Strategic Plan 2009-2013

Aging & Disability Services Administration

EXECUTIVE SUMMARY

The populations served by the Aging and Disability Services Administration (ADSA) are growing and their needs are becoming more complex. Funding for government services is not likely to keep up with the growing demand. The challenge facing ADSA and its partners in the coming biennia is to develop ways to help Washington's citizens with developmental disabilities and those needing long term care to access quality services in a cost effective manner.

Growing caseloads and complexity of cases is evidenced by:

- Advances in medical technology that result in people with significant disabilities surviving longer. Additionally, the incidence of some conditions such as autism, dementia, and traumatic brain injury has increased over time.

- Program experience that indicates rising complexity of needs in older adults as well as children and adults with disabilities. As ADSA provides services, we encounter a growing number of high-risk clients with various combinations of complex medical conditions, behavioral health needs, prescription drug requirements, cognitive deficits and functional and developmental disabilities.

- The Office of Financial Management projects growth in the aging population of 31.64% from 2008 to 2015 and growth in the DDD population of 7.7% during that period. In the longer term, the aging of the Baby Boom generation threatens to overwhelm the long term care financing system and infrastructure nationwide. Washington State's population over 85 is expected to double by 2030 when the first Baby Boomers reach 85.

ADSA brings together under one administrative organization the major long-term care and support service programs for seniors and adults with long term disabilities, chronic illness and related functional disabilities, and for children or adults with developmental disabilities. The array of services includes local and state information, referral, and assistance; assessment of functional care needs and financial eligibility; service planning; case management; home and community based services; family and caregiver support and respite; access to a wide range of community-residential care options, nursing facilities, residential habilitation centers for persons with developmental disabilities; and specialized employment and early intervention services for persons with developmental disabilities. Services are delivered either directly by ADSA employees or through partnerships with counties, Area Agencies on Aging, contracted agencies and providers

In FY 07-09, ADSA will administer a budget of approximately $4.8 billion and directly employ approximately 4,650 people to provide services for individuals in all stages, from birth throughout life. Service providers employ over 50,000 part and full time employees to accomplish program activities. Appendix 1 provides a brief description of some of the services we provide. Appendix 2 lists the statutory authorities under which we operate. Appendix 3 of this plan provides a snapshot of the numbers of clients and providers, and average payment rates for ADSA's core services.

Our strategic plan focuses on five goals for improving access to needed care for persons with developmental disabilities and those needing long term care:

- Continuing to improve the balance between home and community options and institutional use
- Continuing efforts to enhance quality of services
- Maintaining timely access to programs and responsiveness to changing needs, and managing risk through appropriate staffing
- Providing holistic care and serving individuals with complex needs
- Helping individuals and families to access caregiving information and plan for their own future needs

The goals are interdependent. Each goal was woven through the others as we considered how to address these challenges. The goals are not listed in priority order. Each is a critical goal in moving ADSA toward achieving its mission.

In developing the strategic plan, ADSA met with almost fifty stakeholder groups to discuss how to plan for future challenges and opportunities. We received more than 500 different comments from these meetings. ADSA management reviewed all the comments in deciding which we could incorporate in the strategic plan at this time. We greatly appreciate the time that stakeholders devoted to this process and the thoughtful comments we received.

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ADSA's MISSION

The Aging and Disability Services Administration (ADSA) assists adults with disabling conditions due to aging, disease or accident and children and adults with developmental disabilities to gain access to the high quality, cost effective supports and services they need.

VISION

ADSA helps individuals and their families improve quality of life, develop and maintain self-sufficiency, and remain contributing members of their community. We guide a system of services that are high quality, responsive to individual needs and preferences, and cost effective.

We achieve success by supporting individuals, families and caregivers; expanding service options; and continuously improving quality of care and support in all settings. The supports and services we deliver are based on each individual's unique strengths and needs.

We contain overall costs by promoting prevention and self-reliance, reducing unnecessary use of more expensive services, and preventing or reducing the need for future services or resources.

We are developing an increasingly integrated social and health care program. Our objective is a system that delivers seamless medical, habilitative, mental health, long-term care, employment and supportive services in the person's own community.

ADSA programs are accountable for high standards of preventative care. We use chronic care management practices that are outcome oriented and evidence based. In addition, ADSA's programs demonstrate superior service quality, community integration, continuity of care and support, economic value, and consumer satisfaction.

GUIDING PRINCIPLES AND VALUES

ADSA Values:

- Individual worth, dignity, respect, self-direction, self-reliance, choice, and ability to accept responsibility and risk.
- Right to be free from abuse, neglect, abandonment, financial exploitation, and discrimination.
- An individual's social and health needs are strongly linked.
- Family caregivers have a critical role in providing support.
- Prudent management of state and federal resources; use of outcome-oriented, accountable, efficient, research-based practices for maximum public benefit.

ADSA Guiding Principles:

- Individual choice and self-direction are supported by professionals – not replaced by them.
- Services and supports enable people to remain in their own home and community whenever possible.
- Support for families and caregivers that improve client outcomes.
- Appropriate prevention, health management, and intervention services and policies to help alleviate future crises, improve individual and family capacity for independence, and reduce the need for future, more expensive and less preferred services.
- A cost-effective array of services to respond to diverse needs and preferences.

- Monitoring quality, safety, and accountability of federal and state licensed/certified residential care programs in the interest of residents, regardless of payment source.
- Clear and consistent policies and procedures necessary to produce a reliable, accountable service system.
- Services and supports that are culturally and linguistically appropriate.

Goal 1 – Continue to improve the balance between home and community options and institutional use

A number of demographic changes are expected that will challenge ADSA in the future. The aging of the Baby Boom generation threatens to overwhelm the long term care financing system and infrastructure nationwide. Washington State's population over 85 (the age cohort most likely to need long term care services) is expected to double between 2005 and 2030 when the first Baby Boomers reach age 85. Currently, almost 35% of the ADSA caseload is comprised of individuals with disabilities under age 60. Younger individuals are more likely to want to direct their own care and access services such as employment that older clients may not desire. Younger disabled individuals are also likely to need services for a much longer time than do the older adults.

Medical advances mean that people with developmental disabilities are living much longer, often requiring lifetime support. In 2006, there were approximately 77,800 persons with a developmental disability in Washington State. 37,000 of those individuals had received a determination of developmental disability by ADSA and about 21,000 were actually receiving services paid for by ADSA. Clearly, the demand for additional services exists. A challenge to ADSA is to find ways to serve the pent-up demand within funding and infrastructure restrictions.

Washington State's long term care program is considered a national leader for our work expanding service availability. We have done that by focusing on services in the individual's own home and or community and reducing reliance on services in institutional settings. The State's programs for people with developmental disabilities are also increasingly focusing on providing services in home and community settings. Even so, institutional settings will continue to be an important service setting. For some individuals, a nursing home or Residential Habilitation Center is the preference and an appropriate service setting. Home community based options are most often preferred by consumers because they maximize independence and the ability to direct one's own life. While home and community options are most often preferred by consumers and are generally less costly than institutional services, there are associated challenges.

The ability to provide services in home and community settings is contingent on availability of quality home and community options statewide. Providers in institutional and home and community settings across the state are struggling with attracting and maintaining adequate numbers of competent staff. Rural areas have found it difficult to attract service providers. A possible significant increase in training requirements may make it challenging to attract, train, and retain caregivers, particularly in rural communities. It is also challenging to ensure that services consistently reflect different cultural preferences and the needs of tribes.

There are widely divergent opinions on the desired role of the Residential Habilitation Centers. Comments on this strategic plan ranged from suggesting that the RHCs be expanded and considered the center for all DDD services to recommendations that the RHCs be closed. Although stakeholders disagree about the role of the RHCs in service

delivery, there is no expectation that RHC capacity will grow in the future. Neither is there an expectation that the RHCs will close. Given the expected growth in the numbers of persons who will seek services from DDD, there will be a need for additional, stable placement options in community settings. Additionally, as an optional state Medicaid plan service, RHCs must be available to any person with developmental disabilities who meets admission criteria. Since admissions to eligible people cannot be denied, RHCs must receive adequate funding levels to provide needed services.

Expanded use of home and community settings will require that service providers are able to meet a variety of more complex needs. For example, the most frequent comment we received as we discussed the ADSA strategic plan was the need for mental health services tailored to the specific needs of people with developmental disabilities, and older adults and adults with disabilities. ADSA and its service providers must also be prepared to coordinate with providers of housing, substance abuse programs, chronic care, medical care, employment, etc. Services must be flexible, creative, and coordinated with family members and caregivers. They must be available in the settings where people receive long term care or DDD services -- in their own homes and communities.

In 2008, the Legislature funded an update to the cost base for community residential providers as well as implementation of phase one of a payment system containing 17 levels of care that will more closely reflect acuity of clients. This plan to link payments more closely to client need may help to focus resources on clients' specialized needs. Targeted Medicaid payment increases may also encourage growth in numbers of service providers. Over time, we will need to assess whether further adjustments to the payment systems are necessary to encourage providers in rural areas, encourage care for specialized needs, improve wages for caregiving staff, and/or remove disincentives for providers to focus on client care.

Work is needed to ensure that the balance of expenditures for nursing homes and home and community services is appropriate. The 2008 Legislature discussed simplification of the nursing home payment system. ADSA will examine options and make recommendations to the Governor and the Legislature for simplification of the nursing home payment system. We will also continue to work with nursing home providers and the Department of Health to ensure that the approved numbers of nursing home beds in Washington reflects the future need for nursing home services given the availability of other options.

There is a need to improve the ability of home and community providers to serve individuals with a variety of needs. Successful home and community service delivery depends on the ability to coordinate a response to the individual's behavioral health, employment, housing, medical, and pharmaceutical needs and many more. New service models are needed to address these needs.

