

**Developmental Disabilities Strategies for the Future**  
Long-Range Plan

**Phase 3: Final Report**

**December 1, 2002**

Planning for the  
Services and Supports  
Needed by People with  
Developmental Disabilities  
And Their Families in  
Washington State – RCW 71A.12.170

Department of Social and Health Services  
*Dennis Braddock, Secretary*

Aging and Disability Services Administration  
*Kathy Leitch, Assistant Secretary*

Division of Developmental Disabilities  
*Linda Rolfe, Director*



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## ***Acknowledgments***

The Division of Developmental Disabilities (DDD) acknowledges the contributions of the Developmental Disabilities Strategies for the Future Stakeholder Workgroup (SWG) in the preparation of the Phase 3 Final Report.

Many members of the Stakeholder Workgroup have been working in conjunction with DDD since June 1997. They have participated in countless hours of issue discussion, mediation, review, and consensus building. Members of the SWG are individuals associated with various organizations and individuals representing the developmental disabilities community. Without their perseverance and leadership, this planning effort would not have been completed.

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Greg Devereux	WA Federation of State Employees	Olympia	1997-2000
Richard Duncan	WA Federation of State Employees	Bremerton	Member since 2000
Sue Elliott	Arc of Washington State; former DDD Director	Olympia	Member since 1997
Tom Gaulke	Horizon of Sunnyside	Yakima	2000-2002
Darnell Hood	Self-Advocate	Tacoma	Member since 1999
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Ginger Kwan	Ethnic Outreach Services; Arc of King County; Parent	Seattle	Member since 2001
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Steve Start	S.L. Start and Associates	Spokane	1997-2001
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The Stakeholder Workgroup and the division give special thanks and appreciation to Bill Lincoln and Polly Davis of National Center Associates, Inc. Their skill in mediation and consensus building kept the group together and productive through all three phases of the planning effort.

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## EXECUTIVE SUMMARY

The Developmental Disabilities Strategies for the Future Stakeholder Workgroup, also referred to as The Stakeholder Workgroup (SWG) was appointed by the secretary of DSHS in 1997 to reach agreement on a plan for future needs of people with developmental disabilities in Washington State.

In December 1997, the Stakeholder Workgroup achieved an “Agreement in Principle” that established “choice and self-determination” as the foundation for restructuring services and supports. The goal of the agreement was to support an individual/family centered approach with an emphasis on quality, access, responsiveness, efficient utilization of resources, and accountability.

Based on its five years of work, the Stakeholder Workgroup makes the following recommendation - recommendations that are at the very heart of the efforts to implement an individual and family-centered support system.

### **1. Stabilize the developmental disabilities system.**

- ◆ Provide services to eligible citizens with unmet health and welfare needs
- ◆ Enhance case management services to acceptable levels
- ◆ Improve quality and accountability
- ◆ Increase wages of direct care staff for provider stabilization
- ◆ Augment administrative infrastructure to achieve credibility and accountability

### **2. Implement system changes that encourage self-directed services.**

### **3. Enact legislation that includes the following concepts:**

- ◆ A needs-based continuum of supports for families to enable the person with developmental disabilities to live at home
- ◆ A choice-based safety net of residential options for children and adults whose needs are of such intensity that families cannot manage even with supports in place at home
- ◆ A recognition that when the family caregiver(s) reaches age 60 or beyond, there should be an alternative residential option available

### **4. Use SWG work on *The Future of the RHCs* as the basis for developing policy for future use of Residential Habilitation Centers (RHCs). (See Appendix C, Section 1, page 31.)**

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At the direction of the legislature, the Strategies for the Future Stakeholder Workgroup submitted three reports, covering three biennia. The three reports are not stand-alone documents, nor do they provide step-by-step instructions for the future. Taken together, the reports provide important information for those responsible for making budget and policy decisions regarding future developmental disabilities services in Washington State.

**The Phase 1 Report (December 1998)** identified unmet needs in five major areas:

- ◆ Services - \$170.9 M (GF-S)
- ◆ Case Management - \$28.7 M (GF-S)
- ◆ Quality and Accountability - \$5.6 M (GF-S)
- ◆ Provider Stabilization- \$56.2 M (GF-S)
- ◆ Administrative Infrastructure - \$1.7 M (GF-S)

**The Phase 2 Report (December 2000)** was developed from the work of over 100 additional stakeholders who were asked to make recommendations for improvements or activities in four areas. Their work included recommendations about how to restructure the system to implement choice and self-determination (self-directed services) through an individual and family-centered approach.

**The Phase 3 Report (December 2002)** makes recommendations on the implementation of self-directed services and on the respective roles of RHCs and community support services. The department has tested some elements of self-determination with people who are moving out of institutions. Counties have explored development of personal agents. The department is also in the process of implementing the State Supplementary Payment (SSP) program that provides cash grants for services.

While all of these elements have merit in learning about client self-direction, much work is still ahead. A definitive description of how the system should be restructured demands a more comprehensive study. In the future, the department will continue to build upon the work of the Stakeholder Workgroup by implementing agreed-to recommendations and by continuing to move toward a system of self-directed supports and services.

The Developmental Disabilities Stakeholder Workgroup appreciates the importance the legislature has placed upon the needs of people with developmental disabilities and looks forward to working with the legislature to provide for Washington State's most vulnerable citizens in a way that best meets the challenges and problems they face each day.

## CHAPTER 1

### Introduction and Background

The Developmental Disabilities Strategies for the Future Stakeholder Workgroup, also referred to as The Stakeholder Workgroup (SWG), was appointed by the secretary of DSHS in 1997 to reach agreement on a plan for the future needs of people with developmental disabilities in the state of Washington.

In December 1997, the Stakeholder Workgroup achieved an Agreement in Principle that established “choice and self-determination” as the foundation for restructuring services and supports. The goal of the agreement was to give individuals and their families or guardians more control of public resources available to meet their needs.

Subsequently, the legislature put its commitment into current law. Chapter 216, Laws of 1998 was codified in Title 71A RCW.

*RCW 71A.12.180 - The developmental disabilities stakeholder workgroup is the division of developmental disabilities strategies for the future stakeholder workgroup established by the secretary in 1997 to develop recommendations on future directions and strategies for service delivery improvement, resulting in an agreement on the directions the department should follow in considering the respective roles of the residential habilitation centers and community support services, including a focus on the resources for people in need of services. (Expires June 30, 2003)*

The Developmental Disabilities Strategies for the Future Stakeholder Workgroup was directed to submit three reports, covering three biennia.

The three reports are not stand-alone documents, nor do they provide step-by-step instructions for the future. The reports, taken together, provide important information for policy makers in determining the future of developmental disabilities services in Washington State.

**The Phase 1 Report (December 1998)** identified unmet needs in five major areas:

1. Services \$170.9 Million (GF-S)
2. Case Management \$ 28.7 Million (GF-S)
3. Quality and Accountability \$ 5.6 Million (GF-S)
4. Provider Stabilization \$ 56.2 Million (GF-S)
5. Administrative Infrastructure \$ 1.7 Million (GF-S)

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**The Phase 2 Report (December 2000)** was developed from the work of over 100 additional stakeholders who were asked to make recommendations for improvements in four areas. Three of the areas related to current services. These included Residential, Employment and Day Programs, and Individual and Family Supports. The fourth area, Choice and Self Determination, included recommendations about how to restructure the system to support an individual and family centered approach.

The Phase 2 Report set the stage for Phase 3 by describing Phase 3 as providing detail on “what is needed to implement a system based upon choice and self determination” and “to make recommendations on the respective roles of Residential Habilitation Centers (RHCs) and community support services.” (*Strategies for the Future, Phase 2 Report*, page 4.)

**While the Phase 3 Report (December 2002)** makes recommendations on the respective roles of RHCs and community support services, it does not explicitly describe what is needed to implement self-directed services. Funding proposed to “pilot” self-directed services in FY00 and FY01 was not provided.

The division has pursued some elements of self-determination in support of people moving from institutions. Counties have explored the development of personal agents. The division is also implementing the portion of the State Supplementary Payment (SSP) program assigned in the 2002 Supplemental Budget.<sup>1</sup> While all of these elements have merit in learning about client self-direction, much work is still ahead. A definitive description of how the system should be restructured demands a more comprehensive review both of client caseload numbers and of services provided.

During the past eighteen months, the division has undergone several major reviews. These include a federal review of the DD Home and Community Based Waiver by the Center for Medicare and Medicaid Services, a review by the Joint Legislative Audit and Review Committee on case management and client caseload numbers, and a review by Sterling and Associates on internal business practices. As a result of the reviews a corrective action plan has been implemented by the division and is included as Appendix E. In addition, on October 1, 2002, the department announced the creation of a Disabilities and Long Term Care Administration that joins Developmental Disabilities and Aging and Adult Services into one administration. These reviews and next biennium’s projected revenue shortfall ultimately affected the content of the Phase 3 Report.

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<sup>1</sup> For more information see the Program Descriptions in Appendix A, Pages 12-15.

## CHAPTER 2

### Policy Issues and Recommendations

Over the last several years, the Stakeholder Workgroup has made major recommendations regarding changes and improvements in developmental disabilities services. Of primary importance is the recommendation for the design and maintenance of a single comprehensive system of individual and family supports, based upon choice and self-determination. Stakeholders are adamant that self-advocates and families be recognized as a part of the decision-making processes for service design and delivery for people with developmental disabilities. For the vast majority of people, families are the primary caregivers. The support they offer cannot be replicated without huge expense. If the system is to continue to rely on natural supports that families deliver, it is critical that their support needs be addressed.

Based on these recommendations, the secretary of DSHS developed a developmental disabilities services policy statement. The policy statement makes the following recommendations:

- A needs-based continuum of supports for families to enable the person with developmental disabilities to live at home
- A choice-based safety net of residential options for children and adults whose needs are of such intensity that families cannot manage even with supports in place
- An understanding that when the family caregiver(s) reaches age 60 or beyond, there will be an alternative residential option available

The policy statement, attached as Appendix D, is the basis for changes the department will propose to Chapter 71A that governs developmental disabilities services. The changes establish policy direction, incorporate many stakeholder recommendations, and include proposals for revisions to current law to clarify expectations and responsibilities of developmental disabilities services. The policy statement recognizes families as primary caregivers in this state and acknowledges their importance in that role through a clear, transparent continuum of services. The proposed changes to Chapter 71A include the concepts of self-directed services, individual budgets, and person-centered planning.

The Stakeholder Workgroup did not make recommendations regarding early intervention services for infants and toddlers (birth to 3 years of age). However, in its commitment to helping families in this area, the department will request a policy discussion with respect to those services. The stakeholders did accept recommendations of a Birth to Three Workgroup on the viability of having infants and toddlers and their families as part of a self-directed system. They also recommended

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there be adequate resources for early intervention services for all infants and toddlers with developmental delays. (See Appendix C, Section 2, pages 36-39.)

The stakeholders recommended the department take the lead on high school transition services and be given the authority to bring together the various entities responsible for facilitating transition from school to adult employment and community. One specific stakeholder recommendation is that coordination of transition services for all eligible youth begins as early as age fourteen. The policy statement recommends there be a focus on successful post-school employment during the critical transition years of 18-21. This requires purposeful collaboration among the department's Division of Developmental Disabilities and Division of Vocational Rehabilitation, the counties, and the Office of the Superintendent of Public Instruction.

Looking at the system as a whole, the department further recommends a policy be developed and implemented for use of Residential Habilitation Centers (RHCs) to include a rationale for the number of beds and the number of RHCs.

The Stakeholders reached consensus on the Future Role of the RHCs described in Appendix C, Section 1, pages 31-35. The agreement includes eight recommendations related to the RHCs. The fifth recommendation outlines "factors/criteria to be used in considering and/or determining possible consolidation or closure." These include the effect of change on residents of the RHCs, unique factors, programs and services available only at the RHCs, equal or better alternatives for residents and staff when relocated, a review of eligibility, and economic feasibility.

Finally, in addition to the recommendation on RHCs, there are four additional recommendations where the Stakeholder Workgroup achieved consensus over the last two years. These recommendations and the RHC recommendation were submitted to the department for further consideration. They include the following:

1. Respite providers for both children and adults must be available in the community as well as the RHCs.
2. Comprehensive and credible assessment tools should be developed to determine levels of need.
3. Public dollars should support all needed services for those with developmental disabilities, once need can be credibly established.
4. Responsive services, based on informed choice, must be available to people with developmental disabilities as they age.

It should be noted that the Stakeholder Workgroup made other policy recommendations in *The Strategies for the Future Reports, Phases 1 and 2*. A summary of those recommendations and the department's action is included in Appendix C, pages 21-30.

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**CHAPTER 3**  
**Funding Resources**

The following table reflects funding provided by the legislature from Fiscal Year 1998 through Fiscal Year 2003 for the five categories referenced in the *Strategies for the Future Long-Range Plan Report Phase 1*, page 26.

	<b>Total Net Gains FY 98 – FY 03</b>
<b>1. Services</b>	<b>\$37.9 Million (\$20 M GF-S)</b>
<b>2. Case Management</b>	<b>\$3.7 Million (\$2.5 M GF-S) 61 FTEs</b>
<b>3. Service Quality/Accountability</b>	<b>\$345,000 (\$220,000 GF-S) 1.5 FTEs</b>
<b>4. Community Provider Stabilization</b>	<b>\$49.1 Million (\$28.3 M GF-S)</b>
<b>5. Administrative Supports</b>	<b>\$460,000 (\$261,000 GF-S)</b>
<b>Combined Total</b>	<b>\$91.1 Million (\$50.9 M GF-S) 62.5 FTEs</b>

## CHAPTER 4

### Conclusions and Final Recommendations

This report is the third of three reports required of the department by the legislature with the advice and participation of the Developmental Disabilities Strategies for the Future Stakeholder Workgroup. This report completes the assignment of the department and stakeholders to do the following tasks:

- ◆ Gather data and information on the unmet needs of people with developmental disabilities
- ◆ Give advice on the best way to ensure that people with developmental disabilities and their families have choice of services offered
- ◆ Give guidance on the issue of the future role of the Residential Habilitation Centers in the service delivery system.

The department acknowledges and appreciates the numerous hours of volunteer time that stakeholders have put into completing each of the tasks. Many stakeholders have been with the group from its inception in May 1997.

Stakeholders established principles of agreement at the beginning of their service and used this agreement as a guide for their work from 1997 to the present time. (See Appendix B, pages 16-20.) The Stakeholder Workgroup has given the legislature clear information about fiscal needs of people with developmental disabilities who are not served. They have also made recommendations to the department related to system changes that currently and in the future make lives better for people with developmental disabilities.

Much work remains. In future years, the department will continue to build upon work accomplished by stakeholders, will implement many recommendations of the Stakeholder Workgroup, and will continue to move toward a system of self-directed supports and services. The department will also continue to partner with stakeholders from this workgroup and from other groups to gather input and advice on issues of importance for people with developmental disabilities and their families.

The Stakeholders offer their final recommendations in the following four policy areas to be addressed in the future.

