

DRAFT

Washington State Plan on Aging 2018-2022

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VERIFICATION OF INTENT

This State Plan on Aging is submitted for the State of Washington for the period October 1, 2018 through September 30, 2022. The Department of Social and Health Services is the sole state agency designated to develop and administer the state plan. The Aging and Long-Term Support Administration (AL TSA) has been given the authority to develop and administer the State Plan on Aging in accordance with all requirements of the Older Americans Act. AL TSA is primarily responsible for the coordination of all State activities related to the purposes of the Act, i.e. the development of comprehensive and coordinated systems for the delivery of supportive services, including information and assistance, in-home programs, nutrition and caregiver support services, and to serve as the effective and visible advocate for the elderly in the state.

This plan includes all assurances, plans, provisions, and specifications to be made or conducted by the Aging Long-Term Support Administration under provisions of the Older Americans Act, as amended, during the period identified.

This Plan is approved for the Governor by his designee Bill Moss, Assistant Secretary, Aging and Long-Term Support Administration, Department of Social and Health Services, State of Washington, and constitutes authorization to proceed with activities under the Plan upon approval by the Assistant Secretary on Aging.

The State Plan on Aging as submitted has been developed in accordance with all federal statutory and regulatory requirements.

Bill Moss Assistant Secretary

LIST OF ACRONYMS

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

EXECUTIVE SUMMARY

Under the requirements of the Older Americans Act of 1965 as amended, every four years a State Plan on Aging must be submitted to the U.S. Department of Health and Human Services, Administration for Community Living (ACL). The Aging and Long Term Support Administration (AL TSA) an administration of the Washington State Department of Social and Health Services (DSHS), has been designated as the single state agency to administer federal programs under the Older Americans Act (OAA). In that capacity, AL TSA has undertaken the development of this State Plan on Aging.

The State Plan incorporates the requirements of the OAA and is informed by the policy development and priority setting of the Governor's Results Washington¹, the DSHS AL TSA Strategic Plan, and the Joint Legislative Executive Committee on Aging and Disability Issues.

The 2013 Aging Summit hosted by Governor Jay Inslee provided focus for state policy makers and opinion leaders to explore strategic actions state government could take to create a more age-friendly environment, reduce pressure on future state budgets and spark the work of the then recently formed Joint Legislative-Executive Committee on Aging and Disability Issues (JLEC). Topic areas discussed were livable communities, financial security, health care, healthy aging and long term services and supports (LTSS).

The JLEC was originally established in the 2013-15 state operating budget. During the 2015 and 2017 legislative sessions, The mandate of the JLEC is to make recommendations and continue to identify key strategic actions to prepare for the accelerating aging of the population in Washington. This major demographic development will have important implications for policymaking and planning at all levels of government. The JLEC reviews policy and budget oriented recommendations for identified subject areas, establishes priorities for further consideration in the upcoming legislative session, provides direction to state agencies and identifies areas requiring further study.

In 2016, there were about 1,073,300 persons ages 65 and older, representing 15 percent of Washington's total population and growing more ethnically and racially diverse. In 2018, the number of persons 60 and older and OAA eligible is estimated at 1,619,589². As the number of people who can benefit from OAA services substantially increases, funding for OAA over the past two decades has not kept pace with population growth or inflation. By 2040, the elderly population is forecast to reach 1,984,800, representing 22 percent of the state's total population. The State's population over 85 is expected to double by 2030. Those 85 and older have a significantly higher rate of functional limitations and severe chronic health conditions that result in the need for more health and LTSS services.

As the aging population grows, there is increasing risk of abuse, neglect and exploitation. The state's Adult Protective Services (APS) has experienced a 252% increase in the number of reports from calendar year 2005 through 2017. In 2017, APS investigated a total of 43,304 allegations. The largest percentage of allegations, 25 percent, involved reports of financial exploitation.

While Alzheimer's disease is not a normal part of aging, age is the greatest risk factor for developing Alzheimer's or other dementia. Our longer lives increase the risk of developing dementia. Washington

¹ Results Washington is the state's performance system that integrates performance management, continuous improvement and cross-agency collaboration to achieve key goals and improve government effectiveness,

State now has the 12th highest life expectancy nationwide and Alzheimer's disease is the third leading age-adjusted cause of death in Washington State. While death rates of cancer, stroke and heart disease have declined, the death rate for Alzheimer's is on the rise. Currently, about 107,000 people in Washington have Alzheimer's or other dementias. By 2040, that number is expected to grow to over 270,000.³

Washington's aging population is economically concentrated in lower income brackets, with 29 percent having incomes below \$25,000 and 25% in the range \$25,000 to \$50,000. Many of the state's residents are not fully prepared for retirement or the cost of long-term services and supports (LTSS). People who need LTSS qualify for Medicaid only if they meet low-income eligibility requirements. Paying for LTSS out of pocket can be financially catastrophic for individuals and families and result in spending down to the poverty level, thus making them eligible for Medicaid.

Current Medicaid LTSS spending represents 6% of Washington State's operating budget (5% General Fund State) with annual service expenditures of \$2.1 billion. The ALTSA budget is increasing an average of 12% a biennium as the number of individuals qualifying for Medicaid funded LTSS grows consistent with the demographic trends. As the population of adults who are older grows rapidly, there is greater pressure on the state budget to fund LTSS and related services

Setting aside current policy and budgetary uncertainties created by actions of the Administration and Congress, the 2013 implementation of the Affordable Care Act (ACA) has been transformative for the state and its residents. The total uninsured rate declined from 14 percent to just above 5 percent. The ACA has created opportunities for ALTSA and other state agencies to collaborate with the Centers for Medicare Medicaid (CMS) and/or ACL to develop new service delivery models. These models provide more coordination, integration and shared accountability with the goal to reform payment systems by focusing on purchasing for value and reducing avoidable high-cost spending while emphasizing primary and preventative care. The state is currently implementing a five-year 1115 Medicaid transformation demonstration waiver that is allowing us to test and expand access to these services while also evaluating whether they result in overall avoidance or cost savings to state and federal budgets.

Washington has a long and demonstrated history of providing an array of 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 CMS and the ACL and 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 continued innovation to ensure services are high quality, continue to meet changing needs and preferences of the individuals served and are delivered in cost effective ways is at the core of ALTSA's and Area Agencies on Aging approach to delivery of LTSS.

³ Washington State Plan Alzheimer's 2016

Developing and expanding services to support unpaid family caregivers also remains a high priority. This strategy is aimed at improving the health and well-being of the caregiver, ensuring individuals in need of LTSS have another option that assists them to remain in their own homes and delay or divert from more costly LTSS services.

These strategies have proven successful as an approach to delivering services cost-effectively and saving taxpayer dollars. However relying on rebalancing and support of family caregivers as the only strategies for sustaining sufficient funding for LTSS will not save enough money to fund the projected increases in caseload that will result from the demographic population shifts in the state.

The creation of the State Plan to Address Alzheimer's Disease and other Dementias provided the opportunity for the state to improve quality of care, create efficiencies and potentially impact the trajectory of the illness itself as we strive for improved health outcomes. This plan has 7 high-level goals. Each goal identifies strategies and recommendations to move towards these goals. The comprehensive and complex nature of this implementation work will require a phased approach and sufficient funding.

The State and the LTSS network is continually challenged to evolve and to maintain the necessary capacity to provide the quality of support and services needed by Washingtonians. We want to stress the significant role of LTSS partners and our commitment to maintaining and building the partnerships necessary to support the capacity for the LTSS Network to address local needs. It is within this context, mindful of the existing resources available to the state and aligned with strategic policy goals that we present the State Plan on Aging

The ACL has set focus areas for State Units on Aging to frame the goals and objectives of the State Plan on Aging and the Plan is structured around these focus areas.

The broad goals of the plan are

- Person-Centered Home and Community-Based Services
- Elder Rights and the protection of vulnerable adults
- Healthy Aging
- Expanding and strengthening services and supports that prevent or delay entry into Medicaid funded LTSS

INTRODUCTION

The State Plan incorporates the requirements of the OAA and is informed by the policy development and priority setting of the Governor's Results Washington⁴, the DSHS ALTSA Strategic Plan, and the Joint Legislative Executive Committee on Aging and Disability Issues.

Plan development also includes review of Area Agency on Aging Plans, Tribal Summit communications and the input of Washington residents and interested parties. In addition to the required ACL focus areas we include information about innovative models being tested to transform the Long Term Services and Supports (LTSS) system. This testing is necessary to promote sustainable and systemic changes to ensure we are able to meet the needs of older adults and address intensifying long-term care financing challenges.

Following a review and comment period, the final Plan was approved by the State Council on Aging in public session on June _____.

The State Plan outlines key demographic and economic trends and conditions that will shape funding needs and priorities. In addition to services authorized under the Older Americans Act, ALTSA administers a full array of Medicaid funded home and community based services.

In collaboration with Area Agencies on Aging and other key LTSS network partners, ALTSA takes part in continuing discussion about the provision of LTSS including OAA programs and the on-going development of a system that is responsive to the diverse needs of constituents.

For purposes of this discussion, "LTSS" has been defined as a coordinated continuum of maintenance services that address the health, social and personal care needs of individuals with a chronic illness or disability that limits capacity for self-care. Services are designed to facilitate the maximum potential for personal independence. Services are provided consistent with consumer choice with the intent for the consumer to choose the setting and services that are most aligned with individual preferences and goals. Services and supports may be delivered for only a brief period or for a relatively long and indefinite period. Reference to the LTSS system includes the statewide aging and disability network and associated infrastructure.

Aging & Disability Network and Long Term Support Structures Washington State Council on Aging

The Washington State Council on Aging (SCOA) is established to serve as an advisory council to the Governor, the Secretary of DSHS and the office designated as the State Unit on Aging—ALTSA. Council members are designated by the Governor and is made up of one member from each state-designated planning and service area and appointed by AAA Advisory Councils. The governor appoints one member from the Association of Washington Cities and one member from the Washington State Association of Counties. In addition, the governor may appoint not more than five at-large members, in order to ensure that rural areas (those areas outside of a standard metropolitan statistical area), minority populations,

⁴ Results Washington is the state's performance system that integrates performance management, continuous improvement and cross-agency collaboration to achieve key goals and improve government effectiveness,

and those individuals with special skills which could assist the state council are represented. Currently two of the AAA representatives are from members of tribes. The speaker of the House of Representatives and the president of the Senate each appoint two non-voting members to the council; one from each of the two largest caucuses in each house. Council members are also contributing to the following: Dementia Action Collaborative, Health Innovation Leadership Network, Consumer Directed Employment Workgroup, Northwest Training Partnership and a guardianship related workgroup.

Aging and Long-Term Support Administration (ALTSA)

The mission of the Aging and Long-Term Support Administration (ALTSA) is to transform lives by promoting choice, independence and safety through innovative services with the vision that people are healthy, safe and supported and taxpayer resources are guarded.

The State Unit on Aging (SUA) is based in the Home and Community Services Division of ALTSA. The purpose of the Home and Community Services (HCS) Division is to promote, plan, develop and provide long-term care services responsive to the needs of persons with disabilities and older adults with priority attention to low-income individuals and families. We help people with disabilities and their families obtain appropriate quality services to maximize independence, dignity, and quality of life. We work with aging and disability advocates, including the State Council on Aging and Area Agencies on Aging, to ensure a person centered service delivery system.

ALTSA offers services that empower older adults and people with disabilities to remain independent and supported in the setting of their choice. This is accomplished through person-centered case management that works with individuals to build a care plan that reflects individual choices and preferences.

ALTSA is also responsible for protecting the safety, rights, security, and well-being of people in licensed or certified care settings and for the protection of vulnerable adults from abuse, neglect, abandonment, and exploitation in all settings. In addition to investigating abuse, ALTSA offers protective services when the situation requires action in order to ensure vulnerable adults are safe.