We must continue to advocate for support for existing services. A nationally respected leader from Washington State's long term care program liked to say "the most important service is the one you need". There are a variety of "most important services" currently being provided in Washington State. We must advocate for expansion of services such as chronic care management, behavioral supports, family support, home and community waiver slots, respite care, and so on to ensure that the "most important service -- the one that the individual needs-- is available to help maximize quality of life and health status.

A potential threat to existing services is the potential of loss of federal funding. Approximately half of ADSA's budget is federal funds. A recent federal rule change

jeopardizes the federal match that we receive for targeted case management. There are rumors from the federal level that over all federal match rates will change. The funding provided by the federal government to do survey and certification activities in nursing homes has eroded year after year and is threatened to be reduced even more. Washington State must be active in advocating for adequate federal funding for programs.

Objectives and Strategies

Objective: Adjust payment systems where necessary to provide incentives to meet client needs in home and community settings

Strategies

- Continue to phase in a fully funded 17 level payment system in community residential settings to address acuity and ensure that rates are equitable across all community residential settings. Analyze whether further payment incentives in all service settings are necessary to encourage providers in rural areas, reflect specific client needs, encourage quality provider performance, or address specific costs such as insurance. Develop additional strategies for all service settings to ensure adequate numbers of workers & adequate wages. Review payment rates to ensure that they do not provide disincentives to care.
- Develop proposal for the legislature to simplify the nursing home payment system, including analysis and a plan for fair rental system of payment for capital. Assess the need for a new Nursing Facility Information System to operate a simplified system.
- Continue to work with the Department of Health and nursing home provider associations to support a change in the Certificate of Need bed need ratio for nursing homes to reflect the preference for home and community services
- Advocate for appropriate vendor rate increases for all service providers

Objective: Maximize consumer empowerment, self-determination, and direction in the design, implementation, and evaluation of programs and services

Strategies

- Expand New Freedom waiver.
- Train staff in supporting client self-direction through improved person centered planning and self-activation models.
- Evaluate the effectiveness of interventions in supporting self-sufficiency and independence.

Objective: Encourage growth of services in rural areas and services provided by culturally competent providers

Strategies

- Explore securing a home and community based geographic waiver for tribal communities.
- Collaborate with tribes to conduct a needs assessment to identify needs of elders and develop strategies to serve them.
- Work with partners to present periodic individual provider training and/or orientation, demonstration of registry process, orientation to contract requirements for adult family homes and assisted living at tribal locations.
- Request funding for staff training to support cultural diversity of clients.
- Improve access to translation services.
- Continue to develop residential models in underserved communities.
- Consider whether definition of "rural" needs to be changed in payment mechanisms.

Objective: Develop new service models to encourage home and community services and coordination with other supports

Strategies

- Improve partnerships with housing agencies to provide safe, affordable housing – particularly for aging parents, mentally ill individuals who receive services at home, or homeless persons. Develop alternative financing and housing models such as partnership with a housing authority to develop a facility that would take 80% Medicaid clients, new models of public/private partnership, co-housing, care cooperatives in rural areas, housing with services models.
- Increase affordable, accessible housing to improve the ability of consumers to live in the community.
- Expand use of site-based services such as cluster care
- Develop residential options for clients with developmental disabilities and others such as individuals with traumatic brain injuries who are not eligible for DDD services
- Develop a set of expert in-home providers in each community to support DDD social workers to prevent the need for out-of-home placement
- Work with HRSA to develop and request funding for behavioral health services including mental health and substance abuse services that are specific to the needs of older adults, and people with physical or developmental disabilities. Services should intervene early to prevent hospitalization or chronic disease processes, and expand upon evidence-based strategies. They should be coordinated with family members and caregivers, delivered in conjunction with other medical and long-term care supports, and available where the person lives. Work to develop increased availability of on-site, on-call assistance with behavior management.
- Request funding for expanded slots for Enhanced Community Services program providing mental health services in adult family homes and boarding homes.
- Develop additional wrap around services for those with challenging behaviors
- Develop a waiver for services to individuals with Traumatic Brain Injury.
- Implement supports for aging in place throughout the spectrum of services.
- Request state matching funds to implement Administration on Aging consumer-directed nursing home diversion grant.
- Participate in Roads to Community Living grant and request necessary funding and/or legislation to implement proven services into existing long-term care programs.
- Establish a system of on-call caregivers for APS cases, including dedicated APS emergency beds in AFHs & nursing homes.

Objective: Continue to advocate for support for existing service models

Strategies

- Project growth for Basic, Basic+, Core and Community Protection Waivers, Individual and Family Services to ensure that appropriate supports and services are available for people with developmental disabilities including those leaving institutions and those who are severely and profoundly disabled.
- Evaluate use of In-Home Supports Model Waiver to improve understanding of practices that successfully support at-risk children at home in cost-effective ways
- Work with DSHS, OFM, and legislative staff to identify rate or expenditure models that consistently and accurately reflect the cost of services in RHCs. Request funding for RHCs at needed levels to accommodate eligible people that are entitled to admission
- Expand use of in-home and community based options for individuals with chronic conditions
- Support continued funding for adult day health/adult day care

- Educate hospitals and physicians on what settings other than nursing homes can offer
- Provide respite coverage for relative providers to attend trainings to become individual providers or nurse aides.
- Assist current provider agencies with opportunities to grow and add providers
- Advocate for additional Older Americans Act funding for community based programs and AAAs
- Develop request legislation to prohibit private pay admission agreements prior to applying for Medicaid coverage.
- In coordination with changes to the community residential rates, explore regulatory changes to require adult family homes and boarding homes to offer assistance with activities of daily living and intermittent nursing services.

Performance measures:

- Nursing home caseload: target = 10,000 by FY 13. Baseline = 11,219 Jan '08
- RHC census: target = 1,000 by FY 13. Baseline = 992 Jan '08
- Percent LTC clients served in home/community settings: target = 80% by FY 13. Baseline = 78% Dec '07
- Percent of DD clients served in home/community settings: Target = 96% by FY13 Baseline = 94% 2007

Goal 2 – Continue efforts to enhance quality of services

Individuals and families demand quality services as do policy makers and funders on the state and federal level, the public, and the courts. Investments in quality services can help maximize individual abilities, reduce litigation risk, and potentially reduce service needs and costs.

The primary responsibility for quality services rests with care providers. But providers struggle to serve increasingly complex clients; coordinate with service delivery systems such as medical, mental health, employment; find, recruit, train and retain staff with appropriate skills; and meet increasing costs of care. In support of providers, ADSA advocates for adequate Medicaid payment levels, works to appropriately assess Medicaid client needs, assists providers in understanding and meeting care requirements, and assists in coordination of care where possible.

ADSA is responsible for monitoring the quality, safety and accountability of the services provided in Washington State to vulnerable adults and people with developmental disabilities regardless of whether or not those services are paid for by government funds. While Washington's quality assurance system is nationally respected, there are improvements needed. Washington's quality assurance systems need *programmatic* changes to help providers to meet expectations. Additionally, ADSA's quality assurance *processes* need new supports including adequate staffing levels.

Licensure and certification programs have been and should continue to be strengthened by increasing ADSA staff to allow visits to newly licensed adult family homes within 90 days to ensure that providers understand and are meeting requirements. The nursing home and adult family home programs currently benefit from periodic visits of ADSA staff who provide technical assistance. In adult family homes, these visits are targeted to new providers but the adult family home program would benefit from expanding the visits to providers under enforcement actions or about to enter into enforcement actions. Resources should also be made available to develop this program in boarding homes and supported living and to expand the program in nursing homes and adult family homes.

In the Supported Living program, ADSA is beginning to do follow up visits after a certification inspection to ensure that problems have been corrected. Additionally, we are visiting supported living providers more often than every two years when resources allow this additional work. These quality improvements need specific additional funding to ensure that any problems with quality of care, quality of life, or safety of clients are dealt with early.

The ADSA Resident Protection Program pursues serious allegations in which an individual employee of a facility is alleged to have caused a resident harm. After completion of an investigation and due process an individual worker found to have caused a resident harm may be placed on a list which ensures that the individual may not work as a caregiver again. ADSA has operated this program in nursing homes for several years and we received funding to begin the program in boarding homes and adult family homes in 2007. It is clear that continuing the program in boarding homes and adult family homes will require more resources as the program matures.

Changes to Quality Assurance processes can improve quality throughout ADSA's programs. The 2008 Legislature required that ADSA move forward with a 17-level payment system that will better tie needs of community residential clients to payments. This should be a step toward helping providers improve care for individuals with heavier care needs. Additionally, ADSA is working on improvements to the CARE assessment process so that providers have better information about client needs.

ADSA has historically measured our success in complaint investigation in in-home settings (via the Adult Protective Services program) and in residential settings (via Residential Care Services) by our ability to meet established timeframes for initiation of the complaint investigation. We have focused a great deal of energy on meeting timeframes and our results have always been near 100%. This will continue to be an important measure of our success. However, through the GMAP process we are identifying a need to focus on closing cases more rapidly. There has been a significant increase in the number of APS complaints related to financial abuse and self-neglect. Both types of complaints are complex, take a long time, and may demand skills that severely challenge APS workers. More training is needed for workers to investigate these types of complaints on a timely, thorough basis. Additionally, a statewide quality assurance system is needed to identify patterns and improve processes.

More effort is needed to educate the general public and investigative agencies such as the police about what constitutes abuse and how to report it. Additionally, better coordination is needed between all systems that investigate complaints – APS, Residential Care Services, the ombudsman's office, police and tribal agencies.

