- Department of Social and Health Services
  - *Aging and Long-Term Support Administration*
  - *Behavioral Health Administration*
  - *Developmental Disabilities Administration*
  - *Economic Services Administration*
- Department of Children, Youth, and Families
- Health Care Authority

STATE OF WASHINGTON

OLMSTEAD PLAN

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Preamble

Washington state is committed to providing choice to consumers who need services and supports. For more than three decades, Washington has been a national leader in the delivery of home and community-based services. We build our programs through innovative resource development with a focus on addressing barriers to living in the community. As we identify barriers, we work to resolve those barriers and aggressively seek funding and statutory changes through the Washington State Legislature to ensure that we can develop the needed services to provide consumers with additional community options. Throughout the years, we have developed Residential Treatment Facilities, State-Operated Supported Living Alternatives, Assisted Living, Adult Family Home, Supported Living Enhanced Service Facilities and a variety of services and supports available to eligible consumers who prefer in-home services to offer a variety of person-centered, community-based settings and supports for people who need assistance such as personal care, habilitation services and behavioral health treatment.

Skilled services such as nursing tasks can be provided through licensed professionals, nurse delegation and by family members. State law also provides the ability for non-medical professionals to assist with medications in particular circumstances.

As part of our work in behavioral health transformation in Washington, we have added contracts that provide specialized supports within community residential settings and skilled nursing facilities. We have a specialized dementia care program for people living with Alzheimer's disease or other related dementia who reside in contracted Assistive Living Facilities. In addition, we are increasing our number of supportive housing providers and wraparound supports to meet the needs of people who desire to live independently in their community. We provide additional training and support to community care providers who serve people with complex functional and behavioral support needs.

The Department of Social and Health Services continues to respond to the changing needs of the people it serves, partnering with other state agencies, including the Department of Children, Youth and Families, Department of Health and Health Care Authority. Each agency uses a variety of fund sources as appropriated by the Washington State Legislature, including Medicaid State Plan, Medicaid Waivers and General Fund State.

This document provides additional detail on the work Washington is doing to ensure consumers can choose to live in the community setting of their choice.

Brief History of Olmstead

Olmstead, or Olmstead v. L.C., is the name of the most important civil rights decision for people with disabilities in our country's history. In 1999, based on the Americans with Disabilities Act, the U.S. Supreme Court ruled that people with disabilities have a qualified right to receive state-funded supports and services in the community rather than institutions when:

1. The person's treatment professionals determine that community supports are appropriate.

2. The person does not object to living in the community.
3. The provision of services in the community would be a reasonable accommodation when balanced with other similarly situated individuals with disabilities.

On June 22, 1999, the Supreme Court held in Olmstead that unjustified segregation of persons with disabilities constitutes discrimination in violation of Title II of the Americans with Disabilities Act. The Supreme Court held that public entities must provide community-based services to persons with disabilities, taking into account the resources available to the public entity and the needs of others who are receiving disability services from the entity.

The Olmstead decision does not require states to stop serving people in institutions if the person is unable to handle or benefit from a community setting.

The Supreme Court suggested that states demonstrate compliance with the ADA by showing they have comprehensive and effective plans for placing qualified individuals with disabilities in less-restrictive settings and waiting lists that move at a reasonable pace, not controlled by the state's endeavors to keep its institutions fully populated.

INSTITUTIONS IN WASHINGTON STATE

Institution types and responsible agencies in Washington state include:

Department of Social and Health Services

- State Psychiatric Hospitals
- Special Commitment Center
- Residential Habilitation Centers
- Nursing Facilities

Department of Children, Youth, and Families

- Behavioral Rehabilitation Services facility-based placement.
- Contracted facility-based services for dependent children and youth.
- Medically fragile facility-based care.
- Facility-based child-specific contracted placements.

Department of Veterans Affairs

- State Veterans Homes

Background of Washington State's Olmstead Plan

On March 27, 2000, Gov. Gary Locke designated the Department of Social and Health Services as the lead state agency for Olmstead planning in Washington state. Since DSHS has emphasized community transitions since 1990, Washington's Olmstead Plan is intended to be a living document, subject to continuous planning and change.

Initial planning activities included establishing a workgroup, meeting with consumers and stakeholders, assessing current policies and services, and developing budget requests for the

2001-2003 biennial budget. DSHS established an Olmstead workgroup to coordinate planning and accelerate ongoing processes and programs.

Washington's Olmstead Plan includes an overview of current services and activities that further the intent of Olmstead, such as housing, transportation, integration, employment and systems change initiatives.

Planning and Future Updates

This updated plan is the result of a collaborative effort between the following state agencies:

- Department of Social and Health Services
  - *Aging and Long-Term Support Administration*
  - *Behavioral Health Administration*
  - *Developmental Disabilities Administration*
  - *Economic Services Administration*

- Department of Children, Youth, and Families
- Health Care Authority

The Washington State Olmstead workgroup will review this plan and update it as needed each biennium.

Washington State Department of Social and Health Services

In any given month, DSHS provides some type of shelter, care, protection and/or support to more than 2 million of our state's more than 7 million residents. DSHS' goal and commitment is to be a national leader in every aspect of client service. DSHS values honesty, integrity, open communication, equity, diversity and inclusion, and a commitment to service that will transform lives. DSHS' vision is that people are healthy, safe and supported. DSHS has a long-standing policy of emphasizing community services and reducing institutional services. Below is an overview of how DSHS will meet its responsibility to uphold the requirements of Olmstead.

Aging and Long-Term Support Administration

Washington has a long and demonstrated history of providing an array of Long-Term Services and Supports that allow people to choose among settings and providers that will best meet their needs. We have accomplished this through strong federal and state partnerships to leverage federal funding from the Centers for Medicare and Medicaid Services and the Administration for Community Living.

According to the national LTSS Scorecard of States, Washington is currently ranked second in the nation for its high-performing system. Assisting people to receive services in community-based settings remains a priority for ALTSA. A commitment to innovation, providing high-quality services, addressing the changing needs and preferences of people we serve, and delivering

services and supports in a cost-effective way are at the core of ALTSA's and Area Agencies on Aging approach to delivery of LTSS.

Washington is among the nation's leaders in rebalancing away from an over-reliance on institutional settings and supporting individual and family preferences to be served in home- and community-based settings. The Washington State Legislature recognized the desire of most people is to maintain as much independence as possible and to receive services in their own homes and in home-like residential settings that are in local communities. As a result, the Legislature directed DSHS to expand community options that provide opportunities for people to divert and relocate from nursing home, hospital and residential habilitation settings.

Home and Community Services provides and administers long-term care services to eligible people and collaborates with Area Agencies on Aging to share community service options. ALTSA embraces the belief that clients with very high care needs can be cared for and supported in a variety of settings through the implementation of waivers and state plan services that provide alternatives to nursing facility, acute and psychiatric hospital care. Over the last 25 years, ALTSA has developed alternatives to nursing facility care for the people they serve, including people over the age of 18 with functional disabilities. ALTSA's mission has been, and continues to be, to provide an array of long-term care options from which clients and their families can choose.

Area Agencies on Aging were established under the Older Americans Act in 1973 to respond to the needs of Americans ages 60 and over in every local community. AAAs are responsible to plan, coordinate and advocate for the development of a comprehensive service delivery system at local levels to meet the short- and long-term needs of older adults. AAAs develop and promote services and options to maximize independence for elders, adults with disabilities and family caregivers in their Planning and Service Area.

The Aging and Long-Term Support Administration has designated 13 Planning and Service Areas, also referred to as Area Agencies on Aging. AAAs are also the focal points of our No Wrong Door system for people looking for information or connection for themselves or family members with aging and disability services, including support of family caregivers.

AAAs use a variety of federal, state and local funding sources to provide a network of in-home and community services, support programs and assistance to older adults, adults with disabilities and family caregivers. The specific services funded by each AAA are determined through local planning activities and delineated in a four-year Area Plan. AAAs offer a broad spectrum of services: access services, in-home services, nutrition services, family caregiver support, social and health services, legal services and other activities. AAAs also provide case management for Medicaid and state-funded in-home care participants.

For more information on ALTSA's/AAA's full range of services, visit https://www.dshs.wa.gov/altsa.

Community Living Connections can connect people with the right kind of help, when and where they need it. Older adults, adults with disabilities, caregivers, family members and professionals can call CLC at **1-844-348-5464** to get objective, confidential information about community resources and service options, or visit https://www.communitylivingconnections.org/.

ALTSA Programs that Further the Intent of Olmstead

In 2004, less than 12,500 clients lived in nursing facilities statewide (down from 17,500 in 1994) and approximately 34,000 clients were served in a community setting. In 2023, about 7,600 clients live in nursing facilities statewide and approximately 64,000 are served in the community. ALTSA is striving to develop programs that optimize choice and increase independence for people with disabilities. Programs include:

COMMUNITY FIRST CHOICE

CFC is an optional state plan program, which was implemented in July 2015 after a planning and implementation workgroup of stakeholders helped design our state's CFC program. CFC is a Medicaid LTSS program focused on helping people remain living in the community. Under CFC, personal care assistance can be provided outside the home setting, which allows people with disabilities to receive services at school, the workplace and during recreational outings.

CFC provides services to more than 62,000 people served by ALTSA in their own homes, Assisted Living Facilities and Adult Family Homes. CFC services include:

- Personal care.
- Relief care.
- Nurse delegation.
- Personal Emergency Response Systems.
- Assistive technology.
- Skills acquisition training.
- Caregiver management training.
- Community transition services.

COMMUNITY OPTIONS PROGRAM ENTRY SYSTEM WAIVER

The COPES waiver provides services to over 53,000 people. In addition to the personal care services received through CFC, the COPES waiver also includes:

- Client support training.
- Wellness education.
- Skilled nursing.
- Home-delivered meals.
- Environmental modifications.
- Specialized equipment and supplies.
- Transportation.
- Adult day services.
- Community choice guiding.
- Community support, goods and services.

This waiver was implemented in 1982 and provides the supportive wraparound services listed above as well as the ability for people who have incomes up to 300% of the federal benefit level to qualify for needed services.

RESIDENTIAL SUPPORT WAIVER

The Residential Support Waiver provides services to more than 2,600 people with complex behavioral support needs. Services include:

- Personal care.
- Support and 24-hour on-site response staff.
- Development of an individualized behavior support plan.
- Medication management.
- Coordination with a behavior support provider.
- Expanded Community Services, which includes training and support by community behavioral support providers.
- Specialized Behavior Support, which includes increased staffing in residential settings along with training and support by community behavioral support providers.

Additional services include nurse delegation, client training, specialized medical equipment, adult day health and skilled nursing.