A broad array of services are offered through ALTSA, Area Agencies on Aging and an extensive network of locally contracted agencies including, but not limited to:

- Information and Assistance about long term care services & supports and Aging and Disability Resource Centers (Washington Community Living Connections)
- Assessment of functional and financial eligibility for Medicaid long term care
- Personal care and other waiver and state plan HCBS services
- Case management and service planning
- Nursing Home Diversion
- Relocation assistance for individuals wishing to move from institutional to community based settings
- Family and kinship caregiver support services, including Life Span Respite
- Foster Well Being Unit (FWB)-Collaborates with DCFYS, Health Care Authority and other entities to coordinate medical, mental health, and behavioral services; provide consultative expertise in the service delivery to children and youth in out-of-home placement; consulting expertise to managed care organization.

- FWB-Collaborates with DCFYS contract team and Division of Licensed Resources for development of policy and procedures for consultation and oversight review of medically fragile/complex group homes.
- Senior Nutrition – home delivered and congregate meals & senior farmer's market nutrition program
- In-home and supportive services
- Home Care Referral Registry
- Health promotion & disease prevention
- Health Homes
- Community residential licensing, quality assurance & policy development
- Nursing Home, Residential Rehabilitation and state supported living certification and quality assurance
- Nursing Services: Skilled Nurse Waiver, Adult Day Services, Nurse Delegation, Private Duty Nursing, Falls Prevention, Skin Observation Protocol
- Adult Protective Services
- Behavioral Supports services that impact the provision of personal care or continuity of care in LTSS settings
- Senior Employment Services
- Office of Deaf and Hard of Hearing
- Medical care coordination for children in Foster Care
- Program of All Inclusive Care for the Elderly (PACE)
- ACL discretionary grants including but not limited to Alzheimer's and Dementia Day services, Aging and Disability Resource Centers, Chronic Disease Self-Management Programs

ALTSA is made up of four divisions. Descriptions of the functions of each division and an organizational chart is located on page eleven.

Area Agencies on Aging and the Long Term Support Network

Area Agencies on Aging (AAAs) are responsible for planning, coordinating and advocating for the development of a comprehensive service delivery system at local levels to meet both the short and long term needs of older adults in their planning and service area (PSA). The network includes thirteen AAAs designated by ALTSA in accordance with the laws and regulations of the ACL and authorized under the OAA.

The Washington Association of Area Agencies on Aging assists the work of the AAAs with the vision of providing a comprehensive and coordinated local approach to managing a home, community and residential system of services that are client centered, allow maximum flexibility and promote the efficient use of resources; emphasizing the least restrictive interventions and building on the individual's and their family's strengths and responsibility.

Each AAA is required to have an Advisory Council representing the interests of the public to assist in identifying unmet needs, needed services and provide advocacy for policies and programs including the development of Area Plans in each AAA. AAAs are contractors for the State under ALTSA, and their subcontractors are also members of the network.

The subcontractors are service providers who may offer single or multiple services. The network also includes agencies or facilities that serve the needs of older adults but may not be direct recipients of OAA or Medicaid funds. These might include hospitals, churches, senior centers, and other service providers funded by different streams of money including Title XIX of the Social Security Act.

The mission of the network is to promote, plan, and facilitate the development of a comprehensive and coordinated service delivery system responsive to the needs of older adults (age 60+), family and kinship caregivers, and adults with disabilities receiving Medicaid long term care services in community based settings. Priority attention is directed to those who are most vulnerable due to social, health, or economic status. The system is designed to maximize individual options for high quality, timely, and cost-effective service, which enable participants to achieve their highest potential for independent living and maintain personal dignity. The services of the network are intended to be person-centered and build upon, strengthen, and integrate the person's informal support network. It is through these efforts, accomplished by planning, coordination, advocacy and accountability, that the dignity and rights of the individual are maintained.

Because of the limited resources available to the network and other social/health services systems and agencies, resources must be targeted to the vulnerable and those in greatest economic and social need. The system recognizes the need to work with and advocate for all older adults and adults with disabilities.

A list including contact information for the state's thirteen AAAs, is attached in Attachment D.

ALTSA has objectives that respond to the full range of aging needs. The following are objectives and principal components of a systems building strategy that have implications for AAA planning and operations. The AAAs in cooperation with ALTSA must:

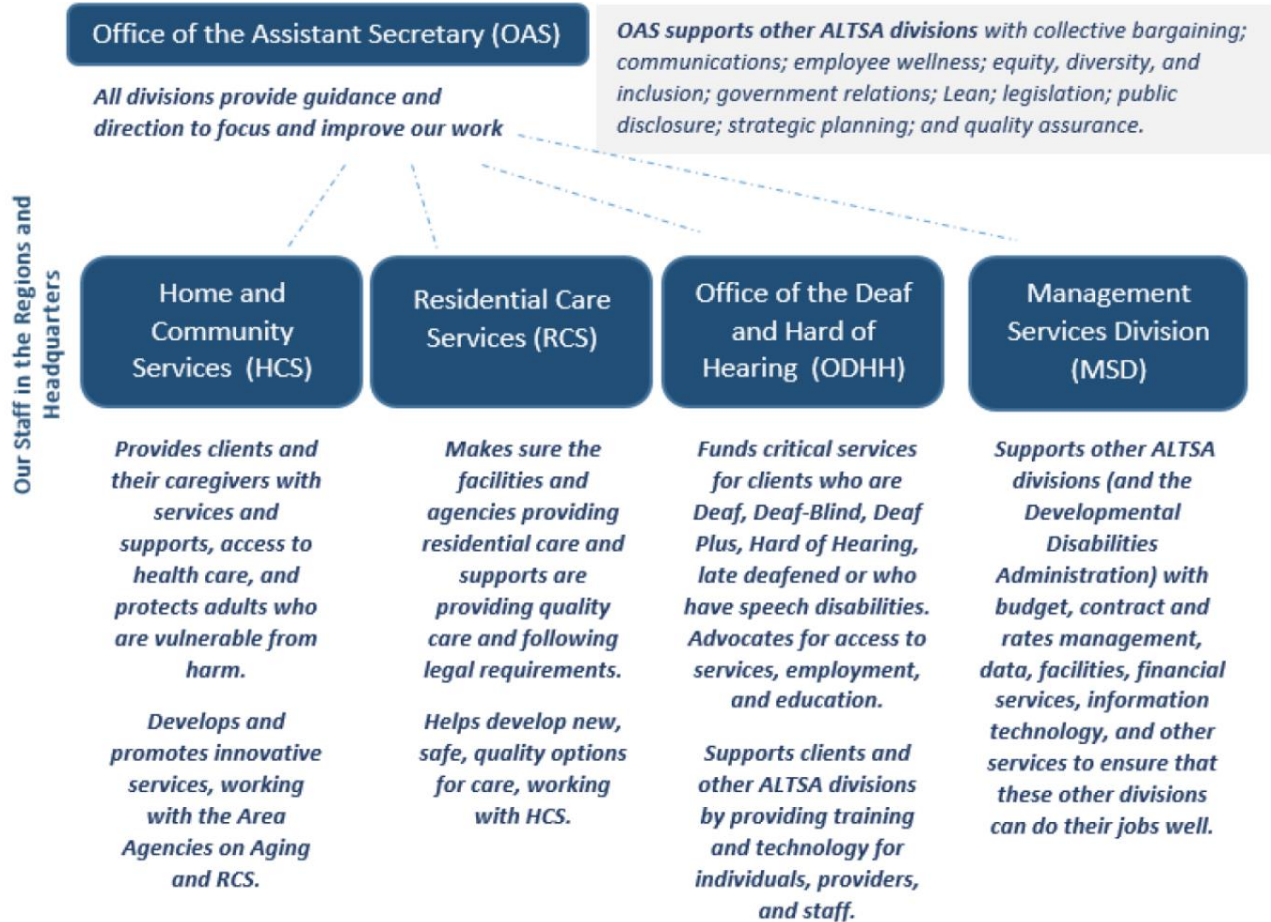
- Target the service delivery system to those age 60 +; age 60 +at or below Poverty; age 60+ who are minorities; who live in rural areas; have limited English speaking ability; and those needing assistance with Activities of Daily Living.
- Develop a service delivery system that incorporates the concept of a continuum of care that includes access, case management, social, health, personal care, and access to and from residential and in-home services.
- Participate in a service delivery system for the aging population that coordinates, to the extent possible, all service delivery programs administered by the Department of Social and Health Services and other agencies providing services to older adults.
- Develop a statewide strategy for service delivery at the community level. This includes developing a strategic plan based in part on AAA plans.
- Establish a system of supportive services that ensures that consumers are provided services that most appropriately respond to their needs.
- Involve advisory councils or boards in informed decision making for all major aspects of ALTSA and AAA functions directed to the establishment of a comprehensive and coordinated system of services for older adults.
- Periodically conduct needs assessments. AAA's must assess needs of the older population as part of its continuous planning process.

ALTSA Organization and Partnerships

OUR MISSION

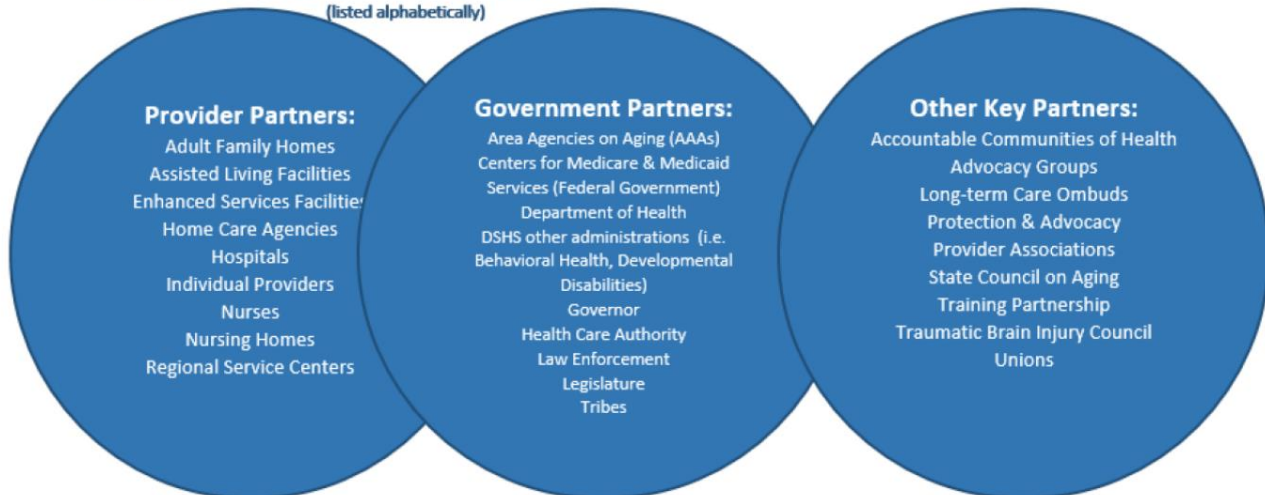
We transform lives
by promoting choice, independence, and safety
through innovative services

Each part of our organization supports the mission and each other's work:



Our partnerships are vital to our mission:

(listed alphabetically)



Sovereign Nations-Serving American Indian and Alaskan Native Elders

There are 29 federally recognized tribes in Washington. Two tribal governments, Yakama Nation and Colville Confederated Tribes are designated as Area Agencies on Aging, serving all residents living on their tribal lands. There are also unrecognized tribes and other individuals of Native American Indian descent who are not members of local tribes.

Federally Recognized Tribes are recognized in federal law as possessing sovereignty over their members and their territory. Sovereignty means that tribes have the legislative, executive, and judicial power to make and enforce laws, and to establish courts and other forums for resolution of disputes.

DSHS, inclusive of ALTSA, follows a government-to-government approach to seek consultation and participation by representatives of tribal governments in policy development and service program activities. This complies with the Washington State 1989 Centennial Accord and current federal Indian policy promoting government-to-government relationships with American Indian Tribes.

ALTSA is responsible for implementing this policy in the planning and delivery of contracted services provided by the AAAs as well as those delivered by State Regional Offices. DSHS Policy 7.01 spells out a number of important definitions and policies regarding working with American Indian Tribes and requires that a 7.01 Implementation Plan be routinely submitted.

All non-tribal governed AAAs are required to develop Section 7.01 plans that are incorporated into their Area Plans and updated on a regular basis. Area Plan instructions have specifically required that one issue area be devoted to the explanation of how services will be provided to American Indian Tribal members and also meet the requirements for coordination between Title III and Title VI under OAA.