ADSA has three data systems that collect information on complaint investigations. APSAS collects data on Adult Protective Services activities, the Complaint Resolution Unit system collects data on complaints in residential facilities, and the Incident Reporting system collects data on complaints in Residential Habilitation Centers and community settings service people with developmental disabilities. The three systems were created years ago and need improvement. One of the most important improvements is to allow the systems to work together since complaint victims and perpetrators may cross systems. This is a very high priority for ADSA but information technology resources are very limited.

ADSA has made significant progress in improving program-specific internal processes by developing Quality Assurance units in Home and Community Services and the Division of

Developmental Disabilities. These units show proven cost savings and cost avoidance. However, their responsibilities have increased as complexity of programs and client needs increase. Residential Care Services needs a Quality Assurance unit to evaluate internal processes, similar to the units in HCS and DDD. In order to be effective, all three units need to be adequately staffed and funded.

Objectives and Strategies

Objective: Develop programmatic changes necessary to improve service quality

Strategies

- Request funding and FTEs to implement quality assurance and technical assistance programs in boarding homes and supported living and expand QA and technical assistance in adult family homes.
- Request increased funding to expand the Resident Protection Program in adult family homes and boarding homes.
- Evaluate specialty training topics for providers and required timeframes for completing training. Identify and develop needed training such as medication management in AFHs.
- Request funding for expert consultation and witnesses for cases involving abuse, neglect or misappropriation for victims with cognitive and/or communication impairment and/or developmental disability to assist with issues related to credibility or reliability at hearings. Request funding for ADSA's due process expenses.
- Request funding to increase supervisory visits of home care agency workers.
- Request funding for consultation to providers on specific issues
- Support actions by the Department of Health to provide broad-based geriatric training for all health care providers
- Provide access to technical assistance for families at risk
- Increase technical assistance to employment and residential providers
- Fund an Employment Services cost study that determines costs for evidence-based effective employment practices. Include consideration of complexity of individual support need
- Enforce policies in place to continue to improve quality assurance for clients and staff in all settings (boarding homes, adult family homes, nursing homes, ICFs/MR, and RHCs).
- Request funding and FTEs to allow a follow up visit after certification of supported living providers and to do certification inspections at least annually.
- Request legislation to simplify the statutory definition of vulnerable adult.
- Redesign and program the APS complaint investigation database to document intake, investigation, outcomes, and due process functions.
- Coordinate with tribal law enforcement agencies regarding APS and/or domestic violence codes.

Objective: Support quality assurance processes

Strategies

- Request FTEs and funding to develop and implement a quality assurance unit in RCS to evaluate program-specific internal processes – similar to units in HCS & DDD. Request funding for QA staffing increases in all divisions commensurate with increases in responsibilities.
- Request funding for QA staff to monitor APS cases on a statewide basis.
- Improve liaison and cooperation among agencies that have investigation responsibility for the same incident and/or individual

- Request FTEs and funding to fully develop linked IT system and other data system improvements for CRU/APSAS/IR.
- Create stronger relationships between APS and 2-1-1 system; educate law enforcement, the financial community, and the general community about APS and guardianships; renew gatekeeper efforts; request funding for education programs for physicians about reporting responsibilities.
- Develop separate budget line item for services provided to APS clients rather than expecting regions to fund emergency services from their administrative budget
- Request funding for 24-hour intake for APS complaints and Complaint Resolution Unit intake in Residential Care Services
- Request funding for APS workers training to develop expertise in dealing with complicated financial abuse allegations and self-neglect cases.
- Recruit more diverse staff and institute on-going training on cultural diversity issues
- Strengthen quality throughout by developing open risk and liability reviews, strengthening citizen input, developing leadership and advocacy training, using health care predictive modeling

Objective: Support development, in sufficient numbers, of an effective workforce to provide home and community-based services.

Strategies

- Improve capability to gather and interpret data on the size and key trends in relation to demand for workers.
- Identify potential incentives related to workforce development that support ADSA strategic directions.
- Work with providers and organized labor in developing long-term mutual goals.
- Engage cooperatively in collective bargaining with provider labor representatives to achieve objectives consistent with ADSA strategic directions.
- Advocate for improved wages for community based programs to reduce turnover and staff vacancies.

Performance measures & targets

- Percent of residential complaints responded to timely: Target = 99.5%
- Percent of inspections done timely: Target = 100%
- Percent of APS complaints responded to timely: Target = 97%

Note: Our current baseline for these measures is the same as the target numbers. ADSA will present basic measures of timely closure of complaint investigations during FY 09. However, the data is difficult to gather with the information systems we currently operate. Development of more sophisticated performance measures will depend on improvements to the data system

Goal 3 – Maintain timely access to programs and responsiveness to changing needs, and manage risk through appropriate staffing

The work of ADSA staff and AAA partners is intended to help vulnerable individuals receive safe, quality, appropriate services. When these functions are not done well, the outcome can be risk to vulnerable individuals and exposure to liability risk. The State of Washington is on of the few states in the nation with no tort limits or immunity. Developing methods to ensure adequate staff and standards to manage risk will provide ADSA the opportunity to provide needed services and avoid liability risk.

As clients' service needs become more complex, it becomes more difficult to assure quality, safety, and accountability. Providing quality services means coordinating ADSA programs with services provided by mental health providers, substance abuse providers, employment providers, Medicare, the Veterans Administration, medical care providers, pharmacists, housing agencies, and so on. There is a need for more case management contacts for all clients and even more contacts for heavier care clients.

For several years, ADSA has used a staffing model to request funding for service authorization and case management functions in the long-term care programs. The model has never been fully funded and is now outdated. An updated model is needed that reflects new requirements, growing caseloads, and increasing complexity of some cases. The new model should include service authorization and case management functions in both long-term care and DDD programs, Adult Protective Services workloads, and the work requirements of licensure, survey, and complaint investigation staff in Residential Care Services. The model should include appropriate supervisor-to-worker ratios. ADSA anticipates that the new model will adjust caseloads to reflect individual client preferences and acuity. The model will recognize that some cases take more time than others and will allow the worker time needed to do the job completely and correctly.

We recognize that there are also efficiencies to be gained in some work processes. We anticipate that these can be included as we develop the staffing model. Efficiencies include developing methods of retaining staff, training staff to implement protocols to work with clients with violent or other challenging behaviors, providing other needed training, ensuring that staff has appropriate work space, expanding the use of staff skills, and so on.

If thoughtfully constructed and fully funded, a revised staffing model can help individuals receive quality, responsive services while helping the state avoid liability risk.

Another key area of accountability that will continue to require management attention and new resources is the need to develop data systems to keep up with program improvements and new requirements. We will continue to devote substantial resources to improving our data systems for assessment of client needs and case management. Additionally, as resources become available upgrades are needed for the data systems used to calculate nursing home payments, and systems for planning and tracking residential facility inspections, adult protective services investigations, complaint investigations in residential settings, and the system-wide incident reporting system used in DDD.

A challenge for ADSA is ensuring adequate office space for staff. The Office of Financial Management projects that the aging population will grow by 31.64% between 2008 and 2015. The DDD population will grow 7.7% during that time period. In the longer term, the aging of the Baby Boomers will double the number of Washingtonians over age 85 by 2030. If service levels provided by ADSA are to remain constant, there will be an immediate need for new staff and adequate space to house those workers. We will work with partners in The Department of General Administration, the Office of Financial Management, and DSHS to identify and obtain needed office space on a timely basis. The need is already critical in Seattle, Tacoma, Vancouver, Yakima, Spokane and the Olympia headquarters. We will work on ways of making efficient use of office space such as examining telecommuting options, and co-locating where possible with all divisions and with our AAA partners.

Objectives and Strategies:

Objective: Identify and request funding for appropriate caseload ratios

Strategies

- Develop and request funding for updated workload study including all HCS, DDD, RCS, AAA field staff and Management Services Division supportive staff functions. Re-aligned caseloads should be acuity-adjusted, keep up with changing requirements and increasing caseloads, and should have adequate supervisor-to-worker ratios. Caseloads should include case management ratios reflecting that some clients need frequent intervention such as medical, behavioral, or community protection needs. Caseloads should be consistent across divisions.
- Develop staffing expertise to deal with clients with chronic, severe, and complex problems by training on and implementing models that are evidence-based, are clinically effective, and measure performance outcomes.

Objective: Develop methods to make work more efficient

Strategies

- Develop strategies to focus on staff retention
- Examine options for telecommuting for staff.
- Examine wage parity for classes with similar duties in ADSA
- Request increased HQ FTEs for proactive policy development in HCS, RCS, DDD
- Request funding for staff training and workforce development
- Request funding for staff training in institutions to implement zero violence protocols and strategies.
- Request funding to expand the use of RHC specialists to support community clients when they are unable to find professional services in their home community.
- Request funding for training for state staff, staff of partners such as AAAs and community provider partners, especially targeted at first line supervisors
- Work with DSHS and General Administration partners to develop more timely planning for office space needs.
- Produce commonly used materials and forms in a variety of languages to enable staff to communicate more efficiently with clients.
- Improve capacity to assess risk and target interventions

Performance measures

- Percent of waiver plans of care done on time: Target =95%. Baseline being calculated
- Percent of annual CARE reviews done on time: Target = 100%. Baseline = 97% May ‘07
- Ratio of social workers/case managers to cases: Target = 1:50 . Baseline depends on program
- Percent of quarterly case reviews completed on time in Community Protection Program: Target = 100%. Baseline = 97 % 4th quarter CY 07

Goal 4 – Provide holistic care and serve individuals with complex needs

ADSA faces growing caseloads and demand for services addressing ever more complex problems. Programs have to be more capable of serving the needs of persons with Traumatic Brain Injuries, chronic diseases, dementias, mental health needs, etc.) but at the same time programs must be broadly coordinated with basic needs for personal care, employment, housing, and medical care.

