Virtual Tribal-ALTSA-HCS-AAA Fall Summit

September 10 & 11, 2020

Money Follows the Person is a federal demonstration program that supports increased use of home- and community-based services for people with complex, long-term care needs. Under this funding, the Centers for Medicare & Medicaid Services (CMS) awarded the Money Follows the Person Tribal Initiative (MFP TI) programs to five states, including Washington. MFP TI, which began in 2014, aims to ensure the availability of tribally provided, community-based, long-term services and supports (LTSS) by increasing the accessibility of Medicaid for tribes, strengthening tribal infrastructure, supporting tribes in attaining enhanced Medicaid reimbursement rates, and expanding contracting opportunities. The Washington State Department of Social and Health Services (DSHS) Aging and Long-Term Support Administration (ALTSA) administers the MFP TI program in Washington and partners with tribes to promote sustainable LTSS led by tribal communities. The annual tribal-ALTSA-HCS-AAA summit convenes tribal partners and stakeholders to discuss updates and best practices.

# Day 1

Crystal Tetrick, Vice President for Health Systems and Policy at Kauffman & Associates, Inc., introduced herself as the conference moderator. She welcomed participants to the conference.

## Opening Remarks and Project Updates

**Bill Moss, ALTSA Assistant Secretary,** welcomed attendees to the conference, discussed the effects of the COVID-19 pandemic on Washington MFP TI efforts, and provided project updates. The pandemic has created delays and pauses in some of ALTSA’s work, but ALTSA has continued to conduct important work on waivers, including waiving certain requirements to expand timelines and create flexibility during the pandemic. For example, ALTSA obtained a waiver through which it established retainer payments, which hold facility space for residents who must leave the facility for a hospital stay.

Challenges related to the pandemic include isolation for residents of nursing homes, adult homes, and assisted living facilities. In August, ALTSA rolled out the Safe Start for Long-Term Care Facilities guidance, which provides options for residents to interact with loved ones, based on each county’s long-term care phase and transmission rate per 100,000 people. This guidance also outlines criteria for safely conducting trips outside the facility, testing, screening, source control, staffing, and use of emergency personal protective equipment (PPE).

Under the 21st Century Cures Act, states are required to implement electronic visit verification (EVV) systems for any Medicaid-funded personal care service. The first phase of EVV implementation for Home Care Agencies will begin in November 2020 and must be completed by January 1, 2021. EVV implementation for Individual Providers will follow.

The consumer-direct employer (CDE) project, under which the state is shifting management of Individual Providers from DSHS to a third-party employer, is delayed. The new anticipated completion date is November 30, 2021. ALTSA will continue to collaborate with tribes to ensure this program addresses their needs.

A recent study by the ALTSA research department identified changing LTSS patterns, including a downturn in the number of elders moving to nursing facilities and an increased use of community-based care prior to seeking facility-based care. Study findings also included a 1% increase in American Indian/Alaska Native (AI/AN) use of LTSS programs, including Roads to Community Living. ALTSA will share the report once it is finalized.

**Donald Clintsman, Washington DSHS Chief of Staff**, thanked attendees for participating, made several announcements, and summarized the DSHS response to COVID-19. DSHS and the Governor’s Office developed a new government-to-government framework for Washington agencies to work effectively with tribal nations to inform policies and practices. The framework will replace the current Indian Policy Advisory Committee structure.

In response to the pandemic, DSHS obtained waivers and amendments to create flexibility for certain requirements and ensured the continued provision of essential in-person services during the pandemic, such as adult protective services and food assistance.

Specific DSHS offices took the following actions in response to the COVID-19 pandemic:

* ALTSA secured presumptive eligibility for LTSS, which means a patient’s attestation of their financial eligibility is sufficient for determining their eligibility and does not require verification. The presumptive eligibility is limited to the duration of the pandemic, but DSHS is working with CMS to make it permanent to help expedite services for patients and reduce avoidable stays at facilities.
* ALTSA worked with providers to develop and implement specialized nursing homes and assisted living facilities specifically for supporting COVID-19 patients to help alleviate the demands on other long-term care facilities that could not isolate residents who tested positive. Additionally, ALTSA developed a program that incentivizes long-term care facilities to transition people from community hospitals to these specialized facilities to help prevent a hospital surge.
* ALTSA worked closely with providers to ensure all services remain available during the pandemic by increasing provider payment rates and obtaining federal and state waivers to create flexibility for providers.
* ALTSA worked with adult day centers to move the bulk of their services online.
* ALTSA developed resources to inform loved ones about the current status of visitation policies among long-term care facilities and a hotline for COVID-19 general information.
* ALTSA Residential Care Services conducted more than 4,000 infection control surveys of long-term care settings to ensure appropriate procedures and slow the spread of the virus.
* ALTSA created a long-term care incident command post, which supplied, and continues to supply, PPE to skilled nursing facilities and community-based residential care facilities that were low on equipment and could not locate more.
* The Office of Indian Policy moved all trainings and meetings online.
* The Economic Services Administration developed methods to better serve families in crisis by moving to electronic communications. They continued providing needed services, like emergency food supplements and disaster cash assistance.
* The Behavioral Health Administration implemented emergency control centers in partnership with other departments and agencies.
* The Developmental Disabilities Administration implemented safety measures for residential habilitation centers and state-run community residential programs and continued to conduct outreach during the pandemic, moving much of its outreach and contact online.

DSHS understands that, even after returning to the office, there will be a need to continue to collaborate with stakeholders to proceed in the safest way possible.

### Questions and Comments

**When do the changes to the state’s tribal consultation policy take effect? How is the new process different?**

The new process and structure are currently in place, after several years of developing the new framework. The DSHS Director of Indian Policy can draft a formal, detailed response on aspects of the new framework that are different.

**Is there a desk manual for waivers?**

No, but there is an ALTSA COVID-19 response document that identifies each gubernatorial proclamation and each federal waiver received.

### Session Materials and Resources

* [Video recording](https://www.youtube.com/watch?v=cmZidP0T6rY&t=7s)
* [ALTSA COVID-19 Response](https://www.dshs.wa.gov/sites/default/files/ALTSA/stakeholders/documents/tribalaffairs/WelcomeOpeningRemarks_Fall2020SummitResources_Website.pdf)

## Workshop #1: Non-Emergency Medical Transportation

**Tracy Graves and James Walters, Washington State Health Care Authority Non-Emergency Medical Transportation Program Managers**

The Washington State Health Care Authority (HCA) offers non-emergency medical transportation (NEMT) to enable access to necessary, non-emergency medical services for Medicaid-eligible people who have no other means of transportation. Six brokers manage this statewide program on behalf of the HCA, communicating directly with patients to arrange transportation. The brokers, which include five nonprofit organizations and the Northwest Regional Council, do not provide the transportation themselves, but arrange transportation for clients with local transportation providers. Typically, transportation must be provided within the client’s local medical community. If the client requests to visit a provider outside of the service area despite the presence of a covered provider within their service area, they must provide justification or documentation of medical necessity for the transportation request to be approved.

The brokers serve 13 regions across the state and are required to staff customer service centers within each region served to ensure that clients who contact them can speak with someone who is familiar with the area’s geography. Brokers are responsible for ensuring all transportation is for Medicaid-covered services for eligible clients, maintaining a network of local transportation providers, and selecting an appropriate mode of transportation for each case. Brokers also conduct a post-verification of transportation services. The HCA ensures broker compliance with program requirements through performance-based contracts.