The 2013 passage of the Affordable Care Act and the American Indian Health Improvement Act created the opportunity for tribes to plan for the provision of community based long-term services and supports specifically for Indian Country. ALTSA collaborated with the Indian Policy Advisory Committee (IPAC), The Washington American Indian Health Commission (AIHC), the DSHS Office on Indian Policy (OIP) and the state Health Care Authority (HCA) to develop a Money Follows the Person Tribal Initiative proposal that was funded in April 2014. The initiative provided resources to advance infrastructure development to support the return of tribal members to their communities of choice from skilled nursing facilities, to further develop culturally appropriate community based resources to decrease the risk of tribal members moving to skilled nursing facilities.

The Money Follows the Person Tribal Initiative (MFPTI), has worked in collaboration with tribes, urban Indian health organizations, other state agencies and county-based AAA's to expand contracting opportunities to Tribes/Recognized American Indian Organizations (RAIOs) in support of sustainable, culturally relevant delivery of long-term services and supports. The goal is to support American Indians/Alaska Natives (AI/ANs) currently residing in institutions and at risk of institutional placement to either return from institutional placements or avoid placement through access to the most culturally significant living environments, as identified by the individual. There are over 1,230 self-identified Native Americans/Alaska Natives, representing over 140 federally recognized Tribes, receiving long-term services in Washington.

Through concerted efforts by Tribes, ALTSA Tribal Affairs, and other ALTSA Divisions the following expanded options are in place or in discussion with Tribes/RAIOs. Integral to the success of this work is the partnerships with the DSHS Office of Indian Policy and the Health Care Authority.

Contracts for:

- Non-emergency Transportation
- In-home Personal Care Agencies
- Adult Day Services
- Kinship Care/Respite Services
- Home Delivered Meals
- Health Home Care Coordination
- In-home staff trainers
- Construction/contracting of
- Adult Family Homes/Assisted Living
- Infrastructure strengthening
- Updated contract language to recognize sovereignty of Tribes
- Development of billing guides
- Exploration of 100% federal Medicaid match and enhanced payment rates

Roads to Community Living⁵ has been working to bring nursing home residents back home to their community since 2008. From 2008 – March 2018:

- 335 Native Americans/Alaska Natives have enrolled in the program
- 252 Native Americans/Alaska Natives have moved back to their community or a less restrictive living environment
- 26 Native Americans/Alaska Natives are currently in the program
- 16 people are currently working on transitioning back to their community.
- 4 of those 16 people are Native American/Alaska Natives.

The broader goals of the Tribal Initiative include:

- Increased accessibility to Medicaid Long Term Services and Supports (LTSS) to eligible individual tribal members who need them;
- Identification of tribal infrastructure needs to enable Tribes/Tribal Organizations (T/TOs) to provide services directly and/or contract to provide services;
- Development of accessible reimbursement mechanisms for service delivery;
- Identification of opportunities to obtain higher federal medical assistance percentages (FMAP) and/or encounter rates as defined in the federal register;
- Expand opportunities for Tribal Contracting for direct service delivery of Medicaid reimbursed LTSS
- Diversify opportunities outside of LTSS Medicaid for service delivery.

CMS has recently approved the Indian Health Care Provider (IHCP) Protocol for the Medicaid Transformation Demonstration, ALTSA will work with tribes to develop an attestation policy for the

⁵ The federally funded Money follows the Person Demonstration Project is referred to as Roads to Community Living.

Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults (TSOA) health services programs. The state will accept tribal attestation of compliance with state provider requirements for the health services if a tribe establishes provider entity standards with comparable client protections. Details on the approved protocol are available at: <https://www.hca.wa.gov/assets/program/mtp-approved-tribal-protocol.pdf>

During state plan development, ALTSA SUA staff met with the DSHS Indian Policy Advisory Committee (IPAC) subcommittee for Aging and Disability services. IPAC contributed to the development, review and distribution of the draft plan for comment. Accordingly, this plan addresses state and tribal governments work to develop strategies for long-term supports and services.

Network Comment and Review of this Plan. Final draft comment date TBD

The State Council on Aging, the Area Agencies on Aging, Tribal Governments, and other interested stakeholders, including members of the State Dementia Action Collaborative were asked to comment and review the plan. Program managers in the Home and Community Services division were consulted about programs and also provided feedback.

The State Council on Aging is a public meeting and plan review and its approval was on the agenda over a series of meetings. A survey targeting people who receive services as well as providers in the aging network was used to broaden input about current services, solicit ideas about future service needs and to gauge compatibility of respondent insights and preferences with the development of State Plan priority areas of focus. The survey was available online and in hard copy format.

Survey respondents indicate that they considered most current OAA funded services and other aging support needs to be high priority need. The following were ranked in the top eight:

- Affordable Housing, accessible housing 90 percent,
- Information and Assistance (ADRC functions) 87 percent;
- Personal in home care services 85 percent,;
- Help returning from hospital with support of remain at home 84 percent;
- Family Caregiver Support Program 83 percent;
- Transportation 84 percent ;
- Prevention of abuse, neglect, exploitation 80 percent and
- Dementia supports and services 80 percent;

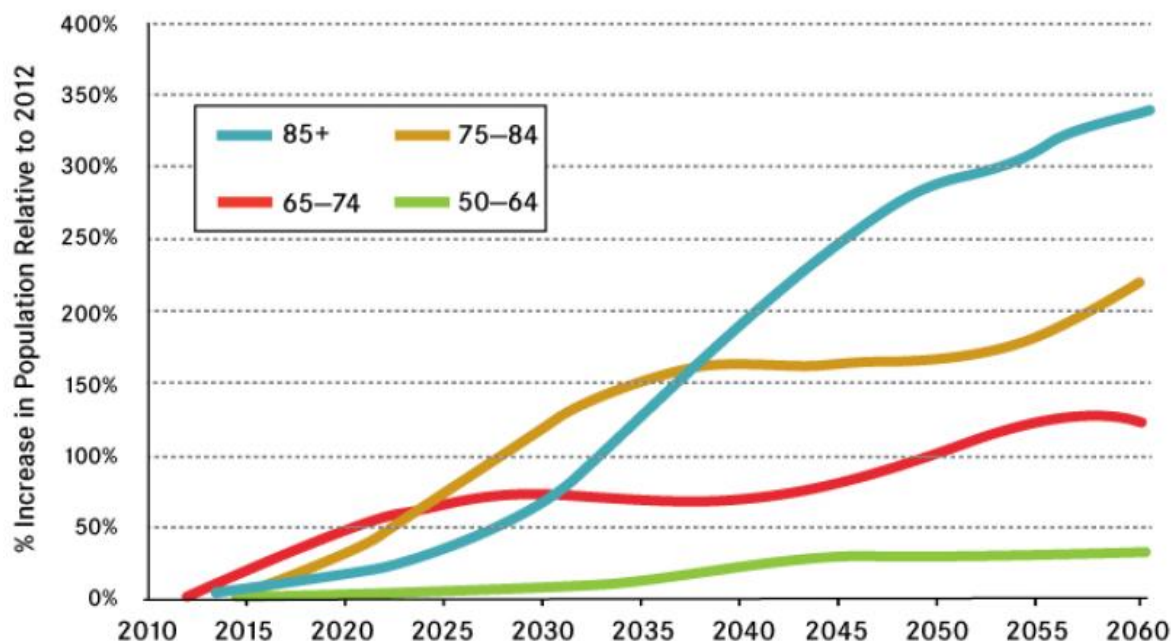
(Please see attachment E for more information about the survey results)

Trends

Demographic

According to the Washington Office of Financial Management (OFM), in 2016, there were about 1,073,300 persons ages 65 and older, representing 15 percent of Washington's total population. In 2018 the number persons 60 and older and OAA eligible is estimated at 1,619,589⁶. As the number of people who can benefit from OAA services substantially increases, funding for OAA over the past two decades has not kept pace with population growth or inflation. By 2040, the older adult population is forecast to reach 1,984,800, representing 22 percent of the state's total population. Current gains per year of 40,000 persons age 65+ per year are expected to sustain through 2028. The State's population over 85 is expected to double by 2030. Those 85 and older have a significantly higher rate of functional limitations and severe chronic health conditions that result in the need for more health and LTSS services and this will have significant fiscal implications for the state.

As the aging population grows, there is increasing risk of abuse neglect and exploitation. The state's Adult Protective Services (APS) has experienced a 252% increase in the number of reports from calendar year 2005 through 2017. In 2017 APS investigated a total of 43,304 allegations. The largest percentage of allegations, 25 percent, involved reports of financial exploitation



Minorities comprise an increasing proportion of the older population as a more diverse group of residents reach age 65. In eleven counties, minorities represent more than twenty percent of the population. These populations all show notably faster rates of increase than their white counterparts do. The racial and Hispanic population projections available from OFM show that in 2030, nearly one three residents will be a minority. Asian and Pacific Islander and Hispanic populations will continue to be the largest and fastest growing minority groups.

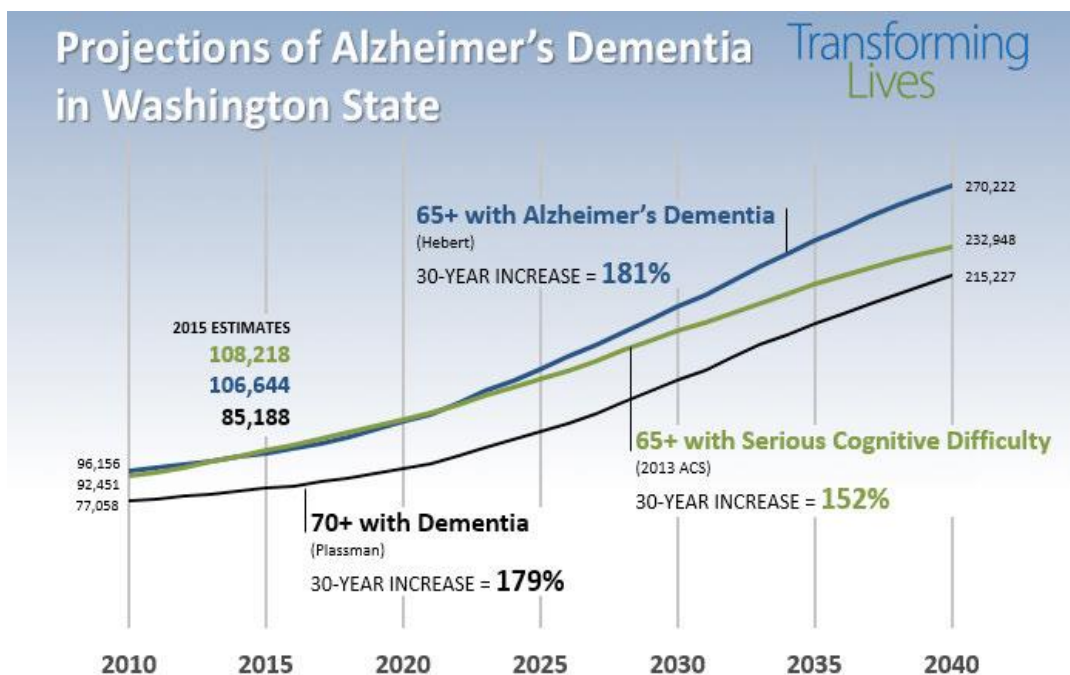
⁶ Forecasts of the Aging Population, Dementia Prevalence and Use of Long-Term Care Services through 2020 in Washington State DSHS RDA

Washington State is also experiencing growth in language diversity. The number of people born outside of the United States now living in our state grew by 54 percent in the years 2000- 2014. It is estimated that 46.7 percent of Washington's total foreign-born population is limited in English-proficiency (LEP).⁷ Current estimates indicated 4 percent of the Medicaid funded LTSS caseload population are LEP.

Older adults who are lesbian, gay, bisexual, transgender and questioning (LGBTQ) are estimated to make up over 5% of the U.S population⁸ and are as diverse as their heterosexual counterparts are. Many older LGBTQ adults have experienced a lifetime of systematic discrimination. Due to their gender identity and/or sexual minority status, many have lacked access to social institutions that provide critical security in later life, such as marriage, family, and employment. As a recent study indicated, older adults whom identify as LGBT may be five times less likely to access needed health and social services because of their fear of discrimination.⁹

There is significant diversity among these minority communities, made up of varied cultural backgrounds, immigration status, and languages. Many of these communities, inclusive of older adults and people with disabilities have experienced a legacy of health disparities, including less access to health care and are disproportionately at risk for food insecurity.