The most frequent comment among the 500+ that we received on this plan was that the current system for delivery of mental health services does not work well for older persons, adults with disabilities, or persons with developmental disabilities. Service plans in home and community settings frequently fail because the individual does not receive mental health treatment, or family caregivers or paid providers cannot manage the individual's mental health needs or difficult behaviors. We, and our partners in the mental health program, face a huge challenge to develop mental health systems that can address the unique mental health needs of older people or younger people with physical disabilities or developmental disabilities. To be effective for our populations, mental health services should be provided where clients live; provide early intervention to avoid more intensive and costly services at a later date; be provided in conjunction with the other health and long-term care supports that the individual needs, and be coordinated with family members and other caregivers. In addition, unaddressed mental health needs are significant factors in increased acute care costs. Developing a mental health system that can provide such responsive and flexible services is an opportunity to provide preferred, less costly services. Failing to provide effective mental health services can result in placements in more restrictive settings that might have been avoided.

ADSA is evaluating several multi-year chronic care case management pilot projects that build on our existing casework infrastructure. These projects coordinating chronic care services and disease management services will be tested to determine if they provide better coordination of care, better client outcomes, and cost-effectiveness. If the evidence supports better outcomes through these types of projects, ADSA anticipates expanding existing projects and developing additional ways to better manage care for individuals with complex, expensive care needs.

There is also a need for a broader array of services to meet individuals' specific needs to be developed or expanded. Flexible services addressing mental health and chemical dependency needs are critical in helping individuals remain in their own homes or communities and reduce unnecessary expenditures. There is a need for services more sensitive to the needs of persons with developmental disabilities who wish to leave Residential Habilitation Centers and/or obtain employment; persons with Traumatic Brain Injuries; veterans; people with Alzheimer's, children with developmental disabilities who need supports to succeed in school, people with chronic care needs, and so on.

ADSA has developed and implemented the CARE assessment for use in assessing persons with developmental disabilities and those with long term care needs. The assessment provides a comprehensive look at the needs of the individual and the existing supports that are available. It provides consistent guidance to case managers authorizing services so those with similar needs receive similar levels of services. Through the CARE assessment process, we are making progress in linking payment rates to service needs. A needed next step is to develop targeted payment rates for individuals with special needs such as mental health needs.

Objectives and Strategies

Objective: Develop Behavioral Health services that meet the needs of ADSA's clients

Strategies

- Work with HRSA/MHD towards mental health access for ADSA clients, encouraging more mental health assessments, and developing services that are flexible enough to meet the specific needs of ADSA clients.
- Expand mental health services through SCSA, leveraging federal funding such as Medicaid, Older Americans Act, or Title XIX funding streams

- Work with Mental Health transformation project to include behavioral and mental health services that will preserve families with children with disabilities, including autism. Include the continuum from prevention to crisis management and chronic outpatient support.
- Develop methods to integrate delivery of mental health services and long-term care in client case plans.
- Request funding for more mental health services and community beds
- Expand COPES waiver services to deal with challenging behavior issues
- Expand COPES ancillary services to in home mental health and substance abuse counseling for seniors and people with disabilities

Objective: Continue to develop and expand chronic care for people with multiple chronic conditions

Strategies

- Develop support services to address the needs of clients with chronic, severe, and complex needs.
- Request funding for expanded Intensive Chronic Case Management program

Objective: Support evidence-based health promotion and disease prevention strategies

Strategies

- Incorporate more established evidence-based interventions for prevention, wellness, and disease management.
- Request funding for programs for high risk and high cost issues such as falls prevention, chronic care and chronic disease models. Request state matching funds for the National Council on Aging Challenge grant to develop the Stanford model for chronic care management.
- Implement person-centered planning and self-activation models

Objective: Develop new or expand upon existing specialized services

Strategies

- Expand the use of RHC specialists to support community clients such as adaptive equipment specialists, speech therapists, OTs, PTS, dentists, MDs
- Form strong partnerships with schools, ESDs, and local school districts to support educational needs of children with developmental disabilities and targeted support to DDD students at behavioral risk
- Partner with the DSHS Mental Health Division to request approval and funding to pursue a state plan or waiver option to expand services for special populations such as individuals with challenging behaviors and individuals with a traumatic brain injury.
- Develop a state plan option to meet the needs of individuals with personal care and behavioral support needs
- Expand the New Freedom waiver to statewide
- Participate in Alzheimer's Demonstration Project and support transition to a statewide program. Incorporate benchmarks for dementia capability, overall capacity, and accountability for resources in ADSA core programs.
- Develop programs to reduce risk factors, and obviate the need for our services such as isolation, substance abuse issues, veterans returning from war
- Expand medication utilization management; coordinate screening and services for oral health, vision & hearing; improving end of life care; use predictive modeling to target interventions
- Increase gatekeeper programs
- Work with stakeholders to build a broader vision for aging including education, work opportunities, civic engagement.

- Support tribal efforts to recoup adequate compensation for health care costs that are culturally consistent and competent
- Support expansion of appropriate use of hospice services

Performance measures

- Percent of waiver clients assessed with behavioral health needs who are receiving behavioral health services
- Number of home and community clients with TBI, Alzheimer's, other special needs
- Number of community clients receiving services from RHC specialists
- Reduction in numbers of in-school behavioral aides needed

Because these are new programs and measures, we have not established performance baselines or targets at this time

Goal 5 – Helping individuals and families to support themselves

Discussions are ongoing in Washington and in the nation about how to prepare for an enormous increase in the number of people needing long-term care and services for persons with developmental disabilities in the next 30-40 years. Clearly, government programs alone will not be able to absorb the growth in this need, even if these programs focus on serving individuals in the least costly settings that are appropriate to their needs.

Multi-part strategies are needed that should include increasing the total amount, efficiency, effectiveness of the Medicaid contribution toward this demand; building and strengthening services outside of Medicaid, and strengthening the ability of individuals and families to plan for, pay for, and provide for their own care needs.

The primary resource for care is family and friends. In Washington State, it has been estimated that more than 570,620 family caregivers provide 611,000,000 hours of care at a value of over $5.4 billion helping adults (18 years and older) who have chronic illnesses or serious disabilities. Caring for an ill or disabled family member can be physically demanding and exhausting, and can leave the caregiver feeling overwhelmed, frustrated, or fearful.

Growth in the population needing care and smaller family size in the Baby Boom generation has combined to decrease the ratio of caregivers to those needing care. It is estimated that in 1990, there were eleven potential caregivers for each person needing care. By 2050, that ratio will be four to one. We anticipate that families and friends will continue to want to provide needed care. But, as the numbers of potential caregivers decrease, it will be more important to provide the flexible supports that caregivers need to enable them to do so. Often a small amount of information or support can help caregivers continue to provide needed services so that individuals need never access government paid services.

Information and assistance is key to supporting individuals, families, and friends to care for themselves or their loved ones. Information must be available to all ages and income levels and must be easily available when it is needed. The federal government is supporting the early stages of transitioning Information and Assistance programs into Aging and Disability Resource Centers (ADRC) through demonstration grants nationwide. Washington currently has one ADRC project in Pierce County that builds upon existing Area Agency on Aging expertise in providing information and assistance to persons over 60. The ADRC provides information to all ages and income levels through walk-in, phone-in, or log-in methods. The ADRC model should be expanded statewide but funding will be

required to staff the ADRCs, train staff in topics not already covered by information and assistance programs, and develop information systems to support them.

Additionally caregivers often need support provided through government programs to help them address specific needs. Services provided through Washington State's family caregiver program and DDD individual and family support services program can help caregivers continue to keep a loved one at home. Services include respite, training, specialized caregiver information and assistance, counseling and support groups, transportation, behavior management, therapies, and supplemental services which provide needed supplies or equipment.

Washington State should make investments in strategies to help individuals plan for and pay for some or all of their own future care needs. Once established statewide, ADRCs can help individuals plan financially for long term needs through links to information about savings mechanisms, long term care insurance, reverse mortgages, and so on. ADRCs can also link individuals to prevention and disease management strategies.

Additional investments by Washington State in employment programs for persons with developmental disabilities, persons with physical disabilities, and older persons who wish to work can help these individuals financially contribute to the economy and to their own care needs.

Investments in prevention and early intervention can help reduce eventual need for more costly, intensive services. The Infant/Toddler Early Intervention program has been found to help 20% of children birth to three who receive services from needing future special education. This program needs adequate funding to provide comprehensive services statewide.

Preventative services can help the individual manage the progression of his or her own disease. These services should be available for both Medicaid-eligible individuals and "Pre-Medicaid" individuals to help them avoid needing Medicaid services. Services might include preventative chronic care, mental health services, dental, nutrition, exercise, and so on.

In both Washington State and nationwide, we have seen the devastation caused by emergencies and natural disasters. Our services support some of the most vulnerable citizens in Washington State. An important part of helping individuals and families to plan for and support their own needs is to help them plan for emergency needs.

Objectives and Strategies

Objective: Improve information and assistance capability

Strategies

- Request funding for expansion statewide of ADRCs to provide information and assistance to persons of all ages and income levels. Request funding for training staff on counseling for long term care options Promote and enhance ADRC website utilization

Objective: Improve supports to family or friends who provide care

Strategies

- Request additional funding for family support services including respite for family members providing care and for caregiver support programs

- Expand existing waivers to include caregiver support services such as respite and counseling
- Provide training on use of caregiver assessment and benefits counseling
- Support legislation for visitation privileges for grandparents.
- Increase outreach/education of kinship or grandparent helping grandchild programs.
- Increase resources and capacity to provide training opportunities to families and self-advocates in their own communities
- Develop model waiver to provide in-home services to children with the most acute needs who are assessed as needing and most likely to benefit from intervention

Objective: Improve supports for individuals to plan for and pay for their own care needs

Strategies:

- Provide employment supports to all students with developmental disabilities leaving high school
- Fund Partnership Project to ensure all students with developmental disabilities leave high school with a job or an employment portfolio
- Request funding for employment to provide services to more people and expand community capacity to develop and support employment options. Use forecast information from high school transition to project employment need
- Request funding to provide higher vendor rates for employment agencies serving Provide varied employment opportunities so all can participate
- Expand existing 1915 (c) waivers to include pre-employment supports
- individuals with higher support needs
- Work with the Office of the Insurance Commissioner to develop LTC Partnership insurance product.
- Train ADRC staff on options for individuals to plan for and pay for their own care needs.