This waiver's implementation in 2014 was out of recognition of a distinct gap in behavioral supports for clients who expressed interest in remaining supported in community settings. In addition to the services provided, it creates the ability for individuals who have incomes up to 300% of the federal benefit level to qualify for needed services.

NEW FREEDOM

New Freedom is a budget-based waiver and provides approximately 400 people living in King and Pierce counties the opportunity to have increased choice and control over their services and supports. New Freedom provides participants a choice from an array of services to meet their needs within a set monthly budget. This program allows flexibility to adjust services, and participants can exercise more decision-making authority to take primary responsibility for obtaining services.

Participants in New Freedom decide:

- What services, goods and supports they need within their budget.
- When and how their services and supports are to be delivered.
- Who will provide those services and supports.

Service categories include:

- Personal assistance.
- Treatment and health maintenance supports.
- Individual directed goods, services and supports.
- Vehicle modifications and training and educational supports.

This waiver was implemented in 2006. In addition to the increased control and autonomy it provides, the waiver creates the ability for people who have incomes up to 300% of the federal benefit level to qualify for needed services.

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY

The Program of All-Inclusive Care for the Elderly is currently provided by three PACE organizations (Providence Elderplace, International Community Health Services and PNW PACE Partners) in King, Spokane, Pierce and Snohomish counties. Approximately 1,400 PACE participants require nursing facility level of care. The PACE team delivers a comprehensive service package, which includes all medical and long-term care services. Most of these services are provided in the PACE center or in the client's home.

This state plan option was first implemented in 1995. This program continues to grow throughout the state, with additional PACE expansions projected to take place in Clark and Thurston counties by 2025.

MEDICAID PERSONAL CARE

Medicaid Personal Care is an optional Medicaid State Plan program that provides personal care for approximately 700 people who need some assistance with personal care, but do not meet the institutional level of care required by the other programs. This program began in 1989.

MEDICAID TRANSFORMATION PROJECT

In January 2017, the Centers for Medicare & Medicaid Services approved Washington state's request for a Section 1115 Medicaid demonstration waiver entitled "Medicaid Transformation Project (MTP)." The activities of MTP aim to improve the health care delivery system's capacity to address local health priorities; deliver high-quality, cost-effective, whole-person care; and create a sustainable link between clinical and community-based services. Over the five-year MTP period, Washington state committed to:

- Integrate physical and behavioral health purchasing and services to provide whole-person care. Whole-person care means care for the mind, body and substance use disorder.
- Convert 90% of Medicaid provider payments to reward outcomes instead of volume of service.
- Support providers as they adopt new payment and care models.
- Improve health equity by implementing population health strategies.
- Provide targeted services to support the state's aging populations and their family caregivers, and address social determinants of health.
- Help our most vulnerable population get and keep stable housing and employment.
- Improve substance use disorder treatment access and outcomes.

On June 30, 2023, the MTP waiver was renewed for another five years to allow the state to continue with the goals started in 2017 and expand other innovative programs and services.

Medicaid Alternative Care:
Medicaid Alternative Care provides supports to unpaid family caregivers who are caring for a loved one who meets nursing facility level of care and is eligible for Apple Health (Medicaid in Washington state). Some of the services available include training, consultation, home-delivered meals, respite, environmental modifications, specialized equipment and supplies, personal emergency response system and adult day health. Eligible people can choose this program to support their caregiver instead of receiving the traditional LTSS programs listed.

Tailored Supports for Older Adults:
Tailored Supports for Older Adults provides a limited set of services and supports to help people avoid or delay the need for Medicaid-funded LTSS programs. These clients are not financially eligible for Apple Health but meet nursing facility level of care. People who are eligible for TSOA can choose supports for their unpaid family member, or if no caregiver is available, they can receive services such as personal care, adult day services, environmental modifications, specialized equipment and supplies, personal emergency response system and home delivered meals.

LTSS Presumptive Eligibility:
LTSS PE is a new initiative to promote health coverage and equitable access to high-quality care for Medicaid beneficiaries and other Washingtonians with low incomes**.** The PE process permits individuals who plan to enroll in Community First Choice, COPES Waiver and Medicaid Personal Care to self-attest to meeting financial and functional requirements. Once it is determined that the person appears to meet financial and functional eligibility requirements, they will receive a limited benefit package for up to 60 days. PE will expedite the delivery of benefits in the least-restrictive setting while the state is conducting a full functional and financial assessment of eligibility for HCBS.

ROADS TO COMMUNITY LIVING
In 2007, the Money Follows the Person grant was awarded to Washington state from the federal Centers for Medicare and Medicaid Services. MFP is a Medicaid program that provides financial assistance to states to help Medicaid beneficiaries who live in institutional settings move back to their homes or community settings. Washington calls their MFP program Roads to Community Living, and in 2008, ALTSA began using demonstration dollars to transition individuals out of institutional settings. The purpose of the RCL demonstration project is to investigate what services and supports would successfully help people with complex, long-term care needs transition from an institution to a community setting and to strengthen the ability of Medicaid programs to provide HCBS to people who choose to transition out of institutions.

Services and supports from the RCL demonstration project that proved successful were transitioned into the state's COPES waiver in 2019. Dedicated staff that had worked on housing, resource development and nursing home transitions during the demonstration period were maintained to continue working on these core strategies. Additional project staff have been

added to continue to assess, implement and review new demonstration service delivery opportunities and impacts.

In 2023, a direct care workforce team was hired to focus on development and implementation of strategies designed to boost recruitment and retention of home care aides and nursing assistants certified. Money Follows the Person administrative grant funding was used to create this team of professionals.

HCS Services that Further the Intent of Olmstead

ALTSA's continued commitment to innovation ensures we provide high-quality services, continue to meet the needs and preferences of individuals served, and deliver services in cost-effective ways. Services include, but are not limited to:

PERSONAL CARE ASSISTANCE SERVICES

Personal care assistance services are provided through home care agencies or individual providers employed by the Consumer Directed Employer. People with disabilities using the CDE have the ability to hire, fire and provide supervision of their provider, while the CDE provides all administrative functions and payroll for the individual providers. This is a co-management model where the CDE is the legal employer and the people with disabilities are the managing employers. With the CDE, family members may be paid to be individual providers.

Trainings are mandatory for all providers, including a two-hour orientation training, three-hour safety training, additional hours as required by state statute that must be completed within the first 120 days of employment and 12 hours of annual continuing education. Background checks are mandatory for all providers and are required prior to providing services, and must be updated every two years. Approximately 13,800 clients use home care agencies and 31,800 clients use individual providers.

IN-HOME CARE SERVICE AGENCIES

In-home care service agencies are licensed to administer or provide home health, home care, hospice or hospice care center services directly or through a contract arrangement to patients in a place of temporary or permanent residence.

Home health services: This may include nursing services, home health aide services, physical therapy services, occupational therapy services, speech therapy services, respiratory therapy services, nutritional services, medical social services, home medical supplies or equipment services and professional medical equipment assessment services.

Home care or non-medical services: This may include personal care such as assistance with dressing, feeding and personal hygiene to facilitate self-care; assistance with household tasks, such as housekeeping, shopping, meal planning and preparation, and transportation; respite care assistance and support provided to the family; or other nonmedical tasks, or delegated tasks of nursing.

In-home care hospice services: This may include symptom and pain management provided to a terminally ill patient and emotional, spiritual and bereavement support for the patient and family. Services are made available in a temporary or permanent residence, including hospice care centers, and may include the provision of home health and home care services for the terminally ill patient through an in-home services agency licensed to provide hospice or hospice care center services.

Hospice care center: Provided in a homelike non-institutional facility, services may include continuous care, general inpatient care, inpatient respite care and routine home care.

DAY CENTERS

Adult Day Care is a supervised daytime program providing core services for adults with medical or disabling conditions that do not require the intervention or services of a registered nurse or licensed rehabilitative therapist acting under the supervision of the client's authorizing practitioner. Services may include personal care, routine health monitoring, health education, nutritious meals and supervision or protection.

Adult Day Health is a supervised daytime program providing skilled nursing and/or rehabilitative therapy services in addition to the core services of adult day care. Adult day health services may also include physical therapy, speech-language pathology, audiology or counseling services.

CONTINUING CARE RETIREMENT COMMUNITIES

CCRCs give older adults the option of living in one location for the duration of their life while guaranteeing that additional care will be provided when needed. People can move into a CCRC when they are fully independent and access assisted living, personal care and skilled nursing as their needs change.

CCRCs have various levels of contract types. People may enter into CCRCs with different levels of financial commitment and service level agreements. Entry fees and monthly fees are typically included in the service agreement.

ASSISTIVE TECHNOLOGY SERVICE

Assistive Technology is a service benefit under multiple Medicaid LTSS programs within ALTSA. One of these programs is the Community First Choice program, which serves most of ALTSA's clients. AT are adaptive and assistive devices and items that enhance the client's independence or substitute for human assistance with an Activity of Daily Living, an Instrumental Activity of Daily Living or a health-related task. This service may include training on the AT item, or maintenance and upkeep of an AT item purchased under this service.

In addition to the Medicaid LTSS programs that have AT as a service benefit, ALTSA has a limited state-funded Assistive Technology program to assist clients who have no other funding source to obtain these items. This program funds evaluations, short-term training and assistive technology services and devices.

PERSONAL EMERGENCY RESPONSE SYSTEMS

Although there are a wide variety of Personal Emergency Response Systems, also called Medical Alert Systems, typically a PERS basic/standard unit consists of a small button-sized transmitter (also called a "help" button) that is worn by the person (usually a pendant or wrist bracelet) and a console that is programed to signal a response-monitoring center once a "help" button is activated. The response-monitoring center is staffed by trained professionals and may be based nationally or locally.

Depending on the type of system used, service provided may include storing relevant medical information with a monitoring center, GPS location, medication reminders, 24/7 monitoring, direct communication with a monitoring center dispatcher, fall detection, an auto call to the person's identified emergency contact or an automatic call to 911.

Numerous companies offer this service with differences in contract terms, technology, level of service and cost that the user should be aware of. Companies provide this service by selling devices, renting devices and providing paid monthly services. In some cases, the cost of the device may be subsidized by another program. PERS is a service benefit under multiple Medicaid LTSS programs within ALTSA.

NURSE DELEGATION

Nurse delegation provides nursing services in a community setting. Registered Nurse Delegators can delegate nursing care tasks to nursing assistants and home care aides, registered or certified, who provide care in adult family homes, assisted living facilities, boarding homes and in-home settings.