To be eligible for NEMT, clients must be Medicaid beneficiaries who have no other transportation options. The NEMT program only covers medically necessary services for eligible clients. In addition, for the transportation to be covered, the provider must be a medical, dental, or mental health care provider enrolled with the HCA or under an HCA-contracted managed care plan. The brokers have access to ProviderOne for verifying client eligibility and are familiar with the services that Medicaid plans cover.

To arrange transportation, eligible clients should contact their broker 2 to 14 days prior to their appointment. The broker will determine the appropriate mode of transportation, ensuring the client’s resources are used before resorting to other modes. The NEMT program may cover transportation for urgent calls and hospital discharges, depending on transportation provider availability. The program does not provide transportation to the emergency department.

Once the broker pre-authorizes the client’s request, they determine the best mode of transportation for the client’s mobility and capabilities, ensuring client resources and the lowest-cost transportation options are used first. Options may include reimbursements for use of a personal vehicle, volunteer drivers, public transit, rideshares, wheelchair vans, taxis, ferries, or tickets for a commercial bus, train, or flight.

To enable reimbursement to tribes for NEMT at a negotiated rate, transportation brokers and tribes must establish a billing agreement. The HCA is updating and finalizing a template for these agreements. Of the tribes in Washington, 17 have already entered agreements with their regional broker. In 2019, the NEMT program reimbursed tribes $1.1 million for NEMT and provided approximately 35,000 trips for tribal constituents. To establish billing agreements or resolve issues, tribes should contact the broker for their area or the NEMT program if there are ongoing issues. Participating tribes must retain all trip-related documentation, as the federal government regularly audits the program.

### Questions and Comments

**Is NEMT for medical appointments only, or can clients use this transportation to shop for essentials or pick up medications?**

NEMT can include stops at a pharmacy on the way to or from a medical appointment, but it cannot make dedicated trips to the pharmacy only.

**Do tribes establish the policies for how NEMT services will operate for their communities?**

NEMT requires the services to be Medicaid-covered and for the client to have no other means of transportation. The program does not limit the number of trips community members can access, so there is no need to implement policies at the local level.

**What kind of documentation do clients need to complete to request services from the broker?**

Clients must share their ProviderOne number so the broker can check their Medicaid eligibility. They also need to provide the date, time, and location of their appointment. If the visit requires the client to travel out of their service area, they must supply justification from their primary care provider.

**How are service areas designated for tribal communities?**

For areas where few services are available nearby, a community’s service area may extend beyond the immediate area.

**Can a client contact their tribe to request NEMT services?**

If the tribe has an agreement in place with their broker, tribal community members can request services through their tribe.

**Is Samish Tribe eligible for NEMT services? If so, how would they go about obtaining services?**

Yes. They need to first work with the broker for their area to execute an agreement. The Northwest Regional Council is the area broker for Samish Tribe.

**If a specialist refers a client to an out-of-area provider, does the client also need to receive justification from their primary care provider for transportation to be covered for the referred service?**

Brokers typically request that the justification come from the primary care provider, but if that information is difficult to obtain, the broker will contact the referring specialist for justification.

**Does the NEMT program serve Confederated Tribes and Bands of the Yakama Nation?**

Currently, there is no agreement in place with Yakama Nation for NEMT services. The tribe uses Pahto Public Passage to provide transportation from the reservation to the city of Yakima.

**The client’s personal vehicle is listed as a transportation option. How does the program cover use of a personal vehicle?**

“Personal vehicle” in this case refers to the client’s own vehicle or a family member’s vehicle. If this mode of transportation is preauthorized, the broker will reimburse for mileage and provide a fuel assistance voucher. The broker will likely request a copy of the client’s driver’s license and vehicle registration prior to approval. After the trip, the client must submit documentation confirming their travel to receive their reimbursement.

### Workshop Materials and Resources

* [Video recording](https://www.youtube.com/watch?v=hh2oPjPkWwA)
* [Map of NEMT Broker Regions](https://www.dshs.wa.gov/sites/default/files/ALTSA/stakeholders/documents/tribalaffairs/NEMTbrokermap.pdf)

## Workshop #2: Veterans & IHS MOU and Reimbursement

**Kara Hawthorne, IHS/THP Program Manager/Special Services Lead, Veterans Health Administration Office of Community Care, Department of Veterans Affairs**

The Department of Veterans Affairs (VA) partners with Indian Health Service (IHS) and tribal health programs (THPs) to cover direct care services provided to eligible AI/AN Veterans. A 2010 memorandum of understanding (MOU) between VA and IHS expanded access to care for AI/AN Veterans, whom VA, IHS, and THPs jointly serve. Under this effort, in 2012, VA and IHS established a national reimbursement agreement, which reimburses IHS facilities for services provided to tribal Veterans. The VA-IHS reimbursement agreement served as a template for VA to enter into individual reimbursement agreements with THPs. VA recently extended its national reimbursement agreement with IHS and individual THP reimbursement agreements to June 30, 2022 and is working on additional extensions. To date, 73 IHS sites are participating in the national agreement, and 116 THPs have reimbursement agreements in place. Through these partnerships, VA has disbursed more than $50 million in reimbursements in FY2020, serving more than 11,000 Veterans.

Benefits of these partnerships include:

* Promoting high-quality care through collaborative relationships
* Connecting AI/AN Veterans with culturally competent care that is close to home
* Eliminating copayments for Veterans receiving care
* Removing the need for prior authorizations for direct care services that IHS and THP facilities provide to eligible Veterans
* Reimbursing facilities for outpatient medications dispensed by a facility that is included in the VA formulary

Reimbursement agreements are separate from VA’s Community Care Network, a network of purchased/referred care providers to which IHS and THP facilities can refer Veterans who need services beyond what they offer.

Reimbursement rates for the lower 48 states include the following:

* Outpatient services are reimbursed at the IHS all-inclusive rate
* Inpatient care reimbursement is based on the Medicare Inpatient Prospective Payment System
* Critical access hospitals receive reimbursement at the Medicare rate
* Ambulatory care is reimbursed at the Medicare rate
* Outpatient pharmacy services are reimbursed at actual cost (Pharmaceuticals must be included in the VA formulary or have prior approval)

VA requests that facilities submit claims electronically if possible and charges a $15 processing fee for paper claims, with the exception of pharmacy claims. VA has a centralized processing center for claims from IHS and THP facilities. They train tribes who enter into reimbursement agreements on claims submission and electronic data interchange.

Reimbursement agreements reimburse IHS and THP facilities for direct care services, meaning contract services are not covered unless provided onsite at the facility. VA does not reimburse for services not included under its medical benefits package or for which the Veteran does not meet qualifying criteria. IHS and THP facilities can refer a Veteran to an outside provider if they do not offer the needed service, and VA is working to standardize the care coordination process between VA, the IHS/THP facility, and the purchased/referred care provider.

THP facilities are responsible for determining a Veteran’s eligibility for health care services within their respective programs, such as by confirming that the Veteran is an enrolled citizen of the tribe providing services. The Veteran must meet IHS eligibility requirements under 42 C.F.R. Part 136 and must be enrolled under the VA medical system before VA can process the claim.