Objective: Support prevention and early intervention

Strategies

- Request additional funding for more capacity in Infant/Toddler Early Intervention programs. Follow up on reports due to the Legislature in fall 2008 regarding additional amounts needed to provide consistent funding for ITEIP programs statewide.
- Fund all counties to deliver birth to three developmental services
- Work in partnership with the Mental Health transformation project to build prevention and family preservation services for families with children with disabilities.
- Work with the Department of Health to develop and implement prevention strategies to reduce future care needs.
- Develop interventions that prevent or slow decline of functioning and increase ability of individuals to maintain community living
- Advocate for services for individuals who are "pre-Medicaid". Services may include expanded respite for family members providing care.
- Advocate for expanded, flexible funding for supportive services for preventive health, dental, nutrition, transportation, exercise, recreation, and referral to other services
- Work with community partners to improve emergency preparedness; require provider business continuity planning; promote individual and family preparedness; encourage coordinated response and support; develop alternative payment & reporting systems; organize training & field testing of emergency response;

increase awareness of emergency needs and training on how to respond; register medication and emergency dependent individuals;

- Address how state staff and partners conduct business during emergencies. Suspend face-to-face assessments, annual verification of eligibility. Implement and fund other staff safety recommendations

Performance measures

- Percent of children who leave the ITEIP program at age three who no longer need special education services: Target =30% by FY 13. Baseline 26% Sept '07
- Percent of DDD waiver clients employed or participating in employment programs vs. community access programs: Target = 75%. Baseline = 40% 2006
- Number of names on Individual and Family Services waiting list: Target = 4,000 by FY 13. Baseline = 9,900 on waiting list December 2007
- Nursing home caseload and RHC census: Target = 10,000 Medicaid clients in nursing homes by FY13, 1,000 in RHCs. Baseline = 11,219 Jan '08 NH, 992 Jan '08 RHCs
- Number of students employed one year after transition from school (we are working on a data sharing agreement with OSPI to get the data that will establish a baseline and target for this measure)
- Percentage of children identified for early intervention. Target = 2.5%. Baseline = 1.8%

Appendix 1 – Description of Services

ADSA provides services to Washington State citizens ranging from newborns to the oldest citizens. Long term care services and services for people with developmental disabilities are primarily paid for through the federal Medicaid program. The federal and state governments share in the cost of Medicaid services. The federal government provides approximately 50% of the funding for Medicaid services and does not place specific limits on the amount of funding available. As long as the state provides its share of funding, the federal government will provide its matching share. As a result, most states have tried to expand the use of Medicaid services.

ADSA projects an average monthly Medicaid long-term care (LTC) caseload of approximately 51,000 seniors and adults with disabilities by June 2008. Approximately sixty-five percent of these clients are over age 65 with 35 percent aged 18-64. An individual must have a substantial unmet need for assistance with an Activity of Daily Living (ADL) such as eating, dressing, or mobility to qualify for Medicaid services.

The administration anticipates providing case management for almost 36,000 individuals with developmental disabilities and arranging for paid services for approximately 20,000 of these clients. Approximately 43% of persons receiving services from the Division of Developmental Disabilities are under age eighteen, 54% are adults between the ages of 18 and 64, and 3% are adults older than 65.

Other programs described in this chapter such as Information and Assistance, Family Caregiver Support, Employment, Respite, and so on, are more heavily state funded making it more difficult to expand these services.

In addition to providing for direct services to individuals eligible for Medicaid or state funding, ADSA provides quality assurance for all community-residential and nursing facilities and Residential Habilitation Centers, regardless of the resident's payment source.

Information and Assistance and Case Management
ADSA provides Information and Assistance (I & A) and Case Management services to ensure that individuals and families receive assistance identifying and understanding their options as they plan for their care and support needs. Another critical responsibility is to ensure that care provided through state- or Medicaid-funded services is managed with a goal of obtaining appropriate, good quality, cost-effective services.

Social workers and case managers use the standardized, electronic CARE assessment tool to assess the needs of individuals and their families and connect them to available supports and services. They coordinate planning and development of resources, authorize payment for any state- or Medicaid-funded services, monitor and review service delivery, provide information about available services, refer persons to other sources of support, and assist individuals in crisis by linking them to resources.

Case management/information and assistance functions are handled differently as we work with persons with developmental disabilities than they are as we work with seniors or younger persons with physical disabilities.

Case managers in the Division of Developmental Disabilities (DDD) provide information and assistance and determine eligibility for DDD services. They provide case management

services for individuals who may or may not receive services funded by the state. "Developmental disability" means a disability attributable to mental retardation, cerebral palsy, epilepsy, autism, or another neurological or other intellectual disability requiring similar services. To be eligible for services through the DDD, the disability must have originated before age eighteen, be expected to continue indefinitely, and constitute a substantial handicap to the individual.

For long-term care services, case management is focused on persons receiving state or Medicaid funded services. ADSA employees throughout the state assess individual needs, and determine financial eligibility, develop service plans, and refer clients to services for state-funded long-term care programs. If an individual is determined eligible for state- or Medicaid-funded long-term care in their own home, ongoing functional eligibility, service planning, case management, and monitoring are provided by the local Area Agency on Aging. If an individual is determined eligible for state- or Medicaid-funded long-term care provided in a community residential setting such as a boarding home or adult family home, or in a nursing home, state employees provide service planning, ongoing case management and monitoring.

The broader information and assistance (I&A) function for seniors age 60 and older and their families who need access to community services that may or may not be government funded, including long-term care services, is provided through contracts with Area Agencies on Aging statewide.

The federal government is interested in improving accessibility to information and assistance and has provided grants to several states, including Washington, to develop an "Aging and Disability Resource Center" (ADRC) pilot site. This grant will test a model in which one agency provides information and assistance for all individuals with disabilities of all ages. The vision is to have Resource Centers in every community serving as highly visible and trusted places where people can turn for information on the full range of long-term support options. The centers will also be a single point of entry to public long-term support programs and benefits. The centers will be a resource for both public and private-pay individuals. They will serve older adults, younger individuals with disabilities, family caregivers, as well as persons planning for future long-term support needs. The Centers will also be a resource for health and long-term support professionals and others who provide services to older adults and to people with disabilities. Currently, Pierce County is ADSA's partner and pilot site for this grant although the vision is to expand ADRC capacity statewide.

Early Intervention and Prevention Services for Children

Early Intervention Services are intended to enhance the development of infants and toddlers and the capacity of families to meet the special needs of their children. The Infant Toddler Early Intervention Program (ITEIP) coordinates existing early intervention services for approximately 7,900 children ages birth-to-three and their families during a year (more than 4,000 children and their families are served on an average day). The program assures that federal service standards are followed. These services include family resources coordination, therapies, and family training and counseling for children age birth to three with developmental delays or disabilities, and their families.

This program allows families to access early intervention services statewide in their local communities. ITEIP contracts with locally-designated lead agencies to ensure statewide service delivery, a multi-agency system, and data collection mechanism. Local Lead Agencies responsible for services within their geographical area hire Family Resources

Coordinators who assist families through a community team process to complete an Individualized Family Service Plan (IFSP). The IFSP defines services, settings and funding sources to assist in meeting the developmental needs of the child.

Local resources are essential in providing necessary services. But local resources may be limited. Washington's legislature recently passed a bill requiring that by 2009 all school districts will provide early intervention services for children ages birth to three in coordination with local lead agencies and other available community resources. It is likely that there will be discussions in the future about strengthening the participation requirements of counties in early intervention programs.

Approximately 70 percent of the children served are eligible for Medicaid services. Over 23 percent of all infants and toddlers, served by ITEIP no longer need special education services as they exit the ITEIP program.

Employment and Day Programs
Approximately 40 percent of adults enrolled by DDD are involved in an employment or day programs. DDD supports employment and day services, including child development services, through contracts and partnerships with county governments. The counties select and contract with service providers or directly provide many of the employment and day services.

The Division of Developmental Disabilities has a "working age adult policy" establishing employment supports as the primary use of employment/day program funds for working age adults. The policy is intended to focus county authorized services on supports to pursue and maintain gainful employment in integrated settings in the community. Community access is being focused on older adults (over age 62) who have retired from work.

In-Home Services
In-home services provided through ADSA are largely funded by Medicaid, and are available statewide. Services are structured to allow an individual to remain living in his or her own home rather than moving to a residential facility. Services include assistance with activities of daily living, as well as necessary home modifications, emergency response devices, adaptive devices or equipment, delegated or directly provided nursing services, and training of participants in addressing their needs. Personal care assistance is provided either by an Individual Provider (IP) who is hired directly by the person needing assistance or by a caregiver who works for a licensed and contracted home care agency. Other types of in-home services are provided through contracts managed by Area Agencies on Aging. ADSA pays for services for eligible individuals.

Residential Services
Residential services provided through ADSA are also largely funded by Medicaid. They are available statewide although program managers report a need for more resources in rural areas and resources that serve persons with special needs such as behavioral, mental health, and chemical dependency needs.

The most commonly used residential options include group homes, adult family homes, boarding homes, community Intermediate Care Facilities for the Mentally Retarded (ICF/MR), State Operated Living Alternative (SOLA), and supported living programs. Residential settings may be licensed facilities (boarding homes, adult family homes, group homes, ICF/MRs) or smaller, certified or contracted settings in which individuals may share housing and services (SOLA, supported living, companion homes). Services in

residential settings may include supervision, personal care, room and board, and limited nursing. In addition to providing direct care, residential providers may help people with developmental disabilities learn new skills such as shopping, cooking, managing money, and using community resources.

Residential options range from small (1-2 individuals) to large (boarding homes have an average of 46 beds). ADSA contracts with providers of the various residential options for services for individuals who are eligible for Medicaid.

The Community Protection program provides intensive 24-hour supervision for individuals with developmental disabilities who have been identified as being a danger to their community due to crimes they have committed. This program provides an opportunity for participants to live in the community and remain out of prison or other justice settings. Safeguards are in place to protect neighbors and community members, to the extent possible. Case managers work with a team of professionals including the provider to develop supports that may eventually enable the individual to live in a less restrictive setting. Case management for these individuals is particularly challenging. In some regions, case managers have difficulty meeting requirements for reviews of client progress. Additionally, the numbers of individuals who might be served in the program is growing as policy makers look for alternatives to criminal justice settings.

Other residential options include nursing homes and Residential Habilitation Centers (RHCs). While these more institutional settings remain important services for the future, discussions are needed about how much investment should be made in these areas.

Most nursing homes are privately-operated facilities, licensed by the state, and contracted with ADSA to provide services for individuals who are eligible for Medicaid. The nursing home occupancy in 2006 was 87.5%. ADSA is in discussions with the nursing home industry and the Department of Health about revising the nursing home bed need ratio downward to reflect the preference for home and community services.

RHCs are state-operated facilities that serve persons with developmental disabilities. They may be certified as ICFs/MR or as nursing facilities. There has been ongoing policy discussion about whether or not to continue operating all five RHCs. At this time, the decision has been made to keep all five facilities open but this will require significant capital investments to maintain state and federal certification requirements.

Projects focused on chronic care and other specific client needs

Nationally attention is being paid to meeting the specific needs, primarily of individuals whose long term care and supportive services are or will likely be relatively costly. The federal government has supported several such projects in Washington State. ADSA is also working with DSHS partners to coordinate projects focusing on coordinating service delivery to maximize quality of care and minimize cost. In most cases, ADSA and/or the federal government will evaluate whether the projects result in; better coordination of care, better client outcomes, and improved cost-effectiveness. Projects in Washington State include:

- The New Freedom Consumer Directed Services pilot program in King County, funded by Robert Wood Johnson and the federal Centers for Medicare and Medicaid Services. This pilot will run through 2009 and offers person-centered planning, financial management services, personal assistance services, and other services related to assess long-term care needs;

- The Intensive Chronic Care Case Management Program (ICCM) in five Area Agencies on Aging which provides a nurse case manager responsible for integrating acute and long-term care services through coordination of care and evidence-based practices that promote improved health outcomes and reduce medical system interactions;
- The HRSA Chronic Care Management Program targeted to help a segment of Medicaid clients with high-risk and expensive chronic conditions to access earlier interventions and more appropriate health care.
- The Stanford University model project for chronic care self management funded through National Council on Aging Challenge grant funds. This project is being managed in cooperation with the Department of Health, three Area Agencies on Aging, and three community based aging service providers.
- The consumer-directed nursing home diversion program for non-Medicaid individuals funded through an Administration on Aging grant.
- The federally funded grant called "Roads to Community Living" whose focus is to increase the use of home and community services by developing person-centered supports to help long term residents of institutional settings such as nursing homes, RHCs, or mental health facilities transition to home and community services.

Informal Caregiver Support and other services

Informal, unpaid caregiving is a critical piece of the long-term care system. Family and other unpaid caregivers provide nearly 80% of all long-term care in this country. In Washington State, it is estimated that more than 570,620 family caregivers provide 611,000,000 hours of care at a value of over $5.4 billion helping adults (18 years and older) who have chronic illnesses or serious disabilities. Caring for an ill or disabled family member can be physically demanding and exhausting, and can leave the caregiver feeling overwhelmed, frustrated, or fearful.

Unlike the Medicaid funded programs, supportive services for informal caregivers are not considered "entitlements". Funding is largely provided by the state and, once funds are spent, people in need may go without services.

Through its partnership with the AAAs, ADSA operates the Family Caregiver Support Program for individuals 18 and older. Unpaid family and other informal caregivers can access a variety of core services: specialized caregiver information and assistance, training, counseling and support groups, respite care and supplemental services which provide needed supplies or equipment.

DDD operates the Individual and Family Services Program that allows participants to pay for flexible, supportive services related to and resulting from their disability. The program provides families with funding for supports such as respite care, transportation, specialized aids, behavior management, and therapies to help continue caring for the family member at home. The program, formerly known as Family Support, has had a long waiting list. In 2007, legislation was passed to reorganize the program and fund additional services. Since 2007, DDD has been working on reducing the waiting list.

Grandparents and other relatives raising children (known as kinship caregivers) are a fast growing group of caregivers. In Washington State, the 2000 census reported that there were at least 35,341 grandparents who are the primary caregiver for their grandchild(ren). These older adults may not need the traditional long-term care services but they do need support in caring for their grandchildren. The AAAs, along with their

subcontracted community agencies provide funds to help with the cost of needed supplies and services, such as housing, food, clothing, and school activities.

Kinship caregivers often lack knowledge of available support services. Currently a number of Kinship Navigators provide a one stop shop service, along with emotional support to help guide kinship caregiver through challenging times.

Some families with children with developmental disabilities participate in the Voluntary Placement Program which allows birth or adoptive parents to retain custody of their child while participating in shared parenting with foster care providers.

ADSA provides a variety of additional supportive services intended to help prevent the need for future, more expensive services. These services may be contracted through counties, Area Agencies on Aging, private agencies, or individual providers and may include medical, dental, professional therapies, transportation, medically intensive services, family caregiver support, adult day health, home-delivered or congregate meals, respite care services, nutrition education and health promotion/disease prevention and legal services.

As the numbers of people needing care increases, supports for informal caregivers and the types of other services mentioned above will become even more necessary to help individuals and families to continue to provide for their own needs.

Services focused on monitoring quality, safety, and accountability:
ADSA is responsible for monitoring the quality, safety and accountability of the services provided to Washington State citizens regardless of whether or not those services are paid for by government funds. ADSA licenses all adult family homes, boarding homes, and nursing homes in the state. We also certify Supported Living programs. The administration has delegated authority from the federal Centers for Medicare and Medicaid Services (CMS) to certify nursing homes and Residential Habilitation Centers for the Medicare and Medicaid programs.

The Medicaid program has certain expectations for state activities to protect the health and safety of people receiving home and community services through Medicaid waivers. These include quality assurance activities and training requirements. ADSA has quality assurance units in the Home and Community Services and Developmental Disabilities Divisions to oversee provider and staff compliance with policy and statutory requirements. Investments are necessary in these programs as expectations increase. Additionally, there is a need for a similar Quality Assurance unit in Residential Care Services to evaluate internal processes in that division.

The timeline for licensure and certification inspections of residential facilities is in statute. Nursing homes must be inspected at least every 15 months with adult family homes and boarding homes receiving inspection at least every 18 months. Supported Living programs are certified every two years. Inspections are unannounced. They are scheduled so that facilities that have had problems are inspected more frequently.

The ADSA residential licensure and inspection program is held up as a national model. However, improvements can be made. Adult family homes may have fewer outside contacts than larger facilities so ADSA has identified a need for additional resources to visit newly licensed adult family homes within 90 days to ensure that providers understand and are meeting requirements. Additionally, the quality of nursing homes benefits from periodic visits of Quality Assurance Nurses (QANs) who provide technical

assistance. If resources were available, this program would improve the quality of services in adult family homes that are not newly licensed and boarding homes.

In the Supported Living program, resources are not currently available to do a follow up visit after a certification inspection to ensure that problems have been corrected. Additionally, supported living providers should be visited more often than every two years to protect vulnerable clients. These more frequent visits would help ensure that any problems with quality of care, quality of life, or safety of clients are dealt with early.

ADSA has the responsibility for following up on complaints made about care provided in all settings, regardless of whether the individual receives paid services or not. Timeframes for complaint investigation are established by policy.

ADSA's Adult Protective Services program (APS) receives and investigates complaints of abuse or neglect of vulnerable adults who live in their own homes, regardless of whether they receive long-term care services. APS also investigates complaints when a vulnerable adult resides in a residential setting and the alleged perpetrator is not an employee of the setting. When a complaint related to a vulnerable adult who lives in his or her own home is substantiated, APS may help the person move to a different care setting, change caregivers, or get a protective order or guardianship. In certain serious situations, an individual caregiver may have their name placed on a registry that will prohibit future employment in long-term care settings.

The federal Medicaid program requires states to develop self-monitoring activities for APS programs. This strategic plan includes activities to develop a comprehensive quality assurance system for APS, including FTE and technology needs. Additionally, national statistics indicate that only one in five allegations of abuse is ever reported. This plan includes strategies to work with local communities, and professionals such as bankers, clergy, coroners, and so on to educate them on what constitutes abuse of a vulnerable adult and how to report abuse. We also include strategies to work with law enforcement to coordinate and strengthen investigations of alleged abuse.

ADSA's Residential Care Services Division (RCS) receives and investigates complaints related to licensed and certified residential facilities such as nursing homes, boarding homes, adult family homes, and supported living. Complaint investigators coordinate with local law enforcement, the long-term care ombudsman's office, and other local agencies to investigate and resolve problems.

If a complaint is substantiated, ADSA may employ a variety of tools to respond to the problem. Residential facilities may be required to develop a plan of correction as a result of a substantiated complaint. They may also receive a fine, a stop placement, a condition of their license or a license revocation in more serious situations.