While Alzheimer's disease is not a normal part of aging, age is the greatest risk factor for developing Alzheimer's or other dementia. Our longer lives increase the risk of developing dementia.



⁷ <http://wahealthalliance.org/wp-content/uploads/2017/02/2016-Disparities-in-Care-Report.pdf>
Washington State DSHS DBHR Disparities Study

⁸ Outing Age: Public Policy Issues Affecting Gay, Lesbian, Bisexual and Transgendered Elders, Grant Jamie, 2010

⁹ <https://www.lgbtagingcenter.org/resources/resource>.

Washington State now has the 12th highest life expectancy nationwide and Alzheimer's disease is the third leading age-adjusted cause of death in the state. While death rates of cancer, stroke and heart disease have declined, the death rate for Alzheimer's is on the rise. Currently, about 107,000 people in the state have Alzheimer's or other dementias. By 2040, that number is expected to grow to over 270,000.¹⁰

Approximately 254,619 individuals who are deaf and hard of hearing live in the state and an estimated 650,000 people are affected by hearing loss. Hearing loss is the most prevalent sensory loss among people as they age and can lead to social isolation, loss of independence, depression, increased risk of dementia, early retirement, financial decline, and difficulty navigating public transit and health systems.¹¹

Current demographic data about individuals who receive services from ALTSA continues to show that our consumer base is at least as diverse as Washington's population and will continue to grow in diversity. We are challenged to ensure that service delivery is attuned to the historical reality of health disparities. We must also ensure the state's LTSS has the capacity to provide culturally relevant and appropriate services including a comprehensive language access policy to ensure appropriate translation and interpretive services are provided for non-English and limited-English speaking clients.

Economic

Washington's economy is growing steadily and is one of twenty-nine states where state revenues have rebounded from the Great Recession.¹² There are urban areas that have experienced strong growth, however areas of the state, particularly rural, continue to experience an uneven economic recovery. There are a number of older adults across the state who face challenging economic conditions. This section is focused on lower income older adults and considers trends that continue to have policy and fiscal implications moving forward.

One in five older adults in Washington rely on social security as their only source of income. Eight percent of the state's older adults 65+ have incomes at or below the federal poverty level (FPL) - currently, an annual income of \$12,130 or less for a single person household or \$16,460 for a two-member household. Older minority adults are over represented in this statistic comprising 27 percent of those at or below FPL. FPL does not take into account medical costs and certain other expenses that reduce disposable income, and it does not factor in the value of in-kind benefits that households can use to meet their basic needs (like energy or housing subsidies).

Medical expenses pose more of a burden for all older adults, but are particularly problematic for those on fixed incomes. While the vast majority of older adults have Medicare coverage to help pay for the cost of hospitalizations, physician visits, and other medical services, most also face sizable out-of-pocket health care expenses. These expenses may include, insurance premiums, deductibles, other cost-sharing requirements, and expenses for services not covered by Medicare, such as dental and long-term

¹⁰ Washington State Alzheimer's and other Dementias State Plan 2016: **National Prevalence of Alzheimer's Dementia for Persons 65+**, by Age: Hebert L.E., Weuve J., Scherr P.A., and D.A. Evans. Alzheimer disease in the United States (2010–2050) estimated using the 2010 census. *Neurology* May 7, 2013 80:1778-1783.

¹¹ Hearing Loss Association of WA report to JLEC ADS 2016

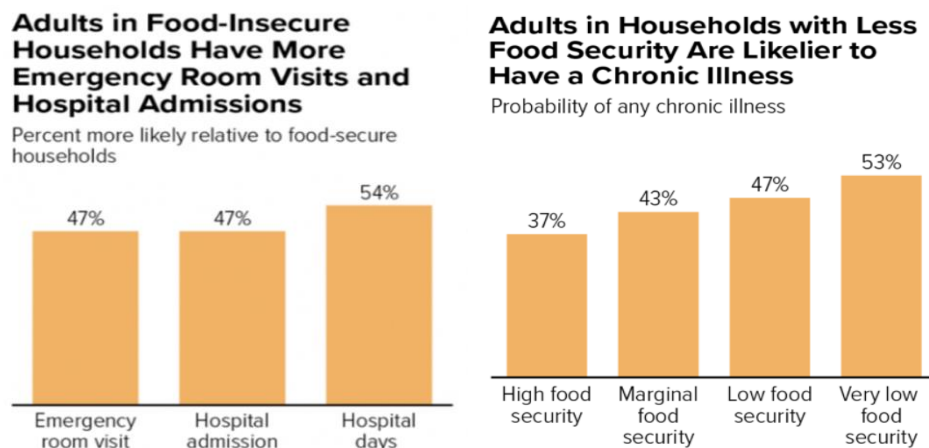
¹² Despite Slow Growth, Tax Revenue Has Recovered in 29 States: States' Fiscal Health Pew Charitable Trust 2018

care.¹³ Rising costs for basic necessities have a greater impact on older adults with fixed incomes and the need for affordable housing and transportation is growing. The demand for access to transportation has increased as people are living longer, staying in their homes and living with multiple and complex conditions. Many older adults live in rural or semi-rural communities that lack the population density to support traditional mass transit. Even in areas where mass transit services are available, decreased mobility and increasing frailty create barriers for older adults who need access to transportation. Transportation to medical appointments is the most frequent destination for the rides provided through the LTSS network.

Affordable and accessible housing was one of the most frequently mentioned priority needs in the state plan survey. The 2018 National Low Income Housing Coalition Gap Report finds that across Washington, there is a shortage of rental homes affordable and available to extremely low-income households, whose incomes are at or below the poverty guideline or 30% of their area median income. Many of these households are severely cost burdened, spending more than half of their income on housing. Severely cost burdened poor households are more likely than other renters to sacrifice necessities like healthy food and healthcare to pay the rent, and to experience unstable housing situations like evictions and vulnerability to homelessness.¹⁴ (See Attachment F)

Food Security

Despite an improving economy, food insecurity rates are higher than at the start of the recession in 2007 and far higher than 2001. Millions of older adults in the United States are going without enough food due to lack of resources and this stubbornly high proportion of food insecure elders continues to impose a major health care challenge. One group of particular policy concern are older adults experiencing very low food security, the ranks of which have swelled since 2001.¹⁵ According the most recent 'State of Senior Hunger Report, Washington's rate for older adults slightly improved from the previous report and are as follows: Threat of hunger-10.95 percent; the risk of hunger-6.16 percent and hunger-2.71 percent¹⁶.



¹³ Key Issues in Understanding the Economic and Health Security of Current and Future Generations of Seniors - KFF 2012

¹⁴ 2018 National Low Income Housing Coalition Gap Report for Washington State http://nlihc.org/sites/default/files/SHP_WA.pdf

¹⁵ The State of Senior Hunger in America 2015 August 16, 2017 Ziliak /Gundersen University of Kentucky /University of Illinois <http://nfesh.org/wp-content/uploads/state-of-senior-hunger-2015-annual-report.pdf>

¹⁶ ibid 16- add USDA SNAP reference

The 2015 GAO report ‘Older Americans Act: Updated Information on Unmet Need for Services’ estimated 90 percent of low-income older adults (those age 60 and older with incomes below 185 percent of the poverty threshold) do not receive meals services like those funded by Older Americans Act (OAA) Title III programs.¹⁷

There is an established link between food insecurity and higher health costs. Adults in food-insecure households have more emergency room visits and those with less food security are likelier to have a chronic illness.¹⁸

In addition to decreasing food insecurity, an Increasing body of research demonstrates potential for meal delivery programs to delay the use of more expensive LTSS services and to reduce the use of costly health care and decrease spending for vulnerable individuals¹⁹

Washington’s aging population is economically concentrated in lower income brackets, with 29 percent incomes below \$25,000 and 25% in the range \$25,000 to \$50,000.²⁰ In 2016 22.9 percent of couples and 47.6 percent of adults 60+ living alone, are in the gap between poverty and economic security, with annual incomes at or below the Elder Economic Security Standard™ Index.²¹ EESSI highlights the high

Table 1: Elder Economic Security Standard Index for Washington, 2016

Expenses	Elder Person			Elder Couple		
	Owner w/o Mortgage	Renter	Owner w/ Mortgage	Owner w/o Mortgage	Renter	Owner w/Mortgage
Housing	\$561	\$814	\$1,593	\$561	\$814	\$1,593
Food	\$256	\$256	\$256	\$470	\$470	\$470
Transportation	\$222	\$222	\$222	\$343	\$343	\$343
Health Care (Healthy)	\$445	\$445	\$445	\$890	\$890	\$890
Miscellaneous	\$297	\$297	\$297	\$453	\$453	\$453
Elder Index Per Month	\$1,781	\$2,034	\$2,813	\$2,717	\$2,970	\$3,749
Elder Index Per Year	\$21,372	\$24,408	\$33,756	\$32,604	\$35,640	\$44,988

¹⁷ <https://www.gao.gov/assets/680/670738.pdf> Older Americans Act: Updated Information on Unmet Need for Services

¹⁸ Source: SNAP is Linked with Improved Nutritional Outcomes and Lower Health Care Costs at <https://www.cbpp.org/research/food-assistance/snap-is-linked-with-improved-nutritional-outcomes-and-lower-health-car>

¹⁹ Meal Delivery Programs Reduce The Use Of Costly Health Care In Dually Eligible Medicare And Medicaid Beneficiaries-2018 Health Affairs 37 no.4

²⁰ Washington State Department of Commerce Retirement Readiness 2017

²¹ Living Below the Line: Economic Insecurity and Older Americans Insecurity in the States 2016 <https://scholarworks.umb.edu/demographyofaging/13/>

risk of economic insecurity experienced by older adults that is especially high for the oldest adults. The index measures the total monthly cost to live not having to go without necessities. ESSSI represents older adults 65+ who are no longer working and living independently in the community. (Please see Table 1 for expense amounts factored for Washington.)

Many of the state's residents are not fully prepared for retirement or the cost of LTSS. Medicare coverage of LTSS for older adults, non-elderly people with disabilities, and people with certain chronic conditions is limited with only medically oriented services covered. For example, home health services are only covered for beneficiaries who are homebound and the services are generally short-term in nature. Post-acute nursing facility care is covered for up to 100 days following a qualified hospital stay. Personal care and other non-medical services are not covered by Medicare resulting in individuals and families using their own private resources and incomes to pay for needed services. People who need LTSS qualify for Medicaid only if they meet low-income eligibility requirements. Paying for LTSS out of pocket can be financially catastrophic for individuals and families and result in spend down to the poverty level making them eligible for Medicaid.

LTSS System Trends

Washington State has a long and demonstrated history of providing an array of LTSS that allow individuals to choose among settings and providers that will best meet their needs. Strong federal and state partnerships to leverage federal funding from the Center for Medicare and Medicaid Services and the Administration on Community Living providing OAA funds and many of the grants used to test models of care over the years have been key to the development of the LTSS system. 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 among states in total LTSS related Medicaid costs.

The state built its system by using a number of strategies including development of Medicaid home and community based setting options, providing consumers more choice and control with the ability to hire family and friends as paid caregivers, developing a robust, though underfunded, system of support of unpaid family caregivers and building diversionary programs through OAA, ACL discretionary grants and dedicated state funding.