#### **1. Stabilize the developmental disabilities system.**

- ◆ Provide services to eligible citizens with unmet health and welfare needs
- ◆ Enhance case management services to acceptable levels
- ◆ Improve quality and accountability

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- ◆ Increase wages of direct care staff to stabilize providers
  - ◆ Augment administrative infrastructure to achieve credibility and accountability
2. **Implement system changes that encourage self-directed services.**
  3. **Enact legislation that includes the following concepts:**
    - ◆ A needs-based continuum of supports for families to enable the person with developmental disabilities to live at home
    - ◆ A choice-based safety net of residential options for children and adults whose needs are of such intensity that families cannot manage even with supports in place
    - ◆ An understanding that when the family caregiver(s) reaches age 60 or beyond, there will be an alternative residential option available
  4. **Use the Stakeholder Workgroup’s “Future of the RHCs” agreement as the basis for developing policy for the future use of RHCs.** (See Appendix C, Section 1, Page 31.)

## ***Appendix A – Current Program Information from the Division of Developmental Disabilities***

The Division of Developmental Disabilities provides a broad range of services and supports to over 34,000 eligible individuals with developmental disabilities and their families/guardians. Services may be provided directly or indirectly in either an individual's home or another setting and may be provided by state employees or contracted providers.

### ***VISION STATEMENT***

People with developmental disabilities and their families are valued citizens of the state of Washington. Washington State public policies will promote individual worth, respect and dignity such that each individual is valued as a contributing member of their community.

### ***MISSION STATEMENT***

To make a positive difference in the lives of people eligible for developmental disabilities services, through offering quality supports and services that are individual/family driven; stable and flexible; satisfying to the person and their family; and meets individual needs. Supports and services are offered in ways that ensure people have the information to make decisions about their options and provide optimum opportunities for success.

### ***CORE VALUES***

- **INDIVIDUAL WORTH AND DEVELOPMENT**  
People are served with dignity and respect for individual differences and have the benefits of relationships with friends and families; personal power and choice; personal value and positive recognition by self and others; integration; competence to manage daily activities and pursue personal goals; and health and safety.
- **CONTINUITY AND COORDINATION OF SERVICES**  
Emphasis is on a flexible system, which enables people to remain in their own homes and communities whenever possible.
- **COMMUNITY PARTICIPATION AND PARTNERSHIP**  
The Division of Developmental Disabilities promotes the involvement of consumers, parents, service providers, advocates, local governments, citizens and businesses.
- **RESPECT FOR EMPLOYEES**  
Employees are treated as the division's most valuable resource.
- **SERVICES QUALITY AND PERFORMANCE ACCOUNTABILITY**  
The Division of Developmental Disabilities is accountable to the public for effective and prudent use of resources. Regular review, evaluation, and modifications of programs and services are conducted.

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- **NON-DISCRIMINATION**

The policy is to not discriminate on the basis of sex, race, color, religion, national origin, age, or disability in admission and access to services, treatment or employment in its program or activities.

### ***Statutory Authority References***

Washington State Constitution- Article XIII, Section 1 - Requires the state to foster and support “educational, reformatory, and penal institutions that are for the benefit of youth who are blind and deaf or otherwise disabled; for persons who are mentally ill or developmentally disabled; and other institutions as the public good may require

Title 71A RCW - passed by the 1998 legislature, this chapter reorganized and clarified laws regarding the provision of service to persons with developmental disabilities. The key sections are:

- RCW 71A.10.020 - Definitions of developmental disabilities
- RCW 71A.10.015 - Service obligations
- RCW 71A.12.010 - Authority to develop and coordinate state services
- RCW 71A.12.030 - Statutory duties and responsibilities
- RCW 71A.12.020 - Service Requirements
- RCW 71A.10.020(4) - Habilitative services defined
- RCW 71A.12.040 - Authorized services listed
- Chapter 71A.14 RCW - Local service options outlined
- RCW 71A.14.080 - Local authority defined
- RCW 71A.16.010 - Service eligibility
- Chapter 71A.18 RCW - Special conditions for services
- Chapter 71A.20 RCW - Residential Habilitation Center operations
- RCW 71A.22.010 - Authorizes training centers and homes

RCW- 74.09.120 - Authorizes the state to purchase services and care in institutions for the mentally retarded.

RCW- 74.09.520 - Authorizes the Department of Social and Health Services to provide Medicaid Personal Care.

Executive Order 92-10 - Designates the Department of Social and Health Services as the lead agency to implement a comprehensive and coordinated statewide system of early intervention services for eligible infants and toddlers with disabilities and support for the State Interagency Coordinator Council (RCW 70.195.30) (Public Law 105-17) (34 CFR, Part 303).

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## ***Program Descriptions***

### **Case and Resource Management**

A case manager is assigned to assess the needs of clients and their families and link and connect them to available supports and services. Case managers coordinate planning and development of resources, authorize payment, monitor and review service delivery, provide information about available services, refer persons to other sources of support, and do crisis intervention.

### **Long Term Care Services**

Long term care services may be provided either in a residential facility or in a person's own/family home. These individuals may receive other supports from a variety of sources to enhance their functional and adaptive skills, including medical, dental, professional therapies, transportation, and medically intensive services.

### **Residential Services**

*Licensed Programs* – In the community-based residential programs, such as group homes, community ICF/MRs, adult family homes and foster care, the provider owns or leases the facility. Room and board expenses are included in the rate paid by the division and the residents participate toward the cost of care. State employees provide services in five state operated Residential Habilitation Centers (RHCs). To provide services in a variety of smaller facilities located in community settings, the division contracts with providers, or coordinates with other DSHS divisions. All facility based programs offer 24-hour supervision.

*Supported Living Services - Non-Facility Based Programs* – These programs are provided to persons who live in their own homes in the community and are not required to be licensed because the person owns or rents their home and the state provides the support staff. Except for the State Operated Living Alternative (SOLA) program, DSHS contracts for these services with organizations or individuals that are certified. These certified organizations or individuals provide services for a few hours per month, up to 24 hours per day. Clients pay for their own rent, food, and other personal expenses. DSHS pays for staff to provide support and training in the client's home. State employees operate the SOLA residential services.

### **In-Home Services**

*Medicaid Personal Care* – This federally matched Medicaid state-plan service provides personal care assistance for Medicaid eligible persons assessed as needing assistance with at least one direct personal care task as a result of the person's disability. This service is provided in the person's own home, adult family home, or adult residential center as a Medicaid entitlement.

*Family Support* – This program provides funding directly to families either through State Supplementary Payments (SSP) or reimbursement to contracted

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providers for services to the individual. This program provides funding for respite care, attendant care, equipment, and specialized aides and therapies, which supports families and assists them in keeping individuals at home with parents or a relative.

*State Supplementary Payment (SSP)* – In the 2002 State Budget, the Washington State Legislature directed the DSHS to implement a State Supplementary Payment (SSP) program to expand family support and high school transition services for people with developmental disabilities, promoting self determination and independence for families with low and moderate incomes. The purpose is to increase or supplement the income of an SSI recipient. The payments are in the form of a cash payment to the recipient. The source of the SSP cash payments is from state, not federal, funds. The amount of the cash grant to each recipient is determined by need or income. The state must demonstrate “maintenance of effort” in its state supplementary payment program from year to year, disbursing at least as much in SSP as was paid in the previous year. Maintenance of effort must be demonstrated to continue receiving Title XIX Medicaid funding.

### **Employment and Day Programs**

Approximately 40 percent of the adults made eligible by the Division of Developmental Disabilities participate in an employment or day program. Approximately 80 percent of children, birth to three, served by the Washington State Infant Toddler Early Intervention Program (ITEIP) are determined DDD eligible to receive DDD case management and some therapy services through county-funded DD human service agencies.

DDD supports employment and day services, including child development services, through contracts and partnerships with county government. The counties select and contract with service providers who directly provide many of the support services that strengthen the community infrastructure.

*Employment Services* – These services provide ongoing support and training for eligible persons with paid jobs in a variety of settings and worksites, including individual or group options in the community, and specialized industry settings.

*Community Access* - These services emphasize the development of social, communication, and leisure skills for individuals whose age or disability currently limits their participation in employment. Persons gain access to community activities through special assistance, advocacy, education, and exploration of interests that lead to employment.

*Child Development Services* - These programs emphasize early intervention services designed to meet the needs of a specific child. They include therapy, education, family counseling, and training, and are provided to children until age

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three when they become eligible for services through public schools or other community programs.

*Person-to-Person* - As an extension of Community Access, services and supports are offered to assist people with disabilities, their families, and friends to:

(1) articulate a personal vision for a desired life in the community, including employment; and (2) locate and connect people to sources of personal support in the community that enhance the vision for a desired life. Services and supports may include, but are not limited to: person centered planning, skill instruction, information, referral, physical support, and one to one relationship building.

*Individual and Family Assistance* - This is available to individuals and families as time limited projects to meet one or more of the following desired outcomes:

(1) supports are provided to additional families and persons with developmental disabilities in need of services and supports within existing resources; (2) individuals and families receiving services have more control and flexibility with the use of the resources; and (3) the individual and family are assisted in connecting to and using natural and informal community supports.

*Information/Education* - A variety of activities and strategies are developed that assure individuals with developmental disabilities and families have full access to current information about services and supports which will assist them in becoming full participants in their communities.

### **Special Programs**

#### *Infant Toddler Early Intervention Program (ITEIP)*

The ITEIP enhances and coordinates existing early intervention services and assures that federal service standards are followed. These services include family resources coordination, therapies, family training, and counseling for infants and toddlers, birth to three, with developmental delays or disabilities and their families.

This program allows families to access early intervention services in their local communities and own homes. To ensure statewide service delivery through a multi-agency system and data collection mechanism, ITEIP contracts with local lead agencies that are designated to be the contact point for each geographic area of Washington.

#### *Voluntary Placement Program*

Children with developmental disabilities who are under 18 years of age may, in certain circumstances, be eligible for out-of-home placement in licensed foster care settings and for other support services. The birth/adoptive parents retain custody of the child and participate in shared parenting with foster care providers.

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### *Community Protection Program*

This program provides intensive 24-hour supervision for individuals who have been identified as being a danger to their community due to the crimes they have committed. The program is an opportunity for participants to live successfully in the community while minimizing the risk of reoffending.

### *Developmental Disabilities/Mental Health Collaborative Plan*

This plan includes a variety of strategies and partnerships with the Mental Health Division and community-based organizations to divert individuals with developmental disabilities from psychiatric hospitalization. These strategies include crisis intervention, prevention, behavioral support and technical assistance, residential outplacement capacity, medication evaluation and monitoring, and the use of diversion beds.

## **Appendix B – Stakeholder Workgroup Charge and Agreement in Principle**

**08/20/98**

### **DDD STRATEGIES FOR THE FUTURE STAKEHOLDER WORKGROUP**

#### **Roles & Responsibilities Proposal**

In April 1997, Lyle Quasim, secretary of the Department of Social and Health Services, charged the DDD Strategies for the Future Stakeholder Workgroup to:

*“develop recommendations on future directions and strategies for service delivery improvement, resulting in an agreement on the direction the Department should follow in considering the respective roles of the RHCs and the community programs, including a focus on the resources for people in need of services.”*

The DDD Strategies for the Future Stakeholder Workgroup submitted their strategy for developing these recommendations in January 1998, referred to as the Agreement in Principle. The Agreement in Principle established the Stakeholder Workgroup’s operating principles, primary strategies, and long-range plan to stabilize the service delivery system and ensure that people with developmental disabilities and their families have access to adequate resources and their preferred choices in service design and delivery.

Secretary Quasim formally accepted the Stakeholder Workgroup’s Agreement in Principle in February 1998. During the 1998 Session of the Washington State Legislature, SSB-6751 was passed and signed into law by Governor Locke (Chapter 216, Laws of 1998). This legislation placed the Stakeholder Workgroup in statute to work with the Division of Developmental Disabilities to develop the long-range strategic plan identified in the Agreement in Principle (with some modifications).

Following is a renewed charge by Secretary Quasim as to the roles and responsibilities of the Stakeholder Workgroup and the division in fulfilling their mutual commitments in the Agreement in Principle, as well as their respective responsibilities in SSB-6751. In accord with this charge, the Stakeholder Workgroup will work in concert with the division to address the challenges faced by Washington’s citizens with developmental disabilities and their families.

The department and the division values the Stakeholder Workgroup and will solicit and support:

- Active participation by the Stakeholder Workgroup in the development and analysis of data characterizing the service and support needs of persons with developmental disabilities and their families
- Active participation by the Stakeholder Workgroup in the division’s evaluation and monitoring activities relating to elements in the strategic plan

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- Active participation by the Stakeholder Workgroup in the division's evaluation and monitoring activities relating to elements in the strategic plan
- Active participation in addressing issues relative to the January 1998 Agreement in Principle

The Secretary acknowledges that the Stakeholder Workgroup values the division and actively supports the division's efforts to carry out its statutory responsibilities.

***\*Active participation*** is defined within this document as "the Division acknowledges the Stakeholder Workgroup's participatory role, via group consensus, in the process of developing the Division's long-term strategic plan. This will be achieved by providing the Stakeholder Workgroup with frequent, meaningful opportunities to contribute their perspectives, expertise, and recommendations."

**01/07/1998**

## **DDD Strategies for the Future Stakeholder Workgroup**

### **-----AGREEMENT IN PRINCIPLE-----**

Herein is our AGREEMENT IN PRINCIPLE, developed through the unified, committed efforts of the DDD Strategies for the Future Stakeholder Workgroup, in response to legislative concerns and in fulfillment of Secretary of DSHS Lyle Quasim's charge:

"to develop recommendations on future directions and strategies for service delivery improvement, resulting in an agreement on the directions the Department should follow in considering the respective roles of the RHCs and the community programs, including a focus on the resources for people in need of services."

Over the last several months, the DDD Strategies for the Future Stakeholder Workgroup, comprised of nineteen stakeholders, representing the diverse group of people concerned about services for persons with developmental disabilities, their families and/or guardians, has built this AGREEMENT, pledging to mobilize these PRINCIPLES into concrete actions and outcomes.

This AGREEMENT acknowledges the needs of all persons with developmental disabilities and their families and/or guardians, whether served, underserved or unserved, and the roles of various programs, whether they are state, county, or community funded/operated, in ways that ensure service credibility, responsiveness, and quality.

This AGREEMENT is intended to commence in three phases: quick start, implementation, and full-operation phases beginning with the 1998 Session of the Washington State Legislature and extending over several biennium to fully implement,

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to start, enhance, and/or improve service delivery systems to all eligible people with developmental disabilities.

Our AGREEMENT is organized as follows:

## CHOICE of SERVICE OPTIONS

Phase I – Quick Start

Phase II – Initial Implementation

## COMMUNITY and RHC SERVICES

IMPLEMENTATION, CONTINUED PLANNING and

MONITORING/EVALUATION

Phase III

## CHOICE OF SERVICE OPTIONS

### Phase I – Quick Start

The stabilization and security of the system that serves individuals with developmental disabilities in Washington State is critical by June of 1998. We agree to support a supplemental budget as an important first step in meeting this critical situation. In addition we want to emphasize that other critical community needs requiring immediate attention are not addressed by the supplemental budget.

