

2014-2018

WASHINGTON STATE PLAN ON AGING

Aging and Long-Term Support
Administration



Washington State
Department of Social
& Health Services

Transforming lives

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Verification of Intent

This State Plan on Aging is submitted for the State of Washington for the period October 1, 2014 through September 30, 2018. 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, AL TSA

7/3/2014
Date

EXECUTIVE SUMMARY

The Aging and Long Term Support Administration (AL TSA) is an administration of the Washington State Department of Social and Health Services (DSHS) and 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. AL TSA has reviewed and taken into consideration the Area Plans on Aging submitted by the state's thirteen Area Agencies on Aging (AAA's) as required by the OAA with extensive focus on each AAA's planning, prioritization and needs assessment process and conducted a statewide survey to solicit plan input.

Plan development was preceded by two key endeavors aimed at developing a statewide age wave policy framework. In October 2013, Governor Jay Inslee hosted an Aging Summit. The purpose was to focus state policymakers and opinion leaders on the age wave, explore strategic actions state government can take to create a more age friendly environment and reduce pressure on future state budgets and to jump start the work of the recently formed Legislative-Executive Committee (JLEC) on Aging and Disability. The major topic areas discussed were livable communities, financial security, health care-healthy aging and long term services and supports.

The JLEC on Aging and Disability Issues was established in the 2013-15 operating budget with the intent of operating for a two year period. The Committee is charged with the responsibility to identify strategic actions, including state budget and policy options to prepare for the aging of Washington's population and to produce a report due in December of 2014.

According to the Washington State Office of Financial Management (OFM) the state's population over 65 has doubled since 1980 and this age wave growth is anticipated to continue at a high level. By 2040, the number of persons 65 and over should reach 1,861,000. The state's long term support and service population is forecast to increase by 91% by 2040.

Accompanying the age wave, the state and national economies sustained a devastating recession. Although slow recovery is underway, the recession was especially hard hitting for vulnerable populations, including older adults and people with disabilities.

The state is at a critical juncture facing the demographic pressure of an aging population, intensifying long-term financing challenges and the structural challenges of the current state tax and revenue system. Years of long decline in revenue collections have moved the state to a rank of 35th and a 30% decline in collections over a 40 year period. In 2014 there is already a large gap between the cost to maintain current services for an expanding population and projected revenues shortfalls that are currently estimated at a minimum of \$1 billion. A

persistent state deficit climate continues to pose challenges the LTSS network's capacity to maintain access to services and supports and limits and AL TSA policy level funding requests for critical infrastructure investments that promote long term savings for the state.

On the federal level, OAA programs sustained a loss in funding as a result of the FFY 13 sequester cuts imposed by Congress. As a result the state lost \$2 million in funding (an average reduction of 8.73%) and these levels have remained intact for most OAA programs in FFY14. This cut followed over a decade of flat funding for OAA not keeping pace with inflation or population growth and had immediate direct impact on AAA's and other LTSS network providers.

Fortunately AL TSA has attained efficiencies through the integrated implementation of OAA programs and state and Medicaid HCBS services throughout the LTSS network. Through a variety of federal grant opportunities, including those from ACL, AL TSA continues to build strong partnerships to leverage resources through collaborations with academic, agency and provider based communities.

For several years, AL TSA and AAA's have made significant strides advancing key innovations while at the same time achieving a ranking as one of the most high quality and cost effective LTSS systems in the nation. With increasing demand for supportive services, stagnant or shrinking funding sources, the State and the LTSS network is continually challenged to evolve to better address these realities and maintain the necessary capacity and quality of support and services needed by Washingtonians. It is within this context we present the State Plan on Aging

The ACL has set focus areas for State Units on Aging to mold their service architecture to address these evolving issues. This State Plan on Aging is structured around these focus areas.

The broad goals of the plan are

- Elder Rights and the protection of vulnerable adults
- Expanding and strengthening services and supports that prevent or delay entry into Medicaid funded LTSS
- Enabling older adults to remain in their homes and maintain quality of life
- Healthy aging & increased integration of service delivery

INTRODUCTION

The State Plan provides continuity building on the blueprint established in the previous State Plan, integrating the requirements of the OAA, the Governor's Results Washington, the DSHS ALTSA Strategic Plan and the input of Washington citizens and service providers. This integrated approach promotes a focus on person centered outcomes and provides a framework for the goals and outcomes that ALTSA and the LTSS network will attain while fulfilling the requirements of the OAA. The Plan was reviewed and approved by the State Council on Aging in public session on June 24, 2014. The State Council on Aging is the advisory council appointed by the Governor and assists in carrying out functions of the Older Americans Act.

ALTSA offers services that empower senior citizens 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.ⁱ

ALTSA's Home and Community Services Division (HCS) is the division mainly responsible for administration of the State Plan on Aging and Older Americans Act programs and funding.

In collaboration with LTSS network partners, ALTSA leads the continuing discussion in this state regarding the provision of long-term supports and services including OAA programs and the on-going development of a LTSS system that is responsive to 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

Advisory Council

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— Aging and Long-Term Support Administration. Council members are designated by the Governor. It is made up of one member from each state-designated planning and service area, commonly referred to Area Agencies on Aging, 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, and those individuals with special skills which could assist the state council are represented. Currently two of the AAA representatives are from Tribal Governments, 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.

Aging and Long-Term Support Administration (AL TSA)

In Washington State, the Aging and Long-Term Supports Administration (AL TSA) houses the State Unit on Aging (SUA). This administration contains the major long-term support programs for older adults and adults with functional and cognitive disabilities.

A broad array of services are offered through AL TSA, 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
- Relocation assistance for individuals wishing to move from institutional to community based settings
- Family and kinship caregiver support services, including Life Span Respite
- Senior Nutrition – home delivered, congregate & farmer’s market
- In-home and supportive services
- Home Care Referral Registry
- Health promotion & disease prevention
- Community residential licensing, quality assurance & policy development

- Nursing Home, Residential Rehabilitation and state supported living certification and quality assurance
- 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, and Nursing Home Diversion.

ALTSA is made up of four divisions: Home and Community Services, Residential Care Services and the Office for Deaf & Hard of Hearing and Management Services. Descriptions of the functions of each division and an organizational chart are attached in Attachment E.