The complaint investigation process in a residential facility focuses on whether the facility systems protected residents. The ADSA Resident Protection Program pursues serious allegations in which an individual employee of the facility is alleged to have caused a resident harm. ADSA recently expanded this program to boarding homes and adult family homes but we will clearly need more resources as the program matures.

A priority for ADSA in the upcoming biennia is to develop an information system that coordinates data about all complaints received by ADSA systems – APS, CRU, and the Incident Reporting system in RHCs. Each complaint system currently operates its own database, through an information system created years ago. Often victims and/or

perpetrators show up in more than one system but there is currently no way to systematically identify these overlaps. We will also continue to devote substantial resources to improving our data systems for assessment of client needs and case management. As resources become available upgrades are needed for the data systems used to calculate nursing home payments, and systems for planning and tracking residential facility inspections.

ADSA has a responsibility to ensure the accountability of its programs. Many of the functions discussed above such as case management, licensure, and complaint investigations have an accountability component. These and other important functions are supported by an infrastructure that helps them accomplish their responsibilities. The infrastructure may include such things as information technology, contracting processes, accounting functions, or supervisory and administrative support. The strategic plan identifies area where these infrastructure functions must be improved to support all of the essential work done by the organization. A critical infrastructure concern is the need for adequate office space for staff. The population needing services is expected to explode in coming years and staff who provide assessments, case management, eligibility determinations, complaint resolution, quality inspections and licensure, and so on will also increase, causing increases in the need for office space.

Appendix 2 – Statutory Authority

The Federal Older American's Act authorizes a network of local Area Agencies on Aging (w/citizen advisory councils), as well as home/community services.

- Title XIX of the Social Security Act authorizes nursing facility services and the COPES, Medically Needy, and DD waivers, which authorize home and community-based services as an option to nursing facility or institutional services.
- Titles XVIII & XIX of the Social Security Act authorize Nursing Facility Survey to ensure consumer protection and quality of care.
- 42 CFR 483.400 authorizes services in ICF/MR facilities.
- Americans with Disabilities Act of 1990 (ADA) ensures equal access for individuals with disabilities.
- Public Law 105-17; The Individuals with Disabilities Education ACT (IDEA), Part C governs Infant, Toddler Early Intervention Services.
- 34 CFR 303 regulates the Early Intervention Program for Infants and Toddlers with Disabilities.
- RCW 74.04.025 authorizes services for Limited English Proficient applicants and recipients of services.
- RCW 74.39.050 authorizes self-directed care.
- Chapter 18.51 RCW authorizes the nursing facility license functions.
- Chapter 18.20 RCW authorizes the boarding home license functions.
- Chapter 74.46 RCW authorizes the nursing facility payment system.
- Chapter 74.42 RCW authorizes nursing facility case management associated with voluntary relocation of residents who wish to be served in community settings.
- Chapter 74.39 RCW authorizes in-hospital LTC assessment.
- Chapter 74.39A RCW authorizes COPES Medicaid Waiver, assisted living, personal care, chore services, Adult Residential Care and LTC quality improvement.
- Chapter 70.128 RCW authorizes the Adult Family Home program.
- Chapter 74.39A RCW authorizes in-home case management by Area Agencies on Aging.
- Chapter 70.195 RCW establishes the State Interagency Coordinating Council for Infants and Toddlers with Disabilities and their families. It also establishes County Interagency Coordinating Councils and requires state and local interagency agreements to define early intervention roles and responsibilities.
- Chapter 74.14A RCW establishes policy for children with emotional disturbances and mental illness, potentially dependent children, and families in conflict.
- Chapter 74.38 RCW (The State Senior Citizens' Services Act) authorizes home and community-based services.
- Chapter 74.34 RCW governs protection of vulnerable adults from abuse and neglect.
- Chapter 74.41 RCW authorizes Respite Services and the Family Caregiver Support Program.
- Chapter 18.18A RCW authorizes delegation of selected nursing functions.

- Title 71A provides for services to persons with developmental disabilities, including coordinated state and local programs.
- Washington State Constitution – Article XIII, Section 1 authorizes institutions for the benefit of persons with developmental disabilities.

Appendix 3 – Snapshot of ADSA's current performance

DSHS Aging and Disability Services Administration

Developmental Disabilities Services

Adult Programs

Services	Number of Clients	Average Monthly Cost Per Client
Employment Programs: Includes Community Assess, Group Supported Employment, Individual Employment, Person to Person, Pre-vocational Employment (July 2007 data)	7,132	$504
Family Support (Oct 2007 data)	108	$272
Medicaid Personal Care (non-residential) (Oct 2007 data)	5,441	$1,238

SOURCES: CCDB, EMIS DEC 2007

1

DSHS Aging and Disability Services Administration

Developmental Disabilities Services

Children's Programs

Services	Number of Clients (Oct 07)	Average Monthly Cost Per Client (Oct 07)
Child Development Services	2,167	$213
Family Support	250	$178
Medicaid Personal Care (non-residential)	1,723	$910
Medically Intensive Services	216	$10,125 RN rate $35.32 per hour LPN rate $27.29 per hour
Voluntary Placement / Foster Care Program	193	$6,186

SOURCES: CCDB, EMIS, DEC 2007

2

Developmental Disabilities Services

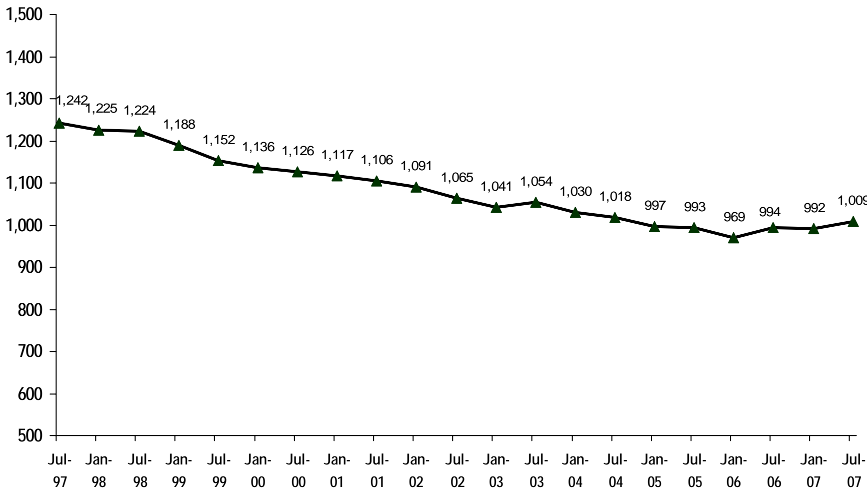
Community Residential Settings

Setting	Number / Size of Programs (Oct 07)	Number of Clients (Oct 07)	Average Monthly Cost Per Client (Oct 07)
Alternative Living	178 providers	293	$455
Community ICFMR	8 facilities Average 7 adults per facility	58	$6,603
Companion Homes	43 providers	42	$4,494
Group Homes	50 facilities 4 - 20 adults per facility	308	$4,713
Residential Habilitation Centers	5 facilities ranging in size from 55 - 391 residents (counts include respite)	999	$15,080
State Operated Living Alternative	Several persons live together as roommates to share living expenses and staff support (24/7 support)	107	$9,246
Supported Living	141 contracted providers - Several persons live together as roommates to share living expenses and staff support (daily to 24/7 support)	3,340	$6,074

SOURCES: CCDB, EMIS, DEC 2007

Residential Habilitation Center Caseload Trend

DD Clients Residing in RHCs (includes short-term stay clients)



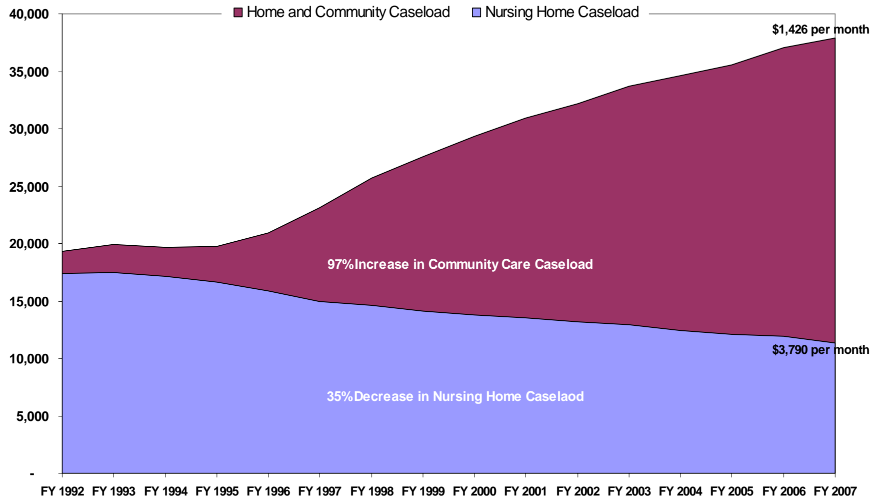
SOURCES: CCDB, EMIS DEC 2007

Long-term Care Services Settings

Setting	Number / Size of facilities (Oct 07)	Number of residents (Oct 07)	Rate range
Adult family home	2,631 licensed facilities Average 5.5 beds	4,114 state-funded residents 14,449 licensed beds	$48.32 to $91.73 per day
*Boarding home	536 licensed facilities Average 51 beds	6,160 state-funded residents 27,170 licensed beds	$48.95 to $110.11 per day
In-home	N/A	28,362 state-funded clients	$9.73 to $16.62 per hour
**Nursing home	246 facilities Average 91 beds	11,237 state-funded residents 22,322 licensed beds	$158.11 average per day

* Excludes ICFMR boarding homes
** Nursing homes that are Licensed and Certified, Licensed only, and Certified Hospitals with long-term care wings

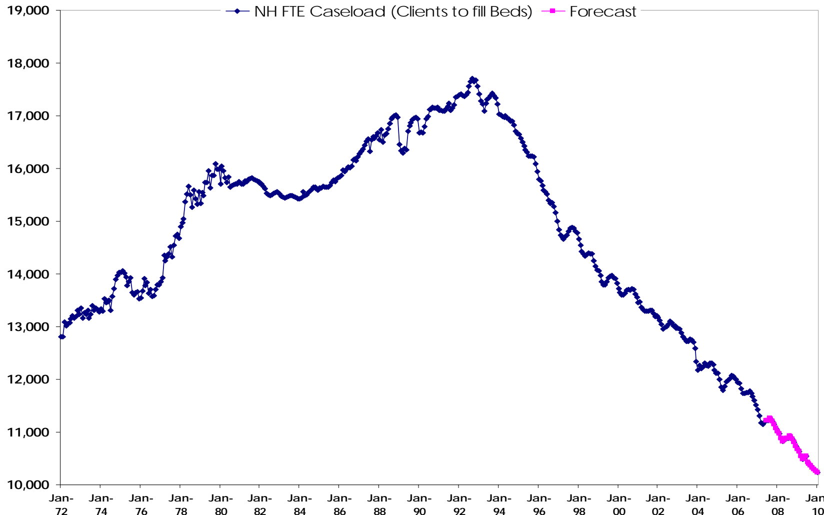
SOURCES: ADSA FACILITY DATABASE, FACILITY MANAGEMENT SYSTEM, EMIS, ADSA RATES DEC 2007



Source: SSPS, MMIS

Nursing Home Medicaid FTE Caseload Trend

January 1972 through January 2010



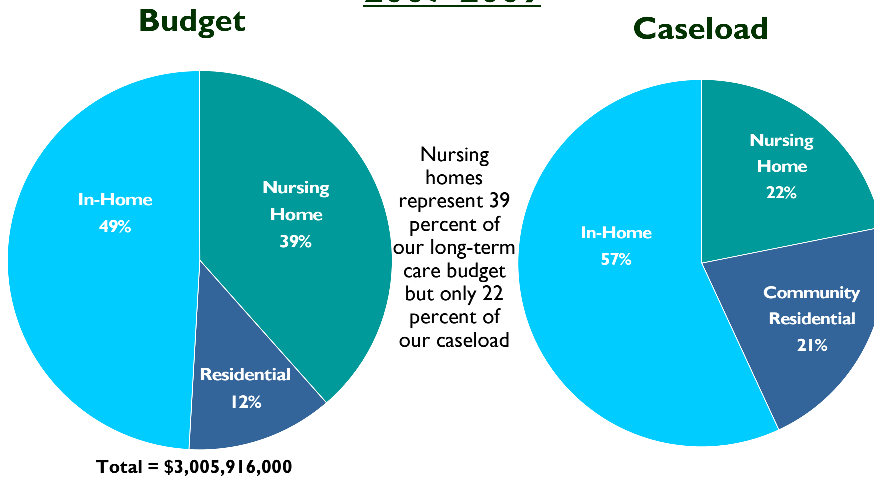
SOURCE: Actuals from Medicaid Management Information System (MMIS), Forecast from Caseload Forecast Council Budget Forecast

Long-term Care Budget and Caseload

2007-2009

Budget

Caseload



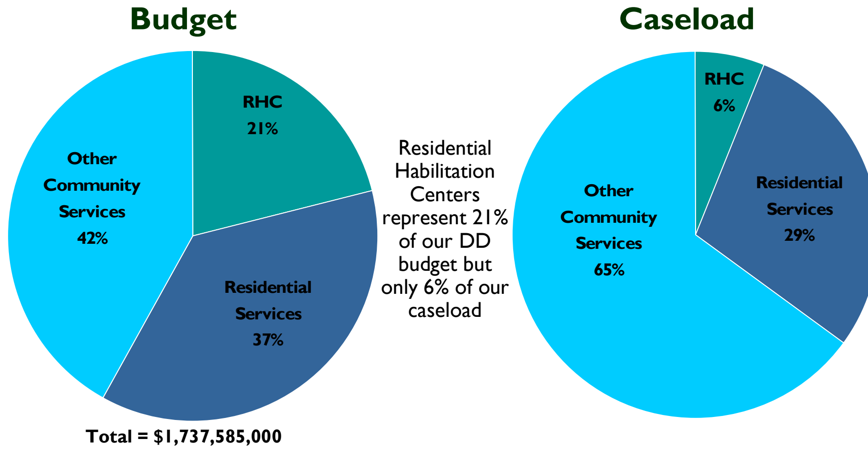
Total = $3,005,916,000

SOURCE: ADSA BUDGET OFFICE DEC 2007

SOURCE: CASELOAD FORECAST COUNCIL DEC 2007

DSHS Aging and Disability Services Administration

Developmental Disabilities Budget and Caseload



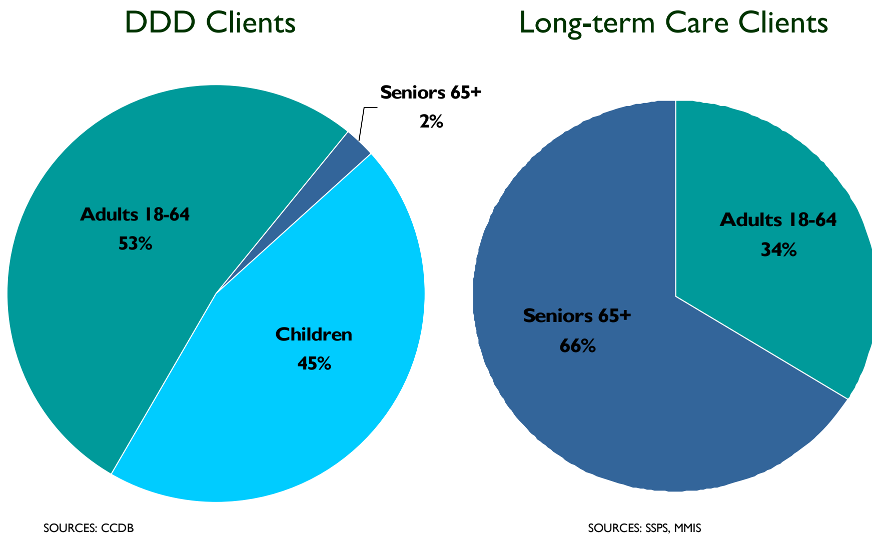
SOURCE: ADSA BUDGET OFFICE 2007

SOURCE: CCDB 2007
Average monthly counts

9

DSHS Aging and Disability Services Administration

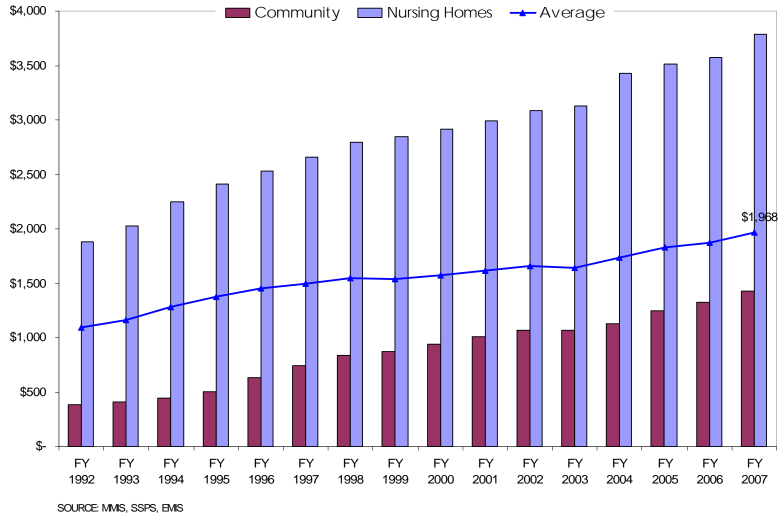
Long-term Care Caseload by Age



SOURCES: CCDB

SOURCES: SSPS, MMIS

10



GOAL: Complete complaint investigations within mandatory timeframes 100% of the time

MEASURE: Timeliness of complaint investigations

ANALYSIS: Timelines continue to be met, however, increased volume of supported living complaints puts pressure on the complaint investigation system.

Complaint reports in residential care settings, CY07 Q1 through Q3

Priority description	Number received	Percent received	Percent timely response
Life Threatening/2 working days	604	3.0%	100.0%
Significant Risk/10 working days	3,201	15.5%	99.6%
Potential Risk/20 working days	3,242	16.8%	99.7%
All others, including 45 and 90 days and quality reviews	15,129	64.7%	Timeframes vary
Totals	**22,176**	**100%**	-

ACTION PLAN	WHO	DUE DATE
Use funding provided in budget to ease pressure on supported living complaint system	RCS Division Director	July 2007 and on-going

RCS = Residential Care Services

Adult Protective Services investigations, CY07 Q1 through Q3
Investigations about potential harm to vulnerable adults living in their own homes

Priority description	Number received	Percent received	Percent timely response
HIGH: Serious or life-threatening harm is occurring or appears to be imminent. Within 24 hours.	222	2.7%	97.3%
MEDIUM: Harm that is more than minor, but does not appear serious or life-threatening. It may be past, present, or possible in future. Within 5 working days.	4,373	53.0%	96.6%
LOW: Harm that poses a minor risk to health or safety. It may be past, present, or possible in future. Within 10 working days.	3,655	44.3%	96.1%
Totals	**8,250**	**100%**	-

DATA NOTES **SOURCES:** APSAS and RCS Complaint databases December 2007