Key pieces of the community service system are destabilized to a level that jeopardizes the health and safety of individuals, as evidenced by the difficulty service providers are experiencing with the workforce market and meeting the rising costs of supporting individuals, and as further witnessed by the loss of Medicaid Personal Care exemptions to policy for family providers. The integrity of the whole community care system is threatened by this crisis.

An analysis of data on all known persons who are DD eligible, both those receiving DSHS funded services or supports, and those waiting for the availability of additional resources, will be completed by DDD with the participation of the Stakeholders Workgroup. A wide range of DSHS and other data sources will be used. Key components of this analysis will assess needs and develop the cost estimates for providing services and supports to meet these needs. This data will not be used to determine or allocate services for individual people. The outcome would be used by DDD, with participation by the Stakeholder Workgroup, to develop a long-term comprehensive plan that would cover six-to-eight years. The plan would commence July 1, 1999 and must include the provision of substantial resources for implementation. This analysis and plan would be reviewed biennially. Together, the Stakeholders Workgroup will approach the 1999 Legislature for the substantial amount of funds needed to build community capacity, serve the underserved and unserved, and stabilize/strengthen the community support system. The analysis and plan will document and bolster the Stakeholders Workgroup presentation to the 1999 Legislature, emphasizing the community support system.

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## Phase II – Initial Implementation

The Stakeholders recognize that this phase reaffirms stated legislative policy, that to the maximum extent possible people with developmental disabilities will be able to receive services without having to leave their own home or community.

A critical step for any plan to receive ongoing, broad-based stakeholder support in the community, is a substantial increase in financial resources for underserved and unserved individuals. Expanded financial resources are essential to rebuild some sense of trust that the Legislature and DSHS are sincere in their long-term commitment to adequately support the needs of people with developmental disabilities. Based on the completed data analysis, the Stakeholders Workgroup will define “substantial resources” necessary for the implementation of choice.

In addition, to develop the trust and support of all stakeholders who value the continued availability of high quality RHC services as a realistic and informed choice by adults (and on an exceptional case-by-case basis for adolescents), RHC services will be available. These services will be available to individuals who have assessed needs which require levels of resources as those provided by the RHC. This option will be available only when adequate resources have been made available for the individual in a community program.

For individuals to exercise the choice to leave an RHC, they must be given adequate resources to do so. Each should have a clear understanding of the services available in the community, the steps necessary to access those services and an individualized plan of community support before they leave the RHC. If the person’s efforts to adjust to the community are not successful, they will have the option to return to the RHC.

For genuine choice to exist, people must know what the options are, all options must be available, and clearly explained services must be customized to fit their unique needs and circumstance. Choice of providers and design of services and supports will be determined by the individual, or the individual’s legal guardian (who may in some instances be the parents), in conjunction with DDD, if such support is necessary.

Funding for services must be assured over the long term with ongoing adjustments for cost of living and caseload growth to ensure preservation of quality and availability.

The size, shape, funding and roles of all services will continue to evolve and change over time in direct response to the choice-oriented, market driven system. On-going periodic analysis and evaluation of consumer needs will be updated and reviewed biennially to plan future service changes and funding requirements.

As a means of implementing a choice-oriented system, RHC staff will continue to increase vocational and community access for current residents. Likewise, specialized RHC services/resources will be more easily accessed by community residents.

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## COMMUNITY and RHC SERVICES

It is agreed by the Stakeholders that until July 1999, the RHCs will remain at current funded levels in order to: a) support the current residents who choose to live there; b) serve respite, community protection, crisis, etc; and c) assure institutional stability during the time period. New and adequate funding will be available for those persons who desire to leave the RHCs. RHC capital expenditures will focus on maintaining quality of life and safety for residents and staff.

### Phase III – Implementation, Continued Planning and Monitoring/Evaluation

The Stakeholders will continue to meet regularly with the current mediators throughout this entire period to implement specific provisions of this agreement, to engage in further planning and to monitor and evaluate both progress and process.

Strategies for the Future Stakeholder Workgroup Signatories for the Agreement in Principle dated January 7, 1998.

Janet Adams  
Richard Bowyer  
Greg Devereux  
Regina Harris  
Duwane Huffaker  
Lynn Pippard  
Cherie Tessier  
Tracy Vandewall  
Mary Jo Wilcox  
Joan Wright  
Trish Borden  
Timothy R. Brown, Ph. D.  
Sue Elliott  
Resa Hayes  
Jackie MacRae  
Steve Start  
Stuart Torgerson  
George Walker  
Dave Wood



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Recommendations	Activities	Progress Report
	<p>their child.</p> <ul style="list-style-type: none"> <li>▪ SSP cash grants will be implemented in September to forward self-direction of services.</li> </ul>	In process
<ul style="list-style-type: none"> <li>• For services and supports to be delivered in a self-determination environment, information and education must be supported by the state, regions, and at the county/community level.</li> </ul>	<p>An Information/Education Initiative was begun in September 2000 to include families and self-advocates in the processes of identifying needed information and presenting and producing it.</p>	On-going
	<p>Family Support project dollars are being used to help provide information and education.</p>	On-going
	<p>Although there was no additional funding in the budget for information and education, the DDD director asked Regions to work with counties to do this within existing funds where possible</p>	On-going
	<p>A “Real Choices” Grant application has been approved to use for information/education work in local areas. It would help provide seed funding for local councils of county, region, parent and self/advocates to work together to gather and disseminate information.</p>	Awarded Sep. 2002
<ul style="list-style-type: none"> <li>• Resource allocation – at the heart of self-directed services are individual budgets managed by individuals with the support of their families/guardians. In order for this to happen, they need to have access to fiscal agents and an assessment tool that will help determine level of need and funding that is attached.</li> </ul>	<p>The Stakeholder Workgroup agreed to not pursue the fiscal agent concept at this time. Further research needs to be done in order to understand the financial implications when combining local, state and federal dollars for use in individual budgets.</p> <p>The decision has been made to work with the SPSS and CHRIS systems for payment of individual budgets. Currently work is underway to detail the way that will be done, and how accounting for individual budgets will occur, as the decision was made for accounting to be done at Central Office and sent to the Regions for distribution and tracking.</p>	<p>Agreement June 2001</p> <p>Begun Sept. 2001 and on-going</p>

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Recommendations	Activities	Progress Report
	<p>Language for self-directed services has now been incorporated into the code for payments that is used by counties, so that it can be a waived service.</p> <p>The Stakeholders agreed to use the North Carolina SNAP assessment if it proved reliable and valid to assess needed levels for individual budgeting. DDD Contracted with RDA to determine whether Washington could obtain the same inter-rater reliability score as North Carolina does using the NCSNAP. After using three different approaches to assess clients, using the SNAP, only 50-60% inter-rater reliability could be achieved.</p> <p>DDD is now exploring other options including: (1) using the new CARE plan developed for AASA by Deloitte Inc, which will be completed in June 2003; and/or (2) developing supplemental questions for the CARE and ISP to use as weighted questions for funding purposes.</p> <p>Hornby Zeller Assoc. Inc. were contracted with by DDD to do a rate study on the payment for VPP. All of the children in VPP foster care have been assessed, using a new instrument and the outcome of this assessment will be used to determine rates. The rate methodology is currently being applied to children in VPP.</p>	<p>In process</p> <p>Completed Nov. 2001</p> <p>In progress</p> <p>In process</p>
<ul style="list-style-type: none"> <li>A new individual planning process (IPP) was identified with the help of a national consultant. Essential to that process was the identification of a Personal Agent who would help the family if authorized by the case manager for a time-limited service.</li> </ul>	<p>Stakeholders' workgroup came to initial agreement on the Personal Agent, which was agreed to by the Union, Counties and State.</p> <p>An Olmstead Steering Committee, representing counties, state, regions, union, case management, parents, self-advocates, and providers met to work on personal agent issues such as description of duties, standards, training, recruitment,</p>	<p>Completed June 2001</p> <p>Began September 2001 and continuing</p>

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Recommendations	Activities	Progress Report
	<p>training, etc. This work is in draft form and will be reviewed in the Fall for issues that need revising.</p> <p>The steering committee also made refinements to the Individual Planning and Service Delivery Process and that process is currently being offered for Olmstead movers.</p>	In process
<ul style="list-style-type: none"> <li>A menu of services and supports was developed to not limit choices but to allow for the broadest array of choices while still honoring the need for the individual to be accountable for their choices.</li> </ul>	<p>The menu of services that the Stakeholders recommended were incorporated into the procedures for Olmstead movers.</p> <p>The new proposed omnibus legislation adds services and supports to accomplish this goal.</p> <p>The waiver that is being submitted to CMS contains broad service categories that include self-directed services and wide choice to meet needs.</p>	<p>In process</p> <p>In process</p> <p>In process</p>
<ul style="list-style-type: none"> <li>Continued discussion of a County/Union/DDD agreement on county role was agreed upon.</li> </ul>	<p>The Olmstead Steering Committee, which drafted the roles and responsibilities of the different government entities, had members of counties, regions and union on the committee. All agreed conceptually to the documents drafted. Documents in Appendix C, Section 4, pages 50-66.</p>	In process
<ul style="list-style-type: none"> <li>Community development strategies in the restructured system will proceed within the conceptual framework established in the county guidelines and current division policy. Resources and technical assistance need to be available to communities for this to occur.</li> </ul>	<p>Counties have many community development projects in process to increase integration in their communities.</p> <p>Work has been going on through a grant that the DDC has, partnering with the division, to work with families of multi-cultural backgrounds and meeting their needs in their own communities.</p>	<p>On-going</p> <p>On-going</p>
<ul style="list-style-type: none"> <li>The state's quality assurance system needs to be strengthened and coordinated, focusing first</li> </ul>	<p>A framework of current quality assurance activities has been prepared and disseminated. Report in Appendix C, Section 3, pages 40-48.</p>	Completed August 2001

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Recommendations	Activities	Progress Report
<p>on individual providers, and monitoring and assessment activities.</p>	<p>A state office of quality assurance has been established and a regional quality assurance coordinator in each region has been identified.</p> <p>The CMS Protocol is being used as one of the necessary measures of an enhanced system.</p> <p>A quality assurance steering committee is helping to identify the roles and responsibilities of each part of the enhanced quality assurance system.</p> <p>The state is designing a Statewide Incident Review System, including a mortality review system.</p> <p>The Regional QA people are beginning to carry out the protocol for quality assurance visits to movers from the RHCs.</p> <p>A revised CAP waiver manual was completed to instruct case managers in the proper implementation of CAP waivers.</p> <p>A second revision is due November 2002.</p> <p>Region 5 is piloting a program to do quality assurance for individual providers and it will be taken to all Regions when funding is available.</p>	<p>November 2001 and on-going</p> <p>On-going</p> <p>November 2001</p> <p>In process</p> <p>Begun December 2001</p> <p>July 2001</p> <p>In process</p> <p>In process</p>
<p><b>RESIDENTIAL RECOMMENDATIONS</b></p>	<p><b>DDD will design and maintain an effective system of residential supports and services that provide a full range of service options based on assessed needs, emphasizing choice and efficient resource utilization.</b></p>	
<ul style="list-style-type: none"> <li>• Combine program categories for people living in their own homes.</li> </ul>	<p>WAC 388-820 was revised. This revision offers more flexibility for providing residential services to clients receiving 40 hours or less of supports per month. This includes individuals who receive less than</p>	<p>Effective January 2002</p>

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Recommendations	Activities	Progress Report
	<p>five hours of support per month.</p> <p>DDD residential categories for Agency Alternative Living, Regular Tenant Support, Support Living and Intensive Tenant Support was centralized into one category of “Supported Living.” This change is reflected in WAC, in the EMIS report, and in data prepared for the DSHS budget office, OFM and legislative staff.</p>	Effective July 2001
<ul style="list-style-type: none"> <li>Stabilize services for individuals living in their own homes and group homes who change their service providers and also for those who do not move.</li> </ul>	<p>Contract language and DDD Policy 6.04 have implemented legislative budget note instructions to have vacancies of no longer than three months.</p> <p>A workgroup of residential providers and state staff have prepared a draft “Unbundling Policy” for review and finalization that address people’s choice to move and resulting consequences for those who remain in that home and do not choose to move.</p> <p>A revised waiver manual provides instructions for the choice of residential options to be offered to waiver participants.</p>	<p>Effective July 2001</p> <p>Draft distributed 8/02</p> <p>Revised July 2001</p>
<ul style="list-style-type: none"> <li>Include the RHCs as one of the choices available under residential options, through forecasting need, assuring quality of services, and using the expertise available in the RHCs in the community. If an RHC is to be considered for closure, certain factors must be considered and state staff needs must also be considered.</li> </ul>	<p>The SWG completed its recommendations and delivered them to DDD to be used as criteria for actions involving the RHCs. Full text of recommendations in Appendix C, Section 1, pages 31-35.</p>	December 2001
<ul style="list-style-type: none"> <li>Improve services for individuals in adult family homes by working with</li> </ul>	<p>This recommendation has not been acted upon.</p>	N/A

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Recommendations	Activities	Progress Report
AASA to transfer adult family home administration to DDD.	In response to the underlying concern of a need for more individualized services, DDD is developing a “companion home” model. This model allows a family or individual to provide services for one individual, who then becomes part of that person’s/families life. Quality assurance is monitored through adherence to the contractual requirements.	In progress
<b>EMPLOYMENT/DAY PROGRAM SUPPORTS RECOMMENDATIONS</b>	<b>DDD will design and maintain an effective system of employment and day programs (which includes birth to three programs) that support and foster early childhood objectives and access to full time employment for all working age adults in inclusive settings or provide other meaningful opportunities.</b>	
<b>Birth-to-three/Early Childhood Recommendations include:</b>		
<ul style="list-style-type: none"> <li>• Identification of need, including early identification, timely referrals, and a common eligibility definition.</li> </ul>	<p>DDD is currently holding hearings on changing the WAC to include a common eligibility for children in the ITEIP program and DDD.</p> <p>Information developed by ITEIP for both parents and physicians on early identification and establishing relationships with medical providers.</p>	<p>In process</p> <p>Completed July 2001 and continuing</p>
<ul style="list-style-type: none"> <li>• Connections to support services should be timely and effective.</li> </ul>	Training provided by ITEIP to DDD case managers and other staff on early intervention.	On-going
<ul style="list-style-type: none"> <li>• Supports and services must be able to meet the needs of the child.</li> </ul>	<p>Natural environments Ad Hoc committee established by ITEIP developed Guidelines for Implementing Early Intervention Services in Natural Environments.</p> <p>Local lead agencies are required to submit an early intervention plan and to coordinate the development of the plan with other local boards including the County DD Board</p>	<p>Completed Sept. 2001</p> <p>On-going</p>
<ul style="list-style-type: none"> <li>• Effective coordination must be in place to assist</li> </ul>	ITEIP Data System provides consistent information including evaluation,	On-line January 2001