Aging & Disability Long Term Support Network

Area Agencies on Aging (AAA's) 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 AAA's designated by ALTSA in accordance with the laws and regulations promulgated by the ACL and authorized under the OAA.

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. AAA's 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 Act 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, goals must be pursued within the confines of finite funding. While scarce 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 Planning and Service Areas, also referred to as AAA's, is attached in Attachment F and sample service descriptions in Attachment O.

ALTSA has objectives that respond to the full range of aging needs. The following are objectives and principle 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; those in rural areas; age 60 + with limited English speaking ability; and those age 60 +needing assistance with Activities of Daily Living.
- Develop a service delivery system which incorporates the concept of a continuum of care which 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 which 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. AAAs must assess needs of the older population annually as part of its continuous planning process.

Serving Native American Elders and Native Americans with Disabilities

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 urban 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 AL TSA follows a government-to-government approach to seek consultation and participation by representatives of tribal governments in policy development and service program activities. This is in compliance with the Washington State 1989 Centennial Accord and current federal Indian policy as outlined by Executive Order #13175 signed by President Clinton in November 2000, promoting government-to-government relationships with American Indian Tribes.

AL TSA 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. Specifically, Policy 7.01 requires that a 7.01 Implementation Plan be routinely submitted.

Each Area Agency on Aging is required to address their planning and coordination efforts in their Area Plan. All non-tribal AAAs are required to develop Section 7.01 plans which are incorporated in to 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 3 and Title 6 under OAA.

With the passage of the Affordable Care Act and the American Indian Health Improvement Act, the opportunity has been created for tribes to plan for the provision of community based long term services and supports specifically for Indian Country. AL TSA partnered 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 will provide 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.

During state plan development, ALISA SUA staff met with the DSHS Indian Policy Advisory Committee (IPAC) subcommittee for aging and disability services. IPAC contributed to the development and implementation of the state plan survey and review of the draft plan. IPAC recommended more information about health disparities be included in the state plan. IPAC members expressed concern that not all 7.01 Implementation plans mirror a collaborative effort with AAA's and tribes. Additionally, there is not a consensus among tribes that providing services and supports to older and/or tribal members with disabilities should need to be done through AAA's.

The current American Indian Health Care Delivery Plan, that provides the policy framework to improve the health of Indian people, conveys the following in regard to LTSS: "American Indians/Alaska Natives (AI/AN) should have equitable access to Medicaid and other state-funded long-term care programs, yet barriers exist in accessing services, including, but not limited to, lack of properly trained, culturally competent assessors, insensitive evaluation tools, inadequate transportation, inability to pay for care, and receiving services through regional state sub-contractors rather than directly contracting with the state".

Although the state has been a national leader in developing a system of long-term care that allows older adults and adults with disabilities dignity and choices in how they wish to live, tribes do not feel as though enough has been done to fully address these issues. The need of tribal governments to assure appropriate care for their citizens must be respected, and they must have access to available resources, as well as information about existing programs for which AI/ANs are eligible. Additional work needs to be done in long-term care to ensure that the aging Indian population in Washington, as well as AI/AN adult with disabilities, has access to essential services and options when they are needed and that individuals can receive these services in their own communities. Developing strategies for Tribes to provide long-term care services must be a priority of both state and tribal government.

Accordingly, this plan addresses the need for state and tribal governments to develop strategies for long term supports and services.

Network Comment and Review of this Plan

The State Council on Aging, the Area Agencies on Aging, Tribal Governments, and other interested stakeholders were asked to 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 the plan and its approval was on the agenda. The State Plan is also intended to establish priorities that will serve as a road map for aging network partners. To discern what these priorities should be, the SUA requires all thirteen AAAs to submit four year area plans. The budgets are updated annually and the narrative component updated every two years. The results of these plans are then submitted to SUA where they are reviewed, approved as appropriate and integrated into the statewide plan process.

A survey targeting people who receive services as well as providers in the aging network was utilized 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 and 1599 responses were received.

Survey respondents indicate that they considered most current OAA funded services and other aging services to be high priority need. The following were ranked in the top ten: Personal in home care services 93.6%, Abuse/Neglect Prevention 86.3%; Information and Assistance (ADRC functions) 85.4%; Transportation 85.5%; Dementia supports and services 85.4%; Family Caregiver Support Program 84.5%; Help returning from hospital with support of remain at home 84.7%; Respite Programs 82%; Home Delivered Meals services 81.6% and other residential and in home services 77.2%.

Predominate concerns expressed in narrative portions of the survey included fear of not being able to afford to stay in their home due to taxes or rent increases, not being able to pay for food or other essentials, not being able to afford services to help them stay at home and/or the state would not be able to afford to provide services.. As one respondent stated “I don’t have any savings or retirement other than Social Security and I know there are many more like me.” Another noted “people in rural areas are land rich and cash poor, so being able to pay for essentials gets tougher by the year as taxes and prices continue to rise & rise”.

Other dominate concerns included having adequate access to transportation, home modifications, being vulnerable to abuse, neglect and financial exploitation, loneliness and fear of falling. Eighty-four percent of respondents consider choice and control of services received to be very important. Older adults age 60 and older were represented by 39% of responses, inclusive of 9% of with a disability. Adults under 60 with disabilities comprised 9% of responses.

Relatives of an older adult that needs care represented 44% of responses and providers of services entered 368 responses or 40% of total.

