

**Aging and
Long-Term
Support
Administration**

Bill Moss, *Assistant Secretary*

2013-2015

Strategic Plan

March 2014



VISION

Seniors and people with disabilities living with good health, independence, dignity, and control over decisions that affect their lives

MISSION

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

VALUES

Collaboration
Respect
Accountability
Compassion
Honesty and Integrity
Pursuit of Excellence
Open Communication
Diversity and Inclusion
Commitment to Service

Introduction

The Department of Social and Health Services Aging and Long-Term Support Administration (AL TSA) offers services that empower senior citizens and people with disabilities to remain independent and supported in the setting of their choice. This is accomplished through person-centered case management that works with individuals to build a care plan that reflects individual choices and preferences.

AL TSA offers a variety of services that support people in the community, including:

- Support for family and kinship caregivers.
- Personal care and supportive services for individuals living in their own homes, adult family homes and assisted living settings.
- Available nursing services in all settings.
- Assistance with movement from nursing homes to independent living.
- Information and assistance regarding services available in-home, and in adult family homes, assisted living facilities, and nursing homes, including options counseling.
- Locally-designed programs focused on the needs of senior citizens.
- Care coordination for foster children to support improved outcomes for the children and their families.

AL TSA is also responsible for protecting the safety, rights, security, and well-being of people in licensed or certified care settings and for the protection of vulnerable adults from abuse, neglect, abandonment, and exploitation. AL TSA conducted more than 16,000 abuse investigations last year. In addition to investigating abuse, AL TSA offers protective services when the situation requires action in order to ensure vulnerable adults are safe.

AL TSA Core Principles

AL TSA's strategies are driven by several bedrock principles.

We believe the people we support:

- Should have the central role in making decisions about their daily lives.
- Will choose supports that promote health, independence, community integration, and self-determination.
- Succeed best when support is person-centered and recognizes that their needs are interrelated.

We believe families and friends of the people we support:

- Are an essential reason many people can live successfully in their own homes and communities.



- Can realize a positive difference in their lives, and the lives of their loved one, with even a small investment in support.
- Act as advocates for quality support and services in the best interest of their family member or friend.

We believe the **system of services** administered by ALTSA must be:

- Accountable for outcomes and costs.
- Informed by evidence of effectiveness.
- Responsive to changing needs.
- Sustainable over time and within realistic resource estimates.
- Collaborative with service recipients, families, communities, providers, partners, and other stakeholders.
- Accessible to individuals who are Limited English Proficient or have a communication barrier due to a disability.
- Able to keep people free from abuse and neglect, and support shared responsibility with individuals, families, providers, advocates and communities to prevent or respond to abuse and abusers.

Goals

Governor Jay Inslee's Results Washington Goals

ALTSA is a partner in Governor Jay Inslee's **Results Washington**, a focused effort to create effective, efficient, and accountable government.

Results Washington Goal Area number 4 is Healthy and Safe Communities. Under this goal area, ALTSA has lead responsibility for two success metrics under the Supported People: Quality of Life success indicator.

The ALTSA **Results Washington** success metrics are:

- Increase the percentage of supported seniors and individuals with a disability served in home and community-based settings from 86.6 percent to 87.2 percent by 6/30/2015.
- Increase the percentage of aging and long-term service and support clients served in home and community-based settings from 82.9 percent to 83.7 percent by 6/30/2015.
- Decrease the percentage of vulnerable adult abuse and neglect investigations open longer than 90 days from 23.2 percent to 12.05 percent by 6/30/2015.

Department of Social and Health Services (DSHS) Goals

As a member of the DSHS team, ALTSA also has lead responsibility for performance metrics that fit within DSHS' departmental goals. DSHS has the following five broad goals:

- Health – Each individual and each community will be healthy.
- Safety – Each individual and each community will be safe.
- Protection – Each individual who is vulnerable will be protected.
- Quality of Life – Each individual in need will be supported to obtain the highest possible quality of life.



- Public Trust – Strong management practices will be used to ensure quality and efficiency.

AL TSA Success Metrics Supporting the DSHS Goals

Health:

- Increase the number of individuals with high medical risks receiving Health Home services.
- Increase the number of individuals receiving coordinated services through Medicare and Medicaid.
- Maintain the number of contacts, care recommendations, and discharge of referred foster children at current levels.

Safety:

- Timely licensing re-inspections of Adult Family Homes, Assisted Living Facilities and Nursing Homes.
- Timely quality assurance for Residential Habilitation Centers and Supported Living Facilities.

Protection:

- Timely response to abuse and neglect allegations for vulnerable adults living at home.
- Decrease the number of open cases per investigative staff (caseload).
- Decrease percentage of abuse investigations open longer than 90 days.
- Improve the response time to abuse and neglect allegations in long-term care facilities.

Quality of Life:

- Increase the percentage of long-term services and support clients receiving services in home and community-based settings.
- Increase the number of clients who relocate from nursing homes to home and community-based settings.
- Increase the percentage of caregivers supported in the Family Caregiver Support Program, as an alternative for care recipients who remained without Medicaid long-term care services for 90 days or longer.
- Increase the number of applications approved within required time frames. Improve the determination of functional eligibility and access to services.
- Increase the number of completed captioned relay calls to better serve people who are deaf, hard of hearing or deaf-blind from 248,181 to 276,210 by July 2015.
- Increase number of sites with assistive listening systems to better serve people who are deaf, hard of hearing or deaf-blind from 4 to 40 by December 2015.
- Successfully meet benchmarks to develop and implement the Medicaid Community First Choice Option, as directed by the Legislature.

Public Trust:

- Implement Track 1 of an electronic payment system that will significantly increase overall payment integrity for social services organizations (known as 1099 providers) that contract with DSHS to provide long-term services and supports to DSHS clients by the end of 2014.
- Implement Track 2 of an electronic payment system and subsystem that will significantly increase overall payment integrity for Individual Providers that contract with DSHS to provide personal care services to DSHS clients by May 1, 2015.





Below are the details of ALTSA's Strategic Plan to meet each Strategic Objective. Strategic Objectives are discussed under the respective DSHS goal area. Strategic Objectives include a statement of importance, a quantified success measure, a timeline and, most importantly, an Action Plan. Strategic Objectives are monitored and reported quarterly at: <http://www.dshs.wa.gov/ppa/strategic.shtml>. Action Plans are updated quarterly (where applicable).

Strategic Objectives, Importance, Success Measures and Action Plans

DSHS Goal 1: Health – Each individual and each community will be healthy.

Strategic Objective 1.1: Improve health outcomes for individuals with high medical risk factors through implementation of the Medicaid Health Home services.

Importance: Individuals with high medical risk factors continue to experience poor health outcomes, in many cases because of low engagement in managing their health needs. This results in poor outcomes for the individual and higher costs for the state. Assisting individuals to self-manage their chronic conditions through the provision of Health Homes can empower them to take charge of their health care.

