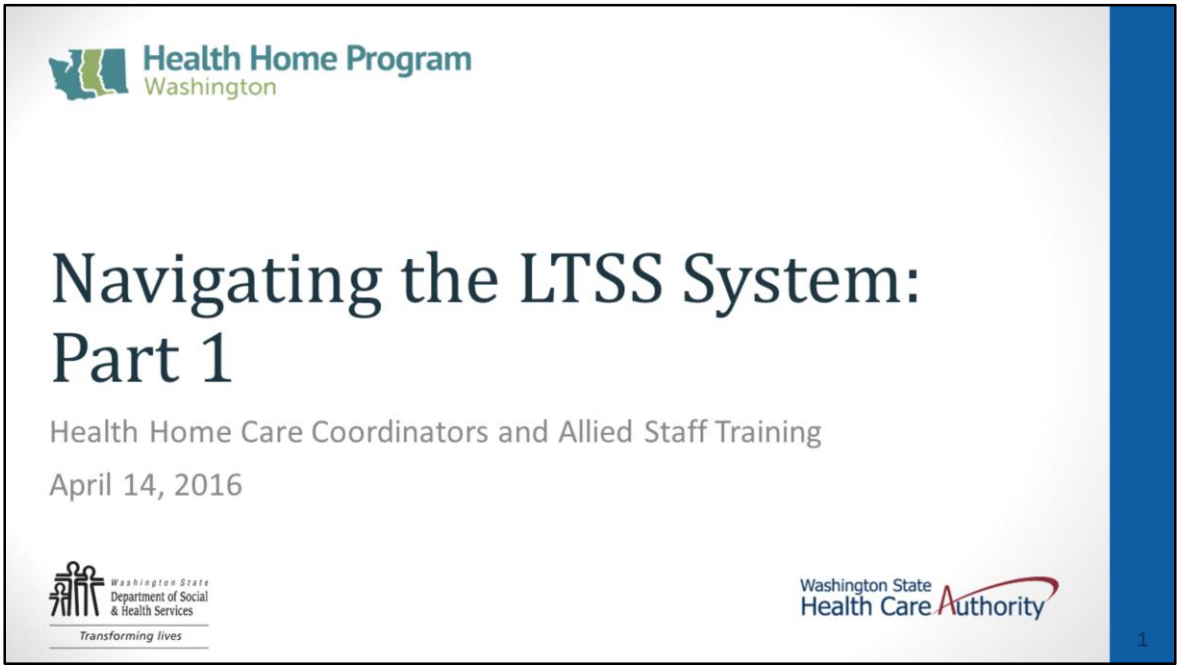

This presentation was provided as a Webinar for Health Home Care Coordinators which aired on April 14, 2016. Review of this PowerPoint presentation satisfies completion of this required special topic training for Health Home Care Coordinators.

This is part one of two Webinars on this topic.

Today's Presenters

- Ron Bryan
  - Developmental Disabilities Administration
  - Program Manager
- Jacqueine Echols, M.Ed.
  - Home and Community Services
  - Program Manager
- Tracey Rollins, MA
  - Home and Community Services
  - Program Manager

Training Objectives

- Introduce DSHS programs for Developmentally Disabled clients
- Introduce DSHS Home and Community Services programs for disabled and older adults

3

Developmental Disabilities Administration

The agency and its programs and benefits

4

Developmental Disabilities Administration

Vision	Mission	Values
Inclusion Continual Improvement Individualized Supports Engaging individuals, families, and stakeholders	*"To transform lives by providing supports and fostering partnerships that empower people to live the lives they want."*	Respect Person-Centered Planning Partnerships Community Participation Innovation

5

VISION: We Envision:

- Supporting individuals to live in, contribute to, and participate in their communities.
- Continually improving supports to families of both children and adults;
- Individualizing supports that will empower individuals with developmental disabilities to realize their greatest potential;
- Building support plans based on the needs and the strengths of the individual and the family;
- Engaging individuals, families, local service providers, communities, governmental partners and other stakeholders to continually improve our system of supports.

MISSION

To transform lives by providing support and fostering partnerships that empower people to live the lives they want.

VALUES

- Respect gained through positive recognition of the importance of all individuals;
- Person-Centered Planning to support each person to reach his or her full potential;
- Partnerships between DDA and clients, families, and providers in order to develop, and sustain supports and services that are needed and desired;
- Community participation by empowering individuals with developmental disabilities to be part of the workforce contributing members of society; and
- Innovation to create services and supports that meet the needs of those individuals DDA serves.