TRANSITION ASSISTANCE FROM NURSING HOMES

ALTSA continues to work actively with clients from the point of admission to a nursing facility to achieve their community transition goals and potential. This includes meeting face-to-face with clients early in their admission and working with families and staff at the facility to advocate that therapies, treatments and training are provided in a timely fashion. The goal is for clients to receive services in the least-restrictive, most-appropriate setting that meets the client's care needs while honoring client choice and preference.

ALTSA embraces the belief that individuals with very high care needs can be cared for and supported in a variety of settings through the implementation of waivers and state plan services, which provide alternatives to nursing facility long-term care. State staff are assigned to every nursing facility in Washington state to ensure residents are aware of community services and to assist in transition planning. ALTSA's mission has been, and continues to be, to provide an array of long-term services and supports options from which clients and their families can choose.

SELF-DIRECTED CARE

This service provides an opportunity for adults (age 18 and older) with functional disabilities who live in their own homes to direct and supervise a paid personal care aide (individual provider) to assist with health-related tasks they could do for themselves if they were physically able. Health-related tasks are those medical, nursing or home health services that enable adults to maintain independence if without a functional disability, they would customarily and personally perform without the assistance of a licensed health care provider. Implemented in home settings in 2000, case management staff inform clients, regardless of their current living setting, of this option during initial assessments and reassessments. This gives the client and the social worker the opportunity to put a plan together for the client to stay in, or transition back to, their own home.

SPECIALIZED DEMENTIA CARE

Specialized dementia care provides services and supports in an assisted living facility dedicated solely to the care of people with dementia, or in a designated, separate unit/wing dedicated solely to the care of people with dementia. The Specialized Dementia Care Program allows residents with dementia to “age in place” instead of requiring nursing facility care.

Specialized Dementia Care services include:

- Intermittent nursing services.
- Medication administration.
- Personal care services, including assistance with eating.
- Supportive services that promote independence and self-sufficiency.
- Awake staff 24 hours a day.
- Daily activities consistent with functional abilities and interests in the form of independent, self-directed, individual and group activities.
- Access to a secure outdoor space with walking paths and protected areas with outdoor furniture.

SPECIALIZED BEHAVIOR SUPPORT

Specialized behavior support provides an enhanced staff ratio for each client served. Staff providing this service receive additional training.

Specialized behavior support services include:

- A behavior support plan developed with the client.
- Recreational opportunities designed and provided to meet behavioral challenges.
- An individually developed crisis prevention strategy.
- Additional support coordination and supervision with a behavioral support provider.

SERVICE SETTINGS

ALTSA offers services that empower older adults and people with disabilities to remain independent and supported in the setting of their choice.

Independent Housing
Individuals may choose to receive services in their homes.

ADULT FAMILY HOMES
Adult Family Homes are licensed to care for up to eight people in a private home setting with staff available 24 hours a day. These homes provide room, board, laundry, necessary supervision, personal care, social services and assistance with activities of daily living. Some also provide nursing care. Approximately 10,335 clients statewide are in adult family homes.

ASSISTED LIVING FACILITIES
Assisted living facilities are licensed to care for seven or more people. They provide room and board, assistance with activities of daily living and supervision, and may also provide limited nursing care. Three distinct Medicaid contracts are used in Assisted Living Facilities:

ADULT RESIDENTIAL CARE
ARC provides room and board as well as help with medications and personal care.

ENHANCED ADULT RESIDENTIAL CARE
EARC facilities offer services provided in an ARC as well as limited nursing care. Approximately 3,611 clients reside in Adult Residential Care facilities.

ASSISTED LIVING FACILITIES
Assisted living facilities with an assisted living Medicaid contract are small studio-like apartments with a private bath and small kitchenette. Congregate meals, laundry, personal assistance services and limited nursing services are offered. Approximately 3,583 clients are receiving services in licensed assisted living facilities.

ENHANCED SERVICES FACILITIES
Enhanced services facilities serve adults coming out of state and community psychiatric hospitals or who have no other placement option due to their complex behavior, medical, chemical dependency and/or mental health needs. These facilities are required to have a licensed or registered nurse on site at all times as well as a mental health professional on site eight hours each day. Approximately 106 clients receive services in Enhanced Services Facilities.

CONSUMER EXPERIENCE SURVEY
In 2018, ALTSA implemented the National Core Indicator-Aging and Disabilities consumer survey. The NCI-AD is a consumer satisfaction survey used to assess the performance of the Long-Term Care programs and delivery system in order to make improvements. The primary aim of the NCI-AD is to collect and maintain valid and reliable data that gives a broad view of how publicly funded services impact the quality of life and outcomes of service recipients.

CASE MANAGEMENT AND CARE COORDINATION
People who receive Medicaid-funded long-term services and supports receive case management services that assist with eligibility determination, assessment, person-centered

service planning, authorization of services and ongoing case management targeted to assist people with understanding their options and accessing services needed for health and well-being.

The Health Home program is a Medicaid service that promotes person-centered health action planning to empower clients to take charge of their own health care, bridge the systems of care and identify possible gaps in their services. This is accomplished through better coordination between the client and all their health care providers, which encourages involvement and independence. Clients receiving Health Home services are assigned a Health Home Care Coordinator who partners with the client, their families, doctors and other agencies to ensure coordination across the systems of care. The Health Home program is designed to ensure clients receive the right care at the right time with the right provider.

The centerpiece of the Health Action Plan is the client's self-identified short- and long-term health-related goals, including what action steps the client and others will do to help improve their health. With client consent, the HAP can be shared with care providers to foster open communication, support and encouragement to reach their health goals. To be eligible, a person must:

- Have at least one chronic condition and be at risk for another.
- Have a PRISM predictive risk score of 1.5 (per WAC 182-557-0225).
- Meet Apple Health (Medicaid) eligibility criteria.

CONSUMER ENGAGEMENT

The purpose of The Service Experience Team is to discuss, educate and provide feedback that represents the clients who are receiving Home and Community Services. Participation helps to promote choice, quality of life, health, independence, safety and active engagement to programs developed and operated by HCS. The Service Experience Team members are a voice for people receiving Long-Term Support Services across the state.

The specific responsibilities of the HCS Service Experience Team include:

- Provide feedback and input into ongoing HCS programs and services.
- Review and provide input regarding proposed or new programs or policy.
- Help identify opportunities to improve the quality of services and the client experience, and address gaps in care.
- Promote community involvement in the support of the HCS mission and vision.

STATE HOSPITAL DISCHARGE AND DIVERSION and COMMUNITY HOSPITAL TRANSITION TEAM

ALTSA partners with the state psychiatric hospitals to assess eligibility for long-term services and supports for patients who are transitioning to community settings. ALTSA is dedicated to problem-solving and increasing cross-collaboration with the DSHS Behavioral Health Administration, the Health Care Authority, Behavioral Health Administrative Service Organizations and Managed Care Organizations to support clients to transition safely to a community setting of their choice. The objective of the **State Hospital Discharge and Diversion team** is to provide support statewide. Support across the state includes care coordination,

provides clinical consultation and offers safe, comprehensive, person-centered transitions. The Transition Coordinators support state hospital transitions and the Transition Specialist support diversion work from community psychiatric and acute care hospital settings into ALTSA settings.

The Hospital Transition team supports statewide complex case consultation for state and acute care hospitals on current community practices and scope of work. This team also provides behavioral health education, training and resources to providers and HCS staff. The focus of the collaboration includes:

- Increasing discharges and diversions from state hospitals.
- Serving clients who meet eligibility requirements for personal care services.
- Increasing the stability of ALTSA clients in the community once they have discharged or diverted from state hospitals.
- Providing statewide complex cases consultation, guidance and oversight.
- Providing behavioral health education and training.

DEPARTMENT OF CORRECTIONS

ALTSA partners with the Washington State Department of Corrections to assess eligibility for people who are incarcerated and are transitioning to community settings. The focus of the collaboration includes people who are transitioning from the Department of Corrections under the Extraordinary Medical Program, going to the Special Commitment Center or determined to be incompetent to stand trial with a dementia, developmental or intellectual disabilities.

ACUTE HOSPITAL TRANSITIONS

Washington state has more than 54 acute care hospitals. ALTSA partners with these hospitals to ensure smooth transitions for individuals in need of LTC services, whether in-home, community residential settings or to nursing home facilities. The goal and focus of hospital assessment activities is to:

- Proactively engage with people seeking long-term care services.
- Provide up-to-date information about Medicaid-funded long-term care options to hospital staff and people seeking these services.
- Assist hospital patients and their families in making informed decisions regarding home and community service options.
- Assist hospitals in working with Medicaid-eligible patients to access LTSS to avoid staying in the hospitals when they no longer need acute care services.
- Prioritize the assessment of long-term care eligibility for people as soon as they are referred for services and anticipate transitioning from the hospital to a less-restrictive setting.
- Expedite the authorization of long-term services and supports.
- Develop rapport and supportive relationships with local hospital discharge planners and long-term service and support providers in the community.

MANAGED CARE ORGANIZATION COORDINATION

As the needs of the population have increased and Managed Care models have expanded, we recognize the need for increased care coordination with MCOs as well as our community partners. The effort to increase cross-systems coordination is to identify barriers, develop and lead processes to improve engagement to support our mutual clients transitioning out of inpatient settings and become successful in their community setting.

This work collaborating with our MCOs and community partners includes:

- Relationship building with our MCOs partners and providing a single point of contact.
- Establishing a pathway for escalation to staff complex clients with our MCO and community partners.
- Establishing bi-weekly care coordination meetings with MCOs to provide a forum for field staff to start care coordination for complex clients.
- Establishing weekly cross-systems coordination with hospitals and MCOs to staff complex clients requiring additional support in transition planning.

HOUSING

DSHS recognizes that lack of availability to affordable and accessible housing can be a barrier to people who desire to live in a community setting. Many Washingtonians face this issue as housing becomes more expensive and out of reach for people with low incomes.

The Housing Team at ALTSA works to administer housing resources and Supportive Housing services to HCS-eligible clients. The Housing Team is the liaison between the field, various contractors and available long-term services and supports, working to support independent housing options for HCS clients by focusing on subsidies and tenancy support.

ALTSA subsidies provide rental assistance for eligible ALTSA clients transitioning from institutional to independent housing through a monthly rent subsidy. The client is responsible for a portion of the rent, paid directly to the landlord, calculated at approximately 30% of their income. ALTSA subsidies assist clients in transitioning into affordable housing while they remain on waitlists for permanent, affordable housing.

Supportive Housing Services provide dedicated housing support to people with complex care needs who wish to live independently. The service offers wraparound support, facilitating cross-sector coordination of all services the person needs, including LTSS, mental health, substance use disorder, physical disabilities and legal or financial issues. Supportive Housing services may be an option for individuals who want to live independently and have a history of unsuccessful housing episodes without coordinated, focused support services. ALTSA seeks to provide person-centered, responsive, low-barrier services for these clients. Supportive Housing services are available through Foundational Community Supports Supportive Housing services or through the Governor's Opportunity for Supportive Housing for people residing at or diverting from Eastern or Western State Hospitals. GOSH clients are also eligible for an ALTSA subsidy as they transition.

The ALTSA Housing Team collaborates with local Public Housing Authorities to increase accessibility to Housing and Urban Development vouchers for ALTSA clients. Various voucher types are available in multiple locations and are listed in the Long-Term Care Manual Chapter 5b.

Emergency Rental Assistance is a one-time payment made directly to landlords on behalf of an ALTSA client facing an immediate eviction due to non-payment of rent. ERA can also help pay for a short-term motel/hotel stay for an individual with a move-in date for permanent housing but nowhere to stay in the interim.

The Housing Team also works continually to increase housing capacity to support the need for immediate/tangible housing to pair with our state subsidies. We lean on existing partnerships and work to develop new opportunities. The partnerships braid services and subsidy funding through HCS with tangible housing via “set-asides” from housing developers, non-profits and property management companies. Our housing capacity projects honor the community integration efforts of our work by ensuring a diverse portfolio of set-asides across the state.

EMPLOYMENT

DSHS recognizes the importance of supporting employment participation in the community to achieve Olmstead Plan goals. The department offers a range of employment supports and programs through several different agencies. ALTSA and the Developmental Disabilities Administration offer Medicaid-funded supported employment services to clients who meet the eligibility requirements and can access the Medicaid waivers that offer the supported employment services. Clients in the Economic Services Administration may also access Medicaid-funded supported employment services under certain circumstances and if they meet the eligibility criteria. The Division of Vocational Rehabilitation’s mission is to enable people with disabilities to obtain and keep paid employment in the community. They offer a broad range of employment and employment support services to the people who meet their criteria and are enrolled in their programs.

Supported employment services are available through the administration (ALTSA, DDA, ESA and DVR) for clients who are Medicaid-eligible and have long-term service needs that make it difficult to gain and retain employment in the community. These services are person-centered and individualized and last as long as needed to support people through pre-vocational assessment, job placement, job coaching and long-term follow-along supports. The supported employment services are funded through a Medicaid waiver and became available to clients in January 2018.

Supported Employment provides clients statewide access to Medicaid-funded employment services to help them gain and retain paid employment in the community. Services include vocational/job-related discovery or assessment, planning for employment, job placement, development and coaching, and skills-building for negotiating with prospective employers. Employment is a key factor in a healthier life for people who receive Medicaid health services,

leading to less frequent institutionalization, greater success in rehabilitation and recovery programs and overall lower medical costs.

The Employment Team provides direct support to clients, field staff, Area Agency on Aging staff and community stakeholders to identify and assess clients for the Foundational Community Supports Supported Employment program and help them apply for eligibility determinations and enrollment for services. Additionally, the position supports clients, staff and providers to assure clients receive quality services through Technical Support to providers, liaison with clients, providers, staff and other government agencies.

DSHS also implements the state's Medicaid buy-in program to support people with disabilities engaged in completive employment. Under Health Care for Workers with Disabilities, employed people with disabilities are able to purchase Medicaid, which may afford them access to the Medicaid-funded supported employment services. Employed people with disabilities can earn and save more money and purchase their health care coverage for an amount based on a sliding income scale. Additionally, Social Security Administration's Ticket to Work and the employment services afforded through the Workforce Innovation and Opportunity Act are available to DSHS clients and may be used in support of the Olmstead Plan employment goals.

Residential Care Services*:* RCS is responsible for the licensing and oversight of adult family homes, assisted living facilities, nursing facilities and intermediate care facilities for people with intellectual disabilities, and certified community residential services and supports. The mission is to promote and protect the rights, security and well-being of people living in these licensed or certified residential settings. Through the licensing and certification process, RCS ensures facilities are meeting the local, state and federal laws and regulations, including regulations that uphold client choice and rights to live in community settings.

To assist clients with remaining in community settings, rather than returning to more restrictive environments, RCS developed a new Behavioral Health Support Team. This team offers technical assistance and training to our community residential providers who give services and supports to people transitioning from state psychiatric hospitals or those providers who currently serve people with behavioral health challenges.

The objectives of the Behavioral Health Support Team include:

- Assisting in the success of people in transition to a new living arrangement.
- Offering services that will lead to long-term success for people with behavioral challenges in home and community-based settings.
- Success for providers within the regulatory structure, by promoting expertise within community settings and assisting them in meeting unique and complex needs in an individualized and person-centered approach.
- Robust coordination across agencies for system success in transitioning people from state and community psychiatric hospitals into community settings.
- Supports for providers in giving high-quality care to clients with complex needs who are able to relocate out of institutional settings.

- Proactively providing the necessary training and consulting education on behavioral health topics that assist providers in being successful in serving this population.

Office of the Deaf and Hard of Hearing: Approximately 529,686 people in Washington state have a hearing loss. ODHH provides an array of services to the deaf, hard of hearing and deafblind communities throughout Washington state. With a history of serving the deaf, hard of hearing and deafblind communities for more than 30 years, ODHH promotes equal access opportunities to effective communication methods. The office operates in accordance to the law and plans for the future and state budget, which funds ODHH services. ODHH holds themselves accountable to the people they serve and partners closely with stakeholders to address gaps in services.

PROGRAM DESCRIPTION

TELECOMMUNICATION EQUIPMENT DISTRIBUTION

Per regulations, eligible consumers apply to receive specialized telecommunication equipment and receive training to effectively use the equipment. Specialized telecommunication equipment distributed matches the consumer's degree of hearing loss or speech disability and preferred communication method. The equipment enables the consumer to make direct telephone calls independently through the telecommunication relay services.

TELECOMMUNICATIONS RELAY SERVICES

Washington Telecommunications Relay Services allow persons who are deaf, hard of hearing, deafblind or have speech disabilities to communicate by telephone in a manner that is functionally equivalent to telephone services used by persons without such disabilities. Under Title IV of the Americans with Disabilities Act, as amended, the Federal Communications Commission must ensure the provision of TRS. TRS is available in all 50 states, the District of Columbia, Puerto Rico and all other U.S. territories for local, long-distance and international calls.

SOCIAL AND HUMAN SERVICES

Social and Human Services contracts with several Regional Service Centers on Deaf and Hard of Hearing throughout the state to provide an array of social and human services. Currently the scope of services includes:

- Information and referral.
- Outreach, education and training.
- Advocacy for communication access that focuses on access to products, services and employment, education, health and legal aid in the private, public and nonprofit sectors.

The centers play a vital role in providing educational, cultural, recreational and social opportunities and making their facilities available to local and regional grassroots community-based nonprofit organizations.

ASSISTIVE COMMUNICATION TECHNOLOGY
This program benefits the deaf, hard of hearing, deafblind and late deafened communities. The Assistive Communication Technology program provides communication access for services offered through DSHS. ACT equipment works well for people who wear a hearing aid or cochlear implant with a t-coil switch. ACT equipment includes devices such as Portable Loop systems, FM kits, captioning and other assistive technology. The provision of existing and emerging technologies will fulfill the reasonable accommodations mandate to ensure equal communication access to DSHS agencies, programs and services.

COMMUNITY OUTREACH PROGRAM
This program provides outreach and educational resources designed to understand the full range of communication access options toward different target audiences including professionals, organizations and deaf, hard of hearing and deafblind communities. It engages consumers to remove communication barriers of legal reasonable accommodation obligations with the opportunity to communicate and have equal access to information. The program coordinates activities such as exhibits at community events and conferences, publications; shares resources via GovDelivery; and produces a calendar of events including community events, workshops and other communication opportunities and supporting presentations to heighten the public profile and awareness of ODHH programs. It connects people in the broader community by creating sponsorship agreements to solicit and maintain funds for special projects on deaf culture, communication access and other issues pertaining to hearing loss, and serves as a statewide clearinghouse, responding to public requests for information and referrals to needed resources.

SIGN LANGUAGE INTERPRETER CONTRACTS AND RESOURCES
This program administers the statewide contract to purchase sign language interpreter services. Washington state agencies are obligated to provide sign language interpreters upon request to people who are deaf, deafblind, hard of hearing or late deafened and seeking accessible government services. The Sign Language Interpreter Contracts and Resources Program in ODHH works in partnership with the Washington State Department of Enterprise Services to manage these contracts.

ODHH/SLICR monitors contractual compliance including quality of services, certification of interpreters and adherence to best practices. SLICR also regulates sign language interpreters' qualifications and standards to interpret in the Washington state courts.

ODHH/SLICR provides and manages an online interpreter request system. In addition to being a request portal, the system tracks requests and records fill rates. ODHH partners with other departments to resolve barriers to communication access.

SLICR also provides an official method for state employees seeking credentials for their American Sign Language Skills credentials.

COMMUNCIATION ACCESS PROGRAM
This program provides training, consultation and environment assessments to service providers of all various DSHS entities who have deaf, deafblind, hard of hearing or late deafened clients on their caseloads. The mission of this program is to support service providers' communication and resources for their clients.

TRAINING AND PRESENTATION PROGRAM
This program provides a wide array of trainings and presentations on skill-building, cultural awareness, diversity initiatives and self-advocacy skills for the deaf, hard of hearing, deafblind and late deafened stakeholders.

Behavioral Health Administration

The DSHS Behavioral Health Administration transforms lives through dedication to the wellness of people, their families and the community through behavioral health intervention, treatment and education. BHA operates three state psychiatric hospitals, the Special Commitment Center and the Office of Forensic Mental Health Services, which deliver high-quality services to adults and children with complex needs.

CHILD STUDY AND TREATMENT CENTER is Washington's state psychiatric hospital for children and youth up to age 18. The center engages families and community teams to participate in the psychiatric treatment and educational services, and to plan for these young clients' successful return to their home community.

EASTERN AND WESTERN STATE HOSPITALS and **BHA RESIDENTIAL TREATMENT FACILITIES** provide evaluations, competency restoration, inpatient psychiatric treatment for people adjudicated as Not Guilty by Reason of Insanity and/or in-patient psychiatric treatment for people who are civilly committed due to serious or long-term behavioral health conditions. The hospitals deliver evidence-based and effective in-patient treatment programs, interventions and activities that promote patient recovery. Our therapeutic approach is designed to empower patients, instilling hope, support, self-discovery and independence.

THE SPECIAL COMMITMENT CENTER specializes in treatment to residents who have completed their prison sentences for a crime of predatory sexual violence and are now civilly committed.

THE OFFICE OF FORENSIC MENTAL HEALTH SERVICES is responsible for the management of Washington's adult forensic mental health care system, providing competency evaluation, competency restoration, services to people adjudicated as Not Guilty by Reason of Insanity, and pre-trial forensic navigation services that seek to support justice-involved people in coordinating services. Forensic mental health services are for adults involved in the criminal justice system and court ordered into treatment services. BHA has been working to increase opportunities to divert people with mental illness from involvement in the criminal court system and, instead, ensure they are receiving appropriate supports and psychiatric services in

their communities. These efforts contribute to the state's overall efforts to decrease the need for people to enter our forensic institutions.

Administration Activities

TRANSITION FROM IN-PATIENT TREATMENT TO LEAST-RESTRICTIVE SETTINGS

BHA, in its management of state hospitals, RTFs, forensic services and the Special Commitment Center, has committed to improving communication and collaboration with our DSHS partners, including ALTSA and DDA. BHA is also committed to improving communication between BHA and other state agencies, including the Health Care Authority, Department of Commerce, Department of Corrections, Department of Health and the Department of Children, Youth, and Families. BHA finds that improved communication and collaboration are foundational to supporting the transition of patients from our hospitals and institutions to community settings and divert people from entering our state hospital programs. These efforts contribute to the state's overall efforts to serve patients in their home communities.

Activities that Support Transition – Special Commitment Center

- Use Lean tools to improve processes to determine how to best support transition and supervision of residents with disabilities into the community.
- Create opportunities to consult with partners on challenging cases early in the treatment process to identify services that would support a resident's treatment, transition, supervision and stability in the community.
- The SCC is committed to exploring contract options with identified placements and treatment providers to support appropriate levels of treatment and supervision for residents.
- Annual reviews to determine resident needs and provide recommendations for treatment and habilitative/support services.

Activities that Support Transition – State Hospitals and RTFs

- Participate in Value Stream Mapping with partners, when needed. Improve processes and identify opportunities to improve communication with our partners.
- Improve communication through inviting partners to treatment planning, case consultation and discharge planning meetings.
- Create opportunities to consult with partners on challenging cases early in the treatment process to identify services that would support patients' transitions and stability in the community (early engagement pilot, cross-system case consultation).
- Improve use of available social work staff to ensure efficient use of resources in relation to providing treatment, communication and discharge planning.

Diversion Activities – State Hospitals

- Use pre-admission screening information to identify patients who have a 90-day involuntary competency restoration order who would benefit from a diversion to treatment in the community.

- Coordinate with facilities treating the patient and our partners within DSHS, other administrations and the community to transition the patient to less-restrictive services and programs in the community.

SHORTEN HOSPITAL STAYS
BHA is committed to treating patients admitted to the state hospitals in the shortest amount of time necessary and to support transitioning patients to programs in the community designed to provide a continuum of care that will allow patients to be served in the least-restrictive setting.

Shorten Hospital Stays Activities
- Increase use of Evidence-Based Practices offered to patients during their treatment at state institutions.
- Educate treatment teams about programs and services in the community that provide services to support patients' return to and stabilization in the community.
- Increase early engagement efforts, discharge planning conferences and case consultation to ensure discharge planning starts at the time of admissions, will include communication and coordination with our partners, and will be an ongoing process throughout the course of treatment.

PROSECUTORIAL DIVERSION PROGRAMS
Since 2016, BHA has contracted these programs to assist prosecuting attorneys, behavioral health providers and other partners to engage people in treatment and assist with housing and other needs. The goals of the program are to prevent charges from being filed or result in the charges being dismissed after successful completion of the program, thus avoiding or decreasing time in jail or other institutional admissions.

JAIL DIVERSION PROGRAMS PROPOSED BY COMMUNITY PARTNERS
Across the state, 13 other diversion programs are in place that aim to divert people with mental illness from involvement in the criminal courts. These programs include a variety of strategies such as having social workers embedded with law enforcement to help deflect people from arrest or providing transition services for people currently in jails to ensure they are connected to appropriate services and supports upon their release.

Developmental Disabilities Administration
DDA offers an array of support options for people who choose to reside in the community. DDA provides these supports through five Home and Community-Based Waivers, Medicaid State Plan options and state-only funding.

Home and community-based residential support recipients receive anywhere from 24-hour one-on-one habilitative supports to just a few hours a week, depending on each person's assessed need. People living in their own home, in Adult Family Homes or with their family receive support with their personal care through the Community First Choice program to meet their daily living needs. Other services provided include respite, employment support and

community engagement. Some people receive state-only funded services that are either paid services or cash payments in lieu of services.

For more information on the full range of DDA services, go to https://www.dshs.wa.gov/dda.

DDA is Reducing Its Institutional Footprint

Overview
DDA operates four facilities for people with intellectual disabilities. Called Residential Habilitation Centers and outlined in Chapter 71A.20 RCW, each one has a unique campus and composition.

- Fircrest and Lakeland Village each contain a Nursing Facility and an Intermediate Care Facility.
- Rainier contains an ICF and an emergency transitional support cottage.
- Yakima Valley contains a NF that includes eight beds for respite and eight beds for crisis stabilization.

Together, the RHCs include seven separately certified long-term care facilities: three nursing facilities, three intermediate care facilities and one state-funded transitional cottage that is currently funded in the 2023-2025 biennial budget.

Washington state law limits admission to the RHCs to people age 16 and older, and the number of residents served in the RHCs has declined steadily from more than 4,000 in 1970 to approximately 500 in August 2023.

Redesigning ICFs
Engrossed Substitute Senate Bill 5268 passed during the 2022 session of the Washington State Legislature, relating to transforming services for people with intellectual and developmental disabilities by:

- Redesigning Intermediate Care Facilities.
- Expanding the number of family mentors.
- Establishing peer mentor services.
- Ensuring clients do not lose their community residential services while receiving stabilization services provided at a Residential Habilitation Center.

DDA was asked to submit a report describing the above efforts and to make any necessary recommendations for policy or fiscal changes to the governor and the Legislature for consideration in the 2023 legislative session. A copy of the report can be found here.

ESSB 5268 also directed DDA to work with the Health Care Authority and Washington state's Managed Care Organizations to establish recommendations for people with intellectual and developmental disabilities who live in the community for access to intermediate care facility-based professionals to receive care covered under the Medicaid state plan. The department was required to consider methods to deliver these services at mobile and/or brick-and mortar

clinical settings in the community and to submit a report describing efforts and any recommendations for policy or fiscal changes to the governor and the Legislature. A description of the community client's access to facility-based professionals report can be found here.

Closing Institutions

DSHS closed the Frances Haddon Morgan Center in 2011, and previously closed the facility known as Interlake School in 1994. The Yakima Valley School will close according to the procedure codified in RCW 71A.20.180. One ICF, Rainier School PAT A, closed in 2019 and Rainier School PAT C, closed in 2023. Clients residing in each of those PATs were successfully transitioned to other settings, many of those in home and community-based settings. One ICF remains in operation at each of the following RHCs: Lakeland Village, Fircrest and Rainier.

Development of Formal Statewide Transitional Care Management Strategy

DDA used lessons learned from the PAT A and PAT C closures as well as a review of national best practices to develop a formal transitional care management structure. This structure includes increased staffing across the agency to focus on community transitions from facility and non-facility settings. We developed a framework that addresses gaps in existing processes and creates connectivity between programs when clients move from one setting to another. The framework focuses on engaging the client at the beginning to talk about their personal goals to facilitate timely and stable transitions and to promote client and family choice. In, 2022 the Washington State Legislature passed SB 5693 "…to establish transition coordination teams to coordinate transitions of care for clients who move from one care setting to another." DDA hired 35 employees, which included additional case management staff, psychologists and nurses to provide professional consultation and support, quality assurance staff and program management staff. These teams have been piloting the transition framework starting January 2023 and a four-phase plan will scale it across the entire DDA system.

Defining the Future

DSHS contracted with the William D. Ruckelshaus Center to facilitate discussions with diverse stakeholders to determine a consensus-based vision for the future of the RHCs and, by extension, the residential support options available to DDA clients. The workgroup first convened in 2018 and submitted a final report to the Legislature on Dec. 1, 2019, entitled "Rethinking Intellectual and Developmental Disability Policy to Empower Clients, Develop Providers and Improve Services." This groundbreaking effort involved many stakeholders, including legislative leaders, and shared specific DDA programmatic and service enhancements to consider in the future. A 2021 legislative report shared updates on efforts to implement the recommendations, and a February 2024 legislative report from the Ruckelshaus Center has just been issued, including a review of perspectives and progress in bringing these recommendations to actuality.

Peer Mentor Project

The Peer Mentor Project was implemented in July 2023. "Thoughts Cost LLC" was the successful bidder for this contract, which runs in Fiscal Years 2024 and 2025. Modeled on the Family Mentor Program, the purpose of the Peer Mentor Project is to develop and implement a Peer

Mentor Services Program. The Peer Mentor contractor will recruit and train Peer Mentors, people who receive (or have received) services from DDA and, preferably, who have the lived experience of transitioning from RHC/facility-based services to community-based services. Peer Mentors will assist clients residing at an RHC ICF/IDD who have expressed a desire to move and receive community-based services.

DDA is Expanding Its Home and Community-Based Services

DDA has five Home and Community-Based Service Medicaid Waiver programs. Each waiver offers specific services to meet the health and safety needs of eligible people in the community. Each waiver offers a variety of services when they are not available through any other resources (private insurance, Medicaid, school, etc.) These five waivers are:

INDIVIDUAL AND FAMILY SERVICES: Supports people who require waiver services to remain in the family home. (Age 3+)

BASIC PLUS: Supports people who require waiver services to meet their assessed health and safety needs in the community. Services are provided in their own home, family home, an adult family home or adult residential center. (Age 0+)

CORE WAIVER: Offers residential options to people at immediate risk of institutional placement or who have an identified health and welfare need for services that cannot be met by the Basic Plus waiver. (Age 0+)

CHILDREN'S INTENSIVE IN-HOME BEHAVIORAL SUPPORT: Supports youth at risk of out-of-home placement due to challenging behaviors. The CIIBS model involves planning and family-centered positive behavior support. (Age 8-20)

COMMUNITY PROTECTION WAIVER: Offers therapeutic, residential supports for people requiring 24-hour, on-site staff supervision to ensure the safety of others. Participants voluntarily agree to follow the community protection guidelines. (Age 18+)

STATE-OPERATED SUPPORTED LIVING MODEL PROGRAM: DDA has expanded its SOLA program from supporting 131 people in 2016 to more than 210 people across 10 different communities statewide in 2023. DDA's SOLA program provides residential habilitation services to DDA-eligible clients who are on the CORE and Community Protection Waivers. Services are provided in integrated settings in the community to people who live in their own homes. Supports are person-centered and are based on the need and preferences of the client. SOLA supports clients transitioning from their family homes, RHCs, community hospitals and psychiatric hospitals to live in their own homes in the community. At this time, SOLA has completed its legislative obligations for adults, to expand services around Washington state.

FAMILY MENTOR PROJECT: The Washington State Legislature funded a Family Mentoring Project to provide information and support to families and guardians going through this

process. The Family Mentoring Project serves as an additional resource for parents, guardians and administration staff to support people through change at RHCs. Funding for the project continues through the DDA Roads to Community Living program. The mentor meets with families who are deciding whether to move a family member from an RHC or other institution. The mentor listens to families, understanding firsthand what they are feeling and thinking. The mentor explains community services and programs from a parent's perspective and suggests helpful strategies for making the process successful.

Family Mentor Project Accomplishments for Fiscal Year 2023 (July 1, 2022 – June 30, 2023)*

- **RHC Transitions**
    - Family Mentors assisted 15 people who completed transitions from RHCs to community-based services.
    - Family Mentors assisted 24 people who are in-process (planning stages) of transition to community-based settings.
- **PASRR/Skilled Nursing Facility Transitions**
    - Family Mentors assisted 15 DDA-enrolled clients who completed transitions from Skilled Nursing Facilities to community-based services.
    - Family Mentors assisted 22 HCS-enrolled clients who completed transitions from Skilled Nursing Facilities to community-based services.

**Data from Family Mentor Project Annual Report, July 3, 2023.*

Reducing State Mental Hospital Stays and Diverting Admissions
DDA continues to work with BHA and other public and private partners to transition people with a dual diagnosis of a developmental disability and psychiatric condition from state psychiatric hospitals to less-restrictive settings. In order to move, each person must be deemed ready for discharge by his or her treatment team.

DDA continues to provide training on a number of topics (e.g., positive behavior support, autism, genetic disorders, cross-system crisis planning, medical issues for persons with developmental disabilities) to community residential, vocational and mental health providers in order to prepare them to provide supports for this population.

Working in collaboration with BHA, DDA has implemented a Comprehensive Review Process to review the quality of community supports for adults with dual diagnoses. Data collected from these reviews is used to target service gaps, identify strengths in the system and inform policy. Further, DDA will continue to work to divert admissions to state hospitals by:

- Continuing to contract with local support networks and community providers for enhanced crisis services, diversion beds and medication management services.
- Reviewing state hospital admissions of people with a dual diagnosis to determine what, if any, additional community services might have diverted the admission.
- Making use of the "Money Follows the Person" federal grant, which provides funding to enhance the opportunities for people to return to the community if they desire to do so.

Roads to Community Living Program
RCL is a statewide demonstration project funded by a federal Money Follows the Person grant. Washington state received the grant from the federal Centers for Medicare and Medicaid Services. The purpose of the RCL demonstration project was to investigate what services and supports will successfully help people with complex, long-term care needs transition from an institution to a community setting. People eligible for RCL have had a stay of 60 days or more at a qualifying institutional setting (RHC, skilled nursing facility or hospital) and are financially eligible on their day of discharge. RCL-enrolled clients receive planning and supports to ensure a successful transition to community-based services. Clients must be enrolled prior to their discharge from a qualifying setting, and they must remain eligible for RCL program services for 365 days following their transition to community-based services. Participants enrolled in the RCL project have access to all services available under the Medicaid State Plan and DDA's five HCBS Waivers.

Roads to Community Living Activity*

DDA RCL Current Enrollment	
Settings Details	
Acute Care Hospitals	33
Mental Health Hospitals	5
Nursing Facilities	27
Other Settings	28
RHCs	75
Total	168

DDA RCL Transitions by Fiscal Year	
FY 2023	160
FY 2022	114
FY 2021	122
FY 2020	118
FY 2019	89

*Data from RCL Caseload Activity Report, Aug. 7, 2023

ALTSA manages the overall "Roads to Community Living" grant and DDA has initiated projects to increase the capacity of the community to provide for people with all kinds of needs in the following ways:

- **Lessons Learned Project** – DDA has engaged independent facilitators to obtain feedback from stakeholders as part of the Ruckelshaus Project commissioned by the Washington State Legislature. This information has helped DDA plan for future moves from institutional settings and establish new services in the community.

- **Eating Safety Project** – DDA contracted with speech pathologists who have expertise in eating and swallowing disorders and have extensive experience with people with developmental disabilities. Staff training has been developed and implemented for community residential staff for clients assessed for being at-risk of eating and swallowing problems, safety risks during eating or any disorders that cause them to ingest non-food items.
- **Nursing Project** – DDA has engaged a registered nurse and a formalized checklist and protocol has been implemented to address client health needs. This checklist better summarizes participant health indicators and identifies needed health and wellness outcomes.
- **Community Crisis Stabilization Services** – DDA developed a framework of crisis and stabilization services across the state to address the needs of clients who experience a crisis or need additional crisis services. The intent of the program is to prevent unnecessary RHC placement. DDA continues to create and explore options to serve adults in crisis and children in crisis across the state.
- **Mental Health Supports** – People with developmental disabilities are benefiting from improvements to the mental health service system that resulted from the coordinated efforts of DDA and BHA.
- **Family, Guardian and Advocate Survey** – Surveys are used to listen to and learn from family perceptions about the moving process, perceptions and feelings on the health and welfare of their family member and overall satisfaction with the new residence.
- **Assistive Technology and Communication** – This project is designed to provide training and information regarding assistive technology best practices. The purpose of the project is to learn and develop strategies for assessing and evaluating the use of a variety of appropriate assistive technologies for individuals leaving institutional settings. This has included assessments as well as staff training. Statewide conferences have provided continuing training to a cohort of community residential providers regarding use of iPad and other handheld devices, which enhance community living experiences for people with developmental disabilities.
- **Serving Individuals on the Autism Spectrum** – The project has identified areas of the community service system that require a change in practices to adequately serve people with autism and to develop a plan for implementing necessary changes. Issues are assessed with the current service provision system, and recommendations are made on how to improve the system and a plan is developed to better meet the needs of people on the autism spectrum.
- **Behavioral Supports** – The project has explored methods for improving client behavioral support work done in the community in the areas of assessment, data collection and analysis of behavioral programming. By improving these areas, we can better improve the behavioral supports clients are receiving and limit return to institutions. Best practices for documentation of behavioral support programs are analyzed and curriculum developed based on this analysis and information shared with residential providers.
- **Community Residential Staff Retention Project** – Staff turnover and productivity are some of the biggest issues that residential agencies face in today’s workplace, and those

issues negatively impact client services. The project focuses on the dynamics of those issues and concentrates on strategies for improving staff performance and retention. A curriculum has been developed and presentations have been made to residential providers.

- **Environmental Support/Housing** – The project has provided guidance and education for community providers and families on appropriate housing and environmental supports for someone leaving an institution. This is based on the use and improvement of checklists and transition planning formats developed through this reinvestment project. DDA continues to focus on making the existing checklists and transition planning formats developed in Phases I and II more user-friendly and web-accessible. The project also provides guidance and education for community providers, families and housing agencies regarding appropriate housing and environmental supports based on creating/adapting housing that goes beyond ADA standards.
- **Employing Difficult-to-Employ Individuals** – The project helps promote activities to sustain employment practices utilized in participating counties to employ people with developmental disabilities who have been difficult to employ. RCL participants, former RCL participants and their respective counties have been a focus of this effort. The project includes developing plans to implement lessons learned regarding how employment systems can better respond to the employment needs of people leaving RHCs. Strategies, systems, best practices and collaborations have been developed to secure employment opportunities for people moving to the community from institutional settings. As part of this, person-centered employment plans have been developed and support activities for designated RCL participants seeking employment. A statewide steering committee supports the project to determine best practices and system change recommendations. In addition, a website (Live Inclusive) was created to share stories and resources about people living and working in the community.
- **Avoiding Institutionalization of Children** – This project develops and facilitates trainings for families regarding natural supports and the wraparound model helping to avoid institutional placement of children. The sessions are for families with children who are DDA clients with behavioral problems. This includes families who may be involved with Children's Long-Term Inpatient Programs to enhance transition planning process for Children leaving CLIPs.
- **Family Mentor** – This project provides information and support to families and guardians of people living in institutions who are deciding whether or not a move to the community is right for their relative. It provides additional resources and strategies for parents and guardians supporting people through this change to make the process successful. The family mentor meets with families who have or have not yet made the decision about a move to the community and explains community services and programs available from a family member's perspective.
- **Increasing Quality in Community Programs** – These projects focus on strengthening the community-based residential system by reducing risk and effectively using RHC resources in the community. Stakeholders are reconvened on a periodic basis, research is completed and protocols have been further refined and evaluated.

- **Practice Change Regarding Community Values and Standards** - The project was originally developed to help staff make the transition from institutions to providing community-based supports. The project has widened in scope to clarify values with a target audience of community providers, families, self-advocates, DDA staff and RCL staff. The work has included the coordination and facilitation of:
  - Make a Difference: Person-Centered Direct Support workshops with up to four Supported Living agencies over a six-month period.
  - Up to six workshops based on Appreciative Inquiry, Valued Social Roles, Building Inclusive Communities to enhance community values and standards.
  - Up to three discussion groups with RHCs, community providers, families, self-advocates, DDA regional staff and RCL team to share information about what community has to offer and to build collaborations.
- **Community Outreach** – This project has involved the production of videos telling the stories of people who have made the transition from an institution into the community. It also includes Community Inclusion Newsletters telling the success stories of people with disabilities who are living in the community. These newsletters help educate clients and family members about the community support system and help people make the decision to leave the institution.
- **Intensified Residential Supports Residential Pilot** - A small number of DDA clients have not been successful in their RCL placements and have returned to the RHCs. In addition, there are other RCL enrollees with similar behaviors who are awaiting community placement. A pilot project is addressing these identified individuals' needs in a systematic manner and developing models for intensive staff training, staffing and increased clinical oversight to support people with more intense needs. Issues with current service provision systems are being identified based on case studies. This information and national research regarding successfully implemented models used in other states is being used to develop service provision protocols.

Quality Assurance for People Moving from Residential Habilitation Centers
When a person decides to move from an RHC to another location, quality assurance activities occur every step of the way. Quality assurance activities begin with all the pre-planning that goes into a move from an RHC to another location. This includes:

- Person-Centered Planning.
- Extensive consultation with the family or guardian and client.
- Information about options and visits to possible locations and providers.
- Once the planning has been done and the person moves, there is a year-long process that follows the person regardless of whether they move to the community or another RHC. The Regional Quality Assurance Manager visits the person three times within the first year of the move to interview and observe the person in their new home. Each time a visit is made, a report is completed and entered into a database. If any concerns are noted, the Quality Assurance Manager works with the person's Case Resource Manager and the residential provider to ensure that they are corrected.

Additional quality assurances include:

- Enhanced funding through the RCL grant to meet transitional needs during the first 365 days after the person moves from an RHC.
- A federally mandated quality assurance survey completed by an independent entity before the person leaves the RHC and at one and two years after moving.
- Three highly trained state staff whose time is dedicated to assisting with the transition process by providing expertise to help community providers, helping people connect with their communities and assuring the quality of the lives of the people who have moved.

Once the person moves to the community, ongoing quality assurance activities take place for all persons in funded community services:

- An Individual Support Plan is developed annually by the Case Resource Manager with the person, family or guardian and provider agencies.
- The residential services provider develops an Individual Instruction and Support Plan based on the information in the ISP. Residential Care Services Division conducts program evaluations and certifies providers.
- Community providers have training requirements as part of their contracts to provide services.
- DDA contracts for technical assistance to providers when issues of concern for the person's health and welfare arise.
- All providers are mandatory reporters and must report any suspected abuse, neglect and exploitation of children and vulnerable adults.
- DDA maintains an Incident Reporting system that providers are required to use to report any suspected abuse, neglect or exploitation and other serious incidents.
- RCS, Adult Protective Services and Child Protective Services all investigate allegations of abuse, neglect and exploitation.
- All community providers must have background checks completed every three years.

Housing and Transportation

The need for affordable housing for people with disabilities has steadily increased for several years. This is a result of national and state trends away from larger facility-based service models in favor of smaller community-integrated services for people with developmental disabilities. DDA programs currently support over 4,000 people in its community residential programs. Approximately 86% live in homes that they rent or lease since DDA does not provide housing for these individuals. These supported living clients reside in non-facility based integrated settings and are responsible for their own rent and utilities. If a person is unable to pay rent for a short time due to unforeseen circumstances, the program pays a non-facility allowance so the person can continue to live in his or her home. However, these dollars are limited.

The Legislature has provided a designated amount of dollars in the Housing Trust Fund for people with developmental disabilities since the mid-1990s. These funds are currently

administered by the Department of Commerce. DDA plays a key role in the HTF usage targeted for people with developmental disabilities. DDA's role includes:

- Identifying areas of greatest need for affordable housing for people with developmental disabilities.
- Promoting the vision for integrated affordable housing through DDA's strategic plan.
- Sponsoring proposals associated with community-based services that reflect current practice and are expected to continue into the future.
- Working with local affordable housing funders to help secure leverage dollars.
- Working with specialized housing developers and consultants.
- Collaborating with Commerce to review and prioritize HTF project proposals each year.

DDA will continue to participate in the cross-program transportation planning committee. This committee develops state-level transportation policy and works to influence local planning and policy development.

Stakeholder Work

DDA places a high priority on listening to stakeholders and interacting with them. The state uses several forums to continually solicit feedback. These activities include:

- A monthly meeting with the Community Advocacy Coalitions where DDA answers questions, provides information and solicits feedback.
- Bi-monthly meetings with county coordinators of services for people with developmental disabilities, with a regular spot on the agenda to present information and solicit feedback.
- An annual statewide DDA Community Summit and resource fair engaging clients, families and other stakeholders, with accessibility options for remote attendance.
- Working in partnership with the Developmental Disabilities Council, the Arc of Washington and People First of Washington to gather input and feedback as well as to co-fund information for families and self-advocates.
- Biannual quality assurance meetings hosted by the DDC that solicit the input of stakeholders on the management of DDA waiver services.
- Resident panels convened by the DDC to yearly review the results of the National Core Indicators survey and provide feedback and recommendations to DDA on improving services and supports.

Economic Services Administration

Nearly one out of every four Washington residents turns to ESA for assistance with cash, food, child support, disability determination, transition to employment and other services. Each day, more than 4,000 employees provide people across the state with the resources and support they need to build better lives. In 2022, ESA served more than 1.8 million people – representing approximately 22% of all Washington state residents.
ESA's core services focus on:

- **Poverty Reduction and Economic Assistance –** Helping people with low incomes meet their basic needs and achieve economic independence through cash grants, food and medical assistance, and employment-focused services. Major programs include Temporary Assistance for Needy Families and WorkFirst; Basic Food and Basic Food Employment and Training; Aged, Blind or Disabled cash assistance; Housing and Essential Needs Referral; Refugee Cash Assistance; and medical assistance for aged, blind or disabled individuals.

- **Child Support Enforcement –**Providing a pathway for parents and guardians to deliver consistent financial and medical support to their children so that families have the resources to thrive.

- **Disability Determination** – Under contract with the Social Security Administration, ESA's Division of Disability Determination Services determines whether individuals medically qualify for benefits from the Social Security Administration and for medical assistance.

ESA is committed to building a client-focused model that is shaped by collaboratively identifying the needs of Washingtonians. To maximize service reach and effectiveness, ESA works with a network of community partners and people with lived experience. Meeting the needs of a diverse population requires serving clients where they are, providing a welcoming and inclusive environment, developing culturally responsive best practices and ultimately making measurable progress toward identified goals.

ESA strives to make accessing services convenient. Direct client services are available to the public through a network of local Community Services Offices and child support offices. Services are also provided through out-stationed staff in local communities, a statewide Customer Service Contact Center and mobile offices.

- The following services are also available by phone at **877-501-2233** or online at www.washingtonconnection.org: checking benefit status information, completing an interview for food or cash benefits, renewing program benefits and reporting changes. Many of these actions can be completed online at www.washingtonconnection.org. Constituent-related services for these programs are available by phone at **800-865-7801.**
- To locate a local DCS office, get additional information, pay child support and download or request an application for child support services, go to www.childsupportonline.wa.gov. Customers can also call 800-457-6202 or email DCSAppRequest@dshs.wa.gov to have an application mailed to them.
- Most child support client-related services are available by phone at **800-442-5437**. Child support constituent-related services are available by phone at **800-457-6202**.

For more information on ESA's full range of services, visit https://www.dshs.wa.gov/esa.

ESA Services that Further the Intent of Olmstead

AGED, BLIND OR DISABLED

ABD is a state-funded program for low-income adults who have no dependents and are aged, blind or disabled. The ABD program provides cash assistance, SSI application facilitation support and a referral to the Housing and Essential Needs program (administered by the Department of Commerce) to adults who are:

- Age 65 or older.
- Blind, based on federal Supplemental Security Income standards.
- Likely to meet SSI disability criteria.

HOUSING AND ESSENTIAL NEEDS REFERRAL

Under the Housing and Essential Needs Referral program, DSHS provides potential access to essential needs items (e.g. hygiene and cleaning supplies) and housing assistance to eligible low-income adults who are unable to work for at least 90 days due to a physical or behavioral health incapacity. The Department of Commerce administers the Housing and Essential Needs program and determines eligibility for housing assistance and essential items through its network of local providers.

BASIC FOOD

Basic Food is Washington's network of federal and state programs that include a basis for nutrition security and a means for linking food benefits recipients to employment and employment readiness training or assistance.

- **Supplemental Nutrition Assistance Program** provides food assistance to eligible low-income individuals and families.
- **Food Assistance Program for Legal Immigrants** provides food assistance for legal immigrants who are not eligible for SNAP.
- **Washington Combined Application Program** is a simplified food benefits program for certain SSI recipients that delivers food benefits through an automated interface between the SSA and DSHS. A client's application for SSI also acts as the application for food benefits. Clients who receive WASHCAP are certified for up to 36 months.
- **Transitional Food Assistance** provides food benefits to families leaving TANF cash and food assistance programs.
- **Basic Food Employment and Training** provides job search assistance, employment, education and skills training, case management, work-based learnings, retention services and support services to individuals receiving SNAP who are not participating in the TANF or Refugee Cash Assistance programs.

MEDICAL ASSISTANCE

- Due to implementation of the Affordable Care Act, most medical assistance clients apply for health care coverage through the Health Benefit Exchange, known as Washington Healthplanfinder. ESA continues to determine eligibility for some medical assistance programs for low-income aged, blind or disabled people, including:

- **Medicare Savings Program –** Payment of Medicare premiums, coinsurance and deductibles for low-income Medicare beneficiaries. Income limits vary by program from 100% to 200% Federal Poverty Level.
- **SSI Medicaid** – Medical assistance for people who receive SSI. The Social Security Administration determines eligibility for SSI using rules based on Title XVI of the Social Security Act.
- **SSI Related Medicaid –** Medical assistance for low-income aged, blind or disabled people who do not receive SSI cash benefits.
- **Medical Care Services –** Health care coverage for adults who are deemed eligible for ABD cash assistance or the HEN Referral program but are legally present immigrants who are ineligible for other medical assistance programs. Beginning Feb. 1, 2022, MCS provides health care coverage to recipients of the State Family Assistance for Survivors of Certain Crimes cash program who are unable to access other health care coverage due to their immigration status.
- **Alien Emergency Medical –** Health care coverage for adults 65+ who have a qualifying medical emergency but do not have an immigration status that qualifies them for another Apple Health medical program.
- **Refugee Medical Assistance –** Medical assistance for refugees and other humanitarian immigrants who are ineligible for any other Apple Health medical program.

TEMPORARY ASSISTANCE FOR NEEDY FAMILIES, STATE FAMILY ASSISTANCE AND WORKFIRST

TANF provides cash grants to families in need. People who are caring for a relative's child, are legal guardians or are acting in the place of a parent are also able to apply for TANF benefits on behalf of these eligible children. People who are ineligible for TANF may be eligible for State Family Assistance. Some TANF and SFA families participate in the WorkFirst program, which helps participants find and keep jobs.

CHILD SUPPORT

ESA’s Division of Child Support assists with establishing parentage as well as establishing, enforcing and modifying child support and medical support obligations. Through a family-centered approach, DCS connects families to over 4,800 community resources and partners to help remove barriers and address their unique needs. Since child Support accounts for as much as 40% of income for families living in poverty, ESA’s poverty reduction goals are served by increasing the amount of child support collected and distributed to low-income families.

REFUGEE AND IMMIGRANT ASSISTANCE

The Office of Refugee and Immigrant Assistance administers multiple programs that help people who are refugees and other eligible immigrants achieve economic stability and integrate into life in the United States. Prominent ORIA programs include:

- **Refugee Cash Assistance –** Provides cash assistance to eligible single and married immigrants without dependents for up to 12 months from the date they are eligible for federal refugee resettlement services.

- **Refugee Health and Wellness Services –** Offers domestic health screenings, navigation and case management and mental health and wellness programming. This includes a specific program targeting refugee elders.
- **Employment and Training Programs –** ORIA invests state and federal funding into four different employment and training programs that help people find and keep a job and learn English. These include the Limited English Proficiency Pathway Program, ORIA Basic Food Employment and Training, Employment and Training for recipients of the Food Assistance Program for Legal Immigrants, and the Career Ladder for Educated and Vocationally Experienced Refugees.
- **Immigration Assistance and Naturalization Services –** Contracted client service providers offer supports for refugees and others in navigating federal immigration applications, including applying for lawful permanent residence, work permits and naturalization.
- **Whole Family Programs –** Funded by the U.S. Office of Refugee Resettlement, these programs offer extended case management, housing stabilization services and supports for refugee children in school, unaccompanied refugee minors and youth.

ADDITIONAL PROGRAMS

- **Ongoing Additional Requirements –** Cash payments to meet a need beyond food, clothing or shelter that are necessary to help someone live independently. This includes payments for restaurant or home-delivered meals, food for service animals, basic telephone service and laundry.
- **State Supplemental Payment –** Provides a state-funded supplemental cash payment to some SSI recipients in addition to their regular SSI payment.
- **Domestic Violence Services –** Through contracts with community-based providers, community-based organizations provide emergency shelter, victim advocacy and other supportive services for survivors of domestic violence and their children. Provides certification for domestic violence perpetrator treatment services (for people who have caused harm). Victim services and perpetrator treatment providers must ensure their services are accessible for people with disabilities.

Washington State Health Care Authority

The Washington State Health Care Authority is committed to whole-person care, integrating physical health and behavioral health services for better results and healthier residents. HCA purchases health care for more than two million Washington residents through Apple Health (Medicaid), the Public Employees Benefits Board Program and the School Employees Benefits Board Program. As the largest health care purchaser in the state, we lead the effort to transform health care, helping ensure Washington residents have access to better health and better care at a lower cost.

HCA embraces the Olmstead decision as a guide to ensure that Washingtonians with a disability will have the opportunity to live close to their families and friends, live more independently, engage in productive employment and participate in community life. This includes:

- The opportunity and freedom for meaningful choice, self-determination and increased quality of life through opportunities for economic self-sufficiency, living and location situation and employment options.
- Systemic changes that support self-determination through revised policies and practices across state government and the ongoing identification and development of additional opportunities and choices.
- Readily available information about rights, options, risks and benefits of these options and the ability to revisit choices over time.

BEHAVIORAL HEALTH SYSTEM

The Legislature appropriated significant new funding to HCA in the 2023-25 operating and capital budgets. The strategies these new funds will support represent the continued commitment to build sustainable systems change that invest immediately in developing community capacity and treatment services. As part of the transformative effort to sustain and enhance the lives of those served, the outcomes, focused on returning to and/or remaining in the community, funded with these targeted investments include:

- People diverted from the state hospitals and those at the hospitals successfully transitioned back to the community:
    - Using Medicaid funding under the Medicaid Transformation Project to provide supportive services to stably house the highest-need chronically homeless individuals.
    - Investing state dollars in rental assistance not provided under MTP for permanent supportive services prioritized for patients discharging from the state hospitals and in capital funding in the Housing Trust Fund for these services for people with chronic mental illness and behavioral health conditions.
    - Investing state dollars in capital funds to pair permanent supportive housing units to people receiving services under the Foundational Community Supports program.
- Long-term strategies to grow the behavioral health workforce while building additional civil commitment beds in the community.
- Investments in the state hospitals to keep them operating and safe for patients and staff while the system is being transformed.

More information on these targeted investments is available at ***Transforming Washington's Behavioral Health Care System***.

EMPLOYMENT SUPPORTS AND SERVICES

The Supported Employment Coordinating Committee stems from the Substance Abuse and Mental Health Services Administration and sponsored Olmstead Policy Academy that was created in 2013. The SECC members are a diverse group, including members from government agencies (Developmental Disabilities Administration, Division of Vocational Rehabilitation, Aging and Long-Term Services Administration, WorkSource and other key stakeholders), people with lived experience, representatives of Foundational Community Support supported

employment programs and representatives of secondary education, including First Episode Psychosis programs.

The SECC functioned as the implementation planning workgroup for the Medicaid Transformation Project, which, as noted above, CMS approved in 2017. Foundational Community Supports was the outcome of planning and provides supportive housing and supported employment services as a Medicaid-reimbursable benefit for Washington residents who are the most vulnerable and have complex care needs.

On June 30, 2023, CMS approved Washington's application for an additional five-year renewal of these crucial services through 2028. This undertaking demonstrates a collaborative effort between state and local agencies that uses evidence-based practices to move adult behavioral health to an outcome-based system based on SAMHSA's working definition of recovery: *A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.* (Making the Case for Change, 2012.)

Supported employment services are provided to people who experience chronic homelessness, frequent or lengthy institutional contacts, or frequent or lengthy stays in residential care. Services include:

- Vocational and job-related discovery or assessment.
- Job placement, job development and coaching.
- Long-term supports to participants and employers to aid in maintaining employment.

HCA, in partnership with the Department of Commerce, also received funding in the 2022 legislative session that provides for up to nine months of additional rental assistance for individuals receiving HEN rental assistance and services while enrolled in the FCS Supported Employment benefit. The funds aim to facilitate the transition off of HEN as eligible participants start earning income as a result of their employment. Known as the Glidepath to Supported Employment enhancement, this program also provides benefits counseling services across the state throughout each of the 10 Regional Service Areas as well as participant flexible funds that allow for coverage of essentials required for returning to work. These items can include licenses, identification, clothing, permits, transportation and more.

The Washington Pathways to Employment web portal is an employment development resource for people with disabilities and a resource for agencies to enhance supported employment services. In addition to helping people understand that working does not have to mean the loss of health care benefits, the platform provides many resources in one place for achieving success, including inspiration from success stories, a resume builder and a benefits estimator. The web portal provides a training platform for supported employment providers and has served as the model for a similar site that promotes readiness for sustainable housing, Pathways to Housing.

- Previously, the agency managed the Medicaid Infrastructure Grant under the Ticket to Work and Work Incentives Improved Act of 1999. Deliverables achieved under the MIG project included development and implementation of the state's Medicaid Buy-in, known as Apple Health for Workers with Disabilities. HWD provides full-scope Medicaid coverage, including access to home and community-based services, for those meeting functional assessment criteria, Apple Health HWD is an affordable health care coverage option for people who meet federal disability requirements.
- Apple Health HWD covers physical and behavioral health care services, including mental health and substance use disorder treatment.
- There is no income or resource limit to qualify for HWD.
- Self-employed people with disabilities may be eligible for affordable health care coverage through Apple Health HWD.
- If a recipient loses their job, coverage continues if they pay the premium and are employed when renewing coverage annually.
- Eligibility criteria:
  - Have a disability that meets federal disability requirements.
  - Are employed part-time, full-time or self-employed.
  - Live in Washington.
  - Are age 16 or older.
  - Meet citizenship standards for Apple Health.

HCA, in collaboration with DDA and ALTSA, launched an outreach campaign in 2023 to increase use of HWD by underserved populations, including working people who identify as American Indian/Alaskan Native, and working people with serious mental illness, among others.

HCA is firmly committed to the vision that people with a disability should have the opportunity to experience lives of inclusion and integration in the community. HCA continues to identify and develop key activities to build an integrated infrastructure and service delivery system that meets the diverse needs of the populations it serves.

For more information about the services available through HCA, visit https://www.hca.wa.gov/.

Department of Children, Youth, and Families

The Department of Children, Youth, and Families is a cabinet-level agency focused on the well-being of children. Our vision is to ensure that "Washington state's children and youth grow up safe and healthy – thriving physically, emotionally and academically, nurtured by family and community." DCYF is the lead agency for state-funded services that support children and families to build resilience and health. We accomplish this by partnering with state and local agencies, tribes and other organizations in communities across the state of Washington. DCYF's focus is to support children and families at their most vulnerable points, giving them the tools they need to succeed.

DCYF has a variety of services available to families before an institutional placement is considered, including:

- Crisis intervention to keep youth at home when there is a conflict in the family.
- Contracted services to help resolve the issues in their family that have led to a crisis between family members.
- Foster care and support for kinship care for families involved in the formal child welfare system to provide a safe and stable living situation for children unable to safely live in their family home due to abuse and neglect or to the inability of the parent to manage the child's behavior.
- Various projects with DSHS, state partners and community organizations to blend resources from multiple systems to serve children with high needs.

Specific examples of support DCYF is providing to families to avoid institutional placement is included below:

DCYF Substance Use Disorder Program

- DCYF has worked with HCA to expand the Parent Child Assistance Program, which is a home visiting program for families impacted by substance use disorder.
- DCYF will contract for 12 SUDPs so that two can be assigned to each DCYF region to provide SUD support and collaboration. Implementation is slated for 2024.

DCYF Mental Health Program

- DCYF has hired six Developmental Disabilities/Mental Health Program Consultants to support each DCYF Region in:
    - Identifying appropriate mental health resources for adults, children, and youth served by DCYF.
    - Workforce education.
    - Collaborating with state and community partners, such as the Health Care Authority, Developmental Disabilities Administration, Managed Care Organizations and Children's Long-Term In-patient Programming, and the Behavioral Health Administrative Service Organization.
    - Facilitating and tracking the Developmental Disabilities Services Planning Meetings required by SHB 1061, which amended RCW 74.13.341 to require DCYF to hold Shared Planning Meetings with representatives from DDA and the Division of Vocational Rehabilitation for youth who are or may be eligible for DDA services when they are between the ages of 16 and16.5 years of age.
- DCYF is also in close collaboration with DDA around the implementation of HB 1188, as they seek to provide DDA waiver services to DCYF dependent children and youth.

For more information about the services available through The Department of Children, Youth, and Families, visit https://www.dcyf.wa.gov/services.

Conclusion

Washington is and has been actively working to develop resources to ensure people can be served in the community setting of their choice. This work continues as the acuity and volume of the individuals we serve increases. Our pathway to success has been to identify barriers to leaving institutions and developing resources in the community to remove those barriers. Success in this work requires a willingness to innovate, funding the efforts and continuing to work with the Legislature on budget appropriations and law changes to support the changing needs of the people we serve.

Washington is committed to serving people in the community. We will continue our innovative resource development and to aggressively seek funding through our Washington State Legislature to remove barriers and promote people living successfully in the community.