WASHINGTON STATE LEGISLATURE

December 19, 2014

Dear Governor Inslee, Chief Clerk of the House, and Secretary of the Senate,

As the co-chairs of the Joint Legislative Executive Committee on Aging and Disability Issues, we are pleased to notify you that the Committee has completed its final report. Enclosed, please find a copy of the final report of the Committee, submitted pursuant to chapter 4, section 206, Laws of 2013 2nd sp. sess. (uncodified).

The work of the Committee over the past two years has been very rewarding. We have come to recognize the strengths of Washington's system of long-term services and supports, in which over 80 percent of the individuals who receive services from the state are served in home and community-based settings. As Washington faces the strains of adjusting to the needs of an aging population, it becomes increasingly important to assure that this long-term care system remains robust and receives the support it needs to maintain and expand this high level of service into the future.

We look forward to continuing to discuss policy options to strengthen the state's long-term services and supports system in the upcoming session.

Sincerely,

Senator Barbara Bailey

Representative Steve Tharinger

Members of the Joint Legislative Executive Committee:

Senator Bruce Dammeier
Senator Jeannie Darneille
Representative Paul Harris
Representative Laurie Jinkins
Representative Norm Johnson
Senator Karen Keiser
Jason McGill, Office of the Governor
Marcie Frost, Director, Department of Retirement Systems
Dorothy Teeter, Director, Health Care Authority
Kevin Quigley, Secretary, Department of Social and Health Services

The Joint Legislative Executive Committee on Aging and Disability Issues

2014 Final Report

Submitted to the Governor and the Legislature
December 2014

I. The Joint Legislative Executive Committee on Aging and Disability Issues

Enacting Legislation and Membership

The Joint Legislative Executive Committee on Aging and Disability Issues (Committee) was established in the 2013-15 operating budget. The Committee was charged with the responsibility to identify strategic actions to prepare for the aging of Washington's population by:

1. Establishing a profile of Washington's older population and population with disabilities and a projection of those populations through 2030;

2. Establishing an inventory of services and supports from health care and long-term services and supports;

3. Identifying budget and policy options to effectively use public resources to reduce the growth rate in state expenditures compared to current policies;

4. Identifying strategies to better serve the health care needs of the aging population and people with disabilities and promote healthy living;

5. Identifying options for financing mechanisms for long-term care services and supports to promote additional private responsibility to meet needs for services;

6. Identifying options to promote financial security in retirement, support people staying in the workforce, and expand the availability of workplace retirement savings plans; and

7. Identifying options to help communities adapt to the aging demographic in planning for housing, land use, and transportation.

The Committee is comprised of four members of the Senate, four members of the House of Representatives, and four members of the Executive Branch. The following persons have been appointed to the Committee:

Senate:

- Sen. Barbara Bailey
- Sen. Bruce Dammeier
- Sen. Jeannie Darneille
- Sen. Karen Keiser

House of Representatives:

- Rep. Paul Harris
- Rep. Laurie Jinkins
- Rep. Norm Johnson
- Rep. Steve Tharinger

Executive Branch:

- Marcie Frost, Director of the Department of Retirement Systems
- Jason McGill, Representing the Office of the Governor
- Kevin Quigley, Secretary of the Department of Social and Health Services
- Dorothy Teeter, Director of the Health Care Authority

2013 Activities

The Committee held two meetings in the fall of 2013: one on September 25 and the second on November 4.

September 25 meeting

At the first meeting, Senator Bailey and Representative Tharinger were selected as co-chairs and members were reminded of their statutory duties. At this meeting, the Committee received background information relating to the aging population and long-term care to provide the members with a broad view of the demographic trends facing Washington, the fiscal implications for the state, and a preliminary look at state programs that serve seniors and those with disabilities. Topics discussed included:

- Information regarding state services for the aging population, including funding and demographic data; and
- Department of Social and Health Services and Health Care Authority initiatives to inventory long-term care resources and demographic data.

November 4 meeting

At the November 4 meeting, members received background information on aging issues and participated in a roundtable discussion on those issues. Topics discussed included:

- A review of the Governor's Aging Summit recommendations;
- Adult Protective Services, including information from the Department of Social and Health Services, the King County Prosecutor's Office, and Disability Rights Washington;
- Options for promoting financial security, including information from the Department of Retirement Services and a presentation on life settlements (converting life insurance to income to pay for long-term care needs); and
- Long-term services and supports, including information from the Olympia Area Agency on Aging, the Department of Social and Health Services, and the Office of the Insurance Commissioner.

Both meetings provided opportunities for the public to provide their testimony and their suggestions for Committee consideration.

In December 2013, the Committee finished its Interim Report to the Legislature. Included in the Interim Report was a summary of the Demographic Trends in Washington and a Budget Overview. Also part of the Interim Report was a Committee Work Plan for 2014. The Work Plan detailed a plan of 5 meetings to address substantive issues such as healthy aging, workforce quality and protection from elder abuse and exploitation, and financial security. The Work Plan also included time for the Committee members to discuss the work completed during its two-year existence with an opportunity to develop recommendations for the Final Report due in December 2014.

The 2013 Interim Report and materials from the 2013 meetings are available at the Committee's website: http://www.leg.wa.gov/jointcommittees/ADJLEC/Pages/default.aspx.

2014 Legislation

During the 2014 legislative session, the Legislature passed two bills that affected the activities of the Committee.

ESHB 2746

ESHB 2746 directs the Department of Social and Health Services to refinance Medicaid personal care through use of the Community First Choice Option (CFCO). The CFCO is an optional entitlement program offered under the federal Affordable Care Act which provides Medicaid matching funds that cover 56 percent of the cost of services, rather than the usual 50 percent.

Under ESHB 2746, savings from refinancing existing services may be used to offset the cost of implementation and any savings remaining must be reserved for additional investment in home and community-based services for individuals with developmental disabilities and individuals with long-term care needs.

ESHB 2746 directs the Committee to provide recommendations for investments in home and community-based services. The Committee's final report to the Legislature must explore the cost and benefit of rate enhancements for providers of long-term services and supports, restoration of hours for in-home clients, additional investment in the family caregiver support program, and additional investment in the Individual and Family Services Program or other Medicaid services that support individuals with developmental disabilities.

SSB 6124

The Interim Report of the Committee listed consideration of developing a state Alzheimer's plan as one of the goals to be discussed at the Committee's first meeting in 2014. However, before this discussion occurred, legislation was introduced during the 2014 legislative session to begin development of such a plan. SSB 6124 directs the Department of Social and Health Services to develop an Alzheimer's plan for the state of Washington, using a group of stakeholders detailed in the bill. These stakeholders include representatives of state agencies, health care providers, adult family home providers, people with Alzheimer's disease and their families and caregivers, health care policy advocates, and researchers.

Two members of the Committee, Senator Keiser and Representative Tharinger, serve on the workgroup. At the September 2014 meeting of the Committee, continuation of the work towards development of an Alzheimer's plan has been listed among the suggestions for future discussion.

2014 Activities

May 19 meeting

The May 19 meeting focused on issues relating to healthy aging. The Committee reviewed the options for seniors and the disabled along the continuum of care and considered the program options for the range of needs that they face. This review included overviews on:

- The Older Americans Act;
- Financing, services, and access of the Area Agencies on Aging;
- Healthy communities and transportation issues, with a focus on the activities of Clark County;
- The Family Caregiver Support Program; and
- The state Alzheimer's plan development.

June 18 meeting

The June 18 meeting focused on issues relating to workforce quality and protection from elder abuse and exploitation. The Committee reviewed the current workforce and potential workforce development issues that need to be addressed to ensure sufficient resources will be available to provide quality care during the upcoming demographic shift. This review included overviews on:

- Health care and home care workforce needs for the elderly;
- Workforce quality, with discussions on the future of the long-term care workforce; and
- Elder abuse and exploitation.

July 14 meeting

The July 14 meeting focused on ways to enable Washington residents to become more financially independent and self-sufficient. This review included overviews on:

- Retirement planning available through the Department of Retirement Systems;
- Long-term care funding, with both public and private sector options being discussed; and
- Long-term care options and Medicaid avoidance.

September 15 meeting

The September 15 meeting was reserved for the Committee to receive any remaining information it needed to develop recommendations to the Legislature and to begin considering what the recommendations should address. The Committee heard from the public and heard presentations on:

- The Community First Choice Option Work Group;
- Use of technology to help people maintain independence; and
- The Training Partnership and workforce quality.

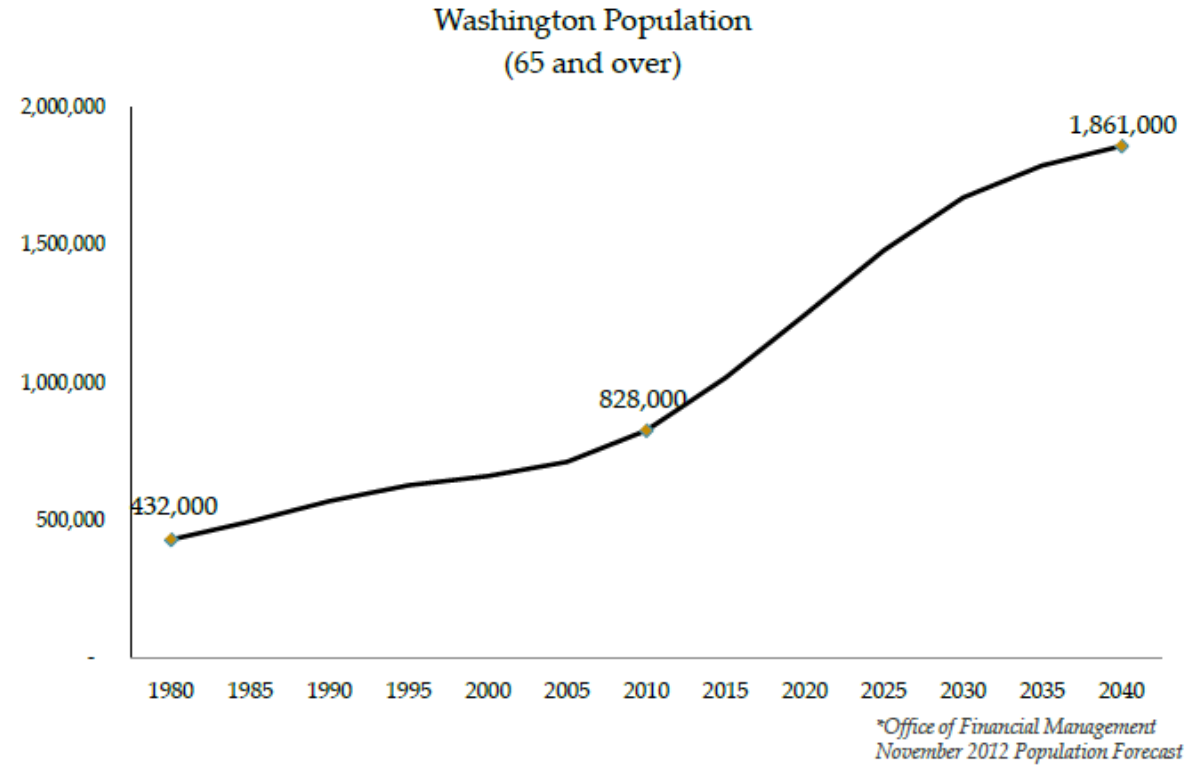
The recommendations of individual Committee members were placed into a table and provided to all Committee members after the September meeting. The table represents all the ideas of the Committee but are not necessarily items that all Committee members agree upon. The original table is available on the Committee's website and the table, as adopted by the Committee in December, is in section IV of this report.

December 15 meeting

The December 15 meeting discussed the Final Report of the Committee. Policy options offered by individual Committee members and the table developed after the September 15 meeting were discussed and voted on by the Committee. Members discussed each option and recommended that they be addressed in the short term (2015 legislative session), mid-term (2016 legislative session), or in the long-term (2017 legislative session and beyond). The table in section IV of this report is the result of this discussion.

II. Population Forecast

Since 1980 Washington's population over age 65 has doubled and is projected to more than double again by 2040. According to the Office of Financial Management's November 2012 Population Forecast, there are currently approximately 830,000 people in Washington who are age 65 and over, or almost 14 percent of the population. By 2040 that number is estimated to reach 1,860,000 people, or 21 percent of the project population.



A 2011 report released by DSHS found that, of the 1.2 million people in Washington age 60 or older in 2011, approximately 91,000, or seven percent, were below the Federal Poverty Level. Almost 47,000 of these people had limited English proficiency. About 261,000 of these people were disabled. In addition, almost 81,000 people in Washington who were age 70 or above had dementia. For the full report, see Appendix A.

The Aging and Long-Term Services Administration at DSHS provides services to low-income seniors in need of long-term services and supports. In fiscal year 2011, DSHS had just over 45,000 senior clients receiving services. About 36 percent of these clients were between age 75 and 84 years old and another 36 percent were age 85 or older. The total cost to Medicaid and Medicare for providing long-term services and supports to these client was $1.042 billion with most of that covered by Medicaid.

Compounding these demographic challenges is the fact that many of those nearing retirement age are not financially prepared to retire. A 2014 Gallup survey found that the top financial concern for Americans between 50 and 64 years old was not having enough money for retirement. Despite that concern, a 2014 report of the Board of Governors of the Federal Reserve System cited results of a survey that found that barely 40 percent of people 60 years old and over had given "a lot of thought" or "a fair amount of thought" to financial planning for retirement, while almost the same number of people responded that they had given such planning "a little thought" or "none at all." For those between 45 and 59 years old, the figures were nearly the same. The survey also found that almost a quarter of those between 45 and 59 have no retirement savings or pension.

III. Service Inventory

One of the responsibilities of the Committee is to establish an inventory of long-term services and supports that are available to Washington residents. The service inventory describes the population that receives long-term services and supports and highlights the array of programs and providers that are available. The Department of Social and Health Services assembled the service inventory and it can be found in its entirety in Appendix B.

The service inventory depicts the population in Washington that receives long-term services and supports through state and local programs. Nearly two-thirds of those receiving services through the Department's Aging and Long-Term Support Administration are over 65 years old. The Medicaid program supports about 60 percent of the nursing home residents in the state and is the primary public payer of long-term supports and services provided in community-based settings. The service inventory also highlights the fact that in Washington 80 percent of all long-term services and supports are provided by unpaid family caregivers. This amounts to over 850,000 people providing services valued at $10.6 billion.

The service inventory details the types of existing services and programs, the intended population to benefit from the services and programs, a description of the programs, and the extent of the availability. Through the Area Agencies on Aging there are programs to support family caregivers, people with chronic conditions, veterans with significant cognitive impairment, lower-income seniors, and adults receiving public assistance. Through the state's Medicaid program there are various program options available to people in need of nursing facility levels of care to allow them to receive specifically tailored services in different types of settings. The state offers services to protect vulnerable adults from abuse, neglect, and financial exploitation through Adult Protective Services, the Long-Term Care Ombuds, and the Office of Public Guardianship. There are also various resources for individuals to receive information about how to access programs to meet their needs. Lastly, the service inventory provides a description of all of the settings and types of providers that are available in Washington, including the number of available providers in the state.

IV. Policy Options

The Committee is responsible for identifying key strategic actions to prepare for the aging of Washington's population. The issues presented by the state's demographic shift will require a sustained effort over the coming years. For that reason, the Committee has framed the following policy options in terms of timing for implementation (short-term is the 2015 session, mid-term is the 2016 session, and long-term is 2017 and beyond). Ten members of the Committee attended the final Committee meeting of 2014 and determined when these policy options should be addressed. How those members voted is reflected in the table below.

	Group	Suggestion	Priority Level		
			Short-Term	Mid-Term	Long-Term
1	Insurance	Long Term Care Insurance Study. Contracted actuarial insurance industry study of options to finance long term care insurance for the citizens of Washington State, including options for public financing and public-private partnerships. ($400,000 total funds; $200,000 GF-State - contingent on $200,000 in private contribution)	10		
2	CFCO	Use Savings from the Community First Choice Option (CFCO): Federal matching funds cover 56% of the cost of services under the CFCO, which is 6% higher than the current rate. Implementing the CFCO is projected to save roughly $80 million GF-State in 2015-17. The Legislature authorized DSHS to utilize *roughly half* the savings to provide services to clients with developmental disabilities: (1) 4,000 additional clients on the Individual & Family Services waiver (to primarily receive respite), and (2) 1,000 additional clients on the Basic Plus waiver (to primarily receive personal care and therapies). The Legislature also directed the JLEC on Aging/Disability to explore options for further investment in home and community based services. The following reinvestment options have been identified by the JLEC as equally important:	10		
		a Family Caregiver Support Program (FCSP). FCSP helps caregivers sustain caregiving activities, and ensure their own mental and physical health. Stress, depression, and caregiving burden are assessed by the Tailored Caregiver Assessment and Referral (TCARE) intervention. TCARE recommends evidence-based strategies, and the Committee supports such strategies, to help caregivers who are most burdened with caregiving responsibilities. In FY13, about 8,000 caregivers received services - such as respite, counseling, support groups, information, and assistance - through FCSP. As an example, DSHS estimates that increasing the annual FCSP budget by $4.5 million GF-State could serve 3,750 additional caregivers. *This option is scalable*.			
		b Medicaid rate enhancements for providers of long-term services and supports. Wages and benefits for Individual Providers (IP) and Adult Family Homes are collectively bargained. Homecare agencies receive rate adjustments based on incremental changes to the IP			

Group	Suggestion		Priority Level		
			Short-Term	Mid-Term	Long-Term
		contract. By statute, rate components for nursing homes are either rebased every two years (non-capital components), or every year (capital components). Medicaid rates for all other providers are adjusted through legislative direction. *This option is scalable*. For reference, the major providers are the following: (1) Individual Providers (2) Adult Family Homes (3) Agency Providers (4) Nursing Homes (5) Assisted Living (6) Adult Residential Care (7) DD Community Residential (8) DD Employment Programs (9) Adult Day Health (10) Managed Care (PACE)			
	c	Restoration of hours for home care clients. Hours of personal care for clients living in their own homes were reduced, on average, by 4% in Fiscal Year 2010 and 10% in Fiscal Year 2011, for a combined savings of roughly $65 million GF-State per year. Savings from the CFCO are insufficient to restore the full reduction, but DSHS has stated that a partial restoration, including a targeted approach, could be possible. For reference, a 1% increase in annual homecare hours would cost roughly $10 million GF-State. *This option is scalable*.			
	d	Pre-Medicaid Services. DSHS has identified items in the agency request 2015-17 Biennial Budget to delay, or divert, individuals from entering the more expensive Medicaid long-term care system, including: (1) $5 million GF-State per year for counseling services to help clients/caregivers understand options, plan for outcomes, and access resources, (2) $500,000 GF-State per year to expand Memory Care & Wellness beyond current programs in limited geographic areas, and (3) $20,000 GF-State per year for an evidence-based program for people caring for someone with Alzheimer's disease, called Star-Caregiver (Star-C). *This option is scalable*.			
	e	Area Agencies on Aging Case Management Funding. AAAs are currently not funded for the 1:62 case manager to client ratio that is spelled out in their contract. Lack of adequate funding creates risk to federal funding, poor client outcomes and failure to fully address clinical needs of clients as well as the ability to fully comply with new federal rules that went into effect March 2014. ($28 million total funds; $14 million GF-State)			

	Group	Suggestion	Priority Level		
			Short-Term	Mid-Term	Long-Term
3	Retirement planning	START Proposal. Create a Save Toward a Retirement Today state retirement savings plan. Permits private employers and employees to participate in retirement plans administered by the Washington State Department of Retirement Systems. Empowers the Washington State Investment Board to invest the funds contributed by participating employers and employees to the Start Plan.		9[1]	
4	Retirement planning	Encourage residents to plan for their retirement using tools available to them in the private market. Encourage planning before retirement with an emphasis on what residents can do for themselves to achieve their own planned retirement, without relying on state action (e.g., through education campaigns).		9	
5	Long-term Care Planning	Similar to the private market retirement planning suggestion, develop strategies and policies that will incentivize individuals to plan ahead and get more involved with their own future long-term care needs. This could be through insurance, savings programs, or other planning tools.		9	
6	Client Safety	Elder Abuse Omnibus Bill. Criminal codes should be updated to include a crime of financial exploitation of an adult and a reduction in the intent standard for the felony criminal mistreatment statute. Law enforcement agencies should be incentivized to use specialized elder abuse detectives and prosecutors as well as multidisciplinary teams There should be additional resources, as identified by DSHS, made available to support Adult Protective Services staffing for financial exploitation and self-neglect cases so that cases may be closed in a timely manner (6 FTE for financial exploitation; 3 FTE for self-neglect cases - $2 million total funds; $1.5 million GF-S)	10		
7	Client Safety	Timely response to complaints must occur within the Residential Care Services Complaint Investigations and Complaint Resolution Unit Intake Staffing.	10		
8	Client Safety	The regulation of CCRCs should be given attention by the Committee in 2015 interim.		10	
9	System Change	End of life care planning, patient counseling, system improvement (like Oregon's) See Bree Collaborative recommendations	10		
10	System Change	Duals pilot and health homes. These programs provide comprehensive services in one place for the highest cost, highest risk populations and should continue. If these service models are proven effective through improved outcomes, additional federal funds may be leveraged	10		

[1] For item 3, one member requested that it be noted for the record that she was recommending no action on this item.

	Group	Suggestion	Priority Level		
			Short-Term	Mid-Term	Long-Term
		through shared savings with Medicare. (13.6 FTEs, $10.1 million total funds; $4.6 million GF-S) Workforce needs associated with the aging population (e.g. primary care, geriatrics, nurse chronic care management, LTC workers supports, community health worker supports). Specialty training particularly around dementia, cognitive impairments, mental health, and executive functioning (decision making capacity) is needed in all areas of the workforce to include health care, long term care, community partners, and informal caregivers. Some solutions include: 1) Implementing a screening tool that will help caregivers and medical professionals understand client capability including executive functioning. This tool will help both professionals and family members know whether or not an individual understands the consequences of their decisions and will increase knowledge about the level of vulnerability for fraud, neglect, and abuse; 2) More in depth training to help family and professional caregivers understand special needs of older adults (For example, how do you help someone who is not taking their medications or how can you allow the client to have maximum independence and choice in their particular situation?); and 3) A social media campaign to address bias and stereotypes about the capabilities and decision making abilities of older adults. 4) The effects of homelessness on the availability of long-term supports and services should be considered. *This option is scalable*.			
11	Committee	The work of the Committee needs to be continued in a forum that includes state-level policy makers to consider long-term care policies. This could be continuing the committee in its current format and specifying a number of meetings yearly with or without an end date in the statute. Other items to consider are whether the committee should submit a report to the Legislature, whether membership should be modified, and the amount of stakeholder involvement.	10		
12	Healthy Living	Comprehensive community-based solutions to issues facing the aging population must be considered, including transportation options, housing options, and the use of community health workers. The state must encourage community efforts to plan for the needs of aging		10	10

	Group	Suggestion	Priority Level		
			Short-Term	Mid-Term	Long-Term
		populations by supporting local initiatives that promote independence or by removing barriers that inhibit local solutions. The state should support opportunities to promote the use of community health workers to assist the independence of residents.			
13	Technology	Policy needs to consider ways that technology can complement or substitute for human caregivers to reduce costs while maintaining or improving the quality of care. Technology can help target the limited supply of caregivers and health care providers to more effectively serve clients. Restrictions on telehealth reimbursement must be removed. The state should increase flexibility in reimbursing for technologies that support independence and home telehealth for those with chronic health conditions where fiscally feasible. A long-term strategy for the cost-effective use of technology to prolong independence and improve quