment Center and the Office of Forensic Mental Health Services which deliver high-quality services to adults and children with complex needs.

CHILD STUDY AND TREATMENT CENTER (CSTC) is Washington's state psychiatric hospital for children and youth up to the age of 18. The center engages families and community teams to participate in the psychiatric treatment and educational services, and to plan for these young clients' successful return to their home community.

EASTERN AND WESTERN STATE HOSPITALS (ESH/WSH) provide evaluations, competency restoration and in-patient psychiatric treatment for individuals who are civilly committed due to serious or long-term behavioral health conditions. The hospitals deliver evidence-based and effective in-patient treatment programs, interventions and activities that promote patient

recovery. Our therapeutic approach is designed to empower patients, instilling hope, support, self-discovery and independence.

THE SPECIAL COMMITMENT CENTER provides specialized mental health treatment to sex offenders who have completed their prison sentences and have been civilly committed.

THE OFFICE OF FORENSIC MENTAL HEALTH SERVICES is responsible for the management of Washington's adult forensic mental health care system, providing competency evaluation and restoration services. Forensic mental health services and competency restoration are for adults involved in the criminal justice system. BHA has been working to increase opportunities to divert persons with mental illness from involvement in the criminal court system, and instead, ensure that these individuals are receiving appropriate supports and services in their communities. These efforts contribute to the state's overall efforts to decrease the need for individuals to enter our forensic institutions.

Administration Activities

TRANSITION FROM IN-PATIENT TREATMENT TO LEAST RESTRICTIVE SETTINGS

BHA, in its management of state hospitals, forensic services and the special commitment center, has committed to improving communication and collaboration with our partners within the Department of Social and Health Services, including the Aging and Long-Term Support Administration and the Developmental Disabilities Administration. BHA is also committed to improving communication between BHA and other departments, including the Health Care Authority, Department of Commerce, Department of Corrections, Department of Health and the Department of Children, Youth, and Families. BHA finds that improved communication and collaboration are foundational to supporting the transition of patients from our hospitals and institutions to community settings and divert individuals from entering our state hospital programs. These efforts contribute to the state's overall efforts to serve patients in their home communities.

Activities that Support Transition – Special Commitment Center

- Use Lean tools to improve processes to determine how to best work together with stakeholders and partners to support transition and supervision of residents with disabilities into the community.
- Create opportunities to consult with partners on challenging cases early in the treatment process to identify services that would support a resident's treatment, transition, supervision and stability in the community.
- Under the current statutory scheme, the court of commitment reviews potential placement options presented to the court by the resident. The SCC is committed to exploring contract options with identified placements to support appropriate levels of habilitative treatment and supervision for residents with disabilities.

- Utilize partnerships to facilitate access to services specifically designed to meet the disability-related needs of the residents who are ordered by the court to a less restrictive alternative.

Activities that Support Transition – State Hospitals:

- Participate in Value Stream Mapping with partners, when needed. Improve processes and identify opportunities to improve communication with our partners.
- Improve communication through inviting partners to treatment planning, case consultation and discharge planning meetings.
- Create opportunities to consult with partners on challenging cases early in the treatment process to identify services that would support patients' transitions and stability in the community (early engagement pilot, cross-system case consultation). Improve utilization of available social work staff to ensure efficient use of resources in relation to providing treatment, communication and discharge planning.

Diversion Activities – State Hospitals:

- Utilize pre-admission screening information to identify patients who have a 90-day involuntary treatment order who would benefit from a diversion to treatment in the community.
- Coordinate with facilities treating the patient and our partners within the Department, other Administrations and the community to transition the patient to less restrictive services and programs in the community.

SHORTEN HOSPITAL STAYS

BHA is committed to treating patients admitted to the state hospitals in the shortest amount of time necessary and to support transitioning patients to programs in the community designed to provide a continuum of care that will allow patients to be served in the least restrictive setting.

Shorten Hospital Stays Activities:

- Increase use of Evidence-Based Practices offered to patients during their treatment at state institutions.
- Educate treatment teams about programs and services in the community that provide services to support patients' return to and stabilization in the community.
- Increase early engagement efforts, discharge planning conferences and case consultation to ensure discharge planning starts at the time of admissions, will include communication and coordination with our partners, and will be an ongoing process throughout the course of treatment.

PROSECUTORIAL DIVERSION PROGRAMS

Since 2016, BHA has contracted these programs to assist prosecuting attorneys, behavioral health providers and other partners to engage individuals in treatment and assist with housing and other needs. The goals of the program are to either prevent charges from being filed, or result in the charges being dismissed after successful completion of the program, thus avoiding or decreasing time in jail or other institutional admissions.

JAIL DIVERSION PROGRAMS PROPOSED BY COMMUNITY PARTNERS

Thirteen other diversion programs are in place across the state that aim to divert persons with mental illness from involvement in the criminal courts. These programs include a variety of strategies such as having social workers embedded with law enforcement to help deflect individuals from arrest or providing transition services for persons currently in jails to ensure they are connected to appropriate services and supports upon their release.

Developmental Disabilities Administration (DDA)

The Developmental Disabilities Administration (DDA) offers many support options for individuals who choose to reside in the community. DDA provides these services through five Home and Community-Based Waivers, the Medicaid State Plan, and state-only funding. Home and community-based residential support recipients receive anywhere from 24-hour one-on-one supports to just a few hours a week, depending on the individual's assessed need. Individuals living in their own home or with their family are eligible for Medicaid Personal Care to meet their daily living needs. Some individuals receive state-only funded services, employment support, and individual and family support.

For more information on the full range of DDA services, go to https://www.dshs.wa.gov/dda

DDA is Reducing Its Institutional Footprint

Overview. Washington State's Developmental Disabilities Administration operates four residential facilities for individuals with intellectual disabilities. The facilities are called Residential Habilitation Centers (RHC), and each one has a unique campus and composition. Fircrest and Lakeland each contain a State-Operated Nursing Facility (SONF) and an Intermediate Care Facility (ICF). Rainier houses three intermediate care facilities and Yakima Valley is a single state-operated nursing facility, plus an eight-bed respite facility with an eight-bed crisis stabilization program. A fifth RHC, the Francis Haddon Morgan Center, closed in 2011. In sum, the four existing residential habilitation centers include eight separately certified long-term care facilities: three state-operated nursing facilities and five intermediate care facilities. Washington State law limits long-term admission to the RHCs to individuals 16 and older, and the number of individuals served in the RHCs has declined steadily from over 4,000 in 1970 to approximately 770 in April 2019.

Closing Institutions. As of this writing, one SONF and one ICF are slated to close, which will further reduce the institutional footprint in Washington state. The Yakima Valley School will close according to the procedure codified in RCW 71A.20.180. The ICF, which is named Rainier School PAT A, is scheduled to close no later than December 31, 2019.

Assisting with Transitions. In addition to these closures, DDA works to proactively identify individuals with developmental disabilities who wish to move from institutions to less

restrictive settings. DDA staff meet with each person currently living in an RHC and their family or guardian on an annual basis to determine if the person would prefer living in the community. To assist families who want to better understand community residential service options, DDA operates the Family Mentor Project. The family mentors are relatives of individuals who transitioned from one of the residential habilitation centers to a home in the community.

Defining the Future. DSHS has contracted with the William D. Ruckelshaus Center to facilitate discussions with diverse stakeholders to determine a consensus-based vision for the future of the RHCs and, by extension, the residential support options available to DDA clients. The workgroup first convened in 2018 by order of the Legislature, produced to the Legislature a report on its progress in January 2019, and has been reauthorized to continue its work for another year. The workgroup's final report to the Legislature is due December 1, 2019.

DDA is Expanding Its Home and Community Based Services

DDA has five Home and Community Based Service Medicaid Waiver programs. Each waiver offers specific services to meet health and safety needs in the community. Each waiver offers a variety of services when they are not available through any other resources (private insurance, Medicaid, school, etc.) These five waivers are:

INDIVIDUAL AND FAMILY SERVICES supports individuals who require waiver services to remain in the family home (Age 3+).

BASIC PLUS supports individuals who require waiver services to meet their assessed health and safety needs in the community. Services are provided in their own home, family home, an adult family home or adult residential center (Age 0+).

CORE WAIVER offers residential options to individuals at immediate risk of institutional placement or who have an identified health and welfare need for services that cannot be meet by the Basic Plus waiver (Age 0+).

CHILDREN'S INTENSIVE IN-HOME BEHAVIORAL SUPPORT (CIIBS) supports youth at risk of out-of-home placement due to challenging behaviors. The CIIBS model involves planning and family-centered positive behavior support (Age 8-20).

COMMUNITY PROTECTION WAIVER offers therapeutic, residential supports for individuals requiring 24-hour, on-site staff supervision to ensure the safety of others. Participants voluntarily agree to follow the community protection guidelines (Age 18+).

DDA is rapidly expanding its State-Operated Supported Living Model (SOLA) from 131 beds in 2016 to more than 200 by 2021. In the 2019 legislative session, the legislature approved funding for 74 additional SOLA beds. In 2010, the Washington state governor and the legislature set an expectation to create a sustainable system of care to serve individuals with developmental disabilities, with a wider range of options near their families. By consolidating

the RHCs over time and using the expertise of DDA, this vision provides for appropriate transition of residents from RHCs and calls for the development of new capacity and services that will address the need for crisis care and behavioral supports in the community.

DSHS began working toward this objective in January 2011 by planning for the closure of the Frances Haddon Morgan Center (FHMC). In June 2011, Senate Bill ESSB 5459 was signed into law. This bill adopted many of the governor's policy recommendations, and called for the closure of FHMC by December 31, 2011. This is the first closure of a state operated institution in Washington state since Interlake School was closed in 1994. The law also calls for the downsizing and eventual closure of another RHC, Yakima Valley School, through attrition. Of the 52 FHMC residents, 31 clients and their families chose community residential placements, while 21 chose a placement in one of the remaining four Washington state RHCs. The last residents of FHMC moved from the facility November 16, 2011. Supporting families through the process of moving a family member from a RHC to the community is extremely important to the success of consolidation efforts.

The 2011 Legislature funded a Family Mentoring Project to provide information and support to families and guardians going through this process. The Family Mentoring Project is an additional resource for parents, guardians and administration staff in supporting people through change at RHCs. Funding for the project continues through the DDA Roads to Community Living program. The Family Mentor is the mother of a person who lived at an RHC who now lives successfully in the community. She meets with families who either have or have not yet made the decision to move a family member from an RHC or other institution. She listens to families understanding firsthand what they are feeling and thinking. She explains community services and programs from a parent's perspective, and suggests helpful strategies for making the process successful.

Reducing State Mental Hospital Stays and Diverting Admissions. DDA continues to work with the Division of Behavioral Health and Recovery (DBHR) to transition people with a dual diagnosis of a developmental disability and psychiatric condition from state psychiatric hospitals to less restrictive settings. In order to move, each person must be deemed ready for discharge by his or her treatment team.

DDA continues to provide training on a number of topics (e.g., positive behavior support, autism, genetic disorders, cross system crisis planning, medical issues for persons with developmental disabilities) to community residential, vocational and mental health providers in order to prepare them to provide supports for this population.

Working in collaboration with DBHR, DDA has implemented a Comprehensive Review Process to review the quality of community supports for adults with dual diagnosis. Data collected from these reviews is used to target service gaps, identify strengths in the system and inform policy. Further, DDA will continue to work to divert admissions to state hospitals by:

- continuing to contract with local support networks and community providers for enhanced crisis services, diversion beds and medication management services;

- reviewing state hospital admissions of people with a dual diagnosis to determine what, if any, additional community services might have diverted the admission; and
- "Money Follows the Person" federal grant, which provides funding to enhance the opportunities for people to return to the community if they desire to do so.

The Aging and Long-Term Support Administration manages the overall "Roads to Community Living" (RCL) grant and DDA has initiated projects to increase the capacity of the community to provide for people with all kinds of needs in the following ways:

- **Lessons Learned Project** – The Administration asked independent facilitators to obtain feedback from stakeholders involved in or affected by the closure of FHMC. Nearly 130 stakeholders participated in the project. This information has helped DDA plan for future moves from institutional settings and establish new services in the community.
- **Eating Safety Project** – DDA contracted with two speech pathologists who have expertise in eating and swallowing disorders and have extensive experience with individuals with developmental disabilities. Every person who moved from FHMC to any location – community-based or another RHC – has been assessed for their risk of eating and swallowing problems, safety risks during eating, or any disorders that cause them to ingest non-food items. Based on this experience, a training has been developed for all community residential staff.
- **Nursing Project** – The Administration has engaged a Registered Nurse who reviewed the health-related elements of each person's transition from FHMC for those who moved to community-based homes. As a result of these health reviews, staff training needs have been identified and a formalized checklist and protocol to address client health needs have been drafted. This checklist better summarizes participant health indicators and identifies needed health and wellness outcomes.
- **Community Crisis Stabilization Services (CCSS**) – DDA developed a framework of crisis and stabilization services across the state to address the needs of clients who experience a crisis or need additional crisis services. The intent of the program is to prevent unnecessary RHC placement. In November 2012, DDA opened the Lakewood CCSS program where crisis services for youth are provided. DDA is exploring opening an adult crisis house in the same general area and two other homes for children in crisis across the state.
- **Mental Health Supports** – Individuals with developmental disabilities are benefiting from improvements to the mental health service system that resulted from the coordinated efforts of DDA and DBHR. With the closure of FHMC, this coordination has been put to a test. DDA and the mental health provider for the county where most of the former FHMC clients now live have developed an effective working relationship. This has included streamlining the referral process and differently prioritizing those referrals. Intakes for services with the mental health provider for this county are now being conducted collaboratively between DDA and an agency staff person who has experience working with persons who have developmental disabilities. Common clients of DDA and this provider have been identified so that they can work together on care for these individuals as well. These procedures can be replicated in other parts of the state.

- **Family, Guardian and Advocate Survey** – This is a telephone survey conducted by RCL staff to obtain FHMC family perceptions about the moving process, the health and welfare of their family member and overall satisfaction with the new residence. The results indicate that over 80 percent of families, guardians and advocates received enough information about move options and were involved in making the choice about where their family member would move to. Eighty-six percent of the families, guardians and advocates reported that the new support staff involves them in important decisions with regard to their family member. Ninety-six percent of families, guardians and advocates reported that staff at the new residential placement always treats them in a respectful and courteous way and 81 percent feel that their family member is safe in his or her new home.
- **Assistive Technology and Communication** – The project is designed to provide training and information regarding assistive technology best practices. The purpose of the project is to learn and develop strategies for assessing and evaluating the use of a variety of appropriate assistive technologies for individuals leaving institutional settings. This has included assessments as well as staff training. Two statewide conferences were held last fiscal year. In addition, two statewide conferences will be organized to provide training to a cohort of community residential providers regarding use of iPad and other hand held devices which enhance community living experiences for individuals with developmental disabilities.
- **Serving Individuals on the Autism Spectrum** – The project is designed to identify areas of the community service system that require a change in practices to adequately serve individuals with autism and to develop a plan for implementing necessary changes. Issues are assessed with the current service provision system, recommendations are made on how to improve the system and a plan is developed to better meet the needs of individuals on the autism spectrum.
- **Behavioral Supports** – The project will explore methods for improving client behavioral support work done in the community in the areas of assessment, data collection and analysis of behavioral programming. By improving these areas, we can better improve the behavioral supports individuals are receiving and limit re-institutionalization. Best practices for documentation of behavioral support programs will be analyzed and a curriculum will be developed based on this analysis and information will be disseminated to residential providers.
- **Community Residential Staff Retention Project** – Staff turnover and productivity are two of the biggest issues that residential agencies face in today's workplace, and those issues negatively impact client services. The project focuses on the dynamics of those issues and concentrates on strategies for improving staff performance and retention. A curriculum has been developed and presentations have been made to residential providers.
- **Environmental Support/Housing** – The project has provided guidance and education for community providers and families on appropriate housing and environmental supports for someone leaving an institution. This is based on the use and improvement of checklists and transition planning formats developed through this reinvestment project. We are now focusing on making the existing checklists and transition planning formats

developed in Phases I and II more user-friendly and web-accessible. The project also provides guidance and education for community providers, families and housing agencies regarding appropriate housing and environmental supports based on creating/adapting housing that goes beyond ADA standards.

- **Employing Difficult-to-Employ Individuals** – The project is designed to promote activities to sustain employment practices utilized in participating counties to employ people with developmental disabilities who have been difficult to employ. RCL participants, former RCL participants and their respective counties are targeted. The project includes developing plans to implement lessons learned regarding how employment systems can better respond to the employment needs of individuals leaving RHCs. Strategies, systems, best practices and collaborations have been developed to secure employment opportunities for individuals moving to the community from institutional settings. As part of this, person--centered employment plans have been developed and support activities will occur for up to 27 RCL participants seeking employment. A statewide steering committee supports the project to determine best practices and system change recommendations. In addition, a website (Live Inclusive) was created and is being maintained to share stories and resources about people living and working in the community.
- **Avoiding Institutionalization of Children** – This project develops and facilitates trainings for families regarding natural supports and the wrap-around model helping to avoid institutional placement of children. The sessions are for families with children who are DDA clients with behavioral problems. This includes families who may be involved with Children's Long-Term Inpatient Programs (CLIP) to enhance transition planning process for Children leaving CLIPs.
- **Family Mentor** – This project provides information and support to families and guardians of individuals living in institutions going through the process of deciding whether or not a move to the community is right for their relative. It provides an additional resources and strategies for parents and guardians supporting people through this change to make the process successful. The family mentor meets with families who have or have not yet made the decision about a move to the community and explains community services and programs available from a family member's perspective.
- **Increasing Quality in Community Programs** – These projects focus on strengthening the community-based residential system by reducing risk and effectively using RHC resources in the community. Stakeholders are reconvened on a periodic basis, research is completed and protocols have been further refined and evaluated.
- **Practice Change Regarding Community Values and Standards** - The project was originally developed to help staff make the transition from institutions to providing community based supports. The project has widened in scope to clarify values with a target audience of community providers, families, self-advocates, DDA staff and RCL staff. The latest phases incude the coordination and facilitation of:
    - Make a Difference: Person Centered Direct Support workshops with up to four Supported Living agencies over a six month period

- Up to six workshops based on Appreciative Inquiry, Valued Social Roles, Building Inclusive Communities to enhance community values and standards
- Up to three discussion groups with RHCs, community providers, families, self-advocates, DDA regional staff and RCL team to share information about what community has to offer and to build collaborations.

The results will include recommendations for next steps.

- **Community Outreach** – This project includes the production of videos telling the stories of individuals who have made the transition from an institution into the community. It also includes the production of at minimum five Community Inclusion Newsletters annually telling the success stories of individuals with disabilities who are living in the community. These help educate clients and family members about the community support system and help people make the decision to leave the institution.
- **Intensified Residential Supports Residential Pilot** - A small number of DDA clients have not been successful in their RCL placements and have returned to the RHCs. In addition, there are other RCL enrollees with similar behaviors that are awaiting community placement. A pilot project is addressing these identified individuals' needs in a systematic manner and developing models for intensive staff training, staffing and increased clinical oversight to support individuals with more intense needs. Issues with current service provision system are being identified based on case studies. This information and national research regarding successfully implemented models used in other states is being used to develop service provision protocols.

Housing and Transportation

The need for affordable housing for people with disability has steadily increased for several years. This is a result of national and state trends away from larger facility based service models in favor of smaller community integrated services for people with developmental disabilities. DDA programs currently support over 4,000 people in its community residential programs. Approximately 86 percent live in homes that they rent or lease since DDA does not provide housing for these individuals. These supported living clients reside in non-facility based integrated settings and are responsible for their own rent and utilities. If a person is unable to pay rent for a short time due to unforeseen circumstances, the program pays a non-facility allowance so the person can continue to live in his or her home. However, these dollars are limited.

The legislature has provided a designated amount of dollars in the Housing Trust Fund (HTF) for people with developmental disabilities since the mid-1990s. These funds are currently administered by the Department of Commerce. DDA plays a key role in the HTF usage targeted for people with developmental disabilities. DDA's role includes:

- identifying areas of greatest need for affordable housing for people with developmental disabilities
- promoting the vision for integrated affordable housing through DDA's strategic plan

- sponsoring proposals associated with community based services that reflect current practice and are expected to continue into the future
- working with localized affordable housing funders to help secure leverage dollars
- working with specialized housing developers and consultants
- Collaborating with Commerce to review and prioritize HTF project proposals each year.

DDA will continue to participate in the cross program transportation planning committee. This committee develops state level transportation policy and works to influence local planning and policy development.

Quality Assurance for People Moving from Residential Habilitation Centers
When a person decides to move from a RHC to another location, quality assurance activities occur every step of the way. Quality assurance activities begin with all of the pre-planning that goes into a move from an RHC to another location. This includes:

- Person Centered Planning
- Extensive consultation with the family or guardian and individual
- Information about options and visits to possible locations and providers
- Once the planning has been done and the person moves, there is a year-long process that follows the person regardless of whether they move to the community or another RHC. The Regional Quality Assurance Manager visits the person three times within the first year of the move to interview and observe the person in their new home. Each time a visit is made, a report is completed and entered into a database. If any concerns are noted, the Quality Assurance Manager works with the person's Case Resource Manager and the residential provider to ensure that they are corrected.

Additional quality assurances include:

- Enhanced funding through the RCL grant to meet transitional needs during the first 365 days after the person moves from an RHC
- A federally mandated quality assurance survey completed by an independent entity before the person leaves the RHC and at one and two years after moving
- Three highly trained state staff whose time is dedicated to assisting with the transition process by providing expertise to help community providers, helping individuals connect with their communities and assuring the quality of the lives of the individuals who have moved.

Once the person moves to the community, there are on-going quality assurance activities for all persons in funded community services:

- An Individual Support Plan (ISP) is developed annually by the Case Resource Manager with the person, family or guardian and provider agencies
- The residential services provider develops an Individual Instruction and Support Plan (IISP) based on the information in the ISP
- The Residential Care Services (RCS) Division conducts program evaluations and certifies providers

- Community providers have training requirements as part of their contracts to provide services
- DDA contracts for technical assistance to providers when issues of concern for the person's health and welfare arise
- All providers are mandatory reporters and must report any suspected abuse, neglect and exploitation of children and vulnerable adults
- DDA maintains an Incident Reporting (IR) system that providers are required to use to report any suspected abuse, neglect, or exploitation and other serious incidents
- RCS, Adult Protective Services and Child Protective Service all investigate allegations of abuse, neglect and exploitation
- All community providers must have background checks completed every three years.

Stakeholder Work

DDA places a high priority on listening to stakeholders and interacting with them. The state uses several forums to continually solicit feedback. These activities include:

- A monthly meeting with the Community Advocacy Coalitions where DDA answers questions, provides information and solicits feedback
- Bi-monthly meetings with county coordinators of services for people with developmental disabilities, with a regular spot on the agenda to present information and solicit feedback
- Working in partnership with the Developmental Disabilities Council, the Arc of Washington and People First of Washington to gather input and feedback as well as to co-fund information for families and self-advocates
- Biannual quality assurance meetings hosted by the DDC that solicit the input of stakeholders on the management of DDA waiver services
- Citizen panels that are convened by the DDC to yearly review the results of the National Core Indicators survey and provide feedback and recommendations to DDA on improving services and supports.

Economic Services Administration (ESA)

The Economic Services Administration (ESA) helps low-income families, children, individuals, pregnant people and persons with disabilities, older adults, refugees and immigrants.
ESA's core services focus on:

- **Poverty Reduction & Self-Sufficiency –** Helping low-income people meet their basic needs and achieve economic independence through cash grants, food and medical assistance, employment-focused services and subsidized child care. Major programs include Temporary Assistance for Needy Families (TANF) and WorkFirst (Washington's Welfare to Work program), Basic Food, Basic Food Employment and Training, Aged, Blind, or Disabled, Housing and Essential Needs Referral, Pregnant Women's Assistance, Refugee Cash Assistance, Working Connections Child Care and medical assistance.

- **Child Support Enforcement & Financial Recovery –** Ensuring parents live up to the responsibility of supporting their children and improving the self-sufficiency of families through increased financial and medical support. In addition to child support, the administration's collection of other debts owed to DSHS protects taxpayers while helping programs meet current expenditures and provide financial assistance, medical care and other benefits and services to those in need.
- **Disability Determination –** Determining whether individuals applying for Social Security disability benefits have a disability that prevents them from working. Under contract with the Social Security Administration, Disability Determination Services determines whether individuals qualify for benefits from the Social Security Administration and for medical assistance.

ESA is committed to building a client-focused case management model that is shaped by collaboratively identifying the needs of not individuals and families in a multigenerational strategy. This is not a one-size fits all approach and it is not done alone. To maximize service reach and effectiveness, ESA works with a network of community partners. Meeting the needs of a diverse population requires serving clients where they are, providing a welcoming and inclusive environment, developing culturally competent best practices and ultimately making measurable progress toward identified goals.

ESA makes accessing services convenient. Direct client services are available to the public through a network of Community Services Offices (CSOs) and child support offices. Services are also provided through out-stationed staff in local communities and two Mobile CSOs.

- The following services may also be provided by phone at **1-877-501-2233** or online at www.washingtonconnection.org: checking benefit status information, completing an interview for food or cash benefits, renewing program benefits and reporting changes. Constituent-related services for these programs are available by phone at **1-800-865-7801.**
- Working Connections Child Care (WCCC) applications can be completed by phone at **1-877-501- 2233** or online at www.washingtonconnection.org.
- To locate a local child support office, get additional information, pay child support and download an application for child support services, visit www.childsupportonline.wa.gov.
- Most child support client-related services are available by phone at **1-800-442-5437**. Child support constituent-related services are available by phone at **1-800-457-6202**.

For more information on ESA's full range of services, visit https://www.dshs.wa.gov/esa

ESA Services that Further the Intent of Olmstead

AGED, BLIND OR DISABLED (ABD)

ABD is a state-funded program for low-income adults who have no dependents and cannot work. The ABD program provides cash assistance and a referral to the Housing and Essential Needs (HEN) program to adults who are:

- Age 65 or older
- Blind, based on federal Supplemental Security Income (SSI) standards
- Likely to meet SSI criteria.

HOUSING AND ESSENTIAL NEEDS (HEN) REFERRAL

The HEN Referral program provides potential access to essential needs items (e.g., hygiene and cleaning supplies) and housing assistance to low-income adults who are unable to work for at least 90 days due to a physical incapacity, mental incapacity, or substance use disorder and are ineligible for ABD cash assistance. The Department of Commerce administers the HEN program and determines eligibility for housing assistance and essential items through its network of local providers.

BASIC FOOD

Basic Food is Washington's network of federal and state programs that include a basis for nutrition security and a means for linking food benefits recipients to employment and employment readiness training or assistance.

- **Supplemental Nutrition Assistance Program (SNAP)**, formerly known as Food Stamps, provides food assistance to eligible low-income individuals and families.
- **Food Assistance Program for Legal Immigrants (FAP)** provides food assistance for legal immigrants who are not eligible for SNAP.
- **Washington Combined Application Program (WASHCAP)** is a simplified food benefits program for certain SSI recipients that delivers food benefits through an automated interface between the SSA and DSHS. A client's application for SSI also acts as the application for food benefits. Clients who receive WASHCAP are certified for up to 36 months.
- **Transitional Food Assistance (TFA)** is a food assistance program that provides food benefits to families leaving TANF or Tribal TANF cash assistance programs.
- **Basic Food Employment and Training (BFET)** provides job search assistance, employment, education and skills training, case management, work-based learnings and support services to individuals receiving SNAP who are not participating in the TANF program.

MEDICAL ASSISTANCE

Implementation of the Affordable Care Act (ACA) significantly changed ESA medical assistance activities. Most medical assistance clients previously served by DSHS now apply for medical assistance through the Health Benefit Exchange (HBE). ESA continues to determine eligibility for some medical assistance programs including:

- **Healthcare for Workers with Disabilities** - Medical assistance for disabled persons who are working and do not receive SSI. Premium amounts are based on income, which cannot exceed 220% of the Federal Poverty Level (FPL).

- **Long Term Care** - Coverage for people residing in a medical institution, receiving home and community based waiver services, or receiving hospice services.
- **Medicare Savings Program -** Payment of Medicare premiums, coinsurance and deductibles for low-income Medicare beneficiaries. Income limits vary by program from 100% to 200% FPL.
- **SSI Medicaid** - Medical assistance for aged, blind or disabled persons who receive SSI. The Social Security Administration determines eligibility for SSI using income rules based on Title XVI of the Social Security Act.
- **SSI Related Medicaid** - Medical assistance for low-income aged, blind, or disabled persons who do not receive SSI cash benefits.
- **Medical Care Services** - Medical assistance for adults who are deemed eligible for ABD cash assistance or the HEN Referral program but are immigrants under the five-year bar or legally present immigrants who are ineligible for other medical assistance programs.

TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF), STATE FAMILY ASSISTANCE (SFA), AND WORKFIRST

TANF provides cash grants for families in need. Persons whom are caring for a relative's child, are legal guardians, or are acting in the place of a parent are also able to apply for TANF benefits on behalf of these eligible children. Persons who are residents of Washington State and are ineligible for TANF as a result of eligibility changes due to the Welfare Reform Act may be eligible for SFA. Some TANF and SFA families participate in the WorkFirst Program, which helps participants find and keep jobs.

CHILD SUPPORT

ESA's Division of Child Support (DCS) assists with establishing paternity as well as establishing, enforcing, and modifying child support and medical support obligations. DCS' Alternative Solutions Program assists paying parents to create and implement a plan to eliminate barriers to paying child support. Alternative Solutions works directly to resolve existing child support issues that may exist as well as making referrals to by making referrals to community based organizations for additional help.

PREGNANT WOMEN ASSISTANCE (PWA)

PWA is a state-funded program that provides cash assistance to low-income pregnant individuals who are not eligible for the Temporary Assistance for Needy Families (TANF) or State Family Assistance (SFA) program for a reason other than not following TANF program rules.

REFUGEE AND IMMIGRANT ASSISTANCE

The Office of Refugee and Immigrant Assistance (ORIA) administers 14 different programs that help people who are refugees and other eligible immigrants achieve economic stability and integrate into life in the United States. Prominent ORIA programs include:

- **Refugee Cash Assistance (RCA)** - Provides cash and medical assistance (Refugee Medical Assistance program) during the first eight months in the U.S.

- **Limited English Proficient (LEP) Pathway** - ORIA partners offer employment services and vocational English language programs. Employment services include job skills training, job search, employment placement and retention assistance. English as a Second Language (ESL) classes are offered by colleges and community-based organizations. Participants eligible for the LEP Pathway Program may be recipients of ESA's cash assistance programs, refugees or humanitarian immigrants who have been in the country less than five years and are not receiving public assistance.
- **Naturalization Services Program** - Assists with the application and preparation process to help low-income permanent residents become U.S. citizens. Services include preparing the application and fee waiver requests, assistance in obtaining test exemptions when appropriate and interview preparation.

ADDITIONAL PROGRAMS

- **Ongoing Additional Requirements -** Cash payments to meet a need beyond the basic needs of food, clothing and shelter. This includes cash payments for restaurant or home-delivered meals, food for service animals, basic telephone service and laundry.
- **Supplemental Security Income (SSI) and State Supplemental Payment (SSP) -** Provides a state-funded supplemental cash payment to some SSI recipients in addition to their regular SSI payment.

Washington State Health Care Authority (HCA)

The Washington State Health Care Authority (HCA) is committed to whole-person care, integrating physical health and behavioral health services for better results and healthier residents. HCA purchases health care for more than two million Washington residents through Apple Health (Medicaid), the Public Employees Benefits Board (PEBB) Program and, beginning in 2020, the School Employees Benefits Board (SEBB) Program. As the largest health care purchaser in the state, we lead the effort to transform health care, helping ensure Washington residents have access to better health and better care at a lower cost.

The Health Care Authority (HCA) embraces the Olmstead decision as a guide to ensure that Washingtonians with blindness or a disability will have the opportunity, both now and in the future, to live close to their families and friends, live more independently, engage in productive employment and participate in community life. This includes:

- The opportunity and freedom for meaningful choice, self-determination and increase quality of life through opportunities for economic self-sufficiency, living and location situation and employment options.
- Systemic changes that support self-determination through revised policies and practices across state government and the ongoing identification and development of opportunities beyond the choices available today
- Readily available information about rights, options, risks and benefits of these options and the ability to revisit choices over time.

BEHAVIORAL HEALTH SYSTEM

Significant new funding was proposed and passed into law as part of the state's 2019-21 operating and capital budgets. The strategies these new funds will support represent the continued commitment to build sustainable systems change that invest immediately in developing community capacity and treatment services. As part of the transformative effort to sustain and enhance the lives of those served, the outcomes, focused on returning to and/or remaining in the community, funded with these targeted investments include:

- Individuals diverted from the state hospitals and those at the hospitals successfully transitioned back to the community:
    - Using Medicaid funding under the transformation demonstration to provide supportive services to stably house the highest-need chronically homeless individuals
    - Investing state dollars in rental assistance not provided under the demonstration for permanent supportive services prioritized for patients discharging from the state hospitals and in capital funding in the Housing Trust Fund for these services for people with chronic mental illness
- Long-term strategies to grow the behavioral health workforce while building additional civil commitment beds in the community
- Investments in the state hospitals to keep them operating and safe for patients and staff while the system is being transformed

More information on these targeted investments is available at *Transforming Washington's Behavioral Health Care System*.

EMPLOYMENT SUPPORTS AND SERVICES

The Supported Employment Coordinating Committee (SECC) is born from the Substance Abuse & Mental Health Services Administration (SAMHSA) and sponsored Olmstead Policy Academy that was created in 2013. Members of the SECC are from the Governor's Advisory Council on Employment, Division of Vocational Rehabilitation, Workforce One-Stop, regional Behavioral Health Managed Care Organizations (BHOs), people with lived experience, the business community, provider organizations, Health Care Authority, Developmental Disabilities and Long-Term Care administrations and other key stakeholders. Conference calls are held the second Monday of each month to review progress toward the goals and objectives of the grant, identify and implement strategic plan action steps, share resources and provide system updates. The SECC has also been identified as the implementation planning workgroup for the 1115 Medicaid Transformation Demonstration Project. The 1115 Medicaid Transformation Demonstration Project special terms and conditions were approved January 9, 2017, between the State Medicaid Authority and the Centers for Medicaid and Medicare. The 1115 Medicaid Transformation Project will provide supportive housing and supported employment (SE) services as a Medicaid-reimbursable benefit for Washington residents who are the most vulnerable and have complex care needs.

In its transformation demonstration, HCA includes the Foundational Community Supports (FCS) program. In addition to the supportive housing assistance described above, this initiative

provides supported employment services to individuals who experience chronic homelessness, frequent or lengthy institutional contacts, or frequent or lengthy stays in residential care:

- Vocational and job-related discovery or assessment
- Planning for employment
- Job placement, developing, coaching
- Skills-building for negotiating with prospective employers

This initiative is implemented as a result of foundational projects done in the state, even without significant funding being made available in supported employments for individuals with chronic mental illness. In 2013, the state's Mental Health Authority submitted an application that was approved for its participation in the Substance Abuse and Mental Health Services Administration's (SAMHSA) Policy Academy. This undertaking demonstrates a collaborative effort between state and local agencies that uses evidence-based practices to move adult behavioral health to an outcome-based system based on SAMHSA's working definition of recovery:

A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. (Making the Case for Change, 2012)

Washington Pathways to Employment web portal is an employment development resource for blind and disabled individuals. In addition to helping them understand that working does not have to mean the loss of health care benefits, the platform provides many resources in one place for achieving success, including inspiration from success stories, a resume builder, and benefits estimator. The web portal provides a training platform for supported employment providers and has served as the model for a similar site that promotes readiness for sustainable housing, Pathways to Housing.

Previously, the agency managed the Medicaid Infrastructure Grant (MIG) under the Ticket to Work and Work Incentives Improved Act of 1999. Deliverables achieved under the MIG project included construction of the Pathways to Employment portal and served to develop and implement the state's Medicaid Buy-in, known as Apple Health for Workers with Disabilities (HWD). HWD provides full-scope Medicaid coverage, including access to home and community based services for those meeting functional assessment criteria, that allows a higher income standard and does not test for assets and resources. Coverage is provided to those who are working, enroll and pay a monthly premium based on a sliding income scale. In preparation for the legislation session that recently ended and at the request of stakeholders and the legislative sponsor, the agency completed work to estimate caseload impact and related costs to make significant enhancements to the program for those who want to work and earn more than current program requirements allow.

As described in SHB 1199 (2019), the state's HWD program will become one of the best in the country. No longer will income be considered for eligibility beyond calculating a percentage of it when determining the monthly premium amount. Beginning in January 2020, individuals with higher earnings will be able to purchase wrap around services that are not provided through

their employer-sponsored insurance, such as personal care. Others will no longer have to refrain from working more hours or a accepting a promotion in order to maintain their HWD coverage. Individuals enrolled in HWD will no longer lose coverage based on their age. Currently, a participant loses coverage on their 65th birthday as prescribed under the Ticket to Work legislation of 1999. HCA will add the authority provided under the Balanced Budget Act of 1997, which does not prescribe a maximum age limit. Lastly, a new incentive will allow individuals to save from their earnings during enrollment in a separate account that will not be counted when applying for any other coverage group thereafter. Typically, Medicaid programs that began before the Affordable Care Act continue to test for resources when determining eligibility for them; these include coverage under programs based on a person's age or their having blindness or a disability, including those that provide long-term services and supports.

The HCA is firmly committed to the vision that people with blindness or a disability should have the opportunity to experience lives of inclusion and integration in the community. The agency continues to identify and develop key activities to build an integrated infrastructure and service delivery system that meets the diverse needs of the populations it serves.

For more information about the services available through HCA, visit https://www.hca.wa.gov/

Department of Children, Youth and Families (DCYF)

The Department of Children, Youth and Families (DCYF) provides services that promote children's safety, permanency, well-being and access to quality early learning programs and childcare. DCYF is the lead agency for state-funded services that support children and families to build resilience and health and to improve educational outcomes. We accomplish this by partnering with state and local agencies, tribes and other organizations in communities across the state of Washington. DCYF's focus is to support children and families at their most vulnerable points, giving them the tools they need to succeed.

DCYF has a variety of services available to families before an institutional placement is considered, including:

- Crisis intervention to keep youth at home when there is a conflict in the family
- contracted services to help resolve the issues in their family that have led to a crisis between family members
- foster care and support for kinship care for families involved in the formal child welfare system to provide a safe and stable living situation for children unable to live in their family home due to abuse and neglect or to the inability of the parent to manage the child's behavior
- various projects with DSHS, state partners and community organizations to blend resources from multiple systems to serve children with high needs.

For more information about the services available through The Department of Children, Youth and Families, visit https://www.dcyf.wa.gov/services.

Conclusion

Washington is and has been actively working to develop resources to ensure individuals can be served in the community setting of their choice. This work continues as the acuity of the individuals we serve increases. Our pathway to success has been to identify barriers to leaving institutions and developing resources in the community to remove those barriers. Success in this work requires a willingness to innovate and funding.

2019-2021 biennial funding will provide additional services in the following areas:

- Home care investments to help stabilize the workforce - **$216 million**
- Rate enhancements for adult family homes and the addition of other services – **$84 million**
- Rate enhancement of assisted living facilities - **$29 million**
- Rate enhancement for DDA community residential providers **- $123 million**
- Funding for additional Enhanced Services Facilities - **$18 million**
- Funding for new community based behavioral health service settings – **$26 million**
- Community Respite Beds - **$4.4 million**
- Community Respite Beds Rate Increase- **$1.1 million**
- State Operated Behavioral Health Training Home- **$1.0 million**
- Complete 47 SOLA Placements- **$12.6 million**
- Enhanced Discharge Ramp-Up- **$10.5 million**
- SOLA Community Options- **$8.4 million**

HCA

- Program for Assertive Community Treatment (PACT) Teams- **GFS= $6021, Total=$18,598**
- Mental Health Drop-in Facilities (aka 24-hour Peer Respite) - **$GFS= $708,000/Medicaid $799,000**
- Long-stay Hospitals (serving 90 - 180 Day Commitments) - **FY20: GFS= $19,522,000 Medicaid-$12,685,000. FY21: GFS= $27,754,000/ Medicaid-$28,995,000**
- Intensive Residential Team to serve individuals in Skilled Nursing Facilities/Adult Family Homes- **FY20: GFS- $1,393,000/Medicaid=$2,984,000. FY21: GFS= $1,423,000/ Medicaid- $3,210,000.**
- Intensive Behavioral Health Treatment Facility (specialty Enhanced Service Facility) **GFS= $1,455,000/ Medicaid = $3,210,000**

DCYF

- Investment in rate increases to providers of facility and home based behavioral rehabilitation foster care placements - **$35.1 million**
- Continued state support for ECLIPSE, a child care program aimed at children who are high risk for abuse and neglect and have behavioral or mental health issues.

- Funding to develop six (6) contracted qualified mental health consultants across the state to support children mental health in child care and early learning settings- **$1.5 million**

Washington is committed to serving people in the community. We will continue our innovative resource development and to aggressively seek funding through our Washington Legislature to implement remove that remove barriers and promote people living successfully in the community.