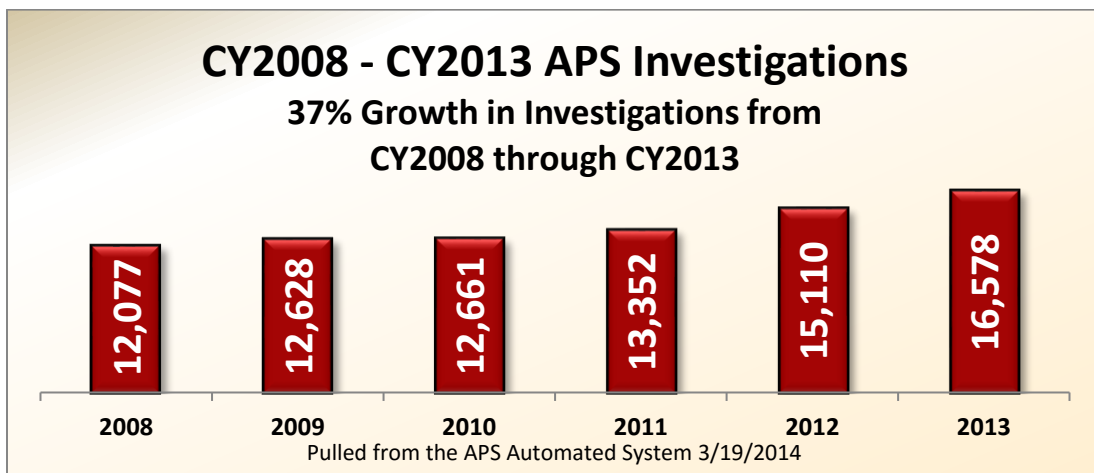
The racial and ethnic response rate was 82% White, 4.4 % Hispanic, 3.5 % American Indian or Native Alaskan, 6.7%, Asian/Pacific Islander, 4 % African American and 3% other. 4% of respondents reported to have a diagnosis of dementia, 47% reported to have a family member or friend with dementia and 36% reported to be a caregiver for a person with dementia.

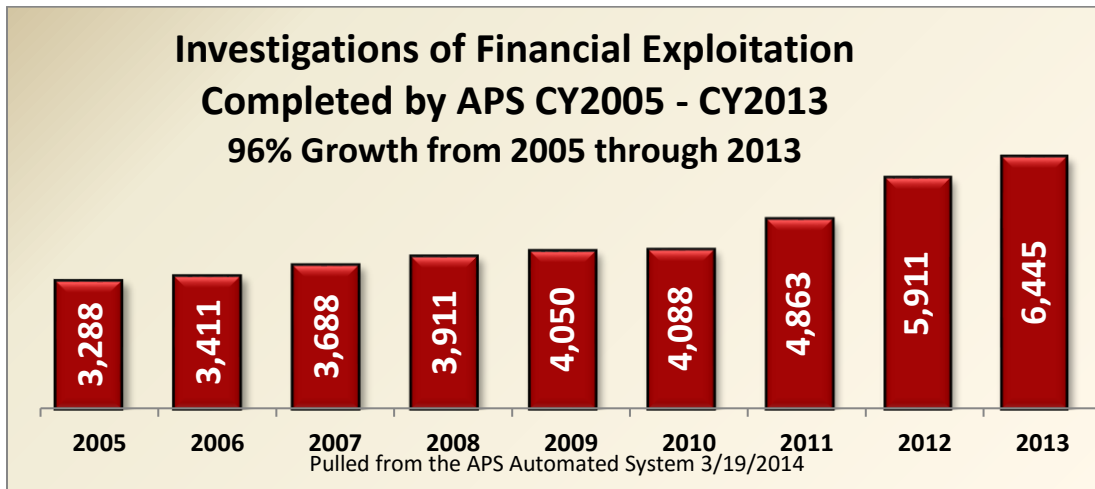
The survey also asked respondents who have received LTSS network services in the past two years to rate their satisfaction. These respondents totaled 40% of responses, of those 50% indicated they were very satisfied, 31 % somewhat satisfied 14.7% 'in the middle, 3%, somewhat dissatisfied and 0.8% very dissatisfied. Residents of rural and urban areas were represented in the survey participation and response rates mirrored the population distribution in the state. (Please refer to separate Attachment P for survey summary)

Trends, Challenges & Strategic Priorities

Demographic

According to the Washington State Office of Financial Management (OFM) the state's population over 65 has doubled since 1980 and is projected to more than double again by 2040. This growth is anticipated to continue at a high level and by 2040, the number of persons 65 and over should reach 1,861,000 and will represent one-fifth of the states' population. Current gains 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 when the first waves of baby boomers reach 85. This represents an aging of the population that will not disappear after the baby boom population; it will be a sustained demographic trend.





Washington recognizes the serious impact of elder abuse on our vulnerable adults and society as a whole. As the aging population grows there is increasing risk of abuse neglect and exploitation. The state’s Adult Protective Services has experienced a 37% increase in the number of investigations conducted from calendar year 2008 through 2013. Exponential growth has occurred for investigations of financial exploitation, with a 96% increase from 2005 through 2013 and self-neglect cases have grown by 71% since 2005. These trends confirm the need to ensure adequate resources are available to effectively manage this significantly increased caseload and protect adults who are vulnerable.

People of color account for a significant share of the Washington population today and show notably faster rates of increase than their white counterparts. The racial and Hispanic population projections available from OFM show that in 2030, nearly one in three residents will be a minority. There is significant diversity among these communities, mirroring 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 disparitiesⁱⁱ, including less access to health care and are disproportionately at risk for food insecurity. For example, recent data from the state Department of health indicates AI/ANs are more likely to live in poverty than any other racial or ethnic group in Washington and also experience disproportionately high mortality and morbidity burden compared to the general population.ⁱⁱⁱ