Tribes interested in establishing reimbursement agreements with VA should notify VA of their interest via email at [tribal.agreements@va.gov](mailto:tribal.agreements@va.gov). VA will respond with additional information and a provider guide, and local VA contacts will connect with the THP to conduct an orientation. The THP will need to complete a form that collects CMS accreditation information, tax ID numbers, and basic information, such as services provided and the anticipated number of Veterans who will receive services. If a tribe completes the form as-is, the VA approval process generally takes 6 weeks. If the tribe needs to modify the form, they should allow additional time for VA legal counsel to review it.

### Questions and Comments

**Are VA medications sent via mail-out pharmacy, and if so, has the postal lag affected their delivery?**

IHS and THP facilities that have reimbursement agreements seek reimbursement for pharmaceuticals they dispense, rather than ordering pharmaceuticals from VA, so delays from VA would not be an issue. A tribal Veteran would only receive prescriptions from VA if they opted to receive prescriptions from the VA mail-out pharmacy, rather than their local clinic. Ms. Hawthorne said she was unaware of any delays with VA’s mail-out prescriptions.

**How does the $15 administrative fee for submitting paper claims work?**

There is no administrative fee for electronic data interchange—only for paper claims. The fee goes to VA for processing a paper claim. It is deducted from the reimbursement issued to the facility.

**What about Aid and Attendance programs for Veterans who need personal services?**

VA reimburses for eligible Aid and Attendance services.

**Are tribally operated adult day programs reimbursable?**

Yes.

**Are reimbursements exclusively for tribal Veterans or do they apply to any tribal citizen? Do they apply to spouses of Veterans?**

The program does not cover family members. For the services to be reimbursable by VA, the patient must be both a benefits-eligible Veteran and a tribal citizen.

**Would a tribal reimbursement agreement be able to include Veteran-Directed Care services for reimbursement?**

If a tribe can provide the services in-house, those services are reimbursable. If the tribe contracts those services out to another provider, they are considered purchased/referred care and are not eligible for reimbursement.

**Does the reimbursement agreements program cover urban Indian health care programs?**

The program is not designed for urban Indian health care programs, though two such programs currently have agreements with VA because they were deemed eligible early in the program. However, VA can always take care referrals from urban Indian health care programs and connect patients to a VA or community care network provider. There is proposed legislation to expand the reimbursement agreement program to cover direct care services provided by urban Indian clinics. Urban Indian programs can request inclusion in VA’s community care network so that services referred to them from IHS or THP facilities are covered.

**In addition to these forums, how else is VA reaching out to tribes to make them aware of the reimbursement agreement program?**

Typically, the Office of Community Care leverages its peer offices—the Office of Tribal Government Relations and Office of Rural Health—for this type of outreach. The Office of Community Care is more involved in administering the program, but they will engage in presentations and outreach efforts as much as possible upon request.

**Can Veteran-Directed Care Services partner with the Combined Federal Campaign (CFC) to reimburse for home- and community-based LTSS?**

If the tribe directly provides those services, they are reimbursable. VA cannot reimburse the CFC contract.

**Can the reimbursement agreements program work with CMS’s Medicaid waiver programs?**

If Medicaid does not cover the eligible services, VA will cover them. However, VA does not work with CMS or any third-party insurance providers. Rather, VA receives the claim from the THP or IHS facility and pays the remaining balance.

**Do all Washington tribes qualify to participate in the reimbursement agreements program?**

All tribes that meet the facility quality requirements are eligible to participate. A barrier that sometimes inhibits tribal participation is a lack of CMS accreditation.

### Workshop Materials and Resources

* [Video recording](https://www.youtube.com/watch?v=ToN_Im5nd8o)
* [PowerPoint presentation from VA on Reimbursement Agreement Program](https://www.dshs.wa.gov/sites/default/files/ALTSA/stakeholders/documents/tribalaffairs/IHS-THP%20Brief_Fall2020SummitResources_Website.pptx)

## Workshop#3: COVID Aging and Disability Resource Center Grant

**American Indian Health Commission staff: Vicki Lowe, Executive Director; Jan Ward Olmstead, Senior Public Health Policy and Project Advisor; and Cindy Gamble, Tribal Community Health Consultant**

ALTSA received Aging and Disability Resource Center Grant funding and contracted with the American Indian Health Commission for Washington State (AIHC) to work with tribes and Area Agencies on Aging (AAAs) to improve access to care and remove barriers to services.

Washington tribal leaders created the AIHC in 1994 to represent the state’s 29 federally recognized tribes and 2 urban Indian health providers in working with state agencies on issues that directly impact tribal health programs. AIHC is a tribally driven, culturally responsive nonprofit organization led by delegates appointed through tribal resolutions and by urban Indian programs. Its mission is to improve the health of AI/AN people through tribal-state collaboration and by providing technical support and advocacy.

The AIHC *Pulling Together for Wellness* project aims to assist the Washington State No Wrong Door network to build statewide capacity to serve AI/AN people during the pandemic. AIHC is developing the culturally grounded, evidence-informed *Pulling Together for Wellness* framework through four steps: (1) engaging with tribal communities and elders to include their voices; (2) identifying existing data and using stories to explain that data; (3) convening tribes and AAAs through regional gathering sessions; and (4) developing a report to disseminate findings and recommendations to the state, tribes, and AAAs.

The framework is visually represented by a medicine wheel containing the four aspects of holistic health: mental, physical, spiritual, and emotional. Recent studies on adverse childhood experiences support the science behind using an integrated approach to health care that involves all four of these aspects. Framework components include:

* mobilizing at the tribal or community level
* engaging leadership and the community to ensure the effectiveness of strategies
* recruiting and retaining partners
* engaging youth and elders
* considering cultural and historical aspects of planning
* balancing data with stories
* using a strengths-based approach
* examining the strengths and impacts of historical trauma that generations carry forward and
* integrating trauma-informed strategies

A 2017 Administration for Community Living (ACL) study of U.S. Census Bureau data found that:

* Those who identify as AI/AN alone account for 0.5% of the national population age 65+
* The poverty rate for AI/AN elders is 17%
* The number of grandparents living with their grandchildren is high within the AI/AN population, and nearly half (47%) of those elders are responsible for their grandchildren
* 41% of AI/AN elders have a disability
* In Washington, AI/AN elders make up 14% of the population of adults age 65 or older
* In Washington, the life expectancy for AI/AN people is 8.6% lower, compared with the white population

In a needs assessment of AI/AN elders and people with disabilities[[1]](#footnote-2), the Urban Indian Health Institute found that culture is integral to their wellbeing, with 81.2% of respondents indicating regular participation in cultural events.

Respect for elders is one of tribes’ strongest values. Many elders are continuing to heal from historical trauma. As community culture bearers, it is important for elders to be healthy and strong. The AIHC gathers stories from elders to inform its work. The AIHC staff shared accounts, including a video, of two tribal elders describing how their tribe’s elder programs have enhanced their lives by providing cultural activities and the opportunities to connect with other elders, feel integrated into the community, and learn about wellness.

The project began outreach in March and April 2020 and is currently gathering data and compiling stories from elders. As a next step, the AIHC will convene regional meetings with tribes, AAAs, and other partners between October and December 2020 to determine how they can collaborate to bring better services to tribal citizens. In January 2021, the AIHC will develop recommendations and disseminate a final report.

### Questions and Comments

**Has the AIHC scheduled dates yet for regional gatherings?**

The AIHC is just beginning to plan these meetings and anticipates identifying dates and notifying tribal partners and stakeholders beginning in October.