Developmental Disabilities Administration

Our Purpose

To make a positive difference in the lives of people, who are eligible for services, by providing supports and services that are:

- Individual and Family Driven
- Stable and Flexible
- Satisfying to the Individual and Family
- Individualized to Meet Needs
- Persistent Across the Life Span

6

Individual and Family Supports that are offered in the family home to meet respite and other critical needs such as therapies, minor home modifications, etc.
The Individual and Family Services (IFS) Program is a state-only funded program of the DDA that provides over 1,800 individuals and their families with a variety of services to help support the DDA eligible family member to be able to remain living in the family home.

Employment and Community Access services to increase the independence, self-respect and dignity of individuals with developmental disabilities.
Employment and Community Access services offer all persons with intellectual and developmental disabilities the ability to fully participate in society. They provide access to employment and other community activities, a path out of poverty and increased independence from social service systems. DDA currently provides employment and day supports to over 7,000 individuals.

Residential Services that include community homes for children and adults as well as residential habilitation centers.
Community residential services provide housing and support services to individuals with intellectual and developmental disabilities who need support services to be able to live in and fully participate in the community. Supports range from a few hours a week to 24 hours a day. DDA currently provides residential supports to almost 6,000 individuals who live in their own homes, Adult Family Homes (AFH) or State Operated Living Alternatives (SOLAs).

Medicaid/Waiver Personal Care Services provide in-home assistance with activities of daily living.
Personal Care services are Medicaid covered services that provide in-home supports for physical and verbal assistance with Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) to over 12,000 individuals. ADL tasks include supports for bathing, bed mobility, body or foot care, dressing, eating, locomotion in room, locomotion outside of room, medication management, personal hygiene, transfers, toileting and walking in room. IADL tasks include supports for meal preparation, transportation to medical appointments, essential shopping, wood supply, and housework.

Supporting Families

- **Families** are the primary caregivers throughout the entire life span for people with developmental disabilities.
- Approximately 27,158 of our 40,166 clients reside with their family.
- We support families by providing respite, therapies, community guides, personal agents, and information and education to help families remain as primary care givers.

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People with developmental disabilities and their families are valued citizens. Programs administered by the Developmental Disabilities Administration (DDA) are designed to assist individuals with developmental disabilities and their families to obtain services and supports based on individual preferences, capabilities, and needs.

Supporting Families

Resources Include…

- Parent to Parent
- Parent Coalitions
- Father's Network
- ARC Chapters
- People First Chapters
- County Programs
- Schools
- Natural Supports
- Self-Advocates of Washington
- Parents are Vital in Education

Who Are Our Service Partners and Stakeholders?

Counties

- Early Childhood services
- Employment and Day Programs

Arc (state and locals)

Autism Society of Washington

Developmental Disabilities Council

- Informing Families Building Trust

Disability Rights Washington

Father's Network

Parent to Parent Support Programs

Parent Coalitions

Self Advocacy Organizations

Who Might Be Eligible for Services?

Who do we serve?

"Developmental disability" means a disability attributable to

- **Intellectual disability**
- **Cerebral palsy**
- **Epilepsy**
- **Autism**
- **or other condition closely related to an intellectual disability**
- **which originates before age eighteen, expected to continue indefinitely, and which constitutes a substantial limitation to the individual.**

RCW 71A.10.020

WAC Chapter 388-823

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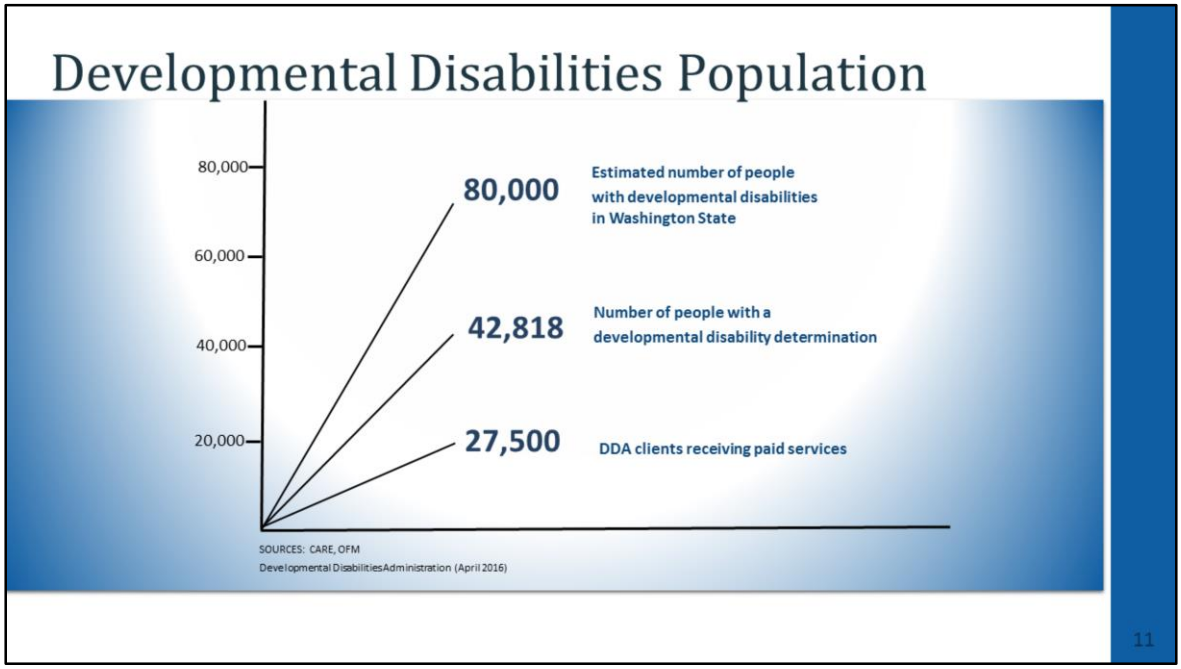
Developmental Disabilities Administration serves individuals who have a developmental disability. We do not diagnose, but we rely on documentation of diagnoses from qualified health care professionals, as defined in our rules. A developmental disability is defined in law in RCW 71A.1.020. Eligibility rules are detailed in Chapter 388-823 WAC.

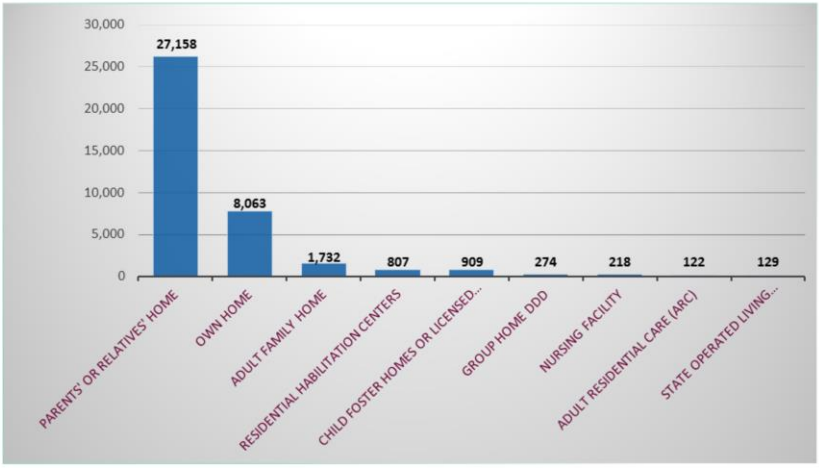


There are estimated to be over 80,000 individuals in the State of Washington who would meet the eligibility criteria defined in RCW and WAC.

As of April 2016, nearly 43,000 eligible individuals

Approximately 27,500 of those have some kind of a paid service.

Where Do Our Clients Live?



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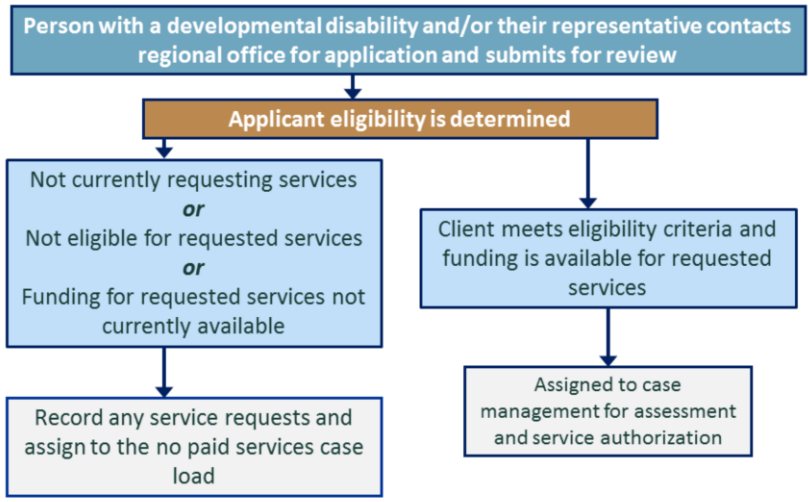
Data from Master Query 12/31/2013

How Does Someone Access Services?



Do All Eligible Individuals Receive Paid Services?

- Not all services are entitlements.
- Services are available based on funding.
- Some people do not ask for services.
- Services are prioritized for those who are in crisis and/or who qualify for entitlements.
- Families are heavily relied upon to provide supports.

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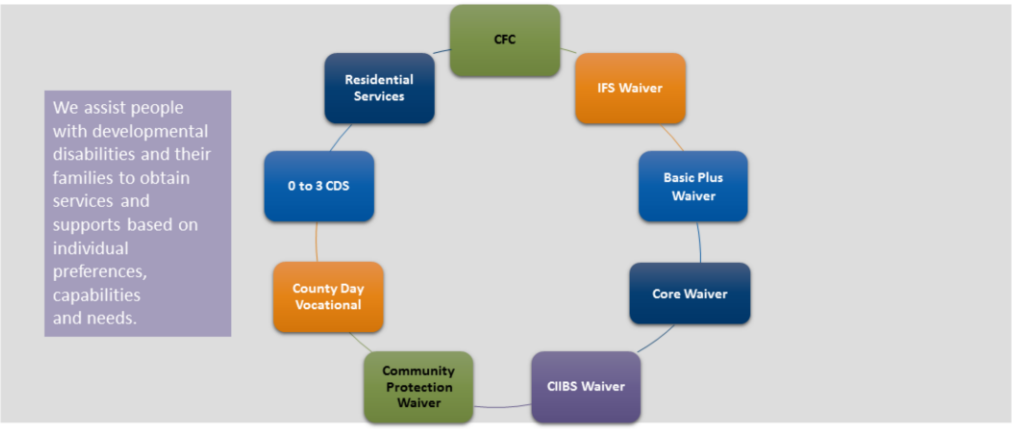
Data DDD Assessment Activity Report November 2013

DDA's Major Programs



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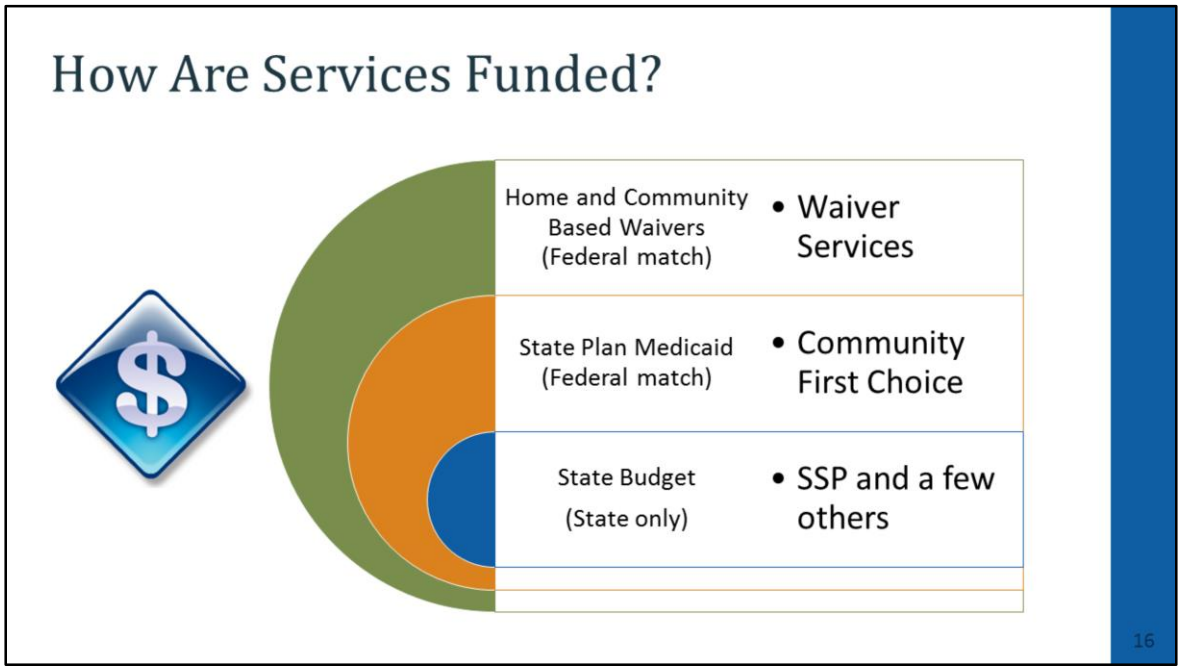
CFC – Community First Choice. Individuals can receive personal care and other services available through this program. This program pays for an in-home caregiver, or adult family home.
IFS Waiver – Individual and Family Services – this is a budget based waiver with a flexible menu of service options. The person and their case manager put together a plan for which services would be beneficial.
Basic Plus waiver – this standard waiver provides services that help a person live more independently in their own home. It provides respite, environmental modifications, equipment and therapies, and other services.
Core Waiver – the primary service through this waiver is supported living. It provides habilitative care in an individual's own home or in shared settings. Services and supports help a person develop and maintain independent living skills. Provides everything from weekly
CIIBS – Children's in-home intensive behavior support waiver – this is a specialized waiver that provides services and supports, such as specialized respite, and behavior management services to help children with challenging behaviors remain in the family home.
Community Protection waiver – theses specialized waiver is for individuals who have committed or at high risk of committing sexual offenses or other offenses which are dangerous to the public. The program provides a structured living environment, supervision, and therapies to help keep the public and the individual safe, and to manage or eliminate the risk.
County Day and Vocational programs – these programs, available in B+, Core, and CP waiver, or as a state funded service, for ages 21 – 62, are to help a person develop employment skills, find, and retain gainful employment.
Birth to Three Child Developmental Services – for children with developmental delays, they can access this service with specialized educational and therapy opportunities to help them catch up to their peers.
Residential Services – like supported living in the Core waiver, there are a variety of services in various residential settings which meet the unique needs of the individual.



- **Our programs are funded with a mix of state and federal monies.**
- **Waivers – the state receives matching federal funds to provide these programs and services**
- **CFC – our state plan Medicaid service, state and matching federal funds.**
- **State funds, allocated by the legislature, pay for some services with no matching federal funds. SSP – state supplemental payment is a supplemental SSI payment which a person can use to pay for their own services.**
- **Others include small case loads of residential/supported living, vocational, and person care.**

Who Are Our Employees?

Case Resource Managers and Social Workers:

- Determine eligibility
- Complete assessments
- Authorize services

Management, program managers, supervisors and support staff:

- Administer Programs
- Develop Policy and Rules
- Provide Quality Assurance

What is the Case Management Role?

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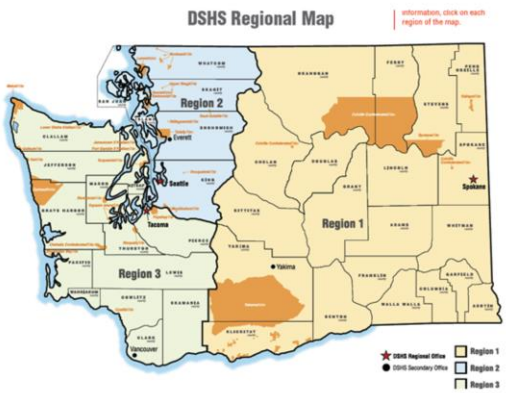
Over 26,000 individuals receive services from the DDA annually. Case management is a service that promotes collaboration for assessments, service determination and individual support planning. Case Resource Managers also coordinate, authorize, monitor and evaluate the effectiveness of services available to address an individual's identified health and welfare needs.

Contact Information



Region 1 (Spokane)
509-329-2900

Region 2 (Seattle)
206-568-5700

Region 3 (Tacoma)
253-404-5500

DDA Headquarters (Lacey)
360-725-3413

For complete contact information, please see:
https://www.dshs.wa.gov/DDA/dda/find-an-office#

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The contact information for each of the main regional offices is listed here. For contact information for each of our 33 field service stations, please see this link.

Questions?

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360-725-2517

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Office Chief

Compliance, Training and Monitoring

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Or visit

https://www.dshs.wa.gov/dda/

Home and Community Services

Programs, services and benefits

Waivers Comparison Chart

ALTSA and DDA Service Comparison Chart
1915(c) Waivers vs. State Plan Programs
Effective July 1, 2015

	DDA 1915c Waivers					ALTSA (HCS) Waivers		State Plan Programs		Grant		State Funds
	BASIC PLUS	CORE	CP	CIIBS	IFS	COPES	RESIDENTIAL SUPPORT WVR	1915k option CFC (DDA & HCS)	MPC (DDA & HCS)	Roads to Community Living (RCL) HCS	Roads to Community Living (RCL) DDA	HCS Washington Roads
Adult Day Care						X				X		
Adult Day Health						X				X		
Adult Family Home Specialized Behavior Support Service							X					
Assistive Technology				X	X			X		X	X	X
Behavior Support & Consultation	X	X	X	X	X					X	X	X
Behavioral Health Crisis Diversion Bed Services	X	X	X	X							X	
Behavioral Health Stabilization Services	X	X	X	X	X					X	X	X
Caregiver Management Training[4]						X	X	X	X	X	X	X
Client Support Training							X					
Client Support Training/Wellness Education						X						
Community Access	X	X									X	
Community Engagement					X							
Community Guide	X	X								X (CCG)	X	X (CCG)
Community Transition			X					X		X	X	X
Emergency Assistance	X											X (RENTONLY)
Enhanced Residential Services							X					
Environmental Modifications	X	X	X	X	X	X				X	X	X
Home Delivered Meals						X				X		

Revised March 2016

What Is a State Plan?

- Describes
  - ✓ Who is eligible
  - ✓ What is offered (amount, duration, scope)
  - ✓ What are the provider qualifications
  - ✓ How the state sets payment rates and makes payment

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It is our agreement that we will adhere to the requirements of the Social Security Act and the official issuances of the Department of Health & Human Services (DHHS).

A CMS approved state plan is required under Section 1902 of the Social Security Act in order to provide Medicaid funded services.

Once someone is determined eligible for state plan services we must deliver those services.

Additional Information

- A State Plan
  - ✓ Includes services required of every state
  - ✓ Includes optional services offered by the state
  - ✓ Must offer services statewide
  - ✓ Cannot use capacity limits
  - ✓ Contains the state's priority programs
    - Must be used before using waiver services

Community First Choice (CFC)

WAC 388-106- 0270 through 0295

Community First Choice

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CFC became effective in Washington on July 1, 2015.

Community First Choice (CFC)

- 1915(k) State Plan Option program
- Priority Program
- Higher Medicaid match at 56%
- Community based care is cornerstone of program

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CFC is a 1915 (k) State Plan program and is the priority program for all recipients.
CFC has a 56% match, which is a higher match than our other programs; MPC 50%, COPES 50%.
Community based care is preferable to many of our clients and is the cornerstone for CFC.

Who is Eligible for CFC?

A client who meets:

- Nursing Facility Level of Care (NFLOC)
- Categorically Needy (CN) or Alternative Benefit Plan (ABP) financial eligibility

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To be functionally eligible for CFC, clients must meet NFLOC; which is outlined in the WAC listed.
To be financially eligible for CFC, clients must meet CN or ABP eligibility criteria. MAGI, SSI, or Waiver eligible
Refer to handout – Doorway illustration

Explain Nursing Facility LOC

CFC Services cont.

- Personal Care
- Skills Acquisition Training (SAT)
- Backup Systems
  - Personal Emergency Response Systems (PERS)
  - Relief Care
- Caregiver Management Training

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CMS requires that we provide four key services to be able to provide CFC:

- Personal Care
- Skills Acquisition Training
- Back-up Systems
  - PERS
  - Relief Care
- Caregiver Management Training

CFC Services cont.

- Assistive Technology (AT)
- Community Transition Services

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We had the option to provide and chose to provide a benefit for assistive technology and community transition services.
Assistive Technology is not a benefit that includes medical equipment or supplies, it is meant to provide other technology that is not normally available in our programs.
Community Transition Services are meant to help relocate clients from institutional settings to home and community based settings.

CFC Services cont.

Annual Limit:

- May be used for SAT and/or AT purchases
- For 2015-2016, it is $500 per fiscal year
  - Fiscal year = July 1 through June 30
  - May not be carried over or saved up between years
  - New $500 is not given at significant change or annual assessments, only every July 1
  - Is not pro-rated

30

Each client has $500 per year to spend on:

- Assistive Technology
- Skills Acquisition Training

This limit is tied to the fiscal year of July 1 through June 30 and resets each July 1 for all clients.

Changes may occur after July 1- will let the field know-

A Closer Look

CFC Monthly Services:

- Clients may allocate CARE* generated hours toward:
  - Personal Care,
  - Skills Acquisition or
  - Relief care
- They can change the allocation any time
  - The authorization will need to be updated when changes are made
  - A new Planned Action Notice is not required when changes are made

*Comprehensive Assessment Report and Evaluation assessment

31

Clients have a choice as to how they use their CARE generated hours. They can divide them in any way they choose between personal care, skills acquisition, and relief care. Because of the language in the PAN, as clients change the use of their hours, a new PAN is not required. It is only required when the number of monthly service hours changes; as when a new assessment is completed.

A Closer Look cont.

Skills Acquisition Training:

- Individual Providers, Agency Providers, and SL providers are limited and may only provide SAT for the following:
  - Cooking and preparing meals
  - Shopping
  - Housekeeping and laundry
  - Limited personal hygiene tasks:
    - Dressing, applying deodorant, applying make up, brushing teeth/dentures, shaving with an electric razor, brushing/styling hair, menses care
    - Washing hands, face, hair, bathing (except transfer)

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Client may use CARE hours or the annual limit
SAT is teaching the client to do a task (an ADL) instead of doing it for the client
When using an IP, AP or Supported Living provider, there are limitations on what they can do.
The client may choose to use some of their CARE monthly service hours to get skills acquisition training.
The client may also choose to use all or part of their $500 annual limit to get skills acquisition training.
If a client uses their $500 annual limit for an AP, IP, or SL Provider, a deduction of $20.17 per hour is made from the annual limit. The provider is paid at their usual rate, this rate is only used to reduce their $500 annual limit.

Client can have up to 24.6 hours (20.17/hr)

A Closer Look cont.

Skills Acquisition Training:

- Home Health Agencies
  - Any Activity of Daily Living
  - Any Independent Activity of Daily Living
  - Any health related task

- May not trade CARE hours, must use annual limit
- Charged to the annual limit at the provider's actual paid amount
- All other payer sources must be exhausted first

33

Home health agencies hire licensed, skilled providers and have no restrictions on what they can do.
The client does not have the option to use their CARE monthly service hours when using a home health agency provider; they must use their $500 annual limit to pay for these provider types. The $500 limit is reduced by the actual billed rate of these providers so make sure to track what is being used carefully.

Agencies charge between $60-$100/hr adding up to about 5 hours a year. Encourage clients to use other insurances first. May be a good final resource.

A Closer Look cont.

Assistive Technology:

- Requires recommendation from a health care professional
- Technology items that increase independence or substitute for human assistance
  - Braille watch
  - Motion sensing equipment
  - PERS add-ons

A Closer Look cont.

Assistive Technology:

- Covered Items List
- SES/AT Vendors List

35

Before a CM can purchase the recommended item for the client, it must be on the covered items list

The SES/AT Vendor List- shows all providers with a contract to provide items

If you do not see an item on the contractors item you can call the contracted provider or call CFC PM.

A Closer Look cont.

Community Transition Services :

- Roads to Community Living is always the priority program
- Client must be discharging from a nursing facility or a state hospital (i.e. ESH/WSH)
- Limit: $850/discharge

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Check the long-term care manual for details. This is a scaled down version of RCL, however it focuses more on items than services. CCGs are not allowed with community transition services, but you can use shoppers (individual transition service providers ITSP) these providers are primarily used as a “payment pass through” or shoppers

Note: $850 limit can be increased with an approved ALTSA Headquarters Exception To Rule (ETR).

Medicaid Personal Care (MPC)

WAC 388-106- 0200 through 0235

Who Is Eligible For MPC?

A client who:

- Does not meet NFLOC
- Has been determined functionally eligible per CARE
- Categorically Needy (CN) scope of care OR
- Alternative Benefit Plan (ABP) scope of care

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Financial workers will determine that the client is CN. Health Benefit Exchange determines MAGI-based N track eligibility

"Categorically Needy" Scope of Care (Not Medically Needy, AEM, etc.). Includes all MAGI N track coverage groups except N05

"**Alternative Benefit Plan**" Scope of Care (MAGI - Adult N05 group)

"Non-Institutional Categorically Needy" Any Medicaid program except those that use eligibility rules for Nursing Home and Waivers, which have higher income and resource rules. (SSI, HWD, etc.)

What Services Are Available In MPC?

- Personal Care is the primary service
- Nurse Delegation on an as needed basis
  - Nurse Delegation allows RNs to delegate certain tasks to certain types of paid caregivers under the instruction and supervision on an RN

What Is a Waiver?

A federal program allowing states to *waive* state plan Medicaid rules in order to provide services outside an institutional setting:

- ✓ Income and Resources (financial eligibility)
- ✓ Comparability (targeting a specific population)
- ✓ Statewideness (targeting a specific geographic area)

Community Options Program Entry System (COPES)

WAC 388-106- 0300 through 0335

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COPES is an example of a 1915c waiver.

Who Is Eligible For COPES Services?

A client who:

- Is age 18 or older & blind or has a disability; or
- Is age 65 or older;
- Meets Nursing Facility Level Of Care as determined by CARE;
- Has needs that exceed the scope of CFC and MPC; and
- Is financially eligible.

Functional and financial eligibility is completed concurrently to ensure timely access to services!

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Functional eligibility for COPES equals Nursing Facility Level of Care. Nursing Facility Level of Care is a higher standard of need than MPC level of care.

The client's needs have to exceed the scope of what MPC and CFC can provide.

What Services Are Available?

- Home Delivered Meals
- Skilled Nursing
- Home Health Aide
- Transportation
- Client Support Training/Wellness Education
- Environmental Modifications
- Specialized Medical Equipment
- Adult Day Care & Adult Day Health

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HDM: In-home clients who are homebound, live alone w/o CG to prepare meal
Skilled nursing examples: Chronic wound care for a client living in home/AFH; Bowel program if unable to self-direct; Catheter change once a month (in home/AFH), client cannot self-direct and does not have a family member to provide it.
Home Health Aide WAC: 182-551-2120; Examples - Client has special needs requiring more specialized care than can be provided by an agency or IP such as bathing assistance for very frail persons or complex bowel and bladder care for persons with paralysis.
Transportation: to therapeutic goal; doesn't replace Medicaid Broker transportation service
CST/WE: need identified in professional eval; meets therapeutic need; targeted to clt's clinical characteristics and health/wellness goals
Env. Mods: ensure H&S; increase independence direct benefit medically
SME: needed to increase independence with ADLs; medical/remedial benefit

Where Can Services Be Received?

- Own home
- Adult Family Home - AFH
- Adult Residential Center - ARC
- Enhanced Adult Residential Center - EARC
- Assisted Living – AL

What Services Are Not Allowed?

- Child Care
- Services provided over the phone
- Services to other household members
- Community living skill development
- Skilled Nursing Care
- Pet Care
- Managing Finances
- Respite
- Yard Care

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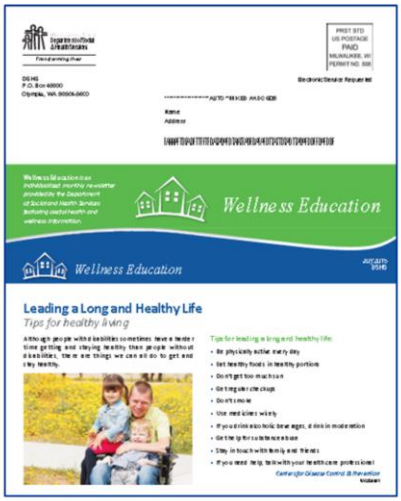
Per WAC 388-106-0020

Post Webinar Discussion

1. Do you have clients on your caseload who receive Long Term Services and Supports (LTSS) either through DDA or HCS?
2. Have you held care conferences with case managers, social workers, case resource managers or nurses from DSHS or your local Area On Aging?
3. Have any clients reported receiving their individualized Wellness Education newsletter ?
4. Have you considered reviewing the newsletter to provide health promotion and education, one of the six Health Home services?
5. Do you have any clients who are taking advantage of some of the additional CFC benefits such as the Skills Acquisition Training?



Health Home Program
Washington

Certificate of Completion

Long Term Services and Supports: Part 1

presented by Ron Bryan, Jacquiene Echols and Tracey Rollins
Department of Social and Health Services
Lacey, Washington

Webinar aired on: April 14, 2016 in Lacey, Washington
for Health Home Care Coordinators and Allied Staff

Training Credit of 1 Hour

Please sign and date to attest that you reviewed this webinar PowerPoint

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Washington State Department of Social & Health Services
Transforming lives

Washington State Health Care Authority

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