Hallmarks of Washington LTSS: Choice and Innovation

Medicaid State Plan <ul style="list-style-type: none"> • "Entitlement" • Mandatory Services • Optional Services • Statewide • No Cap, No Targets • About 83% of budget 	Nursing Home	Medicaid Personal Care	Community First Choice	Program of All-Inclusive Care for the Elderly (PACE)
Medicaid Waiver <ul style="list-style-type: none"> • Not "Entitlement" • Optional Services • Can have caps • Target Locations • Target Populations • About 2% of budget 	Community Options Program Entry System		New Freedom	Residential Support Waiver
Other <ul style="list-style-type: none"> • State Only or Federal Only • About 4% of budget 	Family Caregiver Support Program (state)		Older Americans Act (federal)	Senior Citizens Services Act (federal)

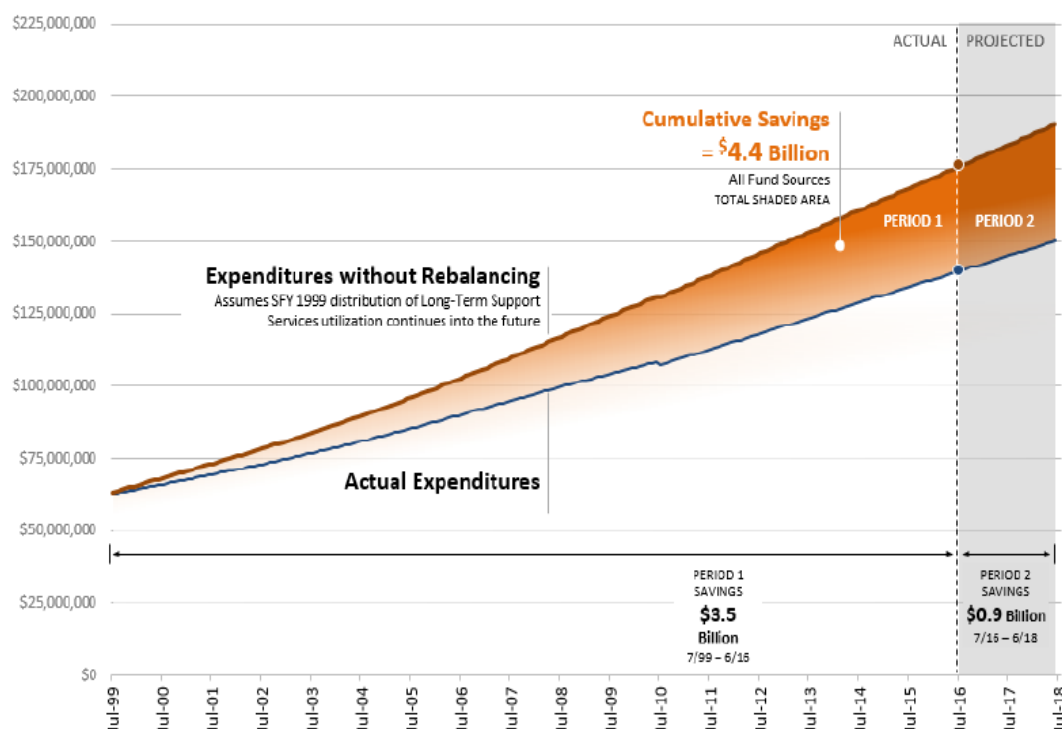
Rebalancing and Caregiver Focus

The state has, to date, managed the demographic pressure increasing demands for LTSS by rebalancing the system from a reliance on costly institutional care to creation of a community-based system that is more cost effective and preferred by individuals receiving services.

Expanding home and community-based services results in greater consumer satisfaction, supports families to stay together and achieved an estimated cumulative savings in taxpayer dollars of \$4.4 billion over the state fiscal year period of 2000-2018.

Savings to Washington's Medicaid LTSS due to Rebalancing

Monthly Service Expenditures • All Fund Sources • SFY 2000-2018



Current Medicaid LTSS spending represents 6% of Washington State's operating budget (5% General Fund State) with annual service expenditures of \$2.1 billion. The ALTSA budget is increasing an average of 12% a biennium as the number of individuals qualifying for Medicaid funded LTSS grows consistent with the demographic trends.

ALTSA will continue assisting individuals to receive services in community based. The core of the approach is a commitment to continued innovation to ensure services are high quality, continuing to meet changing needs and preferences of the individuals served and delivering services in cost effective ways.

Developing and expanding services to support unpaid family caregivers also remains a high priority. Strategies are focused on improving the health and well-being of the caregiver, ensuring individuals in need of LTSS have another option that assists them to remain in their own homes and to delay or divert from more costly LTSS services.

These strategies have proven successful as an approach to delivering services cost-effectively and saving taxpayer dollars. However relying on rebalancing and support of family caregivers as primary strategies of sustaining sufficient funding for LTSS will not save enough money to fund the projected increases in caseload that will result from the demographic population shifts in the state.

The state's five-year 1115 Medicaid transformation demonstration waiver is allowing the state to test and expand unpaid family caregivers access to services while also evaluating whether they result in overall avoidance or cost savings to state and federal budgets.

Workforce Concerns

By 2030, nearly 77,000 home care aides (HCA's) are estimated to be needed to serve Medicaid consumers and action is needed to recruit and retain more HCA's.²² When factoring in high turnover rates the number needed increases to as high as 125,000. Data on national trends continues to show that labor shortages will worsen over the next twenty years. Washington, like the rest of the country, will see a downturn in labor growth. This means that many industries will be competing for the same limited supply of workers.

A shortage of medical and broad based geriatric workers also continues. Given that our state's long term care system is dependent on, long-term personal care workers, medical and multi-disciplinary providers of geriatric services, we will continue to prioritize work on increasing skills and capacity to meet the long term care and health needs of Washington citizens. The workforce issues are complicated by recruitment and retention issues, particularly for the direct care workers that the LTSS industry relies on for day-to-day hands-on care. The Service Employees International Union (SEIU) Northwest Training Partnership, Washington State Health Workforce Sentinel Network, Workforce Training and Education Coordinating Board and others continue their multiple years long efforts to address these concerns.

Strategic Focus Areas

If home and community services are to grow to meet unprecedented consumer demand continued multi-pronged strategies are important. This includes ensuring adequate resources to protect vulnerable adults, addressing Alzheimer's and other dementias, continuing to grow a more robust array of pre-Medicaid services, continuing the state's re-balancing efforts and continuing to develop innovative models that integrate medical and LTSS service delivery calibrated to demographic and economic realities.

Service and Support Integration and Pre-Medicaid Services

The Medicaid Transformation Demonstration (MTD) is a five-year project with the federal Centers for Medicare and Medicaid Services that provides new investment in order to test innovative, sustainable

²² Washington State University Home Care Aides Brief 2011

and systematic changes. As the population of adults who are older grows rapidly, there will be greater pressure on the state budget to fund LTSS and we need innovative services to meet people’s needs. The MTD looks at models that support individuals to meet their needs as well as avoid, delay, or lower usage of traditional Medicaid services.

Expanding support of informal caregivers and addressing social factors of health for all high-risk adults are innovative approaches with a growing evidence base. Families and other informal support providers are integral to Washington’s LTSS system and finding ways to support them while addressing the needs of the caregiver and care receiver is an important Medicaid innovation. Included within the MTD are two new programs: Medicaid Alternative Care and Tailored Supports for Older Adults.

A New Choice Under Medicaid: MAC Support for Unpaid Caregivers

- Provide support for unpaid family caregivers who support individuals eligible for Medicaid but not currently accessing Medicaid-funded LTSS
- Provide necessary supports to unpaid caregivers to enable them to continue to provide high-quality care and focus on their own health and well-being

Age Requirements	Medicaid Requirements	Other Requirements	Benefit Level
The care receiver must be 55+ and the caregiver must be 18+ in age.	Requires the care receiver to currently be on Apple Health (Medicaid).	The care receiver must need help with some activities of daily living, like bathing, walking, medications, transfers, etc.	Depending on your situation, you could receive up to \$550 each month in services and supports.

Medicaid Alternative Care (MAC) is a choice for individuals eligible for LTSS that provides supports to their unpaid family caregivers. Individuals can choose this program to support their caregiver, instead of traditional LTSS services such as personal care. This is the first time federal Medicaid funds are available for this service, which until now had been only provided under the state Family Caregiver Support Program. Individuals can disenroll from using MAC and switch to traditional LTSS at any time.

Tailored Services for Older Adults (TSOA) provides a limited set of services and supports that helps individuals avoid or delay the need for Medicaid-funded services. This is a new eligibility category and a limited benefit package for people financially “at risk” of future Medicaid LTSS use who do not currently

meet Medicaid financial eligibility criteria. Individuals under TSOA can choose to provide supports to their unpaid family caregiver, or if no caregiver is available, they can receive services such as personal care, adult day or home delivered meals.

Delay Impoverishment: Tailored Supports for Older Adults

- Provide a benefit package for individuals at risk of future Medicaid LTSS use
- Help individuals and their families avoid or delay impoverishment and the future need for Medicaid-funded services while providing support to individuals and unpaid family caregivers

Age Requirements	Medicaid Requirements	Other Requirements	Benefit Level
The care receiver must be 55+ in age. Caregivers must be at least 18 years old.	Medicaid eligibility is not a requirement. As of 2017, financial eligibility includes gross monthly income less than \$2,205 and resources below \$53,100 for an individual or \$108,647 for a married couple.	The care receiver must need help with some activities of daily living, like bathing, walking, medications, transfers, etc.	Depending on your situation, you could receive up to \$550 each month in services and supports.

Under the Medicaid Demonstration, we are also testing foundational community supports for high-risk Medicaid populations including Supported Employment and Supportive Housing. These services will be available to ALTSA clients who meet target criteria, as well as to individuals served by the state Health Care Authority and the Behavioral Health Administration.

Foundational Community Supports enhance the availability of housing and employment supports for individuals at the greatest risk for housing instability and/or in need of support to achieve and maintain gainful employment.

Research demonstrates that homelessness and unemployment contribute to poor health. The goal is to boost the availability of Foundational Community Supports for those who are the most vulnerable and have complex care needs to help them live with maximum independence in their communities.

Supportive Housing services will serve Medicaid-eligible individuals who experience chronic homelessness, have a history of instability in residential settings or instability in maintaining in-home services, or who are served in more costly institutional settings.

Supported Employment services will serve eligible individuals receiving long-term care services who have an identified need for supports to attain or maintain employment.

Health Homes Program

The Health Home program 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 and encourages involvement and independence. Area Agencies on Aging play a key role.

The Health Home program includes six services that care coordinators can provide to eligible clients:

- Comprehensive care management
- Care coordination and health promotion
- Comprehensive transitional care and follow-up
- Patient and family support
- Referral to community and social support services
- Use of information technology to link services, if applicable

Participation in the Health Home CMS Financial Alignment Demonstration for those who receive Medicare benefits has provided the first-time opportunity for Washington State to receive shared savings from the federal government by aligning financing between Medicare and Medicaid. In the first two years of the demonstration, over \$67 million has been saved in Medicare and Washington has received over \$20 million in Medicare savings.

Alzheimer's and other Dementias /Dementia Action Collaborative

Alzheimer's disease is the third leading age-adjusted cause of death in Washington. In 2016, about 107,000 people in Washington have Alzheimer's or other dementias. By 2040, that number is expected to grow to over 270,000.

Creating a state plan to address Alzheimer's and other dementias was an opportunity for the state to improve quality of care, create efficiencies and potentially impact the trajectory of the illness itself as we try to achieve better health outcomes. The state legislature charged ALTSA to bring together a specific membership for an Alzheimer's Disease Working Group (ADWG) to develop a Washington State Plan to address Alzheimer's disease.

The ADWG investigated trends in the state's Alzheimer's population and service needs; existing resources and services; and needed strategies, policies and/or responses to address needs and gaps in services. This work resulted in the first Washington State Plan to Address Alzheimer's Disease and Other Dementias.

The Washington state plan has seven high-level goals. Each goal identifies strategies and recommendations to move towards these goals. The comprehensive and complex nature of this implementation work will require a phased approach. The plan identifies short-, mid-, and long-term timeframes for each of the many recommendations. The high-level goals are to:

1. Increase public awareness, engagement and education
2. Prepare communities for significant growth in dementia population
3. Ensure well-being and safety of people living with dementia and their family caregivers
4. Ensure access to comprehensive supports for family caregivers
5. Identify dementia early and provide dementia-capable, evidence-based health care
6. Ensure dementia-capable long-term services and supports are available in the setting of choice
7. Promote innovation and research related to causes of and effective interventions for dementia

The plan's implementation, including action planning, next steps and policy changes, will depend upon the ongoing participation and contributions of a broad group of committed partners. That is why the plan is envisioned as a public-private partnership, and called for the creation of a next generation workgroup to implement the recommendations.