Success Measure: Increase the number of individuals who are engaged in Health Home services through the establishment of a Health Action Plan. Additional success measures will be consistent with performance measures included in the Final Agreement with the federal Centers for Medicare and Medicaid Services. Some performance measures in the final agreement are the percentage of:

- Hospital readmissions;
- Avoidable emergency room visits for individuals receiving Health Home services;
- Individuals with fewer than 30 days between hospital discharge to first follow-up visit.

Action Plan: Implementation of Health Home services went into effect in July and October of 2013. ALTSA will collaborate with the Health Care Authority and Behavioral Health and Service Integration Administration/DSHS to address implementation issues related to consumer enrollment and engagement in Health Home services. ALTSA continues to provide subject matter expertise for care coordination training in the delivery of, and engagement of, long-term care services and supports in Health Home services.

Strategic Objective 1.2: Improve health outcomes, coordination of care and the individual's experience of care through implementation of the HealthPath Washington Integration demonstration project in Snohomish and King Counties.

Importance: Washington is partnering with the federal Centers for Medicare and Medicaid Services to improve care for individuals receiving both Medicare and Medicaid services. HealthPath Washington is a joint demonstration project between DSHS and the Health Care Authority. The project will test a managed care financial model that integrates the purchase and delivery of Medicare and Medicaid



medical care, behavioral health and long-term services and supports through a single health plan. Enrollment will be voluntary and participants will be able to choose between health plans. Both counties have provided valuable input into the design and will continue with implementation efforts, monitoring and evaluation.

Success Measure: Increase the number of individuals receiving coordinated services through Medicare and Medicaid. Performance measures for the demonstration project are under development and subject to approval by the Centers for Medicare and Medicaid Services.

Action Plan: Collaborate and partner with other DSHS administrations to provide input and guidance toward implementation of the fully-capitated model. Determine policy, coordination, waiver authorities and communication strategies on how to incorporate long-term services and supports in the managed care model. Continue to work with King and Snohomish County Area Agencies on Aging and ALTA field offices regarding implementation planning.

Strategic Objective 1.3: Improve health outcomes for children in foster care through delivery of care coordination services.

Importance: The Fostering Well-Being Care Coordination Unit supports the health and well-being of children in foster care by providing an overview of the health care needs of the child, supporting access to health care providers, navigating systems of care as needed, and providing medical, nursing and benefit expertise to social workers and families.

Success Measure: Maintain the number of contacts, care recommendations, and discharge of referred foster children at current levels.

Action Plan: Efforts will continue to maintain staffing levels necessary to sustain this measure. Results of the March 2013 Lean Value Stream Map will be used to implement improvements to unit workflow, products, and communication. A plan will be developed with the Children’s Administration and the Health Care Authority, outlining changes to unit functions and responsibilities when children begin receiving health care through managed care organizations.



DSHS Goal 2: Safety - Each individual and each community will be safe.

Strategic Objective 2.1: Affirm Adult Family Homes, Assisted Living Facilities and Nursing Homes are providing quality care and residents are safe through timely licensing re-inspections.

Importance: This measure ensures licensing re-inspections are completed timely, provider practice is consistent with quality care and vulnerable adults are protected from abuse. Licensing re-inspections are a valuable tool to ensure the quality of care.

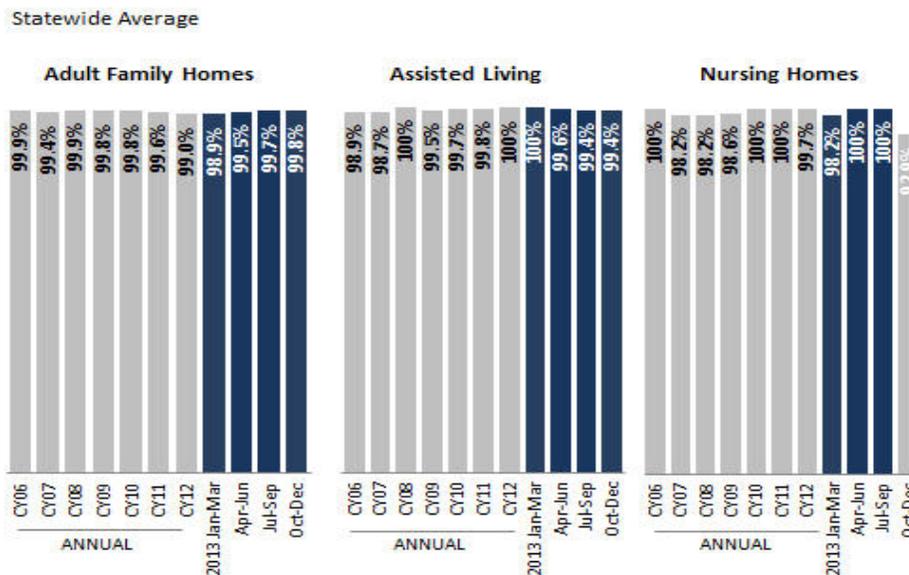
Success Measure: Maintain the percentage of timely re-inspection at 99 percent.



Action Plan: At the end of 2013 and early in 2014, Washington had several late nursing home surveys (as shown in Chart 2.1, below). AL TSA is continuing to identify and address the issues and is on track for surveys, starting in April 2014, to again achieve the performance measure standard of inspection at least every 15.9 months in each facility. AL TSA is also working to regain variability in the survey interval and address underlying factors of this success measure failure such as surveyor recruitment and retention. Effective immediately, the Residential Care Services (RCS) Division Assistant Director will review and monitor the schedules statewide.

AL TSA will regain timely re-inspection in nursing homes and will continue timely re-inspection in Adult Family Homes and Assisted Living Facilities within the required statutory timeframes and assess the provider’s ability to ensure residents’ quality of life, care, and safety needs. Adequate staffing will enhance the capacity to conduct unscheduled inspection visits, which ensure that the Department is getting an accurate picture of the quality of care provided in each facility.

CHART 2.1 Timely Licensing Re-inspections of Adult Family Homes, Assist Living, and Nursing Homes



Strategic Objective 2.2: Affirm Residential Habilitation Centers and Supported Living Facilities are providing quality care and residents are safe through timely quality assurance activities.

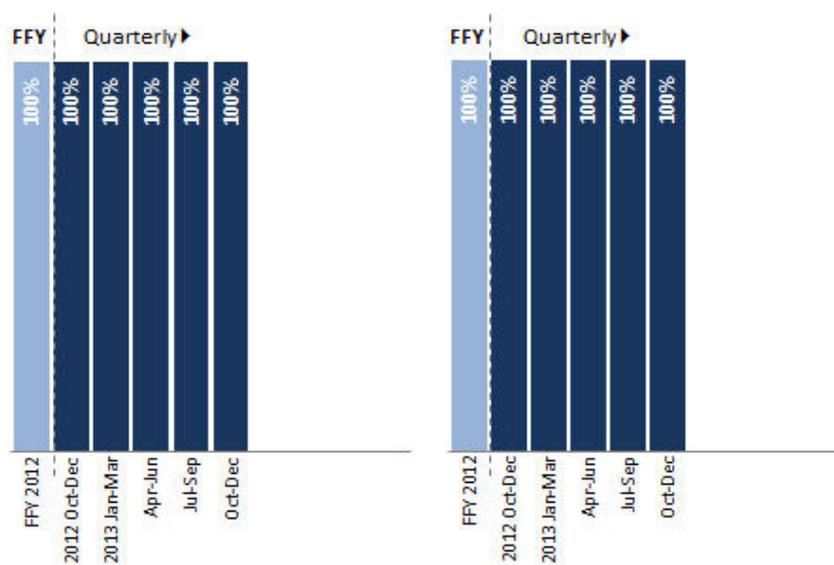
Importance: This measure ensures quality assurance activities are completed timely to help promote the quality of care and protect vulnerable adults from abuse and neglect.

Success Measure: Maintain timely quality assurance activities at 100 percent.

Action Plan: Conduct quality assurance activities in Residential Habilitation Centers and Supported Living Facilities within the required statutory time frames and assess the provider’s ability to ensure residents quality of life, care, and safety needs.



CHART 2.2 Timely Quality Assurance for Residential Habilitation Centers and Support Living Facilities
ICF/IID Supported Living



DSHS Goal 3: Protection - Each individual who is vulnerable will be protected.

Strategic Objective 3.1: Protect vulnerable adults living in their homes through timely responses to allegations of abuse and neglect.

Importance: Adult Protective Services has two primary duties: **1)** ensure vulnerable adults are protected and **2)** investigate allegations to determine if abuse occurred. Timely response is essential if services are needed to protect the vulnerable adult, to preserve evidence when necessary and protect vulnerable adults from perpetrators with final findings.

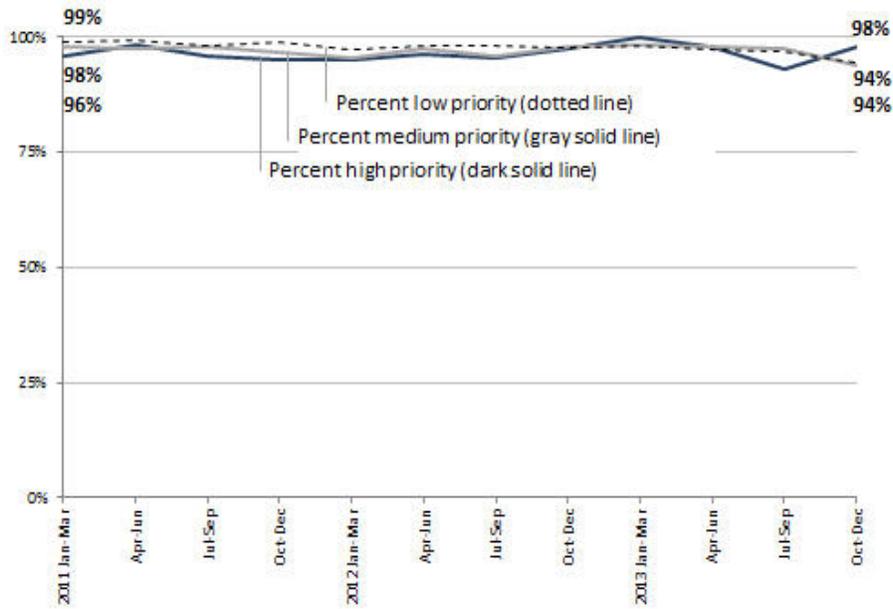
Success Measure: Maintain timely response to high-priority investigations at 99 percent, increase percentage for medium-priority investigations to 98 percent and increase percentage for low-priority investigations to 97 percent by the end of 2014. While a rapid response to individuals at risk of abuse is very critical, it comes at the expense of getting the investigations completed timely. As a result, the backlog of open cases continues to grow, and the quality and comprehensiveness of investigations may suffer while we focus resources on meeting initial response times.

Action Plan: In order to mitigate the lack of staff resources, the Department has leveraged maintenance-level funding to fund some additional staff and is in the process of completing automation enhancements that will further streamline the work of staff. Finally, the Department has conducted several quality reviews using Lean techniques and tools to identify efficiencies that will be put in place.



CHART 3.1 **Timely Initial Response Based on Adult Protective Service Case Priority**

Percent timely APS initial contact based on case priority - Statewide



Strategic Objective 3.2: Obtain adequate Adult Protective Services staff in order to ensure the quality of investigations and timely provision of protective services.

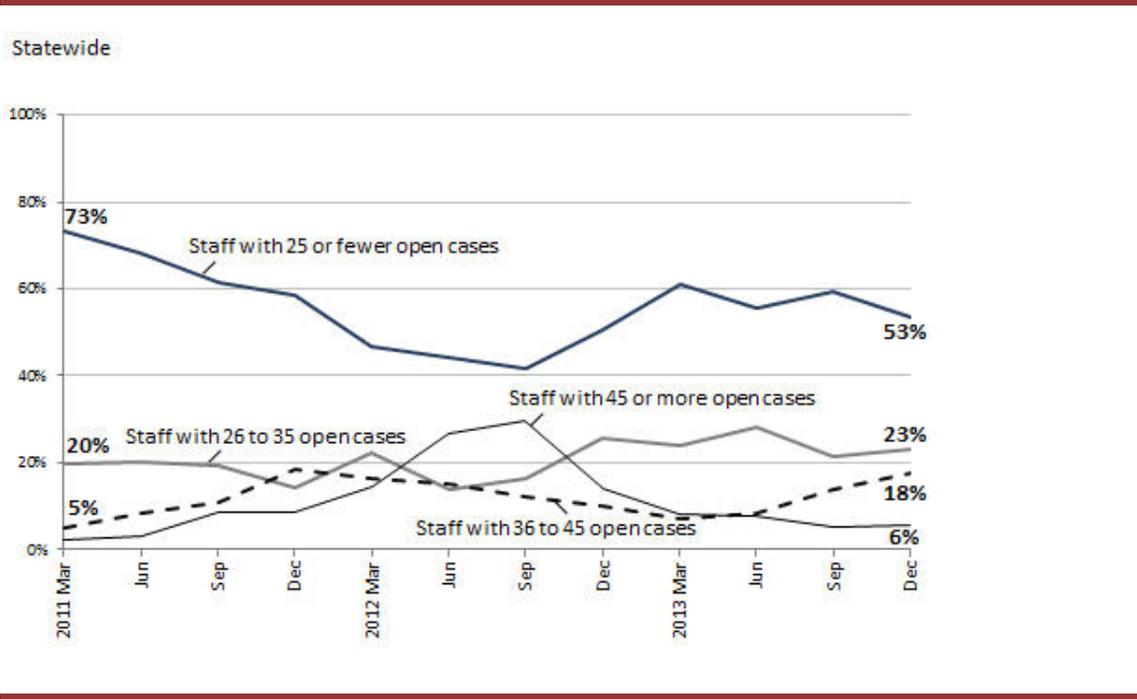
Importance: Current Adult Protective caseloads are too high. This creates a backlog in the number of cases open and makes it difficult for staff to meet response times, especially for medium and lower priority cases. The current caseload ratio is approximately 27:1; a more appropriate caseload ratio is 22:1.

Success Measure: Reduce abuse and neglect caseloads from 27:1 to 22:1 by the end of 2014.

Action Plan: Monitor open cases on a monthly basis. In order to mitigate the lack of staff resources, the Department has leveraged maintenance-level funding to fund some additional staff and is in the process of completing automation enhancements that will further streamline the work of staff. A 2013 Lean A-3 Problem Solving Strategy is being used to identify opportunities to improve effectiveness and create efficiencies. Additional activities are outlined in a related March 2014 A3 update in section 3.3, below.



CHART 3.2 Adult Protective Service Workers by Workload of Open Cases



Strategic Objective 3.3: Ensure investigations are thorough, documented properly, and completed timely to maintain an efficient work flow that eliminates re-work caused by investigations which remain open longer than necessary.

Importance: The lack of adequate staffing has produced a backlog in the number of cases remaining open longer than 90 days. This creates re-work for staff and a delayed results or findings against the alleged perpetrator. These delays expand the time it takes to place a perpetrator on the Abuse Registry. Reducing this backlog will ensure faster results regarding findings of abuse and improve workflow and efficiency.

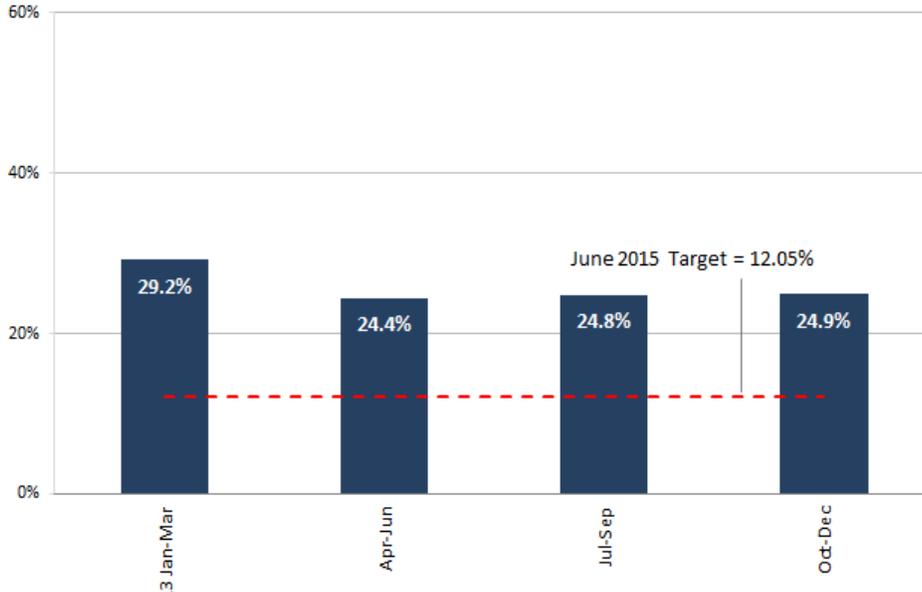
Success Measure: Decrease the percentage of vulnerable adult abuse and neglect investigations open longer than 90 days from 23.2 percent to 12.05 percent by 6/30/2015. This measure is attainable assuming adequate staffing levels are reached.

Action Plan: Monitor investigations open beyond 90 days and track data for use in staffing request and streamlining opportunities. Schedule a Value Stream Mapping (VSM) activity in April 2014 to examine the intake process. Additional activities are outlined in a related March 2014 A3 update, below.



CHART 3.3 Percent of Vulnerable Adult Abuse and Neglect Investigations Open Longer than 90 Days

Statewide - Percent Open Over 90 Days



A3 Problem Solving | % of Investigations of Allegations of Abuse, Neglect, or Exploitation of Vulnerable Adults Closed within 90 days of Receipt of Complaint

Lean!
Bill Moss - Update March, 2014
Assistant Secretary, DHS

Clarify the Problem
Adult protective services (APS) caseworkers investigate allegations of elder abuse, abandonment, neglect and exploitation. Their investigations occur in private homes and facilities, such as licensed Adult Family Homes and Nursing Homes. The increased number of incidents and referrals has far out-paced staffing resources. In addition, the complexity of investigations has increased with more time intensive financial exploitation cases now representing nearly one-third of all investigations. From 2005 to 2013, APS has experienced a 35 percent increase in case reports, a 25 percent increase in cases assigned for investigation, and a 30 percent increase in allegations investigated (one case may contain multiple allegations).

Breakdown the Problem

- The recent statutory requirements have led to increased complexity and workload pressures.
- Staffing ratios are insufficient to address the increased number of cases coming in the front door at intake. This is in part due to a lack of funding and an inability to hire outside of 90 days. (Starting date will be included showing cases open beyond 90 days by reason code (date available no later than 12/22/2015).
- There are two different intake systems for APS and Resident Care Clerk Program (RCCP). Both will roll out for APS and RCCP in May 2014.
- Staff turnover, turnover and training.

Identify Root Cause

Staff Turnover, Process, Financial Target Overdue Disbursements

Not being right person for job, Staff process has work, Main statistic measurement has been to ensure, Don't do what's needed, Over government, Doing well by sometimes, Staff leave, Admin take too long, Elder are being per treated later, Can't connect with people, The quality being, Investigations > 90 days, Long time to receive information on case, FAMILISTVA system not used, Can't keep up with demand, Communication barrier, Decision needed, Decision package needed, Disbursement Requirements, Staff Ratio

Identify Countermeasures

Root Cause	Proposed Countermeasures	Feasibility	Cost	Risk	Impact
Staff Turnover	Identify top training numbers and include RCCP in training and provide one on one support with staff	High	Medium	Low	High
Process	Identify and create checklists to improve the intake process	High	Low	Low	High
Financial	Review financial resources to support "senior" activities	Challenging	Medium	Low	High
Communication	Review financial resources and identify funding opportunities	Challenging	Medium	Low	High
Communication	Review financial resources and identify funding opportunities	Challenging	Medium	Low	High
Communication	Review financial resources and identify funding opportunities	Challenging	Medium	Low	High

Action Plan

Item	Problem to be solved	Action Item	Lead	Team	Due Date	Status
1	Staff Turnover	Identify top training numbers and include RCCP in training and provide one on one support with staff	Bill Moss	Bill Moss	03/20/14	On track
2	Process	Identify and create checklists to improve the intake process	Bill Moss	Bill Moss	03/20/14	On track
3	Financial	Review financial resources to support "senior" activities	Bill Moss	Bill Moss	03/20/14	On track
4	Communication	Review financial resources and identify funding opportunities	Bill Moss	Bill Moss	03/20/14	On track
5	Communication	Review financial resources and identify funding opportunities	Bill Moss	Bill Moss	03/20/14	On track

Evaluate Results Standardize then Repeat

Target Setting

Our short-term goal is to decrease the number of cases open beyond 90 days from 21.17% to 20% by September 30, 2014. Our strategic goal is to decrease the number of cases open beyond 90 days to 12.05% by December 31, 2015. Compare current change in PFD amount through the budget process.

A3 Metric | Click on the image above or click [here](#) to view the A3 Action Plan full sized (17" x 11").

DSHS Goal 4: Quality of Life - Each individual in need will be supported to attain the highest possible quality of life.

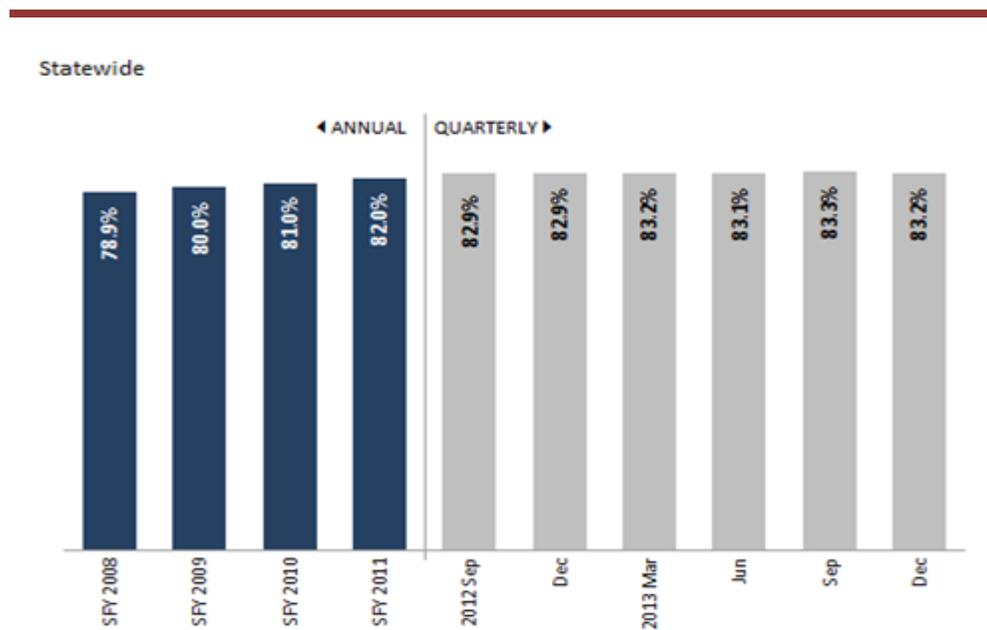
Strategic Objective 4.1: Ensure seniors and individuals with a disability who are in need of long-term services and supports are supported in their community.

Importance: The hallmark of Washington’s long-term services and supports system is that, whenever possible, individuals are given the opportunity to live and receive services in their own home or a community setting. Developing home and community-based services has meant Washingtonians have a choice regarding where they receive care, and has produced a more cost effective method of delivering services. The development of home and community-based services resources continues to evolve as individual’s support needs change. Washington is recognized as a national leader in this area.

Success Measure: Increase the percentage of long-term services and supports clients served in home and community-based settings from 82.9 percent to 83.7 percent by 6/30/2015.

Action Plan: Continue to work with individuals in person-centered service planning to develop service plans that reflect individual needs and preferences. Continue the development of home and community-based resources to ensure individual needs can be met in the least restrictive setting, including services for specialized populations. Conduct a VSM in May 2014 to examine the Individual Providers’ enrollment, training and certification process. Additional activities are outlined in a related March 2014 A3 update, below. Develop additional resources to support families and informal caregivers.

CHART 4.1 **Percent of Long-Term Services and Supports Clients Served in Home and Community-based Settings**



Strategic Objective 4.2: Increase the number of individuals ALTA is able to assist in transitioning to their homes or the community from nursing homes.

Importance: The majority of individuals who require support choose to receive help in their home or a community-based setting. Washington State has developed a system that is cost effective and offers

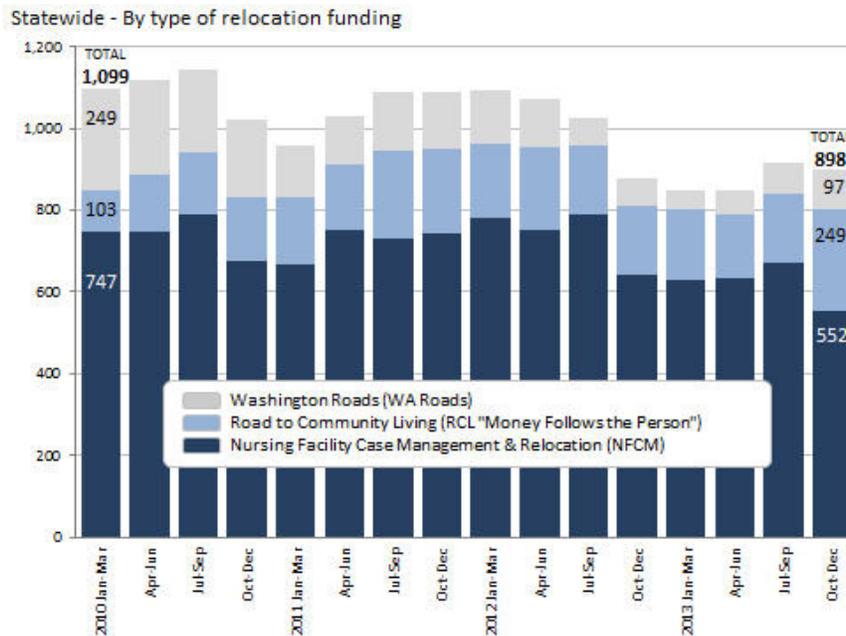


individuals choices regarding how and where they will be supported. We believe there is opportunity to increase the number of individuals being supported in the community. By doing so, we facilitate choice, increase quality of life, and contribute to the financial health of Washington. Washington is recognized as a national leader in this area.

Success Measure: Increase the average number of individuals relocated from nursing homes quarterly to 950 by the end of 2015.

Action Plan: Continue the emphasis on voluntary relocation and diversion, including working with individuals to develop service plans that address barriers to living in the community. Leverage the federal “Money Follows the Person” funding to enroll eligible clients into the program. Provide additional training to nursing facility case management staff to improve nursing facility case management practice and to build the skill set required to help people live successfully in the community setting of their choice. Develop strategies to actively engage hospitals and their discharge personnel. Emphasize the availability of the “Washington Roads” program to meet client needs when federal funding is not available. Continue to develop specialized community resources to serve individuals with complex needs in their homes and community. Additional activities are outlined in a related March 2014 A3 update, below.

CHART 4.2 **AL TSA Clients Who Actively Relocate from Nursing Homes to Home and Community-based Settings**



A3 Problem Solving | Increase % of Long-Term Service and Supports Clients Served in Home and Community Based Settings

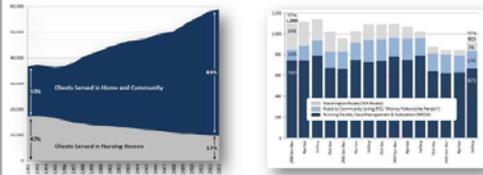
Lean!
 Bill Moss – Update March 2014
 Assistant Secretary, AL TSA

Clarify the Problem

- The number of people age 65 and older will double in Washington over the next twenty years.
- Many of these seniors will need long-term care, such as assistance with (and paying for) dressing, bathing, shopping, cooking, toileting and getting around.
- Most people want to stay at home or live in a home-like, community-based setting, rather than be in a nursing facility. Home and community-based services (HCBS) is also the most cost-effective way to serve seniors and individuals with disabilities.
- By responding to client preferences, we can meet their needs and sustain our ability to provide long-term support. All units within AL TSA contribute toward the goal of a responsive, high quality, and safe HCBS system.

Breakdown the Problem

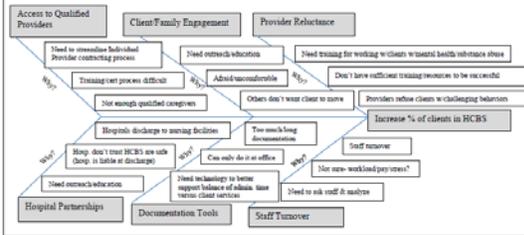
- As of September 2013 82.9% of AL TSA clients were served in community-based settings compared to 53% in 1992.
- In 2013 HCBS staff relocated an average of 300 Medicaid clients per month from nursing facilities to community based settings.
- 1/3 of clients residing in nursing homes are considered low acuity and many could be served in HCBS.
- Legislation changed training requirements for individual Providers (IPs) from 15 hours to 72 hours and now requires testing and certification from DOR. The complicated process has resulted in a reduction of available, qualified providers.



- March Update:
- VSM to look at IP Outsourcing process will be in May 2014
 - Meeting with IT to investigate options for "off-site" documentation will be in April, 2014.
 - Nurses are creating plans for hospital engagement.
 - Review of DSHS employee survey will occur once released.
 - Next meeting April 2, 2014.

Target Condition
 Increase % of long-term service and supports clients served in HCBS from 82.9% to 83.7% by 06/30/2015

Identify Root Cause



Identify Countermeasures

Root Cause	Proposed Countermeasure	Feasibility	Cost	Risk	Impact
Access to qualified providers	Contact Lean risk to simplify intake process for providers to complete application, training and certification process	Easy	Neutral	Low	High
Client/Family Engagement	Develop strategies to give information to clients/families earlier	Easy	Neutral	Low	High
Provider Reluctance	Develop resources for serving clients with challenging behavioral needs	Challenging	Neutral	Low	High
Hospital Partnerships	Focus on developing partnerships with hospitals at local level	Challenging	Neutral	Low	High
Documentation Tools	Investigate current technology vs. staff need	Easy	Neutral	Low	High
Staff Turnover	Investigate why staff leave	Easy	Neutral	Low	High

Action Plan

ID#	Problem to be solved	Action Item	Lead	Due	Status
1	Access to qualified providers	Schedule visit for Provider Outsourcing (apply, train, certify, contract)	Christine	6/30/14	On track
2	Documentation Tools	Meet with IT to discuss options for off-site documentation current system	Christine	6/30/14	On track
3	Hospital Partnerships	Meet with HCS nurses statewide to develop engagement plan with hospitals	Christine	6/30/14	On track
4	Staff Turnover	Evaluate survey. Coordinate with HRD to better utilize current exit interview tool and gather quarterly reports to be analyzed	Christine/Jamy	6/30/14	On track

Evaluate Results Standardize then Repeat

A3 Metric | Click on the image above or click [here](#) to view the A3 Action Plan full sized (17" x 11").

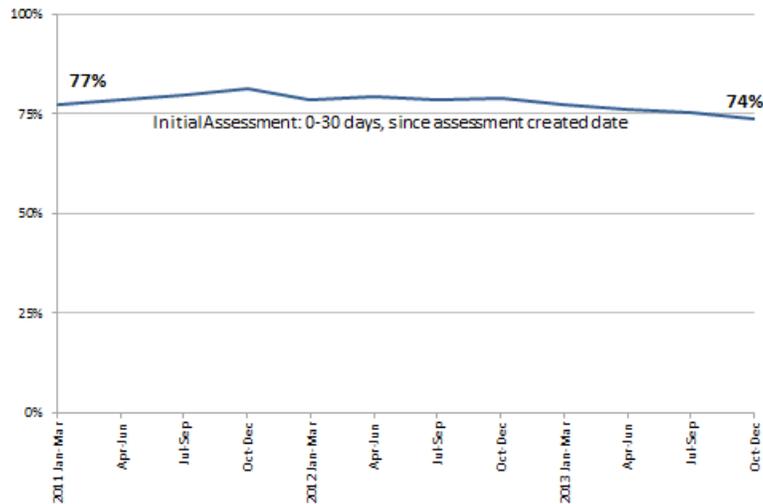
Strategic Objective 4.3: Ensure individuals who apply for services receive them timely so they are supported in the setting of their choice.

Importance: This objective has two success measures as both are related. In order to receive support, an individual must be both functionally eligible (meaning they require assistance with activities of daily living) and they must be financially eligible (meaning their assets and income must be within limits). When this has been established, support services may be provided. It is very important to provide support services in a timely manner to avoid problems that may occur absent the support services, such as loss of mobility, poor nourishment, medication errors and other problems that can produce poor health outcomes for individuals.

Success Measure: Increase the percentage of timely approvals for application from 79 percent to 90 percent by the end of 2014.

Action Plan: AL TSA has prioritized recruitment efforts and will continue to develop strategies to recruit and retain quality staff. AL TSA will also continue to audit a statistically significant sample of client files to measure compliance; continue to require supervisors to audit files and monitor compliance with policies and timelines; and provide training and emphasize the federal requirement for financial eligibility of processing cases within the 45-day timeframe. In 2014, complete a Lean A-3 Problem Solving Evaluation and staff performance evaluations to improve effectiveness and efficiency.

CHART 4.3 Timely Determination of Functional Eligibility and Access to Services



Strategic Objective 4.4: Support families and informal caregivers that provide un-paid support to those in need.

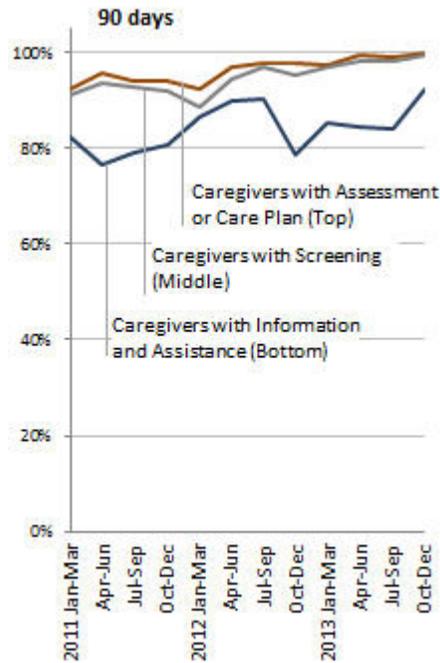
Importance: Families and other informal support providers are integral to Washington’s long-term services and supports system. An investment to support informal caregivers ensures that Washington continues to be a national leader in providing family and caregiver supports. Data indicates that the higher the level of engagement with proven interventions, the greater the level of avoidance to access Medicaid long-term services and supports.

Success Measure: Increase the percentage of caregivers supported in the Family Caregiver Support Program as an alternative for care recipients who remain without Medicaid long-term care services for 90 days or longer.

Action Plan: Continue to train and certify TCARE® users. Work with partners and consultants to translate TCARE® tools into three additional languages. Continue to trend outcomes of TCARE® and the Family Caregiver Support Program. Explore opportunities for federal matching funds. Identify strengths and opportunities for improvements to Family Caregiver Support Program. Continue to develop additional services and supports at local community levels.



CHART 4.4 Percentage of Caregivers Whose Care Receiver Remained Without Paid Long-term Care Medical Services for 90 Days



Strategic Objective 4.5: Remove barriers to telecommunications by providing current and emerging telecommunication services for people who are deaf, hard of hearing or deaf-blind.

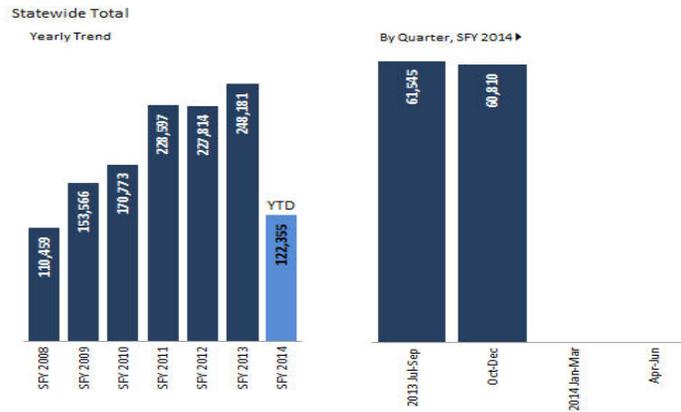
Importance: The rise in the prevalence of hearing loss in the general population, especially among returning veterans, youth and senior citizens, will affect many who experience increasingly limited access to telecommunications. Captioned Telephone Service (CTS) will enable affected persons to make telephone calls with ease.

Success Measure: Increase the number of completed captioned relay calls from 248,181 to 276,210 by July 2015.

Action Plan: AL TSA is currently executing an outreach plan to bring public awareness of CTS and the availability of CTS equipment from the Telecommunications Equipment Distribution (TED) program. July 2013 - June 2014 activities include presentations, booth exhibits and publications. From January - June 2014, AL TSA will advertise CTS services in the Hearing Loss Association quarterly newsletter and promote CTS services through radio and television public service announcements.



Chart 4.5 **Number of Completed Captioned Telephone Service (CTS) Relay Calls**



* Note: SFY 2014 numbers, above, are Year-To-Date.

Strategic Objective 4.6: Provide Equal Access Opportunities to DSHS Services for people who are deaf, hard of hearing or deaf-blind.



Importance: Many individuals with hearing loss do not use sign language. Assistive listening systems aid in ensuring that effective communication occurs between people with hearing loss and employees or contractors providing DSHS services during in-person office visits. These assistive listening systems help clients to access DSHS programs and services.

Success Measure: Increase the number of sites with assistive listening systems from 4 to 40 by December 2015.

Action Plan: ALTSA initiated a Request for Qualifications and Quotations (RFQQ) release by December 31, 2013 and will execute a purchase service contract in the spring of 2014. Ongoing, ALTSA is partnering with the Economic Services Administration (ESA) and the Division of Vocational Rehabilitation (DVR) to identify offices that need access, schedule a contractor to install induction loops and train DSHS employees on how to use the systems.



Chart 4.6 Increase in the Number of DSHS and Contractor Sites with Assistive Listening Systems Installed



Strategic Objective 4.7: Design and implement a Medicaid Community First Choice Option (CFCO-State Plan) program in a manner consistent with legislative direction.

Importance: The Community First Choice Option is a new Medicaid entitlement state plan option established by the Affordable Care Act (ACA). Through CFCO, Washington State has the opportunity to leverage 6% in additional federal funding for the majority of home and community-based services, potentially freeing up state funds for long-term services and support reinvestments. Some of the enhanced match is necessary to meet maintenance of effort requirements, costs of new, required services and program staff necessary for design and implementation. A planning and implementation council made up of clients and their representatives must be involved in planning and implementation of the program.

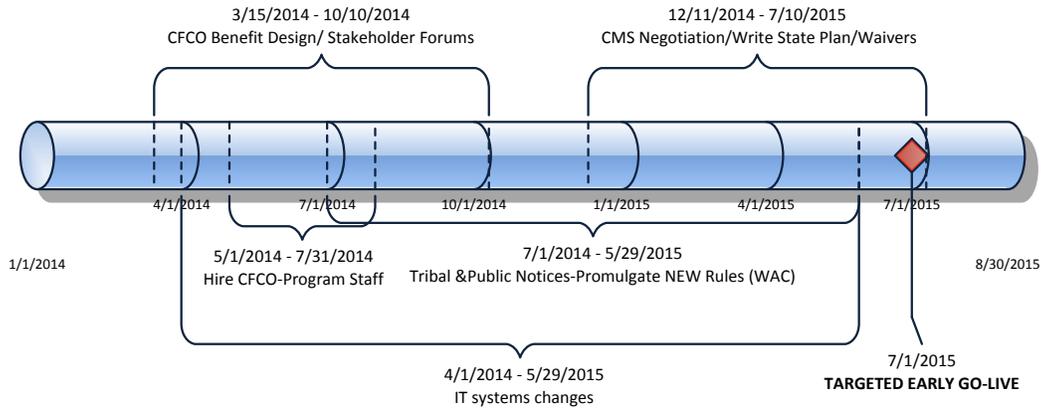
Success Measure: Successfully meet benchmarks to develop and fully implement the Medicaid Community First Choice Option not later later than August 30, 2015.

Action Plan: Major milestones include:

- Evaluate changes to current state plan and waivers and conduct CFCO benefit design forums through a federally-required development and implementation stakeholder process.
- Hire program staff to ensure adequate planning, development and implementation.
- Evaluate and implement necessary IT systems' changes for client care assessment, financial eligibility determination and provider payment.
- Issue public and tribal notices and promulgate new rules.
- Develop new payment codes, policies, manuals and training materials.
- Negotiate to gain final federal approval and submit final state plan and waiver amendments.
- Implement the Community First Choice Option and establish ongoing program support.



**COMMUNITY FIRST CHOICE OPTION TIMELINE FOR JULY 2015
IMPLEMENTATION**



DSHS Goal 5: Public Trust – Strong management practices will be used to ensure quality and efficiency.

Strategic Object 5.1: Implement an electronic payment system (known as ProviderOne Phase 2) that will significantly increase overall payment integrity for social services organizations and Individual Providers that contract with DSHS to provide long-term services and supports to DSHS clients.