**Hearing more from elders directly, possibly through a virtual meeting, would be helpful. Will the AIHC share written summaries of elders’ stories, in addition to videos, in the future?**

The AIHC has begun sharing some elder stories in its newsletter and anticipates summarizing stories in its final report, as well.

### Workshop Materials and Resources

* [Video recording](https://www.youtube.com/watch?v=cIUc7YHm4s8&t=28s)
* [PowerPoint presentation from AIHC on the COVID-19 ADRC Grant](https://www.dshs.wa.gov/sites/default/files/ALTSA/stakeholders/documents/tribalaffairs/COVID%20ADRC%20Grant%20Presentation%20-%20PDF.pdf)

## Breakout Sessions

On Days 1 and 2 of the summit, concurrent breakout sessions covered the following topics:

* Peer counseling services (Workshop 4)
* The Tribal Kinship Navigator Program (Workshop 5)

### Workshop #4: Peer Counseling

**Maureen Bailey, Program Administrator, and Mary Chambers, Peer Support Program Specialist, Washington State Peer Support Program**

Peer counseling services leverage lived experience with substance abuse and mental health challenges to provide hope for recovery. Peer counselors use their personal stories as tools to create connections, support others in their recovery, promote resilience, and reduce stigma. Using a trauma-informed approach, peer counselors follow methods that encourage resilience through personal growth and self-responsibility. Peer counseling services include identifying strengths and goals, using stories to instill hope, connecting people to community resources and supports, teaching self-advocacy skills and daily living skills as needed, and facilitating recovery groups. Studies show that peer counseling:

* boosts self-esteem
* increases responsiveness to treatment
* decreases symptoms
* promotes self-care and wellness
* reduces hospital stays
* enhances social functioning and social supports and
* decreases substance abuse and depression

Medicaid covers peer counseling by agency-affiliated counselors for patients with mental health diagnoses. Washington was one of the first states to deliver peer counseling services using Medicaid funding. There are more than 3,600 certified peer counselors in Washington.

To become certified, a peer counselor must have lived experience with substance abuse or mental health challenges and be well-grounded in their recovery for at least 1 year. The certified peer counselor training requires completion of nine training modules, typically offered as a 5-day, in-person training. (Currently, the training is 10 days and virtual due to the pandemic.) To achieve certification, counselors can choose different training pathways based on their experiences and preferences, such as supportive housing or crisis response. After receiving the training certificate, the peer counselor must take an exam.

Peer counselors can specialize as a youth peer for the 18–24 age group, or as a parent peer for parents or guardians of people with behavioral health challenges. For both specialties, the peer counselors must be part of the group to which they are providing counseling—a youth or a parent/guardian, respectively. Those who wish to support recovery efforts in their community who do not have lived experience with substance abuse can become recovery coaches through Connecticut Community for Addiction Recovery training.[[2]](#footnote-3)

The Washington State Peer Support Program provides trauma-informed training, wellness recovery action plan training, and training on the intersection of behavioral health and the law to support peers who work with people involved in the court system. The program also provides technical assistance to providers or agencies working to operationalize peer support.

#### Questions and Comments

**Are peer counselors required to pass a background check to become certified?**

Peer counselors do not need to clear a background check to earn certification. However, prior convictions may inhibit gaining an agency-affiliated counselor license. The background check requirements vary by agency.

**Who supervises peer counselors?**

Certified peer counselors report to substance use disorder professionals who are well-versed in recovery.

**Can adult family homes receive peer support services?**

Yes, they can receive peer support services if those services are Medicaid reimbursable (provided by an agency-affiliated, certified peer counselor to a patient with a substance use or mental health disorder diagnosis).

#### Workshop Materials

* [Video recording](https://www.youtube.com/watch?v=D60-gm_F9Y4&t=158s)

### Workshop #5: Tribal Kinship Navigator Program

* **Caritina Gonzalez, Samish Tribe**
* **Cheryl Miller, Port Gamble S’Klallam Tribe**
* **Rosalyn Alber, DSHS ALTSA Kinship Navigator Evaluation Program Manager**
* **Tracy Kahlo, Executive Director, Partnerships for Action, Voices for Empowerment (PAVE)**

Kinship caregiving refers to situations in which other family members besides parents, like grandparents, care for children. This relationship can be formal, where children are legally in custody of this other family member, or informal. Kinship navigators provide support, resources, referrals, and advocacy for kinship caregivers. The program is also preventive since it strengthens families and encourages community involvement. Seven Washington tribes offer this program, including:

* Confederated Tribes of the Colville Reservation
* Lummi Nation
* Makah Tribe
* Port Gamble S’Klallam Tribe
* Quileute Tribe
* Samish Indian Nation
* Confederated Tribes and Bands of the Yakama Nation

Collectively, the Tribal Kinship Navigator Program has served 663 Washington kinship caregivers and the 950 children who live with them.

Port Gamble S’Klallam Tribe has offered the Tribal Kinship Navigator program since 2016 and works with all kinship situations, whether formal or informal. The program is connected to wrap-around services as part of the tribe’s Child and Family Services Department, which includes Temporary Assistance for Needy Families, child support, Together for Children maternal home visits, and the Supplemental Nutrition Assistance Program. Their program incorporates cultural activities to promote family stability. Often, they conduct traditional activities, like cedar weaving or dress making, while facilitating a meeting on kinship issues. To keep families engaged in cultural activities during the pandemic, the program created family activity kits and mailed them to kinship families. Program staff have also been checking in with families via phone during the pandemic. The program conducts outreach through a weekly memo, monthly newsletter, and word of mouth from program staff.

Samish Tribe also administers the Tribal Kinship Navigator Program to 17 kinship families. Prior to the pandemic, the program conducted frequent home visits to provide in-person support. Now, they have shifted to mail deliveries and door deliveries. The program distributes kinship kits, which include self-care items for caregivers and activities for children. Additionally, the program stays connected to kinship families through phone calls and virtual cultural events.

Lifespan Respite Washington, provided through PAVE, offers respite care, which provides planned breaks for caregivers to ensure they have the opportunity to care for themselves. Any caregiver, including kinship caregivers, can sign up for respite care from Lifespan Respite. Caregivers who provide 40 or more hours of unpaid caregiving to a loved one may be eligible for a voucher of up to $1,000 to purchase respite care services. Most of the services Lifespan Respite offers involve a caregiver coming to the home to relieve the caregiver. Some camps and adult day services are also available for those who need care to attend, to allow their caregivers respite. The program, which is primarily funded by ALTSA, recently received a 3-year grant with which it will add more respite options. Caregivers seeking respite care can view Lifespan Respite’s provider list and filter providers by county, population served, and so on. Lifespan Respite encourages respite providers not currently included on its provider list to apply for inclusion and welcomes involvement in its coalition meetings. The next meeting is on November 25 at 1:30 p.m. Pacific.