This next generation group is known as the Dementia Action Collaborative (DAC), a voluntary, statewide collaboration of partners committed to preparing our state for the future. The Assistant Secretary of ALTSA, is the Chairperson of the DAC, which includes a range of appointed members – people with dementia, family caregivers, advocates, representatives of the aging network, Alzheimer's organizations, long-term care providers, health care professionals, legislators and governmental agencies. (Please refer to Attachment G & H for more information about DAC accomplishments to date.)

Elder Justice and the Protection of Vulnerable Adults

The protection of vulnerable adults remains a priority goal of the state plan. As the aging population grows, there is an increase in incidents of abuse, abandonment, neglect, self-neglect and financial exploitation -both in-home and within the continuum of residential care. The state will continue to be challenged to be able to provide the resources necessary to keep pace. ALTSA and key elder justice partners including the State Long Term Care Ombudsman recognize the need for continuous & coordinated improvement by continuing to advance system enhancements.

Long Term Care Ombudsman Program

The State Long Term Care Ombudsman and program (LTCOP) is administered under contract with a nonprofit organization. The State Ombudsman is also member of the Joint Legislative Executive Committee on Aging and Disability Issues. A key elder justice partner, the LTCO advocates for people living in nursing homes, adult family homes and assisted living facilities. Led by the State Ombudsman, a core LTCO function is to protect and promote resident rights guaranteed under federal and state law. Regional and volunteer Ombudsman are trained to receive complaints and resolve problems in situations involving quality of care, use of restraints, transfer and discharge, abuse and other aspects of resident dignity and rights. The LTCO also conducts independent research, explores systemic issues and advocates before the legislature. The LTCO leverages critical volunteer resources throughout the state-currently there are just over 19 paid FTEs and 321 volunteer ombudsman.

Legal Assistance Services

The Legal Services Program provides access to the justice system by offering representation by a legal advocate (attorney, paralegal, or law student). The focus is on socially and economically needy older individuals who are experiencing legal problems with particular attention given to low-income, minority individuals, the rural elderly or older individuals with disabilities. The Legal Services annual budget is approximately \$875,000. AAA's contract with suitable legal services providers. The provider receives referrals from community agencies including AAAs, HCS and DDD field offices, case managers and Information and Assistance providers.

Adult Protective Services

As the aging population grows, there is increasing risk of abuse neglect and exploitation. The state's

Adult Protective Services (APS) has experienced a 252% increase in the number of reports from calendar year 2005 through 2017.

Protection of adults who are vulnerable requires consistent and timely investigations and the offering of protective services and referrals for services and supports. Delays create a greater risk of harm to the alleged victim.

Timely investigation means that a confirmed perpetrator can be listed on a statewide registry of people who are not allowed to work with adults who are

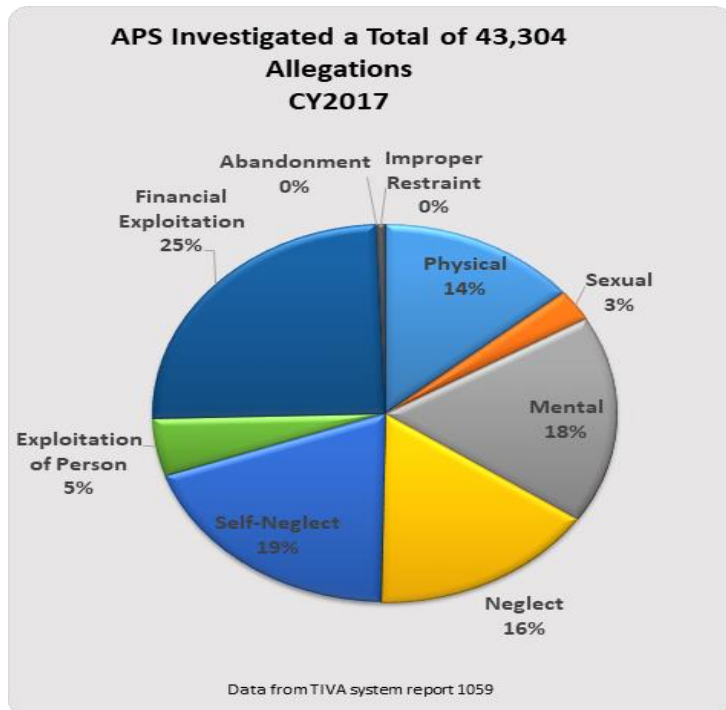
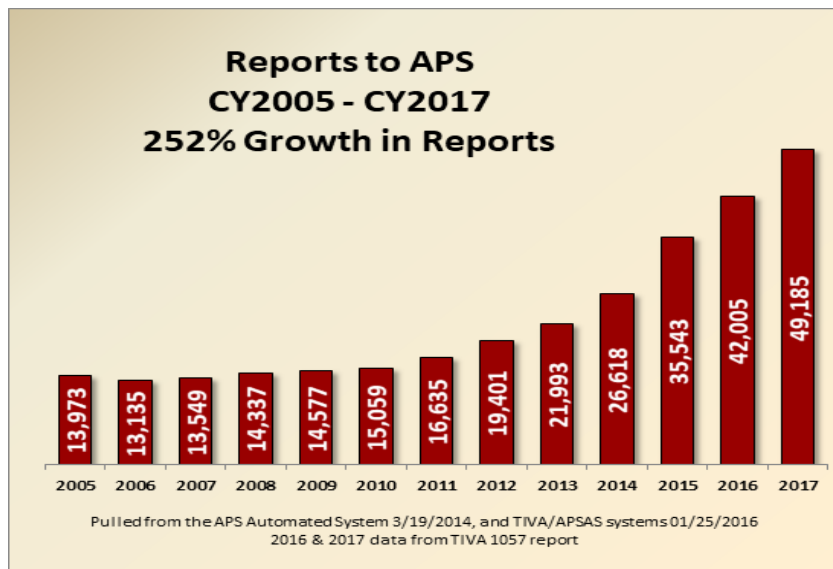
vulnerable. Although there are no state or federal standards or guidelines for Adult Protective Services (APS), ALTSA requires a 90-day standard for investigations. Performance in this has improved due to increases in staffing funded by the Legislature to meet increased reports of abuse and neglect, due to demographic changes and increased public awareness resulting in improved reporting.

In 2017, APS investigated a total of 43,304 allegations. The largest percentage of allegations, 25 percent, involved reports of financial exploitation

Adult Protective Services (APS) has two primary duties: offer protective services to vulnerable adults who are harmed and investigate allegations to determine if abuse occurred. Timely response is essential in order to protect health and safety, including potentially providing protection orders and long-term services and supports.

LTSS Residential Complaint Investigation

The purpose of conducting investigations of complaints in long-term care facilities is to protect residents from abuse, neglect and exploitation; ensure services provided meet the health and safety needs of residents; evaluate whether provider practice meets regulatory



requirements; and to make quality referrals to entities that help protect victims

Aging and Disability Resource Center –Washington States Community Living Connection

Information empowers people to make informed decisions about their futures and assistance is critical to supporting individuals, families, and friends to care for themselves or their loved ones and to use their resources as effectively as possible to meet their individualized needs and goals. The state's Community Living Connections (CLC) network is part of the Federal Aging and Disability Resource Center (ADRC) No Wrong Door (NWD) initiative. The CLC concept is a network of state and community organizations that coordinate to provide consumers of all ages and disabilities with seamless access to private pay and/or publically funded LTSS options in their local community; regardless of what program or organization they may contact or currently utilize. They do this using person-centered concepts and skills.

CLC network partners are highly visible and trusted organizations and places where consumers can learn about and access the full range of LTSS available in the local community, and tailor these options to meet the personal preferences, goals, and health and safety needs of each consumer.

AL TSA supports the statewide Community Living Connections network through the long-standing infrastructure of Area Agencies on Aging utilizing funding for information and access assistance services for older adults (ages 60 and over); unpaid caregivers (ages 18 years and older) of adults with chronic diseases and/or disabilities; unpaid kinship and grandparent caregivers; and Medicare beneficiaries.

Local CLC networks expand the populations served through collaborative partnerships with organizations that are funded and have particular expertise in providing information and access assistance to those populations. Occasionally, grant funding helps support the network to better serve individuals. As funding and staff resources allow, Area Agencies on Aging continue to build capacity through planning and development, and through the expansion and formalization of community partnerships.

The Community Living Connections website www.waclc.org provides Washington State residents and others with information on the full range of LTSS options and how to access local, statewide, and nationwide services and supports.

Collaborative partnerships support high quality, responsive, and accountable service delivery. Listed are just a few of our robust partnerships providing services and working toward our goal of an NWD system within the CLCs as they expand across the state:

Center for Independent Living, The Brain Injury Association of Washington, Statewide Health Insurance Benefit Advisors, Legal Advocacy Organizations, Developmental Disabilities Administration, Veterans Services, Tribal Governments, 211s, National Alliance of Mental Health, Alzheimer's and Dementia Organizations, Office of the Deaf and Hard of Hearing, Department of Services for the Blind, Department of Vocational Rehabilitation / Washington State Council on Independent Living, Long-Term Care Ombudsman

Family Caregiver Support Program

The number of people on the Medicaid LTSS caseload is only a small share of a very large number of older adults and people with disabilities, who, were it not for help from family and friends, could become part of the Medicaid caseload. These caregivers provide \$10.6 billion of unpaid assistance to individuals needing assistance to stay in their homes. Through its partnership with the AAAs, AL TSA operates the Family Caregiver Support Program (FCSP). FCSP provides needed supports and services to

unpaid caregivers throughout the state. Current funding served less than 1% of Washington's caregivers.

The AAA's use a screening, assessment and consultative care planning evidence-based assessment tool called Tailored Caregiver Assessment and Referral (TCARE®). TCARE® provides an objective and reliable tool to assess the stress, depression and burdens of unpaid family caregivers and recommends strategies and services that can best help those caregivers best cope with their unique caregiving responsibilities

DSHS evaluation showed a statistically significant improvement in depression and burdens for participating caregivers and a delay in use of Medicaid long-term services and supports (LTSS). In September 2017, the new MTD 1115 demonstration waiver rolled out statewide and could more than double the number of individuals who can access family caregiver support through these programs. The FCSP program will remain relevant for caregiver/care receiver pairs who don't meet the eligibility requirements or choose FCSP for other reasons.

(More information about FCSP can be located in Attachment I)

Nutrition Services

Good nutrition is crucial to helping older adults and people with disabilities maintain their health and independence as they age. Nutrition Services are a core program of the OAA and include nutritious meals available five days a week. Meals delivered to home and in congregate settings are provided by a statewide network of contracted senior nutrition program providers and are funded through the OAA, state and local funds. Funds raised at the local level cover about 40% of the cost of services provided.

Senior Nutrition programs (SNP) leverage the use of volunteers and conduct extensive fundraising. SNP capacity to expand services is limited by stagnant funding that has not kept pace with inflation or demographic trends. This has direct impact on current service delivery and the ability to make needed infrastructure investments to maintain and expand meal services to an increasing number of older adults.

Beginning in state fiscal year 2018 the state legislature has allocated \$700,000 a year for the expansion of home delivered meals. This will enhance SNP capacity to provide services to additional participants.

Health and Chronic Disease Self-Management

People with chronic conditions are high utilizers of the health care delivery system. Chronic conditions account for three-fourths of all health-related costs nationally. In Washington, 5% of the Medicaid population with chronic care conditions account for 50% of the Medicaid health care expenses. During economic recovery and evolving health system design, the major challenges are managing current health care resources while planning and sustaining funds for the future. When we consider that 38% of Washingtonians over the age of 18 have one or more chronic conditions, we have to continually consider various approaches across populations.

One viable approach, supported by an expanding body of research on the impact of chronic conditions and their management points, focuses on people learning self-management skills, thereby increasing their level of confidence with health-related problem solving.

ALTSA was awarded a 2-year federal grant from the Administration for Community Living, which began in August 2016 and is scheduled to end July 31, 2018. (ALTSA has submitted a new grant) In collaboration with the Washington State Department of Health (DOH), five Area Agencies on Aging (AAA), ALTSA disseminates, designs infrastructure, and plans sustainability for the evidence-based Chronic Disease Self-Management Education (CDSME) programs originally developed at Stanford.