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Recommendations	Activities	Progress Report
children to transition into the school system when they turn three.	<p>assessments and IFSP, which, with the parent's permission, will be available to school districts prior to the child turning three.</p> <p>ITEIP continues to work with Inclusive Child Care Committee and the new DSHS Division of Early Learning to improve options for children birth to eight.</p>	On-going
<b>Adult Employment and Day Services Recommendations</b>		
<ul style="list-style-type: none"> <li>Each individual will be supported to pursue a pathway to work. All individuals, regardless of the challenge of their disability, will be afforded an opportunity to pursue competitive employment. The path will be supported by their personal plan and take into consideration personal consideration.</li> </ul>	Some counties are moving forward with this goal in mind. DDD and counties have worked together to establish how to continue to track employment goals while meeting the need to use less categorical approaches.	In process
<ul style="list-style-type: none"> <li>DDD will take the lead in bringing together those entities responsible for facilitating transition from school to community work or activities, so that a coordinated program will be supported by OSPI, DDD and DVR beginning at age 14.</li> </ul>	In its proposed Omnibus legislation, DDD proposes aggressively pursuing this step.	In process
<ul style="list-style-type: none"> <li>Provider funding needs to be stabilized for a future system of individuals/families/guardians having individual budget and buying services.</li> </ul>	<p>One example of work to stabilize the system is the work on SSP by counties and the state. Transition students will have cash funding and a concerted effort will be made by both counties and regions in helping those who get cash subsidies to have the information and education they need to spend it for employment in a way that brings the best results.</p> <p>The Developmental Disabilities Council will</p>	In process
		Starting date

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Recommendations	Activities	Progress Report
	monitor the implementation of SSP cash grants and report back on the success or failure of this approach for transition students (as well as others who get SSP grants).	August 2002
<b>INDIVIDUAL AND FAMILY SUPPORT RECOMMENDATIONS</b>	<b>DDD will design and maintain a single, comprehensive system of individual and family supports.</b>	
<ul style="list-style-type: none"> <li>The division will conduct a comprehensive study of the current rates and needs of individual providers.</li> </ul>	<p>The state has not done this, however several independent agencies have done current studies showing a need for at least \$10.50 an hour to meet turnover challenges.</p> <p>The legislature funded a 50 cents an hour raise for individual providers during the current biennium to continue to address this need.</p>	<p>N/A</p> <p>In process</p>
<ul style="list-style-type: none"> <li>The division will undertake a pilot project to study and test qualified individual provider recruitment and retention strategies.</li> </ul>	Two projects are currently in place; one in Pierce County (funded by Piece County) and another that is located in both Everett and Spokane that test the ability of the system to provide this service (funded through a grant to AASA).	In process
<ul style="list-style-type: none"> <li>As part of the division's comprehensive information and education plan, the division will develop an orientation and training program for individuals and their families/guardians.</li> </ul>	Two of DDD's 6 Regions have implemented orientation sessions for families.	In process
<ul style="list-style-type: none"> <li>The division will work to increase the array of quality resources available for respite care outside the family home in all six regions including use of the RHCs or community residential services.</li> </ul>	Funding was included in the supplemental budget for additional respite beds at Yakima Valley School.	In process
<ul style="list-style-type: none"> <li>The division will develop legislation to extend the current nurse delegation</li> </ul>	The Department of Health and DSHS intend to submit legislation in the 2003 session to propose that individual providers	In process.

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<b>Recommendations</b>	<b>Activities</b>	<b>Progress Report</b>
statute to cover delegation of nursing tasks to individual providers caring for children and adults living in family settings.	be allowed to take part in nurse delegation of services.	

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## **APPENDIX C**

### **SECTION 1: Residential Habilitation Centers Stakeholder Agreement Approved by the Stakeholder Workgroup at the April 5, 2002 SWG Meeting**

#### Introduction

The Stakeholders Workgroup [SWG] upon its deliberations of specific issues offers eight recommendations.

The purpose of our work is not to intrude upon management processes, but is meant to make policy recommendations to the Division of Developmental Disabilities of the Department of Social and Health Services and the State Legislature to which we, the Stakeholders, are also accountable.

All Stakeholders are committed to the principles of self-determination and informed choice by all persons with developmental disabilities as well as their parents and guardians. The systems for informing persons of their choice options must be available, unbiased, accurate, complete, understood, and consistently applied throughout the Division, e.g., RHC facilities, private vendors, and the broader community. Such information --that which is provided as well as presented--will address eligibility, options, and entitlements currently available as well as opportunities for respite, medical and dental treatment, therapies, employment training and day programs, adaptive equipment and other services available in the community as well as in our state's RHCs.

To be clear: In order for valid choice options to exist there must be practical options for which consumer needs, preferences, and the degree of selection will determine viability. Consequently, the state will respond by expanding or by decreasing or by creating appropriate, practical, and consumer driven menus--but all related processes with regard to entering or leaving an approved residence will be fair, in accord with the Division's policy and so perceived as well.

#### ***Recommendations:***

##### **Issue #1 Forecasting**

In order to determine the current and future need for a sufficient quantity of quality services the SWG recommends that an on-going process be developed and implemented that would forecast the numbers of people having the level of assessed need for service available in the RHCs. We further recommend that the most current data be used for the initial forecast. All services delivered by the Division will be in accordance with self-determination and informed choice.

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## **Issue #2 Basics of RHCs**

RHCs will be an on-going option within the state's Choice/Self Determination policies and practices.

Residential Habilitation Centers (RHCs) are state operated residential facilities that provide a comprehensive array of clinical and support services in a 24-hour setting. These facilities provide active treatment and/or skilled nursing care. They are federally certified and receive matching funds through Title XIX, Medicaid, and Federal Financial Participation (FFP).

Eligibility for residence in an RHC is based on the level of a person's need for services and supports, and is detailed in federal/state regulations. Short-term stays for respite or crisis are available.

## **Issue #3 Quality Assurance and Accountability**

Quality assurance will address the diverse needs of all people whom the Division serves. (1) State and Federal survey processes will assure compliance with rules and regulations, and that ICF/MRs meet the consistent level of quality expected.

(2) Additionally the Stakeholder Workgroup affirms that:

- Residents and their families, guardians and/or advocates will have the opportunity to affect how ICF/MR programs evaluate quality.
- Residents will have access to the benefits described in the Residential and County Guidelines to assure fulfillment of the consumer and family values and principles.
- Residents, with whatever help is necessary from their families or guardians, have the right to choose services at the RHC or in the community.
- The Habilitation Plan (a federal requirement) developed with the resident will be responsive to personal preferences as well as that person's cultural and community values.

Quality assurance can only be achieved if (i) an emphatic distinction is made and maintained between necessary regulatory compliance and consumer satisfaction in relationship to stated needs, the agreed upon individualized plan, and the fulfillment of services promised; (ii) consumer and families receive and provide information about quality and are able to receive and analyze the information; (iii) the process is ongoing in contrast to an annual inspection or audit; (iv) is responsive to change; and (v) that Division leadership will use quality assurance results as a guide to redefining services.

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### **Issue #4 Usage of RHC expertise and resources**

The Division fully acknowledges the value of RHC employee expertise and resources in such areas as the various therapies [i.e., psychological, physical, speech, occupational, etc.], behavioral management, crisis intervention, physician and nursing services, dental care, personal care, recreational opportunities, vocational services, employment opportunities, adaptive equipment modifications, respite services, full team evaluation, etc. Furthermore, the Stakeholder Workgroup recommends the retention and utilization of such expertise and resources including training others in order that such services are available statewide to people who live in RHCs, community residential settings and in family homes in ways which are not competitive to either the community or private sectors. Specific recommendations made by the Kertes Workgroup (1995) as well as those by the Stakeholders' Residential Workgroup (2000) should be used to fulfill this recommendation.

### **Issue #5 Factors/criteria to be used by DSHS/DDD in considering/determining possible consolidation or closure**

It is the intent of the Stakeholder Workgroup that *all* of the following criteria will always be examined if and/or when an RHC is considered for the options of consolidation, closure, or to remain open:

1. Effect(s) of change on residents of the RHC;
2. The unique factors, programs, and the professional service resources available at the RHC;
3. Equal or better alternatives for residents and staff if relocated to other RHCs or to the community, and/or if SOLAs are a viable option with no right of refusal;
4. Review the ICF/MR or NF eligibility for current residents of an RHC;
5. Economic feasibility:
  - i.) A population fully informed of all service options does not choose an ICF/MR or a nursing home within the RHC;
  - ii.) If or when a facility loses its certification, and if funding is not forthcoming after DSHS/DDD have made every attempt to regain certification;
  - iii.) There are not enough residents remaining in the facility to allow the facility to operate in a positive cost-benefit manner;

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- iv.) After consistent reasonable maintenance efforts a facility has physically deteriorated, and it is not cost effective to rebuild it or remodel it to meet applicable standards; and
- v.) When using what the SWG deems as credible equivalent cost comparisons between the community and an RHC a determination is made that services at that RHC are no longer provided in a positive cost benefit manner.

### **Issue #6 Options as how to utilize State employees employed at RHCs in the event of consolidation or closure or if additional monies are available**

The following ideas are some of those that appear in the Kertes Workgroup Report.

Note: State operated programs must *not* compete with existing community private sector programs nor inhibit the development of new community private sector programs; the key is how the referral process is designed.

**RESPIRE:** Both RHCs and SOLA programs currently offer respite services on their sites. RHC and SOLA staff could provide respite services in community private homes and for certain private providers (e.g. non state) at the private providers' sites. Prior to service delivery, adequate data and information regarding the client(s), and the reason(s) for respite must be made to the respite provider. If RHC downsizing continues RHC FTEs could be used to establish respite provider teams.

**CONSULTATION and TRAINING:** RHC and SOLA staff could provide consultation/training at the RHC campus, SOLA site, a person's home, or private providers' site. Private provider staff could offer similar services on RHC and SOLA sites. Combined teams of public and private staff could be formed. Consultation/training services should be conducted at the appropriate location. Field Services could maintain a catalog of experts. These individuals should share information with each other.

**OUTPATIENT SERVICES:** Individuals living in community settings could come to state operated facilities for certain services. The referral process must *not* allow competition with private sector services. Field services could maintain a menu, first seek the service in the community and then refer to a state operated facility but only when the service is unavailable in the community.

**ADAPTIVE EQUIPMENT:** State staff could provide adaptive equipment and environmental modifications. State staff, especially RHC employees, could develop and/or modify equipment, and adapt an individual's environment to meet his/her individual needs.

**FIELD SERVICES SUPPORT:** Under certain conditions RHC and SOLA staff could provide support to Field Services. RHC and SOLA staff could serve as aides and

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assistants to Field Services. This could range from office work to transporting clients to medical appointments.

NOTE: The primary missions of RHCs and SOLA programs must not be diminished. Certain labor/management issues must be addressed and resolved in good faith fashion.

### **Issue #7 Keeping RHC funds in the Division**

SWG recommends that all appropriations and assets which would otherwise have gone to a facility that is closed or consolidated will be retained for alternate use within/by DDD.

### **Issue #8 How to assure and to maintain a credible “entering and leaving” referral process**

SWG recommends in keeping with “choice processes” and a “consumer driven system” that a clear and complete system be implemented that assures all eligible and interested parties will be given a full breadth of choices including opportunities for entering or leaving RHCs and/or community based programs.

## **APPENDIX C**

### **SECTION 2: Birth To Three Workgroup Recommendations on the Inclusion of Families of Babies in a Self-Directed System to the Stakeholder Workgroup** **December 21, 2001**

#### **Workgroup members included:**

Greg Abel, Mediator, Sound Options Training Group, ITEIP  
Janet Adams, Office Chief, DDD Quality Assurance and Self-Directed Services  
Julia Ann Avila, Parent, SICC, Family Leadership Team  
Cindy Card, Region 3 DDD Outstation Manager, Federation Representative  
Linda Cooper, Cowlitz/Wahkiakum Counties Local Lead Agency  
Louise Dobson, Director, Child Development Center  
Richard Duncan, Region 5 DDD Case Manager, Federation Representative,  
Stakeholder Workgroup  
Mike Etzell, Parent, Father's Network  
Waunda Gauntt, Parent, SICC, Family Leadership Team, Parent Coalition  
Regina Harris, King County Arc  
Ginger Kwan, Parent SICC, Family Leadership Team, Stakeholder Workgroup  
Sandy Loerch, Office Chief, ITEIP Program  
Lance Morehouse, Parent Coalition of Spokane, Family Leadership Team,  
Father's Network  
Myra Pacheco, Parent, Benton/Franklin Counties  
Mary Perkins, Grays Harbor County Local Lead Agency  
Minnie Pesina, Grandparent, DDD Stakeholder Workgroup  
Lynn Pippard, DD Coordinator for Spokane County, Stakeholder Workgroup  
Lisa Ross, Spokane County, EIS Local Lead Agency  
Denise Rothleutner, DD Coordinator for Pierce County, Local Lead Agency  
Karen Woodsum, Parent, ITEIP Staff

The Birth to Three Workgroup strongly recommends a system that supports people with developmental disabilities and their families from birth through life. They further support the movement to self-direct services and supports. Every effort should be made to work within and build upon existing federal and state laws and to support local flexibility. As the Division of Developmental Disabilities (DDD) works toward a self-directed system for all people with developmental disabilities, birth through life, the DDD Birth to Three Workgroup recommends the following:

#### **FAMILY ISSUES:**

1. Families should be given opportunities to share their experiences and perspectives about supports, values, choice, etc., so that they can learn from one

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another. This can be done through family gatherings, locally, regionally and statewide.

2. Family activities and gatherings should be a component of DDD Quality Assurance. Time should be set aside for the Division to obtain individual/family input, assist in state policy recommendations and system improvement strategies at frequent intervals. Effective methods should be used to facilitate this process that asks individuals and families what is working, what is not working and help with suggestions and strategies for improvement.
3. DDD should provide funding and support for comprehensive, coordinated family support organizations in each county. Families may access these organizations for emotional supports, information and education, and linkages to local community supports such as: churches, recreation opportunities, day care, clubs, etc.
4. DDD needs to provide on-going applicable information to individuals/families at milestones throughout their lives. The materials need to be consistent, relevant and assist people to self-direct their services. At all points, people should know whom to contact if they need help.
5. Although we recognize providing early intervention services in natural environments are federal law, we also recognize that natural environments are a beginning step to a system based upon family-centered practices and are in accord with informed choice and self-directed services. Therefore services throughout a person's lifetime should be based upon need for quality supports and individual/family preferences within the community.
6. There should be a DDD toll free referral and general information line for families to access from birth through life as needs arise. The number should be on every document and a person should answer the phones. It is critical that there be an automatic link for interpreter services and/or bilingual phone staff.
7. Mediation training should be available to all families and people with developmental disabilities. The training should assist with mediation and negotiation skills to assist individuals and families with self-directed plans and services.

### **SYSTEM ISSUES:**

8. The road to integrating self-directed services from birth through life needs to begin with common eligibility for services in the birth to three years. ITEIP and DDD should make eligibility regulations consistent across both systems through Washington Administrative Code (WAC) change.

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9. It is important that interagency coordination continue for children past three years of age through agreements between state and local agencies, building on the collaborative, comprehensive model established in birth to three services. Continue to build relationships with organizations that serve people with all kinds of needs. DDD Quality Assurance should include outcome measures to monitor this coordination.
10. Assure one plan is used by multiple systems and incorporates all the necessary requirements. The Individualized Family Service Plan should be the one plan for children, birth to three, and their families. This one plan concept needs to continue throughout the person's life and integrate all funding and resources.
11. The plan belongs to the person/family and should be treated accordingly. The plan should be a web-based application and when there is a need for information from that plan, the individual/family should determine who has access. The plan should be transmittable with the permission of the person or parent. Because individuals/families have the right to protect sensitive information, the individual/family should have the ability to request an exception to the one plan model as necessary to assure privacy.
12. Family resources coordinators, community guides and personal agents primary commitment must be to the child/individual/family. They should work to fully inform individuals/families of the full range of options and services available to them. The key is not physical location of the above resources, but their relationship with the family. Those whose services they are recommending should not be their hiring or supervising authority or agency.
13. The Division of Developmental Disabilities should assure training for family resources coordinators, community guides and personal agents to enhance knowledge of services for individuals/families. Efforts need to continue to maximize and clarify roles and to decrease the numbers of people in and through a person's life who have similar roles.
14. As DDD identifies a mechanism for determining individual budget amounts various age categories need to be considered. Allow the individual budget process to utilize the Individualized Family Services Plan and team process for children, birth to three and their families. Ensure the process and assessments are appropriate for the age of the individual and reflects current and individualized needs.
15. Assure Cultural Competency training for all providers of services for people with developmental disabilities in order to increase outreach and service access.
16. Recruitment and marketing for staff diversity needs to be a key focus for DDD. The Division must ensure there is culturally competent bilingual case

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management staff. The DDD diversity plan should guide regional activities to increase staff diversity.

17. DDD should work to increase the public understanding of people with developmental disabilities. DDD should work with staff and local resources to ensure social, health and education components are key elements in self-directed planning.
18. DDD needs to work with MAA to develop contract language for health care plans when implementing Healthy Options, Basic Health Plan, and State Children's Health Insurance Plans to cover early intervention services through an Individualized Family Service Plan and Self-Directed plans. Health care plans should be prohibited from denying or limiting services beyond limits of the state Medicaid plan.
19. DDD should continue to refer to and implement the recommendations of the DDD Birth to Three County Interagency Workgroup and the Stakeholders Birth to Three workgroup as we pursue development of self-directed planning.

### **FUNDING ISSUES:**

20. It is critical that individual budgets contain essential funding for needed services. Current funding levels and service levels for Early Intervention Services should and must not be reduced as we implement self-directed and individual budgets.
21. Individual budgets should be implemented at all stages of a person's life and should be based on the individual/family needs, resources and choice. Every effort must be made to insure that individuals and their families are fully informed to support their decisions. All available funding streams, as well as individual, family and community resources should be considered.
22. There should be a state base of funding to assure that there are services available for people to have choices. The funding base must maintain and insure individual access to services. Provider and service capacity should be maximized, and these services should be monitored for quality and be geographically available. Early intervention service and other entitlements must be protected and built on for every individual and their family.

## **APPENDIX C**

### **SECTION 3: Quality Assurance Framework for the Division of Developmental Disabilities October 2, 2002**

*The mission of the Division of Developmental Disabilities (DDD) is to endeavor to make a positive difference in the lives of people eligible for services, through offering quality supports and services that are: individual/family driven; stable and flexible; satisfying to the person and their family; and able to meet individual needs. Supports and services shall be offered in ways that ensure people have the necessary information to make decisions about their options and provide optimum opportunities for success.*

**In order to assure that quality services are sought, provided, paid for, and continually improved, the following outcomes must be achieved for participants and their families by the Division of Developmental Disabilities, in cooperation with the counties, and all of its contractors/providers:**

“If you have built castles in the air, your work need not be lost; that is where they should be. NOW PUT THE FOUNDATION UNDER THEM.”

Henry David Thoreau

## **QUALITY ASSURANCE OUTCOMES**

### **1. PERSON-CENTERED OUTCOMES:**

- A. Be served with dignity and with respect for individual differences;
- B. Have personal power and choice which enhances positive recognition by self and others;
- C. Have the opportunity for integration into community life and to be supported to experience the benefits of relationships with friends and families;
- D. Be supported to have competence to manage daily activities and pursue personal goals;
- E. Have access to health services;
- F. Be supported in safe environments; and
- G. Self-direction of services and control of an individual budget.

### **2. PROVIDER OUTCOMES:**

- A. Well-trained and informed state staff;
- B. Well-trained and informed contracted providers;
- C. State staff are treated as valued employees;
- D. Contracted providers will be respected and valued; and
- E. Non-discrimination policies and practices will be honored.

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## 3. COMMUNITY PARTICIPATION OUTCOMES:

- A. Involvement of self-advocates and parents;
- B. Being engaged in community activities through County Coordination of services;
- C. Well informed community partners; and
- D. Effective information/input gathering for system management and improvement.

## 4. STATEWIDE SYSTEM OUTCOMES:

- A. On-going monitoring and evaluation activities;
- B. Use information to produce desired outcomes; and
- C. System improvement activities.
- D. Share measurement outcomes with community partners.

## CURRENT QUALITY ASSURANCE LAWS, RULES, POLICIES AND PRACTICES

Washington State has implemented the following laws, administrative codes, policies and practices to achieve the above benefits. These are contained in the following documents or practices. \* Some system pieces are still in development:

<p><b>Revised Code of Washington (RCWs)</b> <b>Washington Administrative Code (WACs)</b> <b>DSHS Administrative Policies</b> <b>DDD Policy Manual</b> <b>Procedures, practices and publications</b></p>
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## 1. PERSON CENTERED OUTCOMES:

- A. *Be served with dignity and with respect for individual differences*
  - Client rights (DDD policy 5.06)
  - Eligibility determination (DDD policy 11.01, RCW 71.A.16 and WAC 388-825-020 to 045)
  - Eligibility under autism (DDD policy 11.02)
  - Human rights committee (RHC) (DDD policy 5.10)
  - Limited English proficiency (LEP) clients (DDD policy 5.05)
  - Positive behavior support (DDD policy 5.14)
  - Protection from discrimination (RCW 71.A.10.040)
  - Public disclosure of records and safeguarding of confidential information (DDD policy 13.01)
  - Restraints (DDD policy 5.11)
  - Waiting list criteria being developed.

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### ***B. Have personal power and choice which enhances positive recognition by self and others***

- Alternative services application (RCW 71.A.18.040)
- Appeal of department actions – rights (RCW 71.A.10.050)
- Choice options for RHC eligible individuals (DDD policy 3.03)
- Civil & parental rights not affected (RCW 71.A.10.030)
- Consent for medical treatment affecting reproductive functions (DDD policy 9.08)
- Oral hygiene program
- Rejection of services (RCW 71.A.18.030)
- Voter registration (DDD policy 5.07)

### ***C. Have the opportunity for integration into community life and be supported to experience the benefits of relationships with friends and family.***

- Program Options for RHC residents, rules (WAC 388-825)
- Redirection of savings to community-based services (DDD policy 6.22)
- Reduced rate fishing license (RCW 77.32.490)
- Referral and placement into community residential services (DDD policy 4.02)

### ***D. Be supported to have competence to manage daily activities and pursue personal goals***

- Authorized services (RCW 71A.12.040)
- Financial and guardianship services (WAC 388-825-050)
- “Olmstead” moving plan
- Service plans (DDD policy 3.01, RCW 71.A.18.010 and WAC 388-825-050)
- Yearly habilitation plans in the RHCs

### ***E. Have access to health services***

- Administration of psychotropic/neuroleptic drugs and other medications for behavior management or treatment of mental illness (DDD Policy 9.02)
- Client autopsy (DDD policy 9.10)
- Consent for proposed treatments and advanced directives (DDD policy 7.03)
- Dual diagnosis (DD/MH) policies and procedures
- Health care task force
- Health services at RHCs and ICF/MRs (DDD policy 9.06)
- Hospice care (DDD policy 9.04)
- Participation in medical treatment and advanced directives (9.01)
- Medically intensive home care program (DDD policy 4.04)
- Preventive dental services (RCW 18.29)

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- Residential medication management (DDD policy 6.19)
- Smoking of tobacco products (DDD policy 9.05)
- Substance abuse task force
- Use of psychoactive medications (DDD policy 5.16)

### ***F. Be supported in safe environments***

- Abuse of vulnerable adults in licensed facilities (RCW 74.34)
- Adult protective services hotline
- Children’s ombudsman
- Client grievances (DDD policy 5.03)
- DSHS administrative policies –Clients (Chap. 8)
- DSHS administrative policies – risk management – health and safety (Chap. 9)
- Due process policy and procedures
- Environmental safety (DDD policy 14.01)
- Governor designated protection and advocacy agency (RCW 71.A.10.080)
- Incident management (DDD policy 12.01)
- Long-term care ombudsman
- Mental health ombudsman
- Ninety-day face-to-face visits for children in Voluntary Placement program
- 1-800 end harm telephone line
- Positive behavior support (DDD policy 5.14)
- Protection from abuse (DDD policy 5.13 and WAC 388-825-282 and 284))
- Residential care unit hotline
- Restraints (DDD policy 5.11)
- Supervision status for RHC clients on outings (DDD policy 14.02)

### ***G. Self-direction of services and control of an individual budget.***

- Community guides (WAC 388-825-220 to 226)
- County “individual budgets” for employment programs
- Family resource coordinators for parents of babies 0-3
- Family support program (WAC 388-825-200 to 260)
- Federal requirements (Part C of IDEA) for natural supports
- Olmstead “movers” self-direction opportunities

## **2. PROVIDER OUTCOMES:**

### ***A. Well-trained and informed state employees;***

- ACES online
- CAP manual (in process)
- CAP program and services (WAC 388-825-170 to 190)
- Case manager core training
- Case managers’ training manual

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- Client participation (DDD policy 6.06)
- Employee volunteer time (DDD policy 8.02)
- Preventing the transmission of mycobacterium tuberculosis in the workplace (DDD policy 9.09)
- Quality Improvement training for all DDD employees
- RHC policies and procedures
- RHC surveys
- Social workers academy for voluntary placement social workers
- Training centers and homes (RCW 71A.22)

### ***B. Well trained and informed contracted providers:***

- Access to initial evaluations and ISPs
- Adult family home specialty training
- CHRIS reporting system for county services
- Certified residential provider biannual evaluations
- Community protection clients (DDD policy 15.00)
- Community Protection standards for intensive tenant support (DDD policy 4.10)
- Community residential services and supports (WAC 388-820)
- Core training for all DDD providers
- Core training requirements for adult family home providers
- Core training requirements for community residential providers
- County oversight and certification of birth to three and day programs
- Criminal history background checks (DDD policy 5.01)
- Day program provider qualifications (DDD policy 6.13)
- DSHS system of quality improvement for long term care services in adult family homes, boarding homes, group homes and individual providers (RCW 74.39A.050)
- Family support emergencies and program transfers (DDD policy 4.06)
- Individual provider information booklet
- Individual service providers qualifications and requirements (WAC 388-825-260 to 280)
- Inter-regional placement planning and transfer (DDD policy 3.02)
- ITEIP data system training manual 2001
- Licensing of facility-based residential providers
- Non-facility based allowance (DDD policy 6.11)
- Nurse delegation policies
- Physical/manual intervention techniques (DDD policy 5.17)
- Plans for service provision if caregiver is unavailable, (implemented in contracted community residential services and licensed facilities)
- Regional and county emergency preparedness plans
- Residential and county guidelines
- Residential program development (DDD policy 6.14)

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- Respite care/emergency placement (DDD policy 4.01)
- Respite care requirements (WAC 388-825-266)
- Positive behavior supports (DDD policy 5.14)
- Quality improvement resource managers for adult family homes
- Residential reporting requirements (DDD policy 6.12)
- Technical assistance contracts to help both residential and employment providers
- Use of restrictive procedures (DDD policy 5.15)
- Voluntary placement into foster care policies and procedures

### ***C. State Employees will be treated as respected and valued staff;***

- DDD policy manual
- DOP annual survey of employee satisfaction
- DSHS administrative policies – employees and employment conditions (Chap. 6)
- DSHS administrative policies – risk management – health and safety (Chap. 9)
- DSHS human resources development plan 2001-2003
- Employee protection from bloodborne pathogens (DDD policy 9.03)
- ICF/MR administrative personnel compensation (DDD policy 6.07)
- Inside DSHS – weekly online newsletter for employees
- Organization/delegation of authority (DDD policy 2.01)
- Overtime and compensation (DDD policy 8.04)
- Proposal for caseload ratio reduction
- Quality improvement teams of state employees

### ***D. Contracted Providers will be respected and valued:***

- Agency grievance policies and procedures
- Damage reimbursement (DDD policy 6.16)
- DSHS administrative policies – vendors (Chap. 10)
- DSHS administrative policies – contracts and licenses (Chap. 13)
- Payments for community services (RCW 71A.12.050 to 070)
- Performance based contracting
- Planning to help reduce provider staff turnover
- Residential programs reimbursement system (DDD policy 6.04)
- Social service payment system (DDD policy 6.01)

### ***E. Non-discrimination policies and practices will be enforced***

- Affirmative action policies (DSHS policy)
- AT&T Language Line Telephone Interpreting Service
- DSHS administrative policies – affirmative action/minority affairs (Chap. 7)
- Human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS) (DDD policy 9.07)

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- Initiative on hiring people with disabilities in state government (DSHS policy)
- Non-discrimination in hiring or contracting (DSHS policy)

### 3. COMMUNITY PARTICIPATION OUTCOMES:

#### **A. *Involvement of self-advocates and parents in all aspects of services***

- Birth to Six Interagency Coordinating Council for early intervention services (RCW 70.195)
- DDD Regional Advisory Committees
- DDD Stakeholders Workgroup (RCW 71.A.12.180)
- DDD State Advisory Committee established since 1996
- Developmental Disabilities Council participation
- DSHS/Washington Protection and Advocacy System access agreement
- Financial support for parent and self-advocate groups
- Washington Protection and Advocacy System access to client records policy maintained by DDD (DDD policy 13.04)

#### **B. *Being engaged in community activities through County coordination of services***

- County authority (RCW 71A.14)
- County plan for mental health and developmental disabilities (WAC 388-850)
- County Developmental Disabilities Advisory Boards (RCW 71.A.14.020)
- Mental Health/Developmental Disabilities collaborative agreement contracts for local coordination of services
- State and local program coordination (71A.12.010)

#### **C. *Well-informed community partners***

- Access by participants to information upon request
- Communication with Attorney General (DDD policy 2.02)
- Conferences – employment and residential
- DDD RCW and WAC on line
- DDD services brochures and publications
- DDD website
- DDD annual newsletter
- DSHS administrative policies – relationships with the public (Chap. 2)
- Information/Education Initiative to involve people with disabilities and families in producing and disseminating information
- ITEIP interactive website
- “No Wrong Door” case management study
- Provide information to the public on people with developmental disabilities and needed services (RCW 71A.12.100)

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- Routine dissemination of core information

## ***D. Effective information/input gathering for system management***

- Family support surveys
- Core Indicators Participation
- ITEIP data system
- Random telephone surveys
- Regional system for collecting incident reports and verification of action
- Sampling methodologies re satisfaction
- Surveys on restrictive procedures usage
- Voluntary placement into foster care satisfaction surveys
- WAC public hearing process
- Workshops and symposiums

## **4. STATEWIDE SYSTEM OUTCOMES:**

### ***A. On-going monitoring and evaluation activities***

- Certification of DDD contracted community residential programs (DDD policy 7.04)
- Computer information security (DDD policy 13.03)
- Control of fixed assets (DDD policy 10.01)
- DSHS administrative policy – audits (Chap. 16)
- DSHS administrative policy – contract monitoring (13.11)
- DSHS administrative policy – delegation of authority (Chap. 4)
- DSHS administrative policy – information systems (Chap. 15)
- DSHS administrative policy – planning, budgeting, accounting and research (Chap. 12)
- DSHS balanced scorecards
- DSHS strategic plan 2000-2006
- ICF/MR program and reimbursement system (WAC 388-835)
- Policy manual management system (3 year review of all policies) (DDD policy 1.01)
- Monitoring of corrective plan of action for certified residential providers
- Monitoring and quality improvement of adult family home services (DDD policy 4.08)
- Nurse oversight of Medicaid personal care providers
- Quality assurance for individual providers pilot in Region 5
- Quarterly file reviews
- Quarterly reviews of performance indicators with regional administrators
- Regulations for early intervention program for infants and toddlers with disabilities (sub part A,B, & C of IDEA part C 34CFR303; PL 10517)
- Residential habilitation centers (RCW 71A.20)
- Voluntary Placement Program for foster care (draft WAC 388-826)

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- Work programs for residents of residential habilitation centers (WAC 388-840)

### ***B. Utilization of information gathered for the betterment of participants***

- CHRIS system to track wages and hours for day programs and analyze cost benefit ratios
- Common Client Data Base
- Electronic Incident Management System
- Infant Toddler Early Intervention electronic data collection
- SSPS system for paying providers of services
- US Health Insurance Portability and Accountability Act (HIPAA) implementation in process

### ***C. System Improvement Activities***

- Address accuracy project
- Alcohol/Drug Investigation Committee
- CAP waiver self-simulated audit
- Case Management Feasibility Study
- Core Indicators Project Evaluation Team
- Health Care Workgroup
- Incident Review workgroup
- Mortality Reviews Committee
- No Wrong Doors project
- Voluntary Placement Rates Review Committee
- Sterling Management Study
- Rhodes Project Planning
- JLARC studies
- CMS Review
- Compliance/Monitoring Team established
- New waivers being written
- Waiver management team being established

## **APPENDIX C**

### **Section 4: Division of Developmental Disabilities Olmstead Agreements March 2002**

#### **Olmstead Protocols, Policies and Procedures**

*In order to achieve the desired outcomes for people leaving RHCs, collaboration between the Person/Family/Guardian, Regional staff, County staff, Personal Agents, and Central Office staff, is imperative. The purpose of this document is to identify the role of each participating entity.*

#### **Role of the Person/Family/Guardian:**

1. Review the person's needs;
2. Review how these are currently being met in the RHC;
3. Identify the community services and supports required to meet the person's needs;
4. Receive initial information on self-directed service options from the RHC coordinators;
5. Decide whether to pursue community options;
6. If the decision is made to investigate community options, meet with Regional Olmstead Coordinator to get additional information;
7. Determine who will facilitate the planning and what method is wanted;
8. Determine if a personal agent will be used for planning and/or other services;
9. Decide on participants in the planning process besides the case manager and personal agent (if desired);
10. Determine direction/participate in the planning process and in the assumptions used to build the budget;
11. Determine how much responsibility the person/family/guardian wants to take in managing and directing the plan implementation and individual budget.
12. Designate whom the responsible entity will be to manage and direct the plan if not the person/family/guardian.
13. Explore community options that the person/family/guardian are interested in considering;
14. Agree to a plan and a budget;
15. Monitor expenditures from the individual budget;
16. Communicate with case manager on any areas of concern; and
17. Attend yearly planning session with the case manager (personal agent could also be requested to attend that meeting) to re-evaluate and plan for the new annual budget and expenditures.

#### **Role of RHC Olmstead Coordinators:**

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1. Assemble information and meet with person/family guardian to review
  - a. the person's needs,
  - b. how their needs are currently being met in the RHC,
  - c. the community service and supports required to meet the person's needs;
2. Provide this information to the Regional Olmstead Coordination;
3. Invite people who live in RHCs/families/guardians to choose community or continue in RHC and maintain a data base of responses;
4. Give information to persons/families/guardians that will include an overview of community options available, including an overview of self-directed services written for both family/guardian and for person in the RHC;
5. Offer persons/family/guardian an opportunity to talk to persons/families/guardians who have chosen community living;
6. As soon as the person has identified interest in moving, and where they want to move to, notify the Regional Olmstead Coordinator;
7. Invite the assigned case manager and county coordinator to meet with the person as soon as possible;
8. Provide all pertinent information and history to the case manager as soon as one is identified;
9. Prepare individual support recommendations in conjunction with the person's treatment team.

### **Regional Processes:**

#### **Role of the Regional Olmstead Coordinator:**

1. Provide information on community options to the person/ family/guardian upon request;
2. Information would include:
  - a. Information on the different planning processes and how to choose which one to use;
  - b. Information on budget building assumptions;
  - c. Information on options that are available (emphasizing creative options);
  - d. Information on the choice of a personal agent;
  - e. Information on individual budget management options;
  - f. Information on quality assurance;
  - g. Information on the self-advocate mentor program;
  - h. A clear description of responsibilities of person/family/guardian, case manager, personal agent, etc;
  - i. Description of the opportunity for exploration;
3. Immediately notify County of the possibility of an Olmstead mover coming to their county;
4. Based on local approvals, submit plan and budget to Central office for final approval;

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5. Send the person/family/guardian financial statements of expenditures against the budget at agreed upon intervals.

### **Role of the Case Manager and/or Resource Manager:**

1. Establish an on-going working relationship with the county to facilitate the services of a personal agent if desired by the person/family/guardian;
2. Authorize the county to make arrangements for a person to use the services of a personal agent, if they desire to do so;
3. If a person does not choose to use a personal agent, facilitate a planning and exploration process;
4. Offer the person the opportunity to have a self-advocate mentor involved in their move;
5. Coordinate with the resource manager to submit a plan and budget to the Regional Olmstead Coordinator;
6. Authorize services based on the individual planning budget, after receiving approval from Central Office for suggested amount;
7. Help find needed services or authorize the personal agent to assist in this process in coordination with the case manager;
8. Ensure contract for services requested in the individual budget;
9. Authorize expenditures from the final individual budget;
10. Meet with person/family/guardian yearly to re-evaluate plan and budget, or more frequently if needed.

### **Role of the Regional Quality Assurance Coordinator**

1. Ensure quality assurance visits at 30 days, 90 days, and yearly or as needed thereafter;
2. Prepare and send an annual quality assurance report to the State Quality Assurance Unit;
3. Assess the on-going relationship between case managers, county, and personal agents (if applicable);
4. Other roles under development.

### **Role of Regional Administration:**

1. Appoint a Regional Olmstead Coordinator;
2. Appoint a case manager from the area in which a person wishes to live;
3. Meet and coordinate with county personnel on procedures for implementing Olmstead moves;
4. Work with the Counties to identify self-advocates in the area, who could act as self-advocate mentors and be ready to offer their help to someone moving into that community.

### **County Processes:**

#### **Role of the County:**

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1. Meet and coordinate with regional personnel on procedures for implementing Olmstead moves;
2. Establish an on-going relationship with the case manager to facilitate the services of a personal agent if desired by the person/family/guardian;
3. Have a time-limited personal agent ready to work with the individual who is moving; if person/family/guardian chooses to use someone they know but has not received any training, provide needed training;
4. Track hours of personal agent service, costs of training, etc. to begin establishing a base of information about the cost of this service;
5. Work with the Region to identify self-advocates in the area, who could act as self-advocate mentors and be ready to offer their help to someone moving into that community;
6. Arrange to have interested self-advocates receive training on mentorship;
7. Contract or arrange for services related to county funding as specified in the person's plan;
8. Ensure funding that is allocated for the person in an individual budget follows the person over time.

### **Role of Personal Agent:**

1. Based on the wishes of the consumer (person/family/guardian):
  - Facilitate, develop and coordinate the consumer's person-centered plan meetings, person-centered plan, and consumer budget;
  - Submit plan and budget to DDD case manager for approvals, including renewals;
  - Assist in implementing the consumer's plan. This includes locating, developing, and accessing resources; negotiating rates, when appropriate; and developing agreements with providers;
  - Assist consumer in developing individual provider job descriptions, recruitment, interviewing, discharging, and employment processing;
  - Assist consumer with mediating any issues between the consumer and the provider;
  - Act as an advocate for the consumer; and
  - Assist the consumer in resolving any problems or issues that arise as a result of implementing the consumer's person-centered plan.
2. Maintain phone contact and visit with the consumer, as specified in the individual service plan;
3. Facilitate the monitoring and completion of all documents and required paperwork with DDD and the county;
4. Maintain an ongoing collaborative relationship with the consumer's DDD case manager, advising them of any issues or changes.

### **Role of DDD Central Office:**

1. Manage total Olmstead budget;
2. Approval process for the final individual budget and plan that is developed;

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3. Track each person's individual budget expenditures from SSPS and CHRIS records and inform the Region monthly of expenditures;
4. Maintain Olmstead data base of information on persons moving, budget allotments and expenditures; quality assurance activities;
5. Meet and coordinate with Olmstead Coordinators, Regions and Counties as needed;
6. Oversee the Regional quality assurance activities for Olmstead movers;
7. Ensure funding that is allocated for the person in an individual budget follows the person over time.

### **SEQUENTIAL LIST OF TASKS REQUIRED TO IMPLEMENT OLMSTEAD**

1. Regional Administrator appoints RHC and Regional Olmstead Coordinator.
2. Region and County personnel meet to discuss procedures for Olmstead moves and maintain an on-going dialogue.
3. RHC Olmstead Coordinator invites people who live in RHCs/families/guardians to choose community living or to continue in RHC; gives information to person/family/guardian that includes an overview of self-directed services written for both family/guardian and for person in the RHC; and offers person/family/guardian an opportunity to talk to persons/families/guardians who have chosen community living.
4. RHC Olmstead Coordinator prepares individual support recommendations in conjunction with the person's RHC treatment team and provides Regional Olmstead Coordinator with pertinent information and history.
5. If person/family/guardian decide to pursue community living and knows where they are interested in living, RHC Olmstead Coordinator notifies Regional Olmstead Coordinator.
6. Regional Olmstead Coordinator provides more detailed information on community options to the person/family/guardian upon request.
7. Region assigns a case manager from the area in which the person wishes to live.
8. County and Region personnel establish an on-going relationship to facilitate the services of a personal agent if desired by the person/family/guardian.
9. RHC Olmstead Coordinator invites the assigned case manager and county representative to meet the person/family/guardian.

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10. Person/family/guardian determines what method of planning is wanted, whether a personal agent is to be involved, and who should participate in the planning in addition to the case manager and personal agent, if desired.
11. Region coordinates with the county to ensure a personal agent, if desired by the person/family/guardian, who is trained or training ready if the person/family/guardian chooses to use someone they know but isn't trained.
12. County tracks hours of the personal agent service, costs of training etc. to begin establishing a base of information about the cost of this service.
13. Person/family/guardian explore community options they are interested in considering.
14. Case/resource manager and/or personal agent working with the person/family/guardian facilitate the planning process.
15. Budget process facilitated by case manager or personal agent working with the person/family/guardian and in conjunction with the county for input on county services.
16. County arranges to have interested self-advocates trained on mentorship.
17. Region and county work to identify self-advocates in the area, who could act as self-advocate mentors and be ready to offer their help to someone moving into that community.
18. Case/resource manager offers person/family/guardian the opportunity for a self-advocate mentor.
19. Person/family/guardian determines how much responsibility they want in managing the plan implementation and individual budget.
20. Person/family/guardian agrees to a plan and budget.
21. Case/resource manager submits plan and budget to the Regional Olmstead Coordinator.
22. Based on local approval, Regional Olmstead Coordinator submits plan and budget to DDD central office for approval.
23. Case/resource manager helps find needed services or authorizes the personal agent, based on the person/family/guardian's wishes, to assist in this process in coordination with the case manager.

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24. Region/County contracts for services identified in the plan, if applicable.
25. Case manager authorizes services based on the approved individual planning budget.
26. DDD central office tracks person's individual budget expenditures from SSPS and CHRIS records and periodically informs region of expenditures.
27. Region sends the person/family/guardian financial statements of expenditures at agreed upon intervals.
28. Person/family/guardian monitor the financial statements.
29. Person/family/guardian communicate any concerns to the case manager.
30. Region assures quality assurance visits at 30 days, 90 days and yearly or more often as needed.
31. Region prepares and sends an annual quality assurance report to the DDD State Quality Assurance Unit and copies the person/family/guardian, case manager, county, and provider, if applicable.
32. Case manager, and personal agent if desired by the person/family/guardian, meets yearly with the person/family/guardian to re-evaluate plan and budget, or more frequently if needed.
33. DDD central office maintains an Olmstead database of information on persons moving; budget allotments and expenditures; and quality assurance activities.
34. State and County ensure funding that is allocated for the person in an individual budget follows the person over time.
35. DDD central office coordinates meetings with Olmstead Coordinators, counties, and case managers as needed.

### **OLMSTEAD INDIVIDUAL BUDGET POLICY DECISIONS**

As provided in the 2001-03 DDD Budget, an average of \$250 per day will be available in an individual budget for each person moving under the Olmstead Proviso, plus other generic funds and natural supports, to provide for the needs of the move. Any exceptions to this amount must be approved by the Olmstead program manager in Central Office.

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### **I. The individual budget will be made up of the following components:**

- A. Residential or personal assistance supports;
- B. Employment or day programs, with the assumption being that working age individuals will be on a pathway to employment (see Section 3, step 4);
- C. Professional or health care services not covered by Medicaid or the person's primary insurance;
- D. Housing, utilities, food, clothing, and other personal needs;
- E. Other demonstrated support needs;
- F. Funding for a personal agent service in developing a person-centered plan; if desired, may be included in the person's individual budget (amounts must be authorized by the case manager); and
- G. Funding if desired, may also be spent to purchase the services of a personal agent to assist in finding supports, advertising, training staff, or other approved services. (Amounts must be authorized by the case manager.)

### **II. Funding for the individual budget will be a combination of:**

- A. DDD authorized state funds for support services;
- B. SSI to pay for housing, food, and other personal needs;
- C. Personal resources, including wages, trusts, etc.;
- D. Family resources;
- E. Food stamps, Section 8, etc.;
- F. Services from DVR, AASA, etc. if applicable;
- G. A one-time start-up fund of up to \$2,500.00 will be available to each person moving to pay for moving costs, furnishings, connection fees, etc.;
- H. Natural supports;
- I. Client allowances, if needed, on a temporary basis.

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### **III. Each person, with the participation of their family/and or guardian, who is funded through the Olmstead Proviso, will have the opportunity to self-direct their services; and will have the option to take the following steps:**

- A. The person/family/guardian will work with either the case manager and/or personal agent to develop a person-centered plan and to identify resources, which will result in an approved budget (following the above guidelines).
- B. The person/family/guardian will be made aware of all medical, financial and other benefits along with any tax liabilities, applicable Labor and Industry rules, etc. that may affect their decisions to self-direct services.
- C. When selecting providers of services, the person/family/guardian are free to choose resources, and providers who are not currently in the DDD provider system, however the provider will need to comply with all contracting/monitoring requirements. In addition, DDD must approve the service provider. Parents may not become the 24-hour providers of services, though they may be part of the service delivery system. The household size must not exceed four individuals unrelated to the person, unless it is a licensed setting.
- D. Information and education should be a primary strategy to help people choose employment as an outcome. All people will be considered to be on a “Pathway to Employment.” For people leaving an institution, a “discover” process through “Person-to-Person” may be necessary to get to know and work with the person to head toward employment. If the process is completed and the individual can work, but chooses not to do so, then funds that typically are used for these resources may not be a part of the individual budget. If the person is of retirement age or unemployable because of the system’s inability to find him/her work, then those funds should go towards day activities.
- E. Services must be approved under the CAP waiver at the present time because of the federal match necessity. Additionally personal agent and person-to-person services are funded out of state-only dollars.
- F. Planning will include looking for natural supports and other fiscal resources, without putting the person’s health and safety at risk.
- G. After the person/family/guardian have reviewed the option for self-directing a budget, an agreed upon level of control and responsibility the person/family want to have in the context of making decisions and over-seeing the budget will become part of the person-centered plan.
- H. The budget amount (based on how many days are left in a calendar year) will then become the person’s individual budget and he/she will carry it forward and plan around that amount the next year. Each year’s budget will start with the

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previous year's individual budget and will be modified according to the annual plan and legislated increases or decreases.

- I. If negotiations are entered into for shared living arrangements, all parties must be made aware of the implications of sharing funding. This includes the right of the person to leave, with three months notice, and take their funding with them, except in emergencies, in which case they may move immediately.
- J. If emergency funding is needed, all resources will be considered, and if none are available, it will be handled out of the general DDD budget, as we are working with a very small group of people (only individuals with funding through the Olmstead Proviso). Records of emergency funding requests will be kept to facilitate learning about this as a system-wide issue. The emergency funding will only be a part of the person's budget during the emergency, unless it is a long-term change and then it may become part of the person's total budget.
- J. In the case where an exceptional funding request is authorized for an individual to move, the person/family/guardian will be informed that the individual budget is temporary and that the person will not have that level of funding permanently, and there must be plans in place for it to be reduced.
- K. The information concerning funding from DDD that is part of an individual budget will be maintained and expenditures tracked by the state, as it has access to all county expenditures through the CHRIS report and SSPS for all other expenditures. Dollars will continue to flow as is currently practiced, only the individual budget tracking will be different. The state will forward budget information to the Region for distribution to Olmstead movers/families/guardians and case managers.
- L. Individuals/families will have the opportunity to apply for one-time expenditures for needed supports if their budget is under-spent due to unforeseen consequences.
- M. If an individual does not submit a plan to use all of their funds by May 1, the counties and state may use the unexpended dollars, on a one time only basis, on behalf of those who are eligible to receive services under the Olmstead Proviso.
- N. Start-up costs will be part of the initial individual budget but will not be part of the continuing budget as they are a one-time budget allowance.
- O. Client allowances will not be considered as an on-going part of an individual budget. However, they must be included in the approved individual budget on a time-limited basis.

## **Best Practices in the Selection of Personal Agents**

### **Personal Agent Standards:**

In order to be approved as a personal agent, each person must:

- Pass a DSHS background check
- Be over age 18
- Be computer literate
- Be a high school graduate
- College preferred/life experience considered
- Have experience in the field
- Be trained and mentored
- Demonstrate competency for each element of the approved training.

### **Personal Agents Infrastructure:**

Personal agents need to have access to:

- a) Collective problem-solving
- b) Training
- c) Mentoring
- d) Infra-structure supports

Personal agents must be trained before beginning to work with people with developmental disabilities and their families. For those currently acting as personal agents in this state or transferring from another state, their experience will be counted against training requirements and they will only be asked to take segments for which they can demonstrate competency.

Counties will make relevant trainings available to individuals and families as often as possible, i.e. negotiation, mediation, etc.

Training will be delivered in the most cost effective way, which is through the state contracting with one entity to deliver training statewide.

The state will set the standards for personal agents, and the counties will implement the standards.

Counties will work with case managers to ensure a smooth referral process.

Case Managers may authorize individuals to provide specific services such as a person-centered plan, but these people will NOT be considered personal agents unless they have met all of the personal agent requirements and have been approved by the county.

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No organization with a contract with the division or county to provide direct services to persons with developmental disabilities may provide personal agent services. This recommendation could impact small counties that provide direct services, so it is recommended that larger neighboring counties work with small counties to offer personal agent services.

Some of the elements of self-directed services are not available to people with community protection issues; i.e., they have to be served by a provider certified to deliver community protection services; they have to agree to work with a Certified Sexual Offender Treatment Provider (SOTP) or a therapist capable of dealing with whatever issue (arson, violence, etc) that they have. In order for DDD to serve them they have to accept the restrictions that their therapist imposes. On the other hand if a person with community protection needs would like to work with a personal agent who can help them figure out specific support needs (within the framework of the restrictions that they have to abide by) it may be authorized by the state manager for the community protection program.

### **Personal Agent Training Curriculum:**

The curriculum must include information and hands on learning on the following topics. It is anticipated that the training will be approximately a week-long and include demonstrations, competency testing, and mentoring skill development. Additional information may also be added at the discretion of the trainer.

- System knowledge
- Residential and County Guidelines
- Basic first aid, CPR, etc.
- Person centered planning
- Facilitation skills
- System navigation
- Negotiation
- Training on working with families
- Contracting knowledge, both with agencies and individuals
- Budgeting
- Hiring Skills
- Mandatory Reporting
- Mediation and problem-solving skills
- Values and importance of language
- Positive Behavior Supports
- Coaching
- Data Tracking
- Creative residential funding
- Creative employment options, and
- Social Security Work Incentives

## **WHAT IS A PERSONAL AGENT SERVICE?**

***A Personal Agent is an independent qualified person who provides advice, information and technical assistance to individuals with disabilities and their families who request additional help to:***

- *Identify different ways to meet personal needs, and*
- *Negotiate and use individualized funding to purchase needed community services and supports.*

### ***Personal Agent relationship with Case Management:***

- Case manager will inform the person/family of the option to use a personal agent,
- Case manager authorizes the personal agent service, and
- Case manager will have final approval on all planning and connecting activities and establishes on-going communication.

### ***Values Upon Which Personal Agent Services are based:***

- Each person has a fundamental right to:
  - Live a life of dignity,
  - Be fully self-determining,
  - Be fully included in community life, and
  - Access the supports needed to be fully included.

### ***Roles that Personal Agents may be Authorized to Perform:***

- Clarifying needs and expectations, and assisting to develop a vision based on the wishes of the participant,
- Preparing and negotiating a person centered plan,
- Assisting with funding negotiations,
- Arranging and helping to implement plans,
- Mediating and resolving problems, and
- Acting as an advocate for the person.

### ***Reasons for Working with a Personal Agent:***

- Ability to select someone whom you have determined has the skills and knowledge that you need to help you make decisions,
- Planning with the agent will be tailored to your specific needs,
- A personal agent can cross all system and organizational boundaries, and
- You may choose someone of similar cultural background if they are available in your community.

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### YOU MAY EXPECT A PERSONAL AGENT TO:

- ✓ Treat you with respect and listen carefully to you so that he-or she can get to know you,
- ✓ Learn with you about the kind, amount, and style of assistance you need to live successfully in your home and community,
- ✓ Learn with you about your interests and preferences,
- ✓ Work with you and your family and friends to identify ways to-develop the assistance you need,
- ✓ Recognize the social, financial, and personal barriers to the kind of life you want and assist you to identify ways to overcome them,
- ✓ Understand the vulnerabilities to your well being that result from your disability and your personal history and carefully negotiate safeguards with you that balance risk and safety in a responsible way,
- ✓ Use their knowledge and expertise to help you be flexible and creative with all the resources available to you to respond to your interests, preferences, and change in needs,
- ✓ Keep responsibilities clear so that, in every area in which you work together, you and your agent will know what you will contribute, what your family and friends will contribute, what your case manager will contribute, what others in your community will contribute and what assistance and support the agent will contribute,
- ✓ Stick by you in difficult times,
- ✓ Learn from their mistakes,
- ✓ Follow through on commitments to you and not make promises to you that they can't keep,
- ✓ Provide you with information,
- ✓ Invite and encourage you to try new experiences,
- ✓ Invite you and encourage you to widen your circle of friends and contacts,
- ✓ Hold high expectations for the quality of your life as a full citizen and community member, and
- ✓ Be responsive to criticism and willing to negotiate new ways of working with you or assist you in finding another personal agent if necessary.

### **Organizations Launch Mentoring Project Orientation for People with Developmental Disabilities**

**Olympia** – Highline Community College's Center for Extended Learning will host a two-day orientation workshop for 25 people with developmental disabilities as part of a self-advocate support and mentorship-training project. The orientation, which will be held at the Dumas Bay Centre in Federal Way on August 9-10, is the first step in training self-advocates as mentors for people who will be transitioning from state institutions to community-based residence. The program is funded by a \$15,000 grant

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from the Washington State Developmental Disabilities Council. Self-advocates are people with developmental disabilities living in the community who actively advocate for themselves and others with disabilities.

Mentors-in-training have already completed an application identifying why they want to be a mentor; stating ideas they have about helping people moving out of state institutions into a new community; describing activities the advocate is currently involved in, such as employment, volunteer work, education or recreation; and listing interests and hobbies. The answers will help project coordinators match up transitioning individuals with mentors who share common interests. Self-advocates participating in the project are from Bellingham, Seattle, Bremerton, Kent, Auburn, Federal Way, Puyallup, Tacoma and Olympia. Mentors will receive a stipend for participation and money for expenses.

A steering committee of self-advocates, service providers and advocacy organization representatives has been working on the new project since April. Following the orientation and mentor trainings project coordinators will begin identifying people making the move who are interested in matching up with a mentor. The committee expects to begin matching participants in the fall.

“This project is the first of its kind for people with developmental disabilities and we’re thrilled to be involved,” said Jenni Sandler, project coordinator for Highline Community College. “The steering committee is doing such a great job and we’re really excited to see our planning efforts pay off next week. All of this wouldn’t be possible without the financial support and commitment of the Council.”

“We’re so excited about how this project is coming together,” said Clare Billings, contracts manager with the Developmental Disabilities Council. “The transition from an institution to community-based living can be both thrilling and frightening at the same time. Having a good support system with a trained mentor who understands what you’re going through will be a blessing to individuals and their family members.”

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## **SELF-DIRECTED SERVICES FOR PEOPLE WHO ARE MOVING FROM THE RHCs**

### **WHAT ARE SELF-DIRECTED SERVICES?**

- An opportunity to decide how much, or how little; YOU want to control the services and supports YOU receive. YOUR family and guardian will also help YOU think about this.
- To self-direct means YOU can choose who helps YOU meet YOUR needs. YOU can choose who provides supports for YOU, what kind of home YOU live in, and how YOU find a job or community activities.

### **WHAT DO SELF-DIRECTED SERVICES MEAN TO YOU AS YOU THINK ABOUT MOVING INTO THE COMMUNITY?**

- You will have an opportunity to plan for your future, with the help of your **CASE MANAGER**, and YOUR family and friends, if YOU would like their help.
- YOUR case manager will tell YOU about a **PERSONAL AGENT**, who can help YOU plan or find the people to provide the supports in YOUR plan; if YOU want that help.
- YOUR plan will be called a **PERSON-CENTERED PLAN**, because it is all about YOU, what YOU like, what YOU need, where YOU want to live and other information like that. YOU can have people YOU know and love, help with the plan, so that it is the very best guide for deciding what supports YOU need to be successful in the community.
- The dollars that YOU need to be supported in the community will be kept in an **INDIVIDUAL BUDGET** and YOU can plan how to use those dollars, in ways that meet YOUR needs best.
- At least once a year, YOU will meet with YOUR case manager to **UP-DATE AND REVIEW YOUR PLAN** for living. After YOU have been in the community for a year, YOU may find that YOU need some different things. Changing YOUR plan, will help direct the dollars in YOUR **INDIVIDUAL BUDGET** to be used in different ways, if that is what YOU need.

### **HOW DO YOU FIND OUT MORE?**

- Talk to the Olmstead Coordinator at YOUR RHC to learn more about self-directing YOUR services.

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**APPENDIX D – Department of Social and Health Services Policy  
Statement for the Division of Developmental Disabilities  
September 2002**

**POLICY STATEMENT**

Families are the primary care system for people with developmental disabilities. State should provide a clear, transparent continuum of services that supports this responsibility.

**STAGES OF SUPPORT**

When a person's family caregiver approaches an age where they cannot continue to provide 24-hour care for the client.

State provides priority access to an alternative to home placement.

When the person lives and is cared for at home.

State provides school, or employment supports, or other day activities and respite care based on the needs of the person.

From birth through graduation from school.

The School provides appropriate educational supports. The Department supports schools and families by providing needs based home support.

During the transition from school to employment.

The Department, Counties and Schools work in partnership to provide the person with employment.

**IMPLEMENTATION**

- ◆ DSHS and OSPI form two workgroups to encourage appropriate birth to 3 support from schools and successful employment opportunities post school.
- ◆ Improve interagency cooperation between schools and DSHS' divisions of Developmental Disabilities and Vocational Rehabilitation.
- ◆ State provides needs-based support to families of people with developmental disabilities throughout the person's life.
- ◆ Evaluate potential for parent participation in Medicaid coverage.
- ◆ Establish a higher priority for placement outside of the home for people whose family caregiver has reached age 60.
- ◆ Provide emergency/urgent out-of-home placement for clients in crisis and community protection placement for public safety.
- ◆ Reevaluate the role of institutional setting for clients.

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**Appendix E – Division of Developmental Disabilities Corrective Action Work Plan**

Item	Narrative	Resource Requirement	Duration	Begin	End	Progress to Date
<b>1</b>	<b>Strengthen Management Capacity of the Division</b>					
1A	<p><b>Appoint Assistant Director</b> Description: Establish new position with responsibility for follow-up on all corrective actions including CMS Waiver, management information system, policy/procedure development for core data and core systems, including consistent regional application. This position will supervise the development/implementation of the new waiver strategy and will ensure consistency and accountability.</p> <p>Outcome: Division gains high-level executive with experience in sound business practices and provides organization focus on policy and procedure compliance.</p>	2 FTEs including Assistant Director and administrative support		July 15, 2002	Ongoing	Assistant Director appointed—started August 1, 2002.
1B	<p><b>Establish Waiver Implementation Team</b> Description: Create a team to manage and implement the new Home and Community-Based Services (HCBS) Waiver program. The team will include an allocation of some current resources and will establish a new Waiver Program Manager position, a data analysis position and a part-time clerical position to support a multiple waiver strategy; control expenditures and meet federal requirements.</p> <p>Outcome: Assure effective implementation of new program. Enhance CMS confidence in Waiver Program improvements.</p>	Assistant Director and 2.5 FTEs plus current staff Will include a program manager, data analyst and administrative support	Develop Waiver—12 months  Implement and Manage Waivers— New Waivers generally approve for 3 years	January 2002  January 2003	December 2002  December 2006	<p>The Waiver Concept Paper has been submitted to the Centers for Medicaid and Medicare Services (CMS).</p> <p>In preliminary discussions with CMS, CMS has volunteered to provide technical assistance to the Department regarding writing the new waiver.</p>

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Item	Narrative	Resource Requirement	Duration	Begin	End	Progress to Date
1B cont						<p>The division will begin discussion with CMS about acceptance of the multiple waiver strategy, cost containment measures and program detail.</p> <p>A new waiver application packet is being completed and prepared for an October 1 delivery to CMS.</p> <p>The Assistant Director is continuing a search for a qualified candidate for the waiver program manager position.</p>

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Item	Narrative	Resource Requirement	Duration	Begin	End	Progress to Date
1C	<p style="text-align: center;"><b>Establish Compliance Team</b></p> <p>Description: Create a HQ unit responsible for establishing business process improvements, designing policies, and creating monitoring reports. Team will define best practices, establish procedural requirements, draft training curricula and create management information reports that will monitor consistency of system practice. After building the compliance and monitoring system, the division will contract for an expert assessment of compliance and monitoring unit needs to establish the resources and monitoring configuration needed to ensure continued compliance with program standards.</p> <p>Please see Item 3 STANDARDIZE BUSINESS PRACTICES for further detail.</p> <p>Outcome: Consistent application of core business practices statewide.</p>	Assistant Director plus Division has 7 FTEs to allot to this team; 1 FTE is needed for administrative and legal support	<p>Process development 12 months</p> <p>Monitoring Ongoing</p>	July 15, 2002	Ongoing	<p>The Compliance and Monitoring Unit Program Manager is scheduling and conducting interviews for team members. It is anticipated all team members will be identified by mid-October.</p> <p>The Compliance Unit Manager continues meeting with field staff and HQ managers to design policies, procedures, and roles regarding compliance. Additional work will continue after the Compliance team is in place.</p> <p>Work is currently under way on identifying tasks and outcomes necessary to ensuring compliance in DDD program activities. The work currently initiated will enhance progress on meeting the requirements of Items 3A through 3E of this document.</p>

## STRATEGIES FOR THE FUTURE REPORT – PHASE 3

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Item	Narrative	Resource Requirement	Duration	Begin	End	Progress to Date
1D	<p><b>Appoint Division Communications Specialist</b> Description: Specific responsibility to focus on the development and delivery of consistent program and management information internally and externally.</p> <p>Outcome: Systematic integration of program and budget information that produces credible consistent policy level data.</p>	1 FTE	Ongoing	July 15, 2002	Ongoing	Communication position currently under review and revision.
1E	<p><b>Division Management Plan</b> Description: Legislation, provisos in the 2001-03 Budget (including the Supplemental), results from a series of audits/reviews including JLARC, Sterling, Centers for Medicaid and Medicare, The Arc v. DSHS; Allen v. WSH and Marr v. ESH and ongoing service delivery have increased the number of activities/accomplishments expected of the division. In order to complete these expectations successfully, the division will seek assistance for the development of a comprehensive work plan that will identify tasks, activities, timeframes, resource needs and expected outcomes.</p> <p>Outcome: A comprehensive plan that provides timeframes and accountable outcomes.</p>	Contract with Strategic Planning Firm	90 days	July 2002	October 2002 (The contract may be extended for continued work)	Rhodes Consulting Services, Inc., the successful bidder of the July 2002 Request For Qualification, began work August 19, 2002.  Rhodes Consulting Services, Inc. is continuing his work with Division Managers identifying and defining tasks and outcomes for the Divisions many projects and assignments.

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Item	Narrative	Resource Requirement	Duration	Begin	End	Progress to Date
1F	<p style="text-align: center;"><b>Division Realignment Plan</b></p> <p>Description: As policy direction is clarified; system and information technology business requirements are defined, management tasks and activities are delineated, the department will review options to meet infrastructure needs, share available resources, expertise or systems and adopt business practices that support policy requirements and program direction.</p> <p>Outcome: Effective and efficient use of available resources; increased organizational credibility.</p>	<p>Current Level</p> <p>Possible Contract with Management Consulting Firm</p>	12 months	July 2003	December 2003	<p>The week of September 2, Secretary Braddock announced the realignment of DDD within a new DSHS administration, Disabilities and Long-Term Care. This new administration will oversee new structures known as the Division of Developmental Disabilities and Aging and Adult Services. The transition, scheduled to begin October 1st, will be accomplished without disruption to the existing Division of Developmental Disabilities structure. Case management and service delivery will not change for clients. No organizational changes are planned at the regional or community levels.</p>

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Item	Narrative	Resource Requirement	Duration	Begin	End	Progress to Date
1F cont						After the realignment is initiated the new administration will concentrate on improving it's central and regional accounting and reporting functions. Over time, some accounting and/or reporting functions in DDD may merge with those in Aging and Adult Services. DDD will benefit from the accountability structure that currently exists in Aging and Adult Services.
2	<b>Information Technology Systems</b>					
2A	<p style="text-align: center;"><b>Data Quality Improvement</b></p> <p>Description: 1. Identify critical decision data, develop clear and consistent data definitions, and document the data source.</p>	Current Resources	3 months		<p>Original due date – July 2002</p> <p>Amended end date - August 2002</p>	<p>Quality Improvement Team appointed in May 2002.</p> <p>1. The team has completed the documentation of the data source, identified 90% of the critical decision data and, the team has completed the development of clear and consistent data definitions. This task was effectively completed by end of August.</p>

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Item	Narrative	Resource Requirement	Duration	Begin	End	Progress to Date
2A cont					Amended End Date, October 2002	2. The extraction process that produces data is being evaluated for accuracy. This forms the basis for developing business rules and revising extracting processes. This task is running one month behind.

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Item	Narrative	Resource Requirement	Duration	Begin	End	Progress to Date
2A cont					November 2002	3. Many reports and data have been defined as not having business rules. The data correction process is underway. Results are being seen in the EMIS and Program Status Reports. Ongoing verification of correct data to be incorporated in the overall data management plan. – On target
					November 2002	4. Policies and procedures have been identified that address key business/data collection processes. More will be developed as needed through the process of ensuring consistent, accurate data collection, analysis and reporting. - On target
	2. Develop appropriate business rules to edit the data and develop and implement a quality improvement plan;	Current Resources	5 months		September 2002	Work on target
	3. Verify and correct data not meeting business rules;	Current Resources	7 months		November 2002	Work on target
4. Develop internal policies and procedures related to the management of data; and	Current Level	7 months		November 2002	Work on target	

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Item	Narrative	Resource Requirement	Duration	Begin	End	Progress to Date
	Outcome: Consistency and accuracy of data improves.					
<b>2B</b>	<b>Technology Planning</b>					
2B1	<p style="text-align: center;"><b>Current Systems Assessment and Inventory</b></p> <p>Description: Develop the following:</p>	Current Resources and possible Contract				
	1. Division requirements inventory in priority order.	Same	3 months	August 2002	October 2002	Priority order determined.
	2. Examine Department systems to identify systems or system components that meet division requirements;	Same	7 months	October 2002	March 2003	Under examination, work on target.
	3. An assessment of how closely the system is aligned to the Division's needs;	Same	3 months	March 2003	May 2003	Work completed on AASA system alignment to DDD needs.
	4. An estimate of the changes needed and ease of making these changes is necessary to develop a mid-term solution; and	Same	3 months	May 2003	July 2003	Phase 1 of a front-end connection between SSPS and the Common Client Database is being tested. Refinements have been identified and corrections made. The product is in acceptance testing at this time.

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Item	Narrative	Resource Requirement	Duration	Begin	End	Progress to Date
2B1 cont	5. Establish partnerships, data share agreements that allow use of and/or build solutions through use of other department systems.	Current Resources	Ongoing	Current effort started with AASA and with CA	Ongoing	Data Share Agreements in process with Children's Admin (CA), and an amendment to the Research & Data Analysis agreement for CSDB information is complete and in place. DDD is also working with AASA on a common electronic adult assessment and planning instrument.

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Item	Narrative	Resource Requirement	Duration	Begin	End	Progress to Date
2B2	<p><b>Develop Long-Range Strategic Technology Plan</b> Description: Develop a strategic plan for technology. This plan will require an:</p> <ul style="list-style-type: none"> <li>• Evaluation of business processes</li> <li>• Analysis of business needs</li> <li>• Define strategic business components and rank in priority order</li> <li>• Determination of technology requirements</li> <li>• Development of a project budget</li> <li>• Design funding structure for maximum use of Medicaid (Federal Financial Participation)</li> <li>• Establishment of project implementation timelines.</li> </ul> <p>Outcome: Comprehensive plan for Information System that makes maximum use of FFP.</p>	<p>MIS Development Contract</p> <p>Project Manager</p>	12 months	Advanced Plan Doc. due 12/2002 Implementation Plan due June, 2003	June 2003	<p>The division has developed a strategic plan for a Management Information System including an analysis of business needs &amp; process and a funding strategy. DDD submitted a grant request for Phase 1 development. DDD is also working on an Advance Planning Document (APD) to submit to CMS for 90/10 funding for planning.</p> <p>DDD should know the outcome of the CMS decision by October 1, 2002.</p>

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Item	Narrative	Resource Requirement	Duration	Begin	End	Progress to Date
2B2 cont	<p><b>Implement Long-range Strategic Technology Plan</b> Description: Deployment and implementation of the technical solution</p> <p>Outcome: Credible, reliable, readily available information providing staff with a seamless interface to all necessary data sources</p>	Implementation Contract	System implements priority components over 3 biennia	First component implemented 12/2003	June 2007	If CMS accepts the APD, FFP at 75/25 would be available for implementation of a Management Info System (MIS). The focus has been on a comprehensive MIS.
3	<b>Standardize business practices</b>					
3A	<p style="text-align: center;"><b>Eligibility Process</b></p> <p>Description: Using the core principles of the Quality Improvement process, assign the Compliance/Monitoring team responsibility to develop clear policies and procedures that are implemented consistently across regions for eligibility. In addition the team will formulate monitoring reports that are reflective of each region's compliance with consistent application of eligibility rules</p> <p>Outcome: Consistent application of policy, uniform generation of data, consistent performance by field staff.</p>	See Compliance Monitoring Team—Item 1C	12 months	August 2002	July 2003	DDD submitted a form CR-101 rewriting WAC 388-825, which governs eligibility, to make the WAC clearer and enable more consistent application of the eligibility rules. Regional training occurs every 3 months on current WAC/eligibility process. A consistent eligibility process is the first priority for the Compliance Monitoring Unit.

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Item	Narrative	Resource Requirement	Duration	Begin	End	Progress to Date
3A cont						<p>Work is under way on defining the specific outcomes necessary to reaching compliance in eligibility determinations. These outcomes will be used to identify tasks, timelines, and outputs in completing this corrective action. This process will also produce the basic structure for completing tasks 3B, 3C, 3D, &amp; 3E.</p>
						<p>The monitoring team will begin with monitoring eligibility compliance. Once in place, the team will determine the risk level of each item in this document and determine which issue to put on monitoring schedule next. The process will be to bring elements (3B thru 3E) onto the monitoring schedule incrementally to allow adequate time for tool build and training for each element.</p>

## STRATEGIES FOR THE FUTURE REPORT – PHASE 3

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Item	Narrative	Resource Requirement	Duration	Begin	End	Progress to Date
3B	<p style="text-align: center;"><b>Service Assessment Process</b></p> <p>Description: Using the core principles of the Quality Improvement process, assign the Compliance/Monitoring team responsibility to develop clear policies and procedures that are implemented consistently across regions for, develop curriculum and train the field.</p> <p>Outcome: Consistent application of policy, uniform generation of data, consistent performance by field staff.</p>	See Compliance Monitoring Team—Item 1C	12 months	August 2002	July 2003	Compliance/Monitoring Unit task and is also connected to the Waiver application to CMS that is due no later than December 2002. The Waiver application will describe the process and this Unit will monitor its implementation
3C	<p style="text-align: center;"><b>Service Authorization</b></p> <p>Description: Under the aegis of the Compliance team, perform Quality Improvement process on this work process that leads to the development of clear policies and uniform procedures, develop curriculum and train the field.</p> <p>Outcome: Consistent application of policy, uniform generation of data, consistent performance by field staff.</p>	See Compliance Monitoring Team—Item 1C	12 months	August 2002	July 2003	Compliance/Monitoring Unit task and is also connected to the Waiver application to CMS that is due no later than December 2002. The Waiver application will describe the process and this Unit will monitor its implementation.
3D	<p style="text-align: center;"><b>Case Management</b></p> <p>Description: Under the aegis of the Compliance team, perform Quality Improvement process on this work process that leads to the development of clear policies and uniform procedures, develop curriculum and train the field.</p> <p>Outcome: Consistent application of policy, uniform generation of data, consistent performance by field staff.</p>	See Compliance Monitoring Team—Item 1C	12 months	August 2002	July 2003	Compliance/Monitoring Unit task and is also connected to the Waiver application to CMS that is due no later than December 2002. The Waiver application will describe the process and this Unit will monitor its implementation.

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Item	Narrative	Resource Requirement	Duration	Begin	End	Progress to Date
3E	<p style="text-align: center;"><b>Service Termination</b></p> <p>Description: Under the aegis of the Compliance team, perform Quality Improvement process on this work process that leads to the development of clear policies and uniform procedures, develop curriculum and train the field.</p> <p>Outcome: Consistent application of policy, uniform generation of data, consistent performance by field staff.</p>	See Compliance Monitoring Team—Item 1C	12 months	August 2002	July 2003	Compliance/Monitoring Unit task and is also connected to the Waiver application to CMS that is due no later than 12/2002. The Waiver application will describe the process and this Unit will monitor its implementation.

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For more information regarding the *Strategies for the Future Long-Range Plan* report or the Division of Developmental Disabilities, please contact:

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This document can be viewed on the DDD website (<http://www1.dshs.wa.gov/ddd>). Copies, alternate formats, or other languages are available by contacting Linda Johnson.