#### Workshop Materials and Resources

* [Video recording](https://www.youtube.com/watch?v=AUiT_dTKuDs&t=133s)
* [PowerPoint presentation on the Tribal Kinship Navigator Program](https://www.dshs.wa.gov/sites/default/files/ALTSA/stakeholders/documents/tribalaffairs/KinshipNavigatorFall2020SummitResources_Website.pdf)
* [Lifespan Respite website](https://www.lifespanrespitewa.org/)
* [Options for Grandparents and Other Nonparental Caregivers: A Legal Guide for Washington State](http://docs.legalvoice.org/Options_for_Grandparents_Handbook.pdf)
* [Toolkit—American Indian and Alaska Native Grandfamilies: Helping Children Thrive through Connection to Family and Cultural Identity](https://www.gu.org/resources/american-indian-alaska-native-grandfamilies-helping-children-thrive-through-connection-to-family-and-cultural-identity/)

## Workshop #6: Health Home Program

**Nicole Dronen, Quality Assurance, ALTSA**

Health Home is a person-centered program for improving health by providing tools and supports to empower clients and their families. The program provides care coordination and comprehensive care management to ensure clients receive the right care from the right provider, decrease duplication of services, and identify and resolve gaps in care. Prior to the program’s implementation, patients had to determine who to contact for different services and how different forms of insurance covered those services. Health Home care coordinators manage these tasks on behalf of their clients. Health Home is a voluntary program at no cost to clients. Ultimately, the program provides a bridge between clients and their care teams and supports. Other outcomes for Health Home patients include:

* increased engagement in self-management of chronic conditions
* greater use of home- and community-based LTSS
* lower emergency department use and inpatient admissions and
* decreased nursing facility stays.

The HCA and DSHS jointly manage the Health Home Program, which is administered at the community and local levels. To become certified, care coordinators must meet certain education and licensing requirements. They may provide care coordination services in person, over the phone, or virtually. These services do not replace any existing services, but rather streamline the existing care delivery system. The program comprises six core services:

* comprehensive care management
* care coordination
* health promotion
* comprehensive transitional care
* individual and family supports
* referrals

To be eligible for the Home Health Program, clients must be Medicaid beneficiaries with a PRISM risk score of 1.5 or higher. They must have a chronic condition and be at risk for a second. For clients to enroll, they must not have duplicate coverage or services and enrollment must not create duplication. For example, people with both Medicaid and a comparable health insurance plan cannot enroll. Many eligible clients are automatically enrolled, but AI/AN patients must provide their consent for the HCA to enroll them based on where they would like to receive services.

Lead organizations are responsible for administrative functions, data collection, and billing. They contract with the care coordination organizations (CCOs) who provide the services, reviewing CCO files and providing training. Requirements to become a lead include having access to One Health Port, the platform for documenting health action plans, and the capability for translating HIPPA transactions. CCOs are responsible for hiring care coordinators. They must contract with an existing lead organization and meet requirements established by the lead.

Tribes have the option to contract with the state to become a lead entity under which CCOs operate, or they can contract with a lead entity as CCOs. Tribal CCOs can specify to which clients they would like to provide care coordination services. If tribes provide the services in person, they are reimbursed at the IHS rate. For services not provided in a face-to-face setting, tribal CCOs would receive fee-for-service tier rates.

### Questions and Comments

**How do Medicare Advantage Plans interact with the Health Home Program?**

A Medicare Advantage Plan combined with the Health Home program would be considered duplication of services, making the beneficiary ineligible for the program. The client would need to choose between the two programs.

**How does COVID-19 affect tribes’ ability to receive the tribal reimbursement rate?**

Because of workarounds, the pandemic should not affect the tribal rate for fee-for-service reimbursements.

**Do you recommend that tribes contract with multiple leads?**

Contracting with multiple leads tends to benefit tribes by providing a more optimal case load. Tribes should consider starting by contracting with one or two leads and assessing the benefits. A drawback of contracting with numerous leads is that most leads have different documentation platforms, meaning tribal care coordinators would need to learn and use multiple systems.

**How many tribal entities are currently participating in the program?**

Two tribes are currently participating in the Health Home program.

**If an organization wants to become a lead, does the program provide technical assistance?**

Yes. All leads throughout the state also support each other with technical assistance and sharing best practices.

**What recommendations do you have for tribes in choosing a lead to contract with? What qualities should tribes looks for?**

Tribes should seek out a lead who can manage multiple CCOs and be significantly involved and invested in building a relationship with the tribe.

### Workshop Materials and Resources

* [Video recording](https://www.youtube.com/watch?v=xKVxOADgOX0)
* [Health Home program webpage](https://www.hca.wa.gov/billers-providers-partners/programs-and-services/health-homes)
* [Health Home program highlights](https://www.dshs.wa.gov/sites/default/files/ALTSA/stakeholders/documents/tribalaffairs/Health%20Home%20Demystified%20Highlights%20FINAL.pdf)

# Day 2

Ms. Tetrick welcomed attendees back to the conference.

## Workshop #7: MFP TI Tribal Grantee Projects

Three tribal programs and an urban Indian center described the projects they are undertaking with MFP TI funds.

### Nisqually Indian Tribe

**Tyron Friday, Manager, Nisqually Tribe Adult Healing House**

Over the past 18 months, Nisqually Indian Tribe has been working with the American Indian Health Commission (AIHC) and DSHS ALTSA to establish a contract with the Thurston County Area Agency on Aging (AAA) for operating the tribe’s Adult Healing House as an adult day program. At the outset of 2020, the contract was close to completion, but the pandemic delayed the project’s full completion. The program has been delivering lunches for elders 6 days a week. Once the adult day program is in effect, the Adult Healing House will also provide a safe place for referred adults to receive care during the day. This care will support clients in remaining independent as long as possible and provide respite for family caregivers. To fully begin offering adult day programming, the tribe must wait until the county enters phase 4 of the Washington reopening plan.

The Adult Healing House opened in 2015, with the original staff comprising a registered nurse and two caregivers. Now, the staff has grown to include seven certified nursing assistants (CNAs), a manager, and two nurses. The program is seeking to hire another nurse and CNA. Currently, because of the pandemic, the program limits the number of staff in the office to three staff members at a time. For CNAs who conduct visits to elders’ homes, the program works to ensure the elder always receives visits from the same caregiver to reduce the likelihood of exposure.

The program received LTSS grant funding for planning the adult day programming. Due to the pandemic, the funding was extended through March 2021. To conduct planning, the program has partnered with the tribe’s elder services department to survey elders about their needs.

The tribe began a general welfare program that disseminates funds to citizens at the beginning of each year, which replaced the per capita payments that citizens received every 3 months. Since tribal citizens do not need to claim general welfare as income, many are now eligible for Medicaid. The program is working with the tribe’s business office to establish a process for requesting Medicaid reimbursements.

### Makah Tribe

**Maureen Woods, Makah Senior Program Manager, and Janet Hansen, Care Coordinator**

Makah Tribe started a health home program in 2017 using funds from the MFP TI program. The Makah Health Home program operates as a nonprofit, using any revenue to expand services. Through this approach, the program financed an office space where clients can meet with care coordinators. In August 2020, the tribe opened the Makah Veterans Assistance Office where Veterans can seek services locally instead of traveling to Seattle. It is located in the same building as the Health Home office.

The tribe is in lockdown due to the pandemic, with limited essential travel allowed. No visitors may enter the reservation. To continue services in this challenging situation, the program provides phone assessments, and, when needed, socially distanced in-person assessments.

The program focuses on clients at high risk for adverse health outcomes, including hospitalization and mortality. Most clients need or are already enrolled in Medicaid plans. Program staff have:

* taught clients about proper hand-washing techniques amid the pandemic
* helped with scheduling appointments, medication pickup, and home repairs
* provided referrals to housing, social services, and adult protective services as needed and
* diligently disseminated updates about the pandemic to the community

To help meet clients’ nutritional needs, the program delivers daily lunches to all elders who are 65 or older and low income, as well as home-bound elders. In total, the program provides 60 home lunch deliveries and delivers groceries to another 60 elders. Nutritional services include the provision of extra vitamins and supplements that would not be Medicaid-covered at an individual level. Additionally, the program:

* conducts nutritional needs assessments and safety assessments
* provides transportation as needed
* offers advocacy services
* provides discharge planning support and
* guides clients in managing their own care, advocating for their own care needs, and honing life skills and safety awareness

Clients have reported significant improvements in health and quality of life. Other outcomes include client participation in health action planning and engagement in health goals. In one example, a client started the program with adenocarcinoma and other issues. By helping her understand her diagnosis and how to manage her condition, the program encouraged her to seek wound care services after a post-surgery wound remained open, delaying chemotherapy. After receiving wound treatment, the client began chemotherapy right away and her cancer is now in remission.

### Lummi Family Services

**Doralee Sanchez, Senior Planner, Family Services**

Prior to Lummi Nation’s shelter-in-place order in response to the pandemic, the tribe’s family services program offered all caregiving services face to face in elders’ homes. The program has integrated available technology to continue services while protecting the elder population.

The family services program includes the following services:

* Community services, such as food delivery and the provision of firewood
* Victims of crime services, such as advocacy, legal services, safety planning, and a domestic violence shelter
* Elder services, including 29 housing units and meal delivery and
* Veterans’ services

The tribe is currently implementing the Lhaq’temish Inherent Family Enrichment (LIFE) Center, which will serve as a single point of entry available to all Lummi households to help clients overcome barriers to meeting their basic needs. It will create a harmonized network of services for clients. Key benefits of the LIFE Center will include avoiding service duplication, enabling clients to seek all needed services, and assuring community members that they will receive equitable care. Currently, family services are fairly scattered, relying on a variety of application and delivery methods. The LIFE Center will synthesize application processes into a centralized website and provide wrap-around care and referrals. These improvements will help the program consolidate and strategize services in times of need.

The program will partner closely with the following tribal departments with the goal of placing elders in the center and surrounding them with services, such as:

* planning
* workforce development
* the health clinic
* behavioral health
* substance abuse treatment
* housing
* youth services
* education
* a higher education reentry program for those released from incarceration
* the fitness center

The program is working to implement Medicaid billing, since many existing services are eligible for Medicaid reimbursement. Additionally, they are implementing a Health Home program and expanding the existing home care programming to include more training and employ more caregivers.

### American Indian Community Center, Spokane, WA

**Linda Lauch, Executive Director**

The American Indian Community Center (AICC) in Spokane, WA, has served clients for 53 years. For most of that time, the program has offered congregate lunches for elders and, often, other elder services. To facilitate congregate meals, AICC provides a space and supplies for Meals on Wheels to deliver meals to elders at a congregate site. The space accommodates 15 elders. Currently, due to the pandemic, there are no in-person gatherings for congregate meals. The program obtained a new space and can host 10 additional elders once COVID-19 restrictions are lifted.

Last year, AICC contracted with ALTSA to gather data on how to best keep elders in home-based care settings and out of nursing homes. AICC hired consultants to develop a survey and was beginning to administer the survey, but it was delayed by the pandemic. To honor elders, AICC opted against interviewing elders virtually or over the phone, so the survey is on hold. AICC is working with local tribes to compile mailing lists for its clients and obtain permission to mail the survey to them.

AICC recently identified an electronic records program to provide billing for care coordination and other elder services. AICC submitted a proposed system to ALTSA and is currently awaiting approval to implement that system. The last phase of the MFP TI contract involves developing programs and services to meet the needs of tribal elder populations, and Ms. Lauch expressed a desire to network with other WA MFP TI programs on best practices once it is safe to do so.

### Workshop Materials and Resources

* [Video recording](https://www.youtube.com/watch?v=b_GjQ2Vi_Mo&t=2103s)
* [PowerPoint presentation: Makah Senior Health Home Program](https://www.dshs.wa.gov/sites/default/files/MFTPI_Fall2020SummitResources_Website.pdf)
* [PowerPoint presentation: Nisqually Adult Healing House](https://www.dshs.wa.gov/sites/default/files/MFTPI_Fall2020SummitResources_Website.pdf)

## Workshop #8: Housing: Assisted Living Facilities, Adult Family Homes, and Enhanced Services Facilities

**Amy Abbott, Office Chief for Policy, Training, Quality Assurance and Behavioral Health, ALTSA Residential Care Services**

The ALTSA Residential Care Services division licenses, certifies, and regulates long-term care programs. It also conducts inspections and surveys at statutorily required intervals, which vary by program. In total, the division oversees more than 4,000 long-term care facilities and agencies in Washington. Ms. Abbott provided information on three types of residential housing and the associated requirements:

* adult family homes
* assisted living facilities
* enhanced services facilities

### Adult Family Homes

Adult family homes are regular residential homes owned by a care provider who is licensed to care for two to six residents. These homes can include duplexes, but not apartments. Providers may own one or several homes, but must meet additional requirements to own multiple adult family homes. If the provider only cares for one resident, they do not need to be licensed as an adult family home, rather they are treated as Individual Providers. Adult family homes are private businesses, including sole proprietors, LLCs, and corporations. Sometimes, the care provider and their family live in the home with residents.

Adult family homes offer rooms, meals, laundry services, supervision, and personal care. Services vary based on the providers’ skills and residents’ needs. Multiple payer sources are available for this type of residential care with the most common being Medicaid and private pay.

Adult family home spaces must meet the following physical requirements:

* Room sizes must be at least 80 square feet for single occupancy and 120 square feet for double occupancy
* No more than two residents may share a room
* There must be at least one toilet for every five people (including the provider and family if they reside onsite)
* Living spaces must comfortably accommodate all residents at the same time
* The home must be safe, sanitary, and free of hazards

There are no required staff-to-patient ratios for adult family homes. Rather, staff numbers are based on residents’ needs. Residents who require extensive care may need more than one caregiver, while one caregiver may be sufficient for those who need minimal services, like medication management. Residential Care Services determines the number of caregivers needed through inspection. At least one staff member must be onsite at all times. Staff must complete background checks every 2 years to have unsupervised access to the home. Staff are not required to be RNs or LPNs, but they must be home care aide-certified, which entails a 70-hour basic training course, a 5-hour safety and orientation course, and a certification test. They must also take first aid and CPR courses and meet continuing education requirements. There are also special training requirements for providing care to clients with developmental disabilities, behavioral health challenges, or dementia.

### Assisted Living Facilities

Assisted living facilities can vary in size from 7 beds to 150+ beds. If a facility has fewer than seven beds, an adult family home license is likely more appropriate. Some assisted living facilities are family-owned, while others are owned by large national corporations. These facilities offer housing, basic services, and oversight of residents’ safety. At a minimum, basic services include housekeeping, meals, and activities. Some provide intermittent nursing and mental health services, and some serve residents with mental health needs, developmental disabilities, or dementia.

Multiple payer sources are available, with the most common being Medicaid and private pay. Some assisted living facilities contract with Medicaid. There are three types of Medicaid contracts: assisted living contracts, adult residential care contracts, and enhanced adult residential care contracts. Assisted living contracts support private apartments, with an emphasis on privacy, independence, and personal choice. These facilities provide intermittent nursing services and help with medication management and personal care. Adult residential care facilities provide medical assistance and personal care, and residents may need a different level of supervision. Enhanced adult residential care contracts entail medication administration, personal care services, intermittent nursing care, and nursing delegation. No more than two residents may share a room. These facilities also include a specialized dementia care component.

There are no staff-to-patient ratio requirements for assisted living facilities. Rather, Residential Care Services determines the number of staff required by assessing resident needs. Assisted living facilities are not required to employ RNs/LPNs unless they are required under a Medicaid contract to provide intermittent nursing. Staff must complete background checks every 2 years to retain unsupervised access to the facility. Like adult family homes, training requirements for assisted living facilities include home care aide certification, first aid and CPR certification, and continuing education. Nurse delegation and specialty trainings may apply, as well. For facilities with an enhanced adult residential care contracts, there are specific training requirements that staff must complete within their continuing education hours.

### Enhanced Services Facilities

Enhanced services facilities are small, community-based residential settings for up to 16 people who have complex care needs and who require support from trained caregivers beyond typical support for home-based care settings but not at the level of support found in institutional settings. Services include personal care, medication management, crisis prevention services, and a high level of specialized staffing, including 24-hour onsite nursing care and 8 hours per day of behavioral health support from mental health professionals.

These facilities are contracted through a residential support waiver program, and as such, must include a section on behavioral care support in their care plans. The facilities must also have quality improvement committees and submit continuous quality improvement project updates annually.

These facilities must employ at least one staff member per every four residents. This staffing ratio enables the provision of more intensive services than are typically available through other types of residential care. Staff members must complete 3 hours of training each quarter, plus 10-12 hours annually of continuing education credits that are relevant to the population served.

The purpose of enhanced services facilities is to reduce the length of hospital stays for people who are receiving involuntary hospital treatment and require behavioral health supports. Once a hospital determines a patient is stable, ALTSA begins working with the individual, the hospital, and local behavioral health care providers to develop a transition plan.

Physical space requirements are similar to those for the other types of residential care, but limit occupancy to one resident per room. These requirements also include considerations for suicide prevention, including having at least one room where extra precautions are in place for suicidal residents.

### Questions and Comments

**Are RNs and LPNs required to complete the 70 hours of long-term care basic training to attain home care aide certification?**

No. RNs and LPNs are exempt from the home care aide training and certification for all residential care types. This training is for staff without previous training or licensing in the medical field. CNAs are also exempt, since they have previous medical training.

**Would a client need to have treatment services in place before they can move to an enhanced services facility?**

Yes. Hospital treatment includes setting patients up with treatment services before they leave. Residential Care Services confirms that those services are in place and that they have a community-based mental health case manager.

**What would you recommend for housing options for homeless elders who have behavioral health challenges?**

The appropriate residential care setting depends on the level of care needs. The client might be well suited for an assisted living facility where they have both oversight and independence. Many assisted living facilities work with clients who have behavioral health challenges, and some facilities only take clients with those challenges.

**Are adult family homes fairly common and easy to find?**

They are fairly common, with more than 3,000 of them in Washington. Many of the adult family homes in Washington are in rural locations, and are more likely than skilled nursing and assisted living facilities to serve rural areas. Most of these facilities take on Medicaid contracts, though a few only accept private pay.

### Workshop Materials and Resources

* [Video recording](https://www.youtube.com/watch?v=PciIFUePg0k)
* PowerPoint presentation on housing for elders

## Workshop #9: Long-Term Care Trust

**Benjamin W. Veghte, LTSS Trust Director and Janette Benham, Paid Family and Medical Leave Rules Coordinator, Washington Employment Security Department**

The long-term care trust is a new program for Washington employees that sets aside funds through payroll deduction to provide long-term care insurance. Washington was the first state in the country to enact a universal long-term care program.

More than 90% of seniors are uninsured for long-term care, and only 4% of working-age people have long-term care insurance. Despite this lack of coverage, most people will need LTSS at some point in their lives. Currently, seniors without long-term care insurance must either rely on family members for care or spend their life savings down to the poverty level to qualify for Medicaid. Further, this heavy reliance on family caregivers often forces family caregivers to leave the workforce to provide unpaid care, thereby losing their own income and benefits.

Under the long-term care trust program, employees pay in, but employers do not. Employees will contribute up to $0.58 per $100 of earnings. Those who are self-employed can opt into the program. Those who already have long-term care insurance can apply for exemption between October 1, 2021, and December 31, 2022. Each eligible person who paid into the program can receive funds of up to $36,500 for a wide range of LTSS, including professional care at home or in a facility, medical equipment, training and pay for family members who provide care, home safety evaluations, meal delivery, and transportation.

Access to benefits in the LTSS program is predicated on vesting. To receive the long-term care insurance, a person must have worked at least 3 of the previous 6 years or 10 years without a break longer than 5 years. Employees must work at least 500 hours within each of those 3 or 10 years. Those who have paid into the program for the required length of time and who need LTSS to support at least three activities of daily living will qualify for benefits.

The LTSS Trust Commission, comprising 21 members who include legislators, stakeholders, and long-term care workers, will oversee the program. The group will recommend criteria for determining client eligibility, provider eligibility, maximum payment amount per service, and rule changes for program improvement. The Commission is responsible for monitoring administrative expenses, developing annual reports, assisting the State Actuary with reporting, and taking other actions as necessary to maintain program solvency. They will also determine whether to extend benefits to people who become disabled before age 18. Additionally, the Commission will establish an investment strategy subcommittee that comprises 14 members and advises the state investment board about investment strategies. There will also be a 12-member trust council who will ensure the program can keep pace with inflation. Four key agencies will administer the program, with responsibilities as listed in the Table 1.

Table 1. Key Agency Roles and Responsibilities for the Long-Term Care Trust

| Agency | Responsibilities |
| --- | --- |
| DSHS | * Administers program benefits * Manages providers * Determines which services are eligible for payment * Registers and deregisters providers * Determines individual eligibility * Disburses benefit payments to providers * Communicates with beneficiaries and the public * Adopts rules and procedures * Chairs and provides administrative support for the LTSS Trust Commission * Tracks data to inform the program * Provides customer service for questions and complaints * Determines potential savings in Medicare expenditures * Applies for a CMS demonstration waiver to share in Medicaid and Medicare savings |
| Employment Security Department | * Collects premiums * Gathers employer wage reports * Determines eligibility * Accepts applications for exemptions * Adopts policies and procedures * Determines the compliance of premium payments * Engages in rulemaking |
| Washington State Health Care Authority | * Processes payments for eligible beneficiaries * Tracks the use of lifetime benefits * Coordinates benefits across programs/payers and bills accordingly * Makes necessary payment system changes * Verifies the provision of services * Adopts policies and procedures |
| State Actuary | * Analyzes program solvency * Makes recommendations to the commission and legislature on how to maintain solvency * Makes recommendations to the Pension Funding Council on changes to the premium rate * Performs biennial actuarial valuations of the trust fund * Provides cash flow projections to assist in developing an ongoing asset allocation policy |

The Employment Security Department will conduct rulemaking in three phases, which will include rules on the following:

1. Exemptions, the processing of exemption requests, employee responsibilities
2. Premium collection and reporting, employees covered by the bargaining agreement, election of coverage by the self-employed, refunds
3. Auditing functions, state actuary functions, determinations of individual status, appeals

Rulemaking will begin in April 2021. Phase 1 rules will take effect in June 2021, Phase 2 rules will take effect in September 2021, and Phase 3 rules will take effect in April 2022.

The implementation timeline is as follows:

* **January 1, 2021**: The commission will deliver its first report, marking the formal beginning of their participation in the project’s governance
* **October 1, 2021**: The period begins during which holders of long-term care insurance can opt out of the trust; the opt-out window closes December 31, 2022
* **January 1, 2022**: Employers will start deducting the premium from employee wages, and self-employed people can begin to opt into the program
* **January 1, 2025**: Eligible beneficiaries can begin using funds from the trust
* **December 2026**: The commission begins annual reporting on program solvency

The law implementing the trust fund does not include a clause classifying tribal governments as employers or providing tribal employers the opportunity to opt in. Therefore, premiums will not be assessed for tribal governments. Currently, there is no path under the legislation for employees of tribal governments to contribute or receive benefits. There is no option for a tribal government to pay into the program on behalf of its employees, since employers do not pay in under this program. Tribal citizens who are employees of non-tribal employers will have the same access as other employees across the state who have paid into the program for the required time period. If tribes are interested in opting into the trust as employers, a statutory change will likely be necessary.

### Questions and Comments

**Will those who retire prior to January 2025 be eligible to receive benefits?**

No. The program requires at least 3 years of work and contribution to the trust, and employees cannot begin paying in until 2022. If a person nearing retirement wants to benefit from this program, they may consider delaying their retirement until they have achieved 3 full years of program participation.

**Would tribes be able to opt in at any time if a statutory change occurs?**

Yes. There is no end date by which self-employed people must opt in, and it would be the same for tribes if they are included.

**Is the $36,500 lifetime benefit a per-person amount?**

Yes.

**What kind of outreach will DSHS use to communicate this information to the general public?**

Currently, communication about this program is in the early stages of development, but it will be similar to the outreach that occurred for the Paid Family and Medical Leave Act. DSHS will also target outreach to employers to explain their roles.

**Is there an age requirement?**

Employees must be 18 or older to begin paying in or to apply for exemption.

**What does the eligibility assessment process look like?**

The process will be similar to Medicaid’s process for determining beneficiary eligibility, in that a home visit will determine the extent to which a beneficiary needs assistance with activities of daily living. Upon approval, beneficiaries will be eligible for any covered service by a covered provider, not just those evaluated during the home visit.

### Workshop Materials and Resources

* [Video recording](https://www.youtube.com/watch?v=CE48cE9K9iQ&t=1s)
* [PowerPoint presentation](https://www.dshs.wa.gov/sites/default/files/LTSS%20Trust%20Act_Gov%20Indian%20Health%20Advisory%20Council_FINAL.pptx)

## Workshop #10: Delivery of Elder Services During COVID-19 Pandemic

**Eve Austin, Muckleshoot Elders In-Home Support Services Director, Muckleshoot Tribe**

The Muckleshoot Elders In-Home Support Services program offers the following services:

* a medical alert system for dispatching 911 to elder homes in case of emergency
* pharmacy and supply delivery
* medical transportation
* electronic device loans to elders
* nursing triage
* social work case management
* support from the tribal health and wellness center and coordination with physical therapy providers
* in-home care services for elders and vulnerable adults living within a 30-mile radius of the program

In response to the pandemic, Muckleshoot Tribe initiated an emergency operations center (EOC) using the Federal Emergency Management Agency model tailored to meet the tribe’s needs. The Muckleshoot EOC worked closely with King and Pierce Counties, leveraging the counties’ insights on funding and criteria for home health aides. These collaborations helped achieve the best outcomes possible. The Muckleshoot EOC grew from having no access to COVID-19 tests to operating its own drive-up testing tent, which is open daily, through grant funding.

Challenges the tribe faces due to the pandemic include complications in delivering supplies to elders and caregivers and isolation of elders and the ensuing mental health impacts. To mitigate issues with supplies delivery, the program conducts home deliveries using door hangers. The program also partnered with IHS and Amazon to obtain high-demand supplies.

Supporting elders socially and emotionally is also a crucial aspect of the program’s response. Home health aides increased phone contact with elders. The program prioritized sharing facts as a way to combat fear stemming from the pandemic and associated isolation. Safety measures included providing PPE and screening for caregivers in situations where home visits are necessary. To identify any asymptomatic cases among staff, the program conducted testing of all caregivers and may do so again in the near future. The program also supplied PPE to help keep elders safe during any needed home visits. The program disseminated virtual trainings and outreach to caregivers about staying safe. Additionally, the program developed a protocol for responding if a caregiver or client has COVID-19 symptoms.

The program’s office has reopened substantially, with limits to ensure safety, including temperature screening, staggered schedules, and remote work options when possible. Due to operating with limited staffing, the program leveraged caregiver overtime and supplemental care by family members during the initial pandemic response, but it is now rebuilding its staff to full capacity.

### Questions and Comments

**Can the program’s caregivers bill to Medicaid?**

Currently, 25% of staffing cost is Medicaid reimbursable. Tribal support covers the remainder.

**What would you do differently if you could start the pandemic response over again?**

Ms. Austin responded that she would spend more time determining how to increase communication between elders and the program and between elders and the elder community. Loaning out electronic devices to all elders and providing training on how to use them would have helped them stay better connected to their loved ones and the community through Facetime and other channels.

**Did the tribe have support from FEMA in establishing the EOC?**

The tribe has an internal expert who had already completed FEMA training on how to run an EOC. King and Pierce Counties are helpful resources for providing EOC training.

**Did the program do testing for non-tribal members?**

The program tested only program staff and tribal citizens.

**Recommendation: Pen pal programs can help elders stay connected to their communities and avoid loneliness.**

Recommendation: Spokane Tribe established a list of all elders on the reservation, including tribal and non-tribal elders, so a health coach could reach out to them. This type of list never existed previously but may be useful beyond pandemic response. Its compilation was peer-to-peer driven, with the tribe asking each elder it contacted for the contact information of other elders they knew.

**Has the program’s experience with COVID-19 uncovered gaps in services for elders that were not previously noted?**

The pandemic highlighted the connection between companionship and behavioral health and the importance of peer-to-peer interactions. It is important for programs to facilitate connections among the people they serve.

### Workshop Materials and Resources

* [Video recording](https://www.youtube.com/watch?v=om2X_PfQh3A)
* PowerPoint presentation on the LTSS trust

## Breakout Sessions

On Days 1 and 2 of the summit, concurrent breakout sessions covered the following topics. Because the same topics were covered on both days, the summaries for each are listed under Day 1.

* [Peer counseling services](#_Peer_Counseling) (Workshop 4)
* [The Tribal Kinship Navigator Program](#_Tribal_Kinship_Navigator) (Workshop 5)

## Closing

Ms. Tetrick announced that planning for the 2021 spring conference will begin in January and noted that those interested in participating should contact Ann Dahl at [ann.dahl@dshs.wa.gov](mailto:ann.dahl@dshs.wa.gov).

Ms. Tetrick thanked the presenters and participants and adjourned the conference.

1. Urban Indian Health Institute. (2019*). Fulfilling the Commitment to Our Community: A Needs Assessment for Urban Disabled and Elder Natives*. <https://www.uihi.org/resources/fulfilling-the-commitment-to-our-community-a-needs-assessment-for-urban-disables-and-elder-natives/> [↑](#footnote-ref-2)
2. https://addictionrecoverytraining.org/ [↑](#footnote-ref-3)