The specific types of CDSME programs Washington state implements are: 1) Chronic Disease Self-Management Program; 2) Tomando Control de su Salud; 3) Diabetes Self-Management Program; 4) Programa de Manejo Personal de la Diabetes; 5) Chronic Pain Self-Management; 6) Better Choices, Better Health (online CDSMP); 7) Enhanced Wellness; 8) PEARLS.

These programs are also available under the COPES Waiver.
(Additional information may be found in Attachment J)

Ensuring access to a LTSS system that promotes quality, choice and consumer preferences

Continuing the state's rebalancing trend will be one of the keys to continuing to meet consumer demand and sustaining long-term services into the future. To do that effectively, we will need to continue to adjust the HCBS service package in response to shifts in the population (for example, improving supports for people with dementia as the average age of the population increases). We will also continue to work with the nursing home industry to shift its role toward stabilization and rehabilitation, followed by discharge to supported community care, increase the number of people we are able to relocate and divert from nursing homes to their home or other community-based setting and integrate OAA programs as appropriate.

There must also be a continual focus on ensuring high quality care in all settings, which may mean additional targeted future investments. While essential to managing future growth, expectations must be balanced with the realization that the state's relatively balanced system results in diminishing returns to the level of savings that can be achieved through continued rebalancing efforts.

Participant Direction

The state has long offered participant direction as a core component of its employer model HCBS system. Participant direction is also key to the success of collaborative efforts underway to enhance participants' ability to self-manage chronic health conditions. As noted in the state plan survey, an increasing percentage of respondents continue to consider choice and control of services to be very important.

Policy direction for the assessment tool used in the state, CARE, continues a deliberative shift to produce more person centered planning process.

In support of the principles related to participant direction, ALTSA involves consumers and consumer representatives in helping to decide how services are designed and improved. ALTSA coordinates a Service Experience Team (SET). The SET is a consumer advocacy group and is intended to increase our ability to provide information, receive input, and to better understand the impact of our policies and services on the individuals who receive them.

ALTSA is also working with consumers and stakeholders to develop and implement the Consumer Directed Employer (CDE) to manage the Individual Providers (IP) who care for people receiving services.

IPs will be employed by the CDE and consumers will continue to select, schedule, manage and dismiss their IPs.

This is happening because managing nearly 40,000 IPs has become increasingly complex and takes time away from case management. This change will free up time for case managers to be able to focus on case management support needs of people receiving services.

Community First Choice (CFC) -State Plan

The CFC is a Medicaid entitlement state plan option established by the Affordable Care Act (ACA). CFC provides services to over 50,000 individuals in their own homes, Assisted Living Facilities (ALF), and Adult Family Homes (AFH).

Services include personal care assistance, nurse delegation, skills acquisition training, Personal Emergency Response Systems (PERS), relief care, caregiver management training, community transition services, and assistive technology.

A planning and implementation workgroup of stakeholders helped to design the program and it was approved by CMS in 2015. Through CFCO, Washington State has been able to leverage 6% in additional federal funding for the majority of home and community-based services. This frees up state funds for reinvestments in home and community based services. About half of the enhanced match is necessary to meet maintenance of effort requirements, costs of new, required services and potential caseload growth. Some of the savings have been identified by the legislature to fund services while also considering other needed reinvestments.

State Plan Goals and Objectives

The ACL has set focus areas for State Units on Aging to frame the goals and objectives of the State Plan on Aging and the Plan is structured around these focus areas.

The broad goals of the plan are

- Promote Person-Centered Home and Community-Based Services
- Elder Rights and the protection of vulnerable adults
- Promote Healthy Aging
- Expanding and strengthening services and supports that prevent or delay entry into Medicaid funded LTSS

The Plan includes strategies to promote and improve the quality of person centered supports and services; increase the safety of adults who are vulnerable; expand and strengthen existing services that delay entry into Medicaid funded LTSS; empower the informed decision making of people by increasing access to information they need; support the efforts of the Dementia Action Collaborative; improve health status through expansion of evidence based health aging programs and evidence informed practices and improve food security by increasing access to nutritious food. Plan goals and objectives rely on maintaining the collaborative partnerships necessary to support the ability of the LTSS to meet needs at the local level.

The State and the LTSS network is continually challenged to evolve and to maintain the necessary capacity to provide the quality of support and services needed by Washingtonians. It is within this

context, mindful of the existing resources available to the state and aligned with strategic policy goals that we present the Goals and Objectives of the State Plan on Aging

Goal 1: Promote Person- Centered Home and Community-Based Services

Supports: Quality of Life – Each individual in need will be supported to attain the highest possible quality of life. Health - Each individual and each community will be healthy.

Strategic Objective 1.1: Medicaid Transformation Demonstration project - develop and expand approaches to serve adults who are older, Medicaid recipients and their caregivers.

Measure 1.1: Implement Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults (TSOA) to meet targets for the MTD: 2,581 clients by December 2018.

Strategic Objective 1.2: Mental Health Transformation – provide new long-term services and supports for individuals transitioning from state psychiatric hospitals

Measure 1.2: Create the capacity to serve an additional 138 individuals in Specialized Community Options by June 2019.

Strategic Objective 1.3: Serve individuals in their homes or in community-based services.

Measure 1.3: Increase the percentage of LTSS clients served in home and community-based settings from 85.6 percent in July 2017 to 86 percent by June 2019.

Strategic Objective 1.4: Support people to transition from nursing homes to care in their homes or communities.

Measure 1.4: Consistently achieve a quarterly average of 950 nursing facility-to-community setting transitions by June 2019.

Strategic Objective 1.5 Support individuals option of at home or community residence through available community-based services and programs through 2022

Measure 1.5a: continue to provide in-home skilled nursing services

Measure 1.5b: continue to provide access to Adult Day Health and Adult Day Care

Measure 1.5c: continue to provide delegation of nursing tasks through Nurse Delegation

Measure 1.5d: continue to provide one-to-one nursing care for higher acuity vent dependent clients in-home or in specially contracted Adult Family Homes

Measure 1.5e: continue to identify tools to maintain safety for clients at higher risk for falls,

Measure 1.5f continue to provide skin assessments for clients at risk for significant skin breakdown and injury

Strategic Objective 1.6: Assess and develop service plans for those who apply for services in a timely way so that individuals can be supported in the setting of their choice

Measure 1.6a: Increase the percentage of financial eligibility determinations completed timely from 88 percent in June 2017 to 93 percent as of June 2019. (A financial eligibility determination is conducted timely when it is completed within 45 days from the date of intake.)

Measure 1.6b: Increase the percentage of initial functional assessments completed within 30 days of creation from 72 percent in June 2017 to 93 percent by June 2019. (Policy requires that assessments be completed within 30 days of when they are begun. Policy also requires an assessment be fully completed within 45 days of intake; data for this latter item is currently under development.)

Measure 1.6c: Increase the percentage of timely functional reassessments from 96.7 percent in June 2017 to 98 percent by June 2019. (A functional reassessment is conducted timely when the case manager completes the annual reassessment within one year of the last assessment.)

Strategic Objective 1.7: Provide assistive communication technology (Office of the Deaf and Hard of Hearing).

Measure 1.7: Increase the number of locations that serve the public and clients with assistive listening systems from 140 in July 2017 to 200 in June 2018.

Strategic Objective 1.8: Expand case management services (Office of the Deaf and Hard of Hearing).

Strategic Objective 1.9: Provide education and training to DSHS staff and providers to better serve residents and clients (Office of the Deaf and Hard of Hearing).

Strategic Objective 1.10: Ensure older adults and individuals with a disability who are in need of long-term services and supports have a voice in the types of services they receive.

Measure 1.9: Continue the function of the Service Experience Team (SET) to inform key policy decisions and services through 2022

Strategic Objective 1.10: Continue to collaborate with key partners to stabilize, strengthen and continue to build the workforce needed to meet the current and future demand for quality LTSS.

Measure 1.10a Continue to ensure the availability of a well-trained and qualified provider workforce statewide.

Measure 1.10b Continue to work with the Joint Legislative Executive Committee on Aging and Disability, service providers, training programs, the Department of Health, and disability advocates to address barriers to a stable home and community-based workforce

Goal 2: Increase the Safety of Adults Who are Vulnerable

Strategic Objective 2.1: Abuse and neglect – complete investigations timely and thoroughly

Measure 2.1: Increase the percentage of adult abuse and neglect investigations completed within 90 days (or remaining open for “good cause”) from 95.4 percent in calendar year 2016 to 97 percent by June 2019.

Strategic Objective 2.2: Abuse and neglect – respond on-time and appropriately.

Measure 2.2: Increase timely initial response to investigations based on priority to 100 percent for high-priority investigations and maintain at 99 percent for medium and low-priority investigations by June 2019

Strategic Objective 2.3: Facility health and safety - investigate complaints in a timely manner.

Measure 2.3: Reduce the long-term care facility complaint investigation backlog of non-immediate jeopardy complaints from 152 in June 2017 to consistently 100 or fewer by June 2018.

Strategic Objective 2.4 Enhance the prevention and investigation of elder abuse through education and collaboration with related agencies in the state and raise awareness of the cultural, social, economic, and demographic processes affecting elder abuse and neglect

Strategic Objective 2.4 Maintain the capacity of the Long Term Care Ombudsman Program to support people living in adult family home, assisted living and nursing facilities through individual consultation, complaint investigation education and systems advocacy

2.4 Measures

- a. Adherence to performance outcomes outlined in contract with the Department of Commerce
- b. Documented systems advocacy in annual report to ACL (reviewed annually).
- c. Documented outcomes in measures required in annual report submitted to ACL (reviewed annually).
- d. Continue to ensure that the ombudsman program meets the OAA requirements, adheres to State law, and coordinates with existing State elder justice activities through 2022

Strategic Objective 2.5 Ensure inclusion of the needs of older adults and people with disabilities in the development and implementation of emergency preparedness plans (EPP). (Please refer to Attachment L & M for more details about coordination and plan requirements)

Goal 3: Improve Quality in All Long-Term Services and Supports

Strategic Objective 3.1: Conduct timely oversight and quality assurance of facilities and agencies providing residential care and supports.

Strategic Objective 3.2: Conduct quality assurance (QA) activities and comply with federal, state, and program requirements.

Measure 3.2a: Maintain 100 percent completion of Home and Community Services Division case management, adult protective services, and financial eligibility compliance record reviews each calendar year

Measure 3.2b: Achieve 100 percent completion, within 90 days of the monitoring exit interview, of all final reports for the Area Agencies on Aging (AAAs) during each calendar year by December 2018.

Measure 3.2c: Increase the percentage of audited Nursing Home Statements of Deficiency (SODs) sent to the facility within the federal regulatory standard to 95 percent by June 2019

Goal 4: Expand and strengthen existing services and supports that prevent or delay entry into Medicaid funded LTSS

Strategic Objective 4.1; Empower the informed decision making of older people, their families, persons with disabilities, and others by providing easy access to information, person-centered counseling, assistance, and planning for both public and private health and long term service and support options

4.1 Measures

- a. Continue to organize and host an annual caregiving conference in June of each year
- b. Continue to sponsor the annual Fabulous Aging conference.
- c. Educate the public about warning signs of possible dementia, the importance and benefits of getting an early diagnosis and asking their health care provider for a cognitive assessment when memory and/or cognitive issues become a concern. (State Dementia Plan Recommendation (SDP) 1.C.1).
- d. .In coordination with sister state agencies and organizations, and local AAAs, increase the number of certified NWD person-centered counseling and two-day person-centered thinking trainers in Washington State to achieve a minimum of six total certified trainers; and support at least two person-centered thinking trainers to achieve mentor certification in Washington State by December 2021.
- e. .In collaboration with Community Living Connections partner organizations, PCT Trainers, and PCT Trainer Candidates; conduct a minimum of fifteen (15) person-centered counseling/thinking classes by September 2021.

- f. Continue to incorporate and expand use of Washington State’s Community Living Connections (ADRC/NWD) brand across the state and through multiple social marketing venues.
- g. Transition the Community Living Connections single statewide toll-free number to an Interactive Voice Response (IVR) system so that individuals can more easily access local information, person-centered counseling, assistance, family caregiver support and Community Living Connections (ADRC/NWD) local access points by September 2019.
- h. Provide outreach materials (press release and a Governor’s Proclamation) on a new theme each year for Family Caregiver Month (November) to bring greater awareness to the critical service unpaid family caregivers provide in our state.
- i. Improve the State Unit on Aging’s/ALISA caregiver web page to be more user- friendly and connect with other relevant websites (e.g. Lifespan Respite WA and Community Living Connections).
- j. In collaboration with subject matter experts and AAA stakeholders, enhance the Community Living Connections public-facing self-service website by including more information about Alzheimer’s disease and dementia, end-of-life planning, advanced care planning, assistive technology, and a continually more robust resource directory. .
- k. Continue to disseminate marketing and outreach materials for TBI awareness month advertising the TBI help line in March of each year

Strategic Objective 4.2: AAAs and the State Unit on Aging have access to and use a statewide Information System to facilitate easy access to client data, increased efficiency and accuracy in data management, resource information, and the ability to look across the scope of our consumers to better understand their needs, and identify gaps in service options at the local level as well as statewide.

4.2 Measures:

- Continue to improve the skills and expertise of information system (IS) users resulting in accurate and complete data so that the state, AAAs, and participating provider organizations have robust information for planning, forecasting, gap analysis, and identifying areas for service quality improvement
- Establish a batch process for uploading SHIP and ADRC/SHIP Duals options counseling data into the SHIP National Reporting system by December 2015

Strategic Objective 4.3: Support families and informal caregivers that provide un-paid support to those in need. Strengthen the statewide system of caregiver support to prevent or mitigate caregiver stress

and burden. Assure family caregivers receive appropriate, timely information, education and services, tailored to their unique strengths and needs which enable them to continue caring for their loved one.

4.3 Measures: (through 2022)

- a. Increase the percentage of caregivers supported in the Family Caregiver Support Program (FCSP) as an alternative for care recipients who remain without Medicaid long-term care services for 90 days or longer through 2022 (if state and/or federal funding increases).
- b. Continue to train and certify TCARE® (Tailored Caregiver Assessment and Referral) Assessors (Family Caregiver Specialist) to conduct this evidence-based caregiver assessment statewide.
- c. Work with partners and consultants to translate TCARE® tools into three additional languages by 2022.
- d. Develop recommendations for FCSP based upon a three pronged, in-depth FCSP program evaluation to identify strengths, challenges and opportunities for improvements.
- e. Continue to incorporate and support additional services and supports with an emphasis on evidence-based models at local community levels based on available federal and state funding.
- f. Continue to work with TCARE® developer, Rhonda Montgomery, PhD (University of Wisconsin – Milwaukee) to further develop research findings on TCARE® outcomes, including the impact of the FCSP on the reduction of caregiver stress and burdens.
- g. Work with Tailored Care Enterprises to revise the TCARE screening, making it more concise.
- h. New and ongoing FCSP staff (I&A and TCARE® Assessors) will receive resources and training on effective methods to serve special or hard to reach populations such as, caregivers providing care to persons with dementia, individuals who have behavior issues, a Traumatic Brain Injury or belong to a geographically isolated population and/or ethnic community.
- i. Expand Lifespan Respite WA) to build a sustainable program and financial infrastructure for family caregivers to include gap filling services for unpaid family caregivers who provide care to individuals across the lifespan.
- j. Explore ways to expand services to caregivers in diverse cultures throughout Washington
- k. Provide targeted outreach to, and support for, caregivers of individuals with memory loss and dementia, to make them aware of the value of early diagnosis and of taking action steps to plan for the future, to include dissemination of the Dementia Road map: A Guide for Family and Care Partners
- l. Further populate and enhance dementia resources within the ADRC/CLC.

Strategic Objective 4.4 Increase the dementia-capability of the ADRC and Family Caregiver Support Program to enable adults with memory loss and/or dementia to remain in their homes and maintain quality of life. Support efforts of the Dementia Action Collaborative in implementation of Washington's State Plan for ADRC

4.4 Measures

- a. Seek funding to integrate evidence-based or evidence-informed early stage memory loss services into the Family Caregiver Support Program.
- b. Measure: Increase availability of early stage memory loss support services to areas beyond King County by 2021.
- c. Integrate dementia-capable Person-Centered Counseling and informational elements into the ADRC system statewide by 2021.
- d. Strengthen capacity of the WA State Information and Assistance system by educating staff about recognizing possible dementia, making appropriate referrals, and by building links with relevant partners and organizations. (SDP Recommendation 1.A.2).
- e. Educate staff and public in order to promote advance care planning and legal and financial planning in the early stages of dementia in order to avoid costly or unnecessary court proceedings and/or guardianships." (SDP Strategy 1.D.)

Strategic Objective 4.5 Sustain and expand access to evidence based and evidence informed practices
Measures

- a. Sustain the evidence-informed Memory Care & Wellness Services (MCWS) dementia day service model through the Family Caregiver Support Program and/or Medicaid Transformation Demonstration.
- b. Seek funding for expansion and/or explore of new funding streams, e.g., Veterans Administration, private pay, and/or new initiatives such as Community First Choice, Medicaid Transformation Demonstration Project (waiver). .
- c. Sustain integration of EnhanceMobility (EM) within MCWS. EM is a structured exercise program based on evidence-based exercise programs adapted especially for people with dementia - developed in collaboration with the UW School of Nursing, Senior Services of King County, ADSA, and the Memory Care & Wellness Services sites.
- d. Increase the number of people accessing MCWS through the Family Caregiver Support Program and other funding sources by 2022.
- e. Sustain and expand evidence-based STAR-C intervention designed to impact mood and behavioral disturbances of people with dementia, integrated into the Family Caregiver Support Program. Create infrastructure to support the training and certification process for STAR-C consultants.

- f. Establish an infrastructure to support the training and certification process for STAR consultants by 2020.
- g. Increase the number of people accessing STAR-C through 2022.
- h. Explore, pilot and integrate evidence-based and evidence-informed interventions that target people with dementia in the early stages and interventions that support family caregivers to understand and respond to behaviors of loved ones with dementia.

Goal 5: Improve health status by empowering older people and people with disabilities to stay healthy and active through expansion of evidence based healthy aging programs and improve health outcomes through coordination of care through integrated health and long term supports and services.

Strategic Objective 5.1: Continue to implement models that help individuals to manage their health and chronic conditions.

Measures

- a. Deliver evidence- based interventions designed to support the client and their caregivers with improved self-management skills.
- b. Administer evidence based screening tools periodically to identify client opportunities, strengths and detect changes.
- c. Disseminate and sustain the Self-Management Resource Center Chronic Disease Self-Management Education (CDSME) programs in Washington State.
- d. Provide technical assistance and support in the development and maintenance of a statewide network of evidence-based programs designed to support clients and caregivers.
- e. Continue to partner with the Department of Health to engage community health workers and local health jurisdictions into local program delivery networks.
- f. Target special populations with health disparities including Native Americans and people with developmental disabilities.
- g. Continue to support implementation and maintenance of PRISM and expand access to the tool to case managers and social workers supporting Medicaid LTSS clients (predictive modeling tool).

Strategic Objective 5.2 Improve food security by supporting older adults to increase their access to nutritious affordable food and increase healthy eating

Measures

- Explore strategies to increase funding for senior nutrition programs through 2022

- Continue to collaborate with AAA's and Washington Association of Senior Nutrition Providers (WASNP) to implement innovative adaptations to senior congregate meal programs through 2022
- Continue collaborative efforts to embed nutrition counseling, nutrition educations & home delivered meal supports in hospital discharge transitions, health home models through 2022
- Continue to partner with Economic Services Administration,, WASNP, and Anti-Hunger Coalition to promote focus on older adult food security issues through 2018

Strategic Objective 5.3. Improve health outcomes for individuals with high medical risk factors through implementation of Medicaid Health Home Services: through implementation of the Medicaid Health Home services.

Measures

- Increase the number of individuals who are engaged in Health Home services through the establishment of a Health Action Plan to reduce hospital readmissions, avoidable emergency room visits for individuals receiving Health Home services, and individuals with fewer than 30 days between hospital discharge to first follow-up visit through 2022
- Provide subject matter expertise for care coordination training in the delivery of, and engagement of, long-term care services and supports in Health Home services.
- Participate in regional meetings to promote on-going communication and coordination between health home coordination between health home coordinator and LTC system.
- Make referrals to health homes services for clients that may be eligible for services

GOAL 6: Promote Equity, Diversity, and Inclusion (EDI) practices

Measure 6.1 100 percent of new and existing ALTSA staff will be trained in culturally and Linguistically Appropriate Services (CLAS) Standards by June 2019.

- Establish agency requirements for all staff completion of CLAS Standards training.
- Expand Quality Assurance policies and procedures administration-wide to incorporate CLAS Standards.
- Develop training plans for onboarding new employees and existing staff on CLAS Standards.
- Embed Equity, Diversity, and Inclusion principles throughout the organization planning and operations, as measured by completion of the Action Plan below by June 2019.
- Develop an annual strategic EDI communication plan.
- Have a fully developed Communities of Practice that include executive leadership and staff working collaboratively to identify gaps in EDI.
- Establish a workgroup to explore the collection of SOGI data.
- Analyze population shifts, services used and the forecast for the future need for services by a

diverse aging state population to project future needs costs and resource impacts.

Quality Improvement Strategy Roles and Responsibilities

Quality Assurance Unit

The Quality Assurance Unit monitors consumer satisfaction, program eligibility, accuracy and quality of file documents, adherence to policy, procedures, and state and federal statutes including waiver requirements. The QA unit is responsible for monitoring three state regional areas and 13 Area Agencies on Aging for each review cycle. This monitoring includes verifying that corrections have been made to all items within 30 days of the area receiving the regional/AAA final report and that health and safety concerns are corrected immediately. The QA unit reviews and approves Proficiency Improvement Plans (PIP) to ensure all required issues have been addressed. They also perform other quality improvement activities each review cycle (i.e., inter rater reliability reviews, nursing facility discharge assessments, participant surveys, etc.), in addition to participant record reviews.

State Unit on Aging (SUA)

The SUA is responsible for oversight of Area Agency on Aging operations. The oversight duties include:

- Monitoring implementation and compliance with contract requirements, state and federal laws and regulations, policies and procedures;
- Reviewing the PIPs submitted by AAAs with the QA unit to improve proficiencies; and
- Reviewing monitoring reports submitted by AAAs for subcontractors to determine compliance with inter-local agreement and related laws and regulations.

Home and Community Programs (HCP) Unit responsibilities include:

- Developing policy and procedures related to HCS quality assurance/improvement activities,
- Overseeing assessment, service planning and delivery models, and
- Monitoring compliance to Home and Community Programs (HCP), including HCBS.

Clinical Effective and Performance Improvement (CEPI) Unit measures the effectiveness of assessment, care planning and interventions and recommends performance improvements.

Adult Protective Services (APS) Unit investigates and makes official findings on any accusations of abuse, neglect or exploitation of a vulnerable adult except those who live in a licensed setting or is served by a certified residential service provider. Local and statewide reports are available and reviewed by APS headquarters managers and field managers.

Area Agency on Aging and Home and Community Services Field Supervisors are responsible for monitoring, at a minimum, three participant records per worker per year. All Reports and aggregate data generated by the QA application are available on a continuous basis for use by managers, supervisors and the QA Unit. HCS QA policy and procedure mandates that reports be used for discovery, remediation and to identify strengths and areas of improvement, training needs, areas of deficiencies and identify corrective action plans. There is continuity and integration of report review throughout HCS.

The Waiver Management Committee ensures regular opportunities for discussion and waiver oversight between the State Medicaid agency and the Operating agency. The committee includes representatives from administrations within the operating agency: the Developmental Disabilities Administration (DDA), Aging and Long-Term Support Administration, and the Behavioral Health and Service Integration Administration. The committee meets at least quarterly to review all functions delegated to the operating agency, current quality assurance activity, pending waiver activity (e.g. amendments, renewals, etc.), potential waiver and rule changes and quality improvement activities.