Importance: Washington State is engaged in the second phase of consolidating long-term care services and supports payments into a single, federally-certified payment system (also referred to as ProviderOne Phase 2). This new payment system will significantly increase overall payment integrity impacting 75% of all social service Medicaid and state long-term care payments issued. Track 1 of this project pertains to payments made to 1099 social service providers while Track 2 implements a subsystem design for payment of Individual Providers who provide personal care services to DSHS clients. Every payment will be verified and accounted for by automatically checking client and provider eligibility, and other audit requirements, bringing the state into compliance with federal requirements. With these changes, Washington State will continue to be a model for other states to follow.

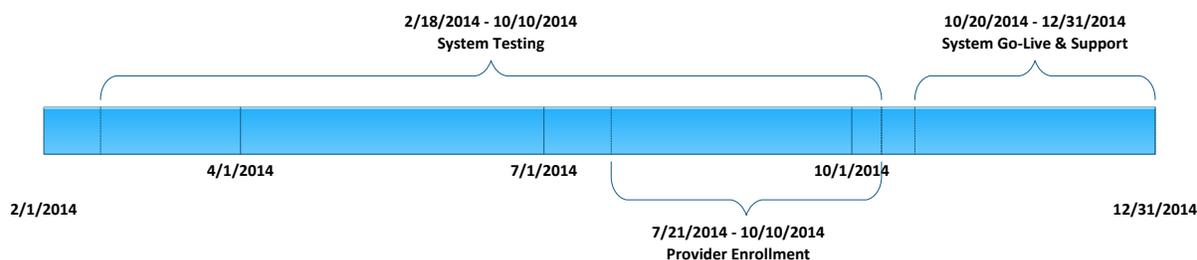
Success Measure: Meet identified benchmarks to successfully implement the payment system for social services organizations and Individual Providers that contract with DSHS to provide long-term services and supports to DSHS clients.

Action Plan: Key Milestones:

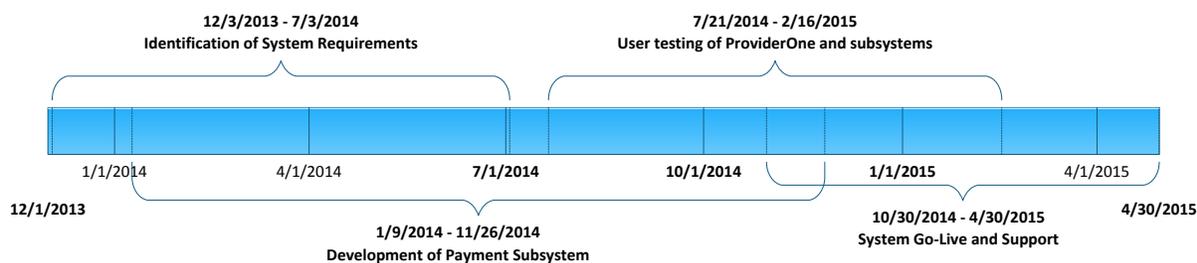
1. Identification of system requirements
2. User testing of ProviderOne
3. Provider Enrollment implementation
4. System Go-Live and Support



Track 1: ProviderOne Phase 2 Implementation Timeline for Social Service Organizations



Track 2: ProviderOne Phase 2 Implementation Timeline for Individual Providers



Other important work in ALTSA

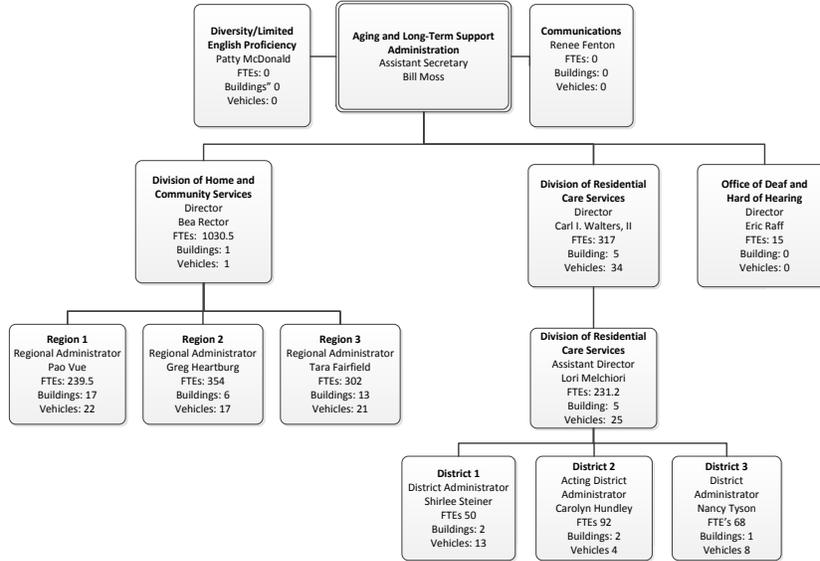
- Partner with Tribal governments to establish Tribal home care agencies to serve the growing number of American Indian and Alaska Native people in need in their communities.
- Streamline the Area Agency on Aging contracting process to simplify Tribal government involvement and allocation of resources to serve Tribal people.
- Build a sustainable future through development and implementation of innovative services designed to leverage federal funding and assist individuals and their caregivers to manage their own care when possible.
- Develop and adapt performance measures for inclusion in Area Agencies on Aging contracts by July 1, 2015, as required under House Bill 1519, related to: improvements in client health status and wellness; reductions in avoidable high-cost services; increases in stable housing in the community; and improvements in client satisfaction with quality of life.
- Improve capacity to support individuals with dementia and traumatic brain injury in community-based settings.
- Support the work of the Joint Legislative/Executive Committee on planning for aging and disability issues.
- Modify the five-year plan for sustainability of the Aging and Disability Resource Centers and continue expansion to reach the statewide coverage goal for a diverse population.
- Continue to develop specialized information, supports, and support groups for people with traumatic brain injury.



- Update the Cultural Competency Action Plan to address: cultural competency accountability measures; building community partnerships and ensure language access.
- In partnership with the Division of Vocational Rehabilitation, create a work plan outlining key employment support strategies and milestones designed for people with physical disabilities.
- Develop Enhanced Services Facilities to provide community-based long-term services and supports for people who are currently without a community-based option.
- Implement recommendations of the Adult Family Home Quality Assurance Panel enacted by the Legislature in Substitute Senate Bill 5630, which includes: completing the development of a care and service disclosure form for Adult Family Homes; developing a separate disclosure form for the financial cost of Adult Family Home care and services; creating a customer-oriented website; and reviewing specialty training to determine need for revision.
- Continue to ensure the availability of a well-trained and qualified provider workforce statewide. Continue to work with service providers, training programs, the Department of Health, and disability advocates addressing barriers to a stable home and community-based workforce.
- Continue to work with Area Agencies on Aging to deliver quality services pursuant to the federal Older Americans Act. This includes reviewing and approving updates for the two-year Local Area Plans.
- Work with the federal Housing and Urban Development, the State Department of Commerce, local housing authorities, and landlords to develop affordable and accessible housing options for individuals served by ALTSA.



Department of Social and Health Services
Aging and Long-Term Support Administration



February 20, 2014