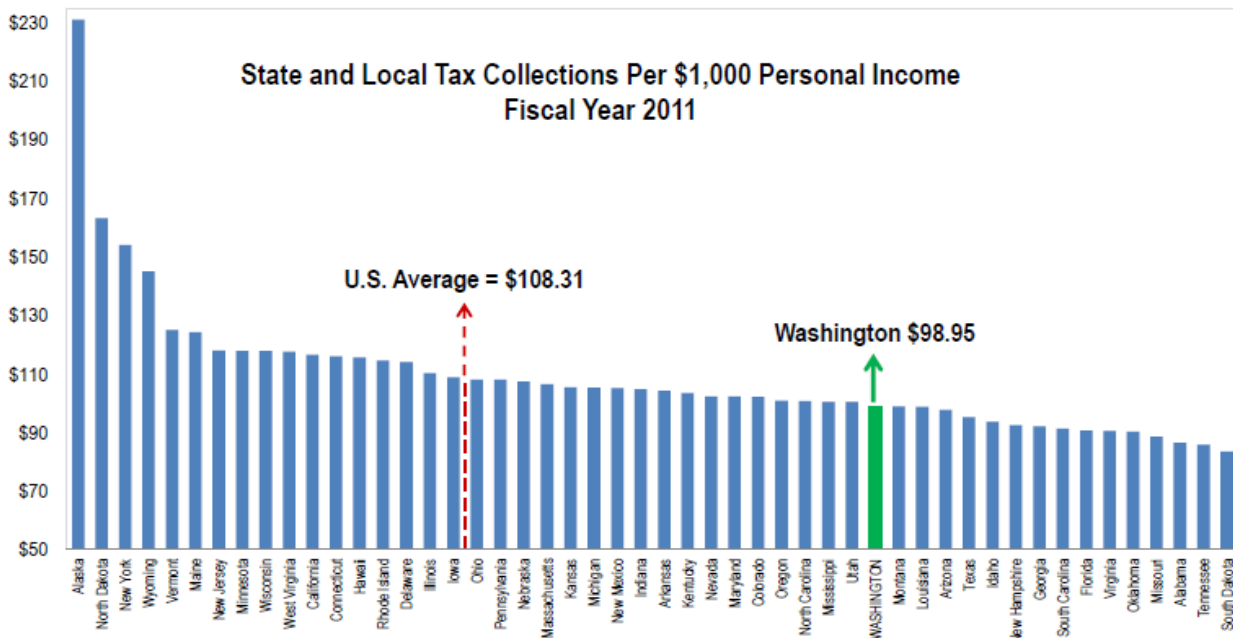
Older adults who are lesbian, gay, bisexual, and transgender (LGBT) are estimated to make up over 5% of the U.S population^{iv}and are as diverse as their heterosexual counterparts. As a recent study indicated, older adults whom identify as LGBT may be five times less likely to access needed health and social services because of their fear of discrimination.^v

Current data on individuals who receive paid services from ALTA continues to indicate that our client 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

The state and national economies have sustained a devastating recession and are on a path of slow recovery. The recession has been especially hard hitting for vulnerable populations in Washington State, including older adults and people with disabilities. To address multiple years of state budget deficits, the long term services and support network endured successive years of cuts to services, administration and staffing, or flat funding not keeping pace with significantly increased caseloads.

This has challenged the system’s capacity to maintain access to services and supports. The continued reality of maintenance level expenditures outpacing revenue collections also limits the ability to get critical infrastructure investments. This has included not being able to fully fund requests at regional and AAA offices to address rising caseload ratios, periodic backlogs in assessments, more fully address the critical need for more rapid investigation and resolution of Adult Protective Service complaints, to investigate an increasing number of complaints related to client protection in residential settings or provide adequate investment to expand ADRC & the Family Caregiver Support program



The state is at a critical juncture facing the demographic pressure of an aging population, intensifying long-term financing challenges, and the structural limitations of the current state tax and revenue system. Years of long decline in revenue collections have moved the state to a rank of 35th and a 30% decline in collections over a 40 year period. In 2014 there is already a large gap between the cost to maintain current services for an expanding population and projected revenues shortfalls that are currently estimated at a minimum of \$1 billion. In 2012 the state Supreme Court issued the McCleary decision, finding the state was not meeting its constitutional obligation to fund K-12 basic education. As a result, the state is required make a \$4.5 billion investment in K-12 by 2018.

As of 2014 the state ranked 34nd in the nation in total Medicaid LTSS expenditures for all populations, spending \$355 per person compared to \$445.96 per person in U.S. ^{vi} Significantly, the state also continues to ranks second in the nation for providing quality long-term supports.^{vii} Of critical concern is how the state will responsibly meet the important obligation of basic education and also maintain equally important investments- including those providing support for an increasing number of older adults and people with disabilities.

Washington has one of the most cost effective LTSS systems in the nation. We have focused on increasing community capacity to safely serve individuals who choose to live in their homes and community residential settings. By being responsive to individual choice and moving toward a more balanced system, the state has saved hundreds of millions of dollars over the past twenty five years. As such, the system is very vulnerable to budget reductions. As a result of efficiencies already in place, any reduction in funding results in an immediate impact on services and narrows the margin of return on investment (ROI) for many initiatives.

In the current budget climate, programs that depend on state funds to provide vital services will remain at risk. One example is the Family Caregiver Support Program (FCSP) which has demonstrated the cost effective outcome of delaying or avoiding the need for Medicaid services. FCSP currently provides support to 1% of the state's unpaid caregivers. Expansion of the program requires the investment of state funds to achieve much greater long term cost savings to the state.

On the federal level OAA programs sustained a loss in funding as a result of the FFY 13 sequester cuts imposed by Congress. As a result the state lost \$2 million in funding (an average reduction of 8.73%) and these levels have remained intact for most OAA programs in FFY 14. This cut followed over a decade of flat funding for OAA and had immediate direct impact on AAA's and community service providers. A recent Congressional Research Service report demonstrates that inflation-adjusted funding appropriated for OAA nutrition services

decreased substantially over the past two decades: \$768 million in FY 2013 compared to \$1.04 billion in FY 1990. ^{viii}

The economic security of older adults remains a significant concern given the impact of the recession and the current economic climate. 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. LTSS Network advocates and many academics increasingly reference the Elder Economic Security Index as a more factually based measure of economic status than the federal poverty level (FPL). EESI uses supplemental measures that include adjustments to reflect homeownership status, regional cost of living and out of pocket expenses like healthcare. A 2012 AARP report using a comparable measure (250% FPL) found 34% of the state's population 65 and over to be at or below this measure. Using standard FPL for the same year the state percentage is 7.8%. A significant number of state plan survey respondents expressed both future and current concern about not having enough money to buy essentials, access affordable housing or afford personal care services to help them remain at home. A recent AARP survey addressing long term personal finance issues found that 25% of the boomer generation have saved less than \$25,000, increasing the risk of poverty and need for services. These economic realities have significant policy implications for a range of systems including the LTSS Network. (Please refer to Attachment G for more information about the EESI)

Between 2001 and 2011 the number of food insecure older adults more than doubled^{ix} representing nearly 1 in 12 older adults. This trend was made worse by the recession. Compared to 2007, the number of food insecure older adults in 2011 was 50% higher-a dramatic increase. In the state of Washington food insecurity is currently estimated at 13.2%^x of the population 60 and older. For older adults, protecting oneself from food insecurity and hunger is more difficult than for the general population.

A February 2011 U.S. Government Accountability Office (GAO) report found that only about 9 percent of an estimated 17.6 million low-income older adults received meals like those provided by the OAA, an estimated 19 percent of low-income older adults were food insecure, and about 90 percent of them did not receive any meal services

Washington is fortunate to have a strong network of dedicated professionals and volunteers providing senior nutrition programs. Over the past several years this network has experienced funding reductions, either directly, as demonstrated by the recent sequestration cuts or indirectly through flat funding that does not compensate for increased food and transportation costs. As an increasing number of older adults struggle with food insecurity it's critical to protect and strengthen cost effective nutrition programs to support healthy aging.

As confirmed in AAA Area Plans and the state plan survey, adequate access to transportation to link older adults to health care, community and supportive services continues to be significant area of need. Funding for transportation services has not kept pace with the increasing numbers of individuals needing the service. Access is more challenging in rural areas and there are a number of rural counties that have no publicly funded transportation. Lack of access to transportation creates a barrier for older adults and people with disabilities who want to remain in their communities as well as a barrier for good health outcomes for those unable to access adequate transport to medical services. The Washington State Council on Aging is engaged in analysis of transit issues, collaboration with transit advocates and has recently taken part in a meeting with State's Secretary of Transportation, AL TSA and the Aging Network must continue to expand collaborative partnerships with local, state and federal transportation organizations and departments to more adequately address the specific needs of older adults and adults with disabilities.

The ability to provide services in home and community settings is dependent on availability of quality home and community options statewide. LTSS providers across the state have faced the challenge of flat funding or decrease to rates in recent years. Medicaid LTSS service providers including nursing homes, boarding homes, adult family homes and home care agencies experienced rate reductions or flat rates as part of addressing the recent budget deficit. These cuts have disproportionately impacted providers who serve higher percentages of Medicaid clients and face increased risk of not remaining viable.

According to a 2011 Washington State University workforce brief on home care aides by 2030 nearly 77,000 home care aides are estimated to be needed to serve Medicaid consumers and action is needed to recruit and retain more HCA's. ^{xi} This is compounded by high turnover rates which increase the number needed to as high as 125,000. (See Attachment I) Data on national trends indicates 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. There continues to be a shortage of medical and broad based geriatric workers. This has negative impacts on the management of health, particularly for older adults with multiple chronic conditions. 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 need to 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.

ALISA's LTSS service population (combined in-home personal care, community residential and nursing facility caseloads) is forecast to increase by 91% by 2040. There are an increasing number of clients with complex needs and these individuals require a complementary set of medical, prescription drug, personal care, and supportive services. It is clear the Medicaid program will not be able to absorb the growth in this need, even if the program focuses on serving individuals in the least costly settings within existing budget allocations. People who need long-term care qualify for Medicaid only if they meet low income eligibility requirements. Paying for long-term services and supports 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.

The state has rebalanced its system by utilizing a number of strategies including development of Medicaid home and community based setting options, allowing consumers more choice and control with the ability to hire family and friends as paid caregivers, continuing to strive to build a robust system of support of unpaid family caregivers and building diversionary programs through Older Americans Act, ACL discretionary grants and dedicated state funding.

Strategic Focus Areas

If home and community services are to grow to meet unprecedented consumer demand multi-pronged strategies are important. This includes ensuring adequate resources to protect vulnerable adults, 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.

Protection of Vulnerable Adults

The protection of vulnerable adults remains a priority goal of the state plan. As the aging population grows there's 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. ALISA 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 through the Adult Abuse/ Neglect Response Workgroup. To date, many of the Workgroup recommendations made by interested stakeholders have been implemented, are in process or need additional funding or statute changes to be implemented. (Descriptions of the Elder Justice Components, Adult Protective Services, State Long-Term Care Ombudsman program, The Vulnerable Adult Abuse Response Workgroup and related LTCO systems advocacy are located in Attachment H)

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. Over 850,000 Washington State citizens are unpaid family caregivers who provide 80% of the services needed to allow family members to remain at home for as long as possible. These caregivers provide \$10.6 billion of unpaid assistance to individuals needing assistance to stay in their homes. Contrast this with the \$1.5 billion spent on Medicaid Long Term Services and Supports (LTSS) each year which covers, Nursing homes, personal care and supportive services in licensed residential settings and personal care in the client's own home Without these unpaid caregivers the amount needed for Medicaid LTSS would be much higher.

Through its partnership with the AAAs, ALTA operates the Family Caregiver Support Program (FCSP) for individuals 18 and older. Unpaid family and other informal caregivers can access a variety of core services. In FY2013, FCSP provided 8,600 (just over 1%) unpaid family caregivers with education and training, consultation, counseling, access to support groups and respite care.

A 2014 evaluation examined how the expansion of FCSP in SFY 2012 affected the utilization of Medicaid long-term care services. Due to the FCSP expansion, caregivers screened in SFY 2012 were more likely to receive a full assessment and a broader range of support services than those screened in prior years. Results show that care receivers whose caregivers were screened post-expansion were slower to transition to Medicaid long-term care services, controlling for differences in baseline characteristics; the FCSP expansion is likely a contributing factor to this positive outcome. Family caregivers are a vulnerable population. To address the aging of Washington's population, we need additional investments to FCSP. We need to reach more people before their resources are exhausted and they must turn to the state for Medicaid LTSS.

(More information about FCSP and FCSP evaluation can be located in Attachment J)

Aging and Disability Resource Center System-Community Living Connections

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.

As an outcome of a series of CMS & ACL grants, the state continues to build upon the Senior I&A infrastructure by developing new partnerships to expand these networks into a statewide

Aging and Disability Resource System called Community Living Connections (CLC). CLC is a system of services available to people age 60 and over, persons with disabilities, caregivers of all ages and those seeking information about benefits planning, options counseling and local services and supports. ADRCs can also link individuals to healthy aging interventions focused on prevention and disease management strategies. Preventative services and self-management training can help the individual manage their health and/or the progression of his or her own disease.

In addition to integrating OAA programs into the information and options counseling provided consumers, it does the same for the full range of private and public long-term services and supports. The ADRC model should be strengthened statewide and additional funding will be necessary to adequately make this level of service available to all individuals with disabilities regardless of age or disability type. Funding will be required to adequately staff the ADRCs and continue to build necessary collaborations and partnerships, (More information about the role of ADRC including Care Transitions, options counseling, and information system can found in the Goal 2 section and in Attachment K)

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); 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 integrating OAA programs as applicable.

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 in regards to the level of savings that can be achieved through continued rebalancing efforts. (Please see Attachment L and M for more information about the state's rebalancing efforts)

State Alzheimer's Plan and Dementia Supports and Services

In 2012 the first 'National Plan to Address Alzheimer's Disease' was released. The national plan calls for a comprehensive collaborative approach, acknowledging the critical need to better coordinate towards effective prevention, treatment and management of Alzheimer's and related dementias. There are opportunities for Washington to improve quality of care, create efficiencies and potentially impact the trajectory of the illness itself as we strive to achieve better health outcomes.

Recently passed state legislation outlines membership for an Alzheimer's disease (AD) working group that will develop a Washington State Alzheimer's Plan. The group is directed to consider and make recommendations on the following: 1. Trends in the state's AD population and service needs; 2. Existing resources, services and capacity and; 3. Detection and diagnosis of AD and dementia, the provision of coordinated services and supports to persons and families living with AD or dementia disorders, the capacity to meet these needs, and strategies to address identified gaps in services. (Please see Attachment N for more information)

Participant Direction

Washington State has long offered participant direction as a core component of its employer model HCBS system and also offers variations of it in other service delivery models. Participant direction is also critical to the success of collaborative efforts underway to enhance participants' ability to self-manage chronic health conditions. As noted in the state plan survey, respondents continue to consider choice and control of services to be very important.

In support of the principles related to participant direction, AL TSA involves consumers and consumer representatives in informing policy and implementation of strategic initiatives. AL TSA is in the process of establishing a standing Consumer Advisory Council. AL TSA is seeking to provide an established and routine mechanism to enhance the capacity for consumer contribution to policy decisions and the design of LTSS service delivery.

Service Integration Initiatives

The Affordable Care Act (ACA) has opened opportunities for the state to partner with CMS and/or ACL to develop new service delivery models that provide more coordination, integration and shared accountability. These integration models are intended to improve alignment of LTSS with health services, improve health through an array of prevention and health promotion programs and attempt to lower cost by making services more efficient and reforming payment systems. AL TSA is pursuing these goals through multiple initiatives and the active participation of the LTSS network. Through this process AL TSA, state agencies and network partners have been increasingly engaged in modifying systems of service delivery. This

is a complex transition as systems capacities and ways of doing business are adapted to new models of delivering and paying for services and supports, while at same time attempting incorporate existing HCBS approaches that have been effective. Currently ALTSA and network partners are developing shared performance measures and expected outcomes to incorporate into related service coordination contracts as directed by the legislature.

Some examples of integrated initiatives are:

1) Health homes (Managed fee for service financial demonstration model)

Individuals with high medical risk factors continue to experience poor health outcomes, in many cases because of low engagement in managing their health needs. This results in poor outcomes for the individual and higher costs for the state and federal governments. Health Homes assist individuals to improve self-management skills and attain improved health outcomes. Implementation of Health Home services began in July and October of 2013 & some of the performance measures include reducing hospital readmissions and avoidable emergency room visits for individuals. ALTSA will continue to collaborate with the Health Care Authority, AAA's and Behavioral Health and Service Integration Administration to 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.

2) Duals Project (Full financial integration capitation via a three-way contract between a health plan, State and CMS)

HealthPath Washington is a joint demonstration project between DSHS, ALTSA and the Health Care Authority in partnership with King and Snohomish County Area Agencies on Aging and ALTSA field offices. The project will test a managed care financial model that integrates the purchase and delivery of Medicare and Medicaid medical care, behavioral health and long-term services and supports through a single health plan. Enrollment will be voluntary and participants will be able to choose between health plans. All parties are working diligently to develop a viable model that can be approved by CMS.

Community First Choice Option-State Plan

As an outcome of 2014 legislation ALTSA is working with a planning and implementation workgroup to design and implement a Medicaid Community First Choice Option (CFCO-State Plan) program in a manner consistent with legislative direction.

The CFCO is a new Medicaid entitlement state plan option established by the Affordable Care Act (ACA). Through CFCO, Washington State has the opportunity to leverage 6% in additional federal funding for the majority of home and community-based services, potentially freeing 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 has already been identified by the legislature to fund services for individuals with developmental disabilities and the legislature is looking to two committees/workgroups to provide recommendations for other needed reinvestments.

State Plan Goals

GOAL 1: Improve individual and public safety & protection by ensuring the rights of older people and preventing their abuse, neglect and exploitation and ensuring emergency preparedness plans include the needs of older adults and people with disabilities.

Strategic Objective 1.1: Protect adults who are vulnerable living in their homes and in facilities through timely responses to allegations of abuse, neglect and exploitation.

Measures

- a. Maintain timely response to high-priority investigations at 99 percent through 2018,
- b. Increase percentage for medium-priority investigations to 98 percent through 2018
- c. Increase percentage for low-priority investigations to 97 percent by the end of 2018

Strategic Objective 1.2: Maintain adequate Adult Protective Services staff in order to ensure the quality of investigations and timely provision of protective services.

Measures

- a. Maintain abuse and neglect caseloads from at 22:1 through 2018.

Strategic Objective 1.3: Ensure investigations are thorough, documented properly, and completed timely to maintain an efficient work flow that eliminates re-work caused by investigations which remain open longer than necessary.

Measures:

- a. Decrease the percentage of vulnerable adult abuse and neglect investigations open longer than 90 days from 23.2 percent to 12.05 percent by 6/30/2015. This measure is attainable if additional resources are appropriated to achieve adequate staffing levels.
- b. Monitor investigations open beyond 90 days and track data for use in staffing request and streamlining opportunities.

Strategic Objective 1.4 Ensure Adult Family Homes, Assisted Living Facilities and Nursing Homes are providing quality care and residents are safe through timely licensing re-inspections and to confirm provider practice is consistent with quality care and vulnerable adults are protected from abuse.

Measures

- a. Maintain the percentage of timely re-inspection at 99 percent.
- b. Conduct inspections at least every 15.9 months at each facility at 98%.

Strategic Objective 1.5 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

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 adult protective services activities through 2018.

Strategic Objective 1.6 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 Q for more details about coordination and plan requirements)

Measures

- a. Continue to partner with state, regional and county lead agencies in the updating of EPP's through 2018.

- b. Continue to ensure that AAA's embed EPP's in the area planning process and plan document through 2018.

GOAL 2: Expand and strengthen services and supports that prevent or delay entry into Medicaid funded LTSS.

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

Measures

- a. Continue to organize and host an annual caregiving conference in June of each year.
- b. Disseminate and provide technical assistance and training on Washington State's ADRC marketing plan to the full ADRC system by December 2015.
- c. Expand the capacity of the single statewide toll-free number, established for Health Home options counseling, to become the single statewide toll-free telephone number to access local information, options counseling, and assistance, family caregiver support and ADRC local access points by December 2016.
- d. 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.
- e. 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).
- f. Populate and implement a statewide ADRC resource directory and customize a self-service public-facing ADRC website by February 2015.
- g. Continue to disseminate marketing and outreach materials for TBI awareness month advertising the TBI help line in March of each year.
- h. Continue to maintain and develop the TBI Washington website.

2.2 Strategic Objective: 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 needs and identify gaps in service options at the local level as well as statewide.

Measures:

- a. Launch new statewide information system August 2014.

- b. Continue to improve the skills and expertise of information system (IS) users to ensure accurate and complete data for planning, forecasting, gap analysis, and identifying areas for service quality improvement.
- c. 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 2.3 Support families and informal caregivers that provide unpaid 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.

Measures:

- 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 2018 (as 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 2016.
- 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[®] outcome including the impact of the FCSP on the reduction of caregiver stress and burdens.
- g. Provide resources and training to new and ongoing FCSP staff (I&A and TCARE[®] Assessors) 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.
- h. Expand Lifespan Respite WA (if 2014-2017 ACL/AoA's Lifespan Respite Grant funded) 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.

Strategic Objective 2.4 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.

- a. Seek funding to integrate evidence-based or evidence-informed early stage memory loss services into the Family Caregiver Support Program.

Measure:

- i. Increase availability of early stage memory loss services to areas beyond King County by 2017.
- b. Integrate dementia-capable Options Counseling and informational elements into the ADRC system by 2016.

Measure:

- i. Data elements around memory loss and dementia and dementia-specific tools integrated into the ADRC information system by 2016.

GOAL 3: Enable older adults to remain in their homes and maintain quality of life by strengthening the statewide system of home and community based services.

Strategic Objective 3.1: Ensure older adults and individuals with a disability who are in need of long-term services and supports are supported in their community.

Measures

- a. Develop, organize and implement a Consumer Advisory Council to inform key policy decision and services and support design and implementation by June 2015.
- b. Increase the percentage of long-term services and supports clients served in home and community-based settings from 82.9 percent to 83.7 percent by June 2015.
- c. Continue to build expertise and capacity to serve individuals with complex needs in the community through resource development and stabilization services geared to reduce unnecessary institutionalization.

Strategic Objective 3.2: Collaborate with key partners to stabilize, strengthen and continue to build the workforce needed to meet the current and future demand for quality LTSS.

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

Strategic Objective 3.3: Increase the number of individuals AL TSA is able to assist in transitioning to their homes or the community from nursing homes.

Measures

- a. Increase the average number of individuals relocated from nursing homes quarterly to 950 by the end of 2015.
- b. Continue the emphasis on voluntary relocation and diversion, including working with individuals to develop service plans that address barriers to living in the community through 2018.
- c. Leverage the federal “Money Follows the Person” funding to enroll eligible clients into the program through 2018.
- d. Provide additional training to nursing facility case management staff to improve nursing facility case management practice and to build the skill set required to help people live successfully in the community setting of their choice through 2018.
- e. Develop & implement strategies to actively engage hospitals and their discharge personnel through 2018.
- f. Emphasize the availability of the “Washington Roads” program to authorize targeted services to meet client needs when federal funding is not available through 2018.
- g. Continue to develop specialized community resources to serve individuals with complex needs in their homes and community through 2018.

Strategic Objective 3.4: Ensure individuals who apply for services receive them timely so they are supported in the setting of their choice.

Measures:

- a. Increase the percentage of timely approvals for application from 79 percent to 90 percent by the end of 2014.
- b. Continue to develop strategies to recruit and retain quality staff through 2018.

- c. Continue to audit a statistically significant sample of client files to measure compliance through 2018.
- d. Continue to require supervisors to audit files and monitor compliance with policies and timelines through 2018.
- e. Use Lean activities and strategies to identify where areas of efficiency and effectiveness can be improved by June 2015.

Strategic Objective 3.5: Increase Access and Options for Participant Directed Models of Care.
Measures:

- a. Continue to provide the New Freedom waiver in Pierce and King Counties, explore expansion to an additional county in 2015 and another additional county in 2016.
- b. Continue to provide Veterans Directed Home Services to eligible veterans referred by VA Puget Sound Health Care System in four Area Agencies on Aging.
- c. Expand Veterans Directed Home Services to at least one additional geographic location and VA Medical Systems in Washington State.
- d. Conduct at least one education/training event each year to increase knowledge base of field and headquarters staff on participant directed philosophies and service delivery options
- e. Continue to train staff in supporting client self-direction through improved person centered planning and self-management models.
- f. Continue to disseminate Participant Directed DVD and related materials through 2018.
- g. Work with training partnership, SEIU 775 and providers to identify current providers who are interested in working for other LTC consumers and link them to the Home Care Referral registry.

Strategic Objective 3.6: Design and implement a Medicaid Community First Choice Option (CFCO-State Plan) program in a manner consistent with legislative direction.

Measures: Successfully meet benchmarks to develop and implement the Medicaid Community First Choice Option by July 2015 but not later than June 2016.

- a. Evaluate changes to current state plan and waivers and conduct CFCO benefit design forums through a federally-required development and implementation stakeholder process.
- b. Hire program staff to ensure adequate planning, development and implementation.
- c. Evaluate and implement necessary IT systems' changes for client care assessment, financial eligibility determination and provider payment.
- d. Issue public and tribal notices and promulgate new rules.
- e. Develop new payment codes, policies, manuals and training materials.

- f. Negotiate to gain final federal approval and submit final state plan and waiver amendments.
- g. Implement the Community First Choice Option and establish ongoing program support.

Strategic Objective 3.7 Continue to collect client and staff diversity data to better understand the administration's demographics annually in order to build a diverse workforce reflective of our client base.

Measures

- a. Establish a continual review of the Department's Research and Data Analysis Unit (RDA) staff and client demographics.
- b. Continue with development and review of new and current trainings and policies for cultural competence.
- c. Continue to develop strategies to reach ALTSA's Affirmative Action Goals in hiring people with disabilities and staff who are bilingual.

Goal 4: 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 4.1 Improve health outcomes for individuals with high medical risk factors through implementation of the Medicaid Health Home services.

Measures

- a. 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 2018.
- b. Collaborate with the Health Care Authority and Behavioral Health and Service Integration Administration/DSHS to address implementation issues related to consumer enrollment and engagement in Health Home services.
- c. 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.
- d. Participate in regional meetings to promote on-going communication and coordination between health home coordination between health home coordinator and LTC system.
- e. Make referrals to health homes services for clients that may be eligible for services.

Strategic Objective 4.2: Improve health outcomes, coordination of care and the individual's experience of care through implementation of the HealthPath Washington Integration demonstration project in Snohomish and King Counties.

Measures:

- a. Increase the number of individuals receiving coordinated services through Medicare and Medicaid. (Performance measures for the demonstration project are under development and subject to approval by the Centers for Medicare and Medicaid Services.) through 2018
- b. Collaborate and partner with other DSHS administrations to provide input and guidance toward implementation of the fully-capitated model through 2018.
- c. Determine policy, coordination, waiver authorities and communication strategies on how to incorporate long-term services and supports in the managed care model through 2018.
- d. Continue to work with King and Snohomish County Area Agencies on Aging and ALTSA field offices regarding planning and implementation through 2018.

Strategic Objective 4.3: 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 Stanford University Chronic Disease Self-Management Education (CDSME) programs in Washington State. Programs offered for CDSME include the Chronic Disease Self-Management Program, Tomando Control de su Salud, Diabetes Self-Management. Chronic Pain Self-Management Education and Better Choices/Better Health (online CDSMP).
- d. Continue to build sustainable local/regional infrastructure to deliver CDSME programs.
- e. Continue to provide technical assistance to licensed organizations and Area Agencies on Aging.
- f. Continue to partner with the Department of Health to engage community health workers and local health jurisdictions into local program delivery networks.
- g. Target special populations with health disparities including Native Americans and people with developmental disabilities.
- h. 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).

- i. Continue to develop & maintain cross systems (public and private) relationships for promoting improved dental health for HCBS participants, their caregivers and kinship caregivers.
- j. Develop and adapt performance measures for inclusion in Area Agencies on Aging contracts, as related to: improvements in client health status and wellness; reductions in avoidable high-cost services; increases in stable housing in the community; and improvements in client satisfaction with quality of life by July 2015.

Strategic Objective 4.4 Develop a Washington State Alzheimer’s Plan, in response to legislative direction in SSB 6124.

Measures:

- a. Meet benchmarks to develop and implement the requirements of SSB 6124.
- b. Produce a report providing the findings and recommendations of the Alzheimer’s’ Disease working group, including any draft legislation necessary to implement the recommendations to the governor and the health care committees of the Senate and the House of Representatives by January 1, 2016.

Strategic Objective 4.6 Improve food security by supporting older adults to increase their access to nutritious affordable food and increase healthy eating

Measures

- a. Explore strategies to at minimum maintain funding for senior nutrition programs at current levels through 2018.
- b. Continue to collaborate with AAA’s and Washington Association of Senior Nutrition Providers (WASNP) to implement innovative adaptations to senior congregate meal programs through 2018.
- c. Continue collaborative efforts to embed nutrition counseling, nutrition educations & home delivered meal supports in hospital discharge transitions, health home models through 2018.
- d. Maintain redemption of Senior Farmers Market Nutrition Program vouchers at a minimum 85% statewide average or higher through 2018.
- e. Continue to partner with Economic Services Administration, WASNP, and Anti-Hunger Coalition to promote focus on older adult food security issues through 2018.

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.

Appendix 1: End Notes

ⁱ ALTSA Strategic Plan June 2014

ⁱⁱ As defined by CDC health disparities are preventable differences in the burden of disease, injury, violence or opportunities to achieve optimal health that are experienced by socially disadvantaged populations* Populations can be defined by factors such as race or ethnicity , gender, education, or income, disability, geographic locations (e.g. rural or urban) or sexual orientation. Health disparities are inequitable and are directly related to the historical and current unequal distribution of social, political, economic, and environmental resources.

ⁱⁱⁱ American Indian Health Care Delivery Plan <http://www.doh.wa.gov/Portals/1/Documents/1200/phsd-AIHHealthCare.pdf>

^{iv} Outing Age: Public Policy Issues Affection Gay, Lesbian, Bisexual and Transgendered Elders, Grant Jamie, 2010

^v Services and Advocacy for Gay, Lesbian, Bisexual & Transgender Elders (SAGE) Rising to the Challenge on LGBT Aging

^{vi} 2009 AARP Report

^{vii} 2014 Long Term Supports and Services Score Card: [2014 AARP WA State Score Card](#)

^{viii} 2011 Congressional Research Service report on the OAA <http://www.gao.gov/assets/660/650451.pdf>

^{ix} Senior Hunger Research Executive Summary- Researchers James Ziliak and Craig Gunderson documented the state of hunger among senior Americans age 60 and older in 2011 using data from the Current Population Survey- in their report they concentrated on the category of food insecurity established by the USDA

^x *State of Senior Hunger in America 2012: An Annual Report*, conducted by Dr. James P. Ziliak and Dr. Craig G. Gunderson. Commissioned by NFESH and underwritten in part by the RGK Foundation, the report examines the extent and distribution of hunger threat among seniors in 2012.(released May 21 2014)

^{xi} Washington State University Home Care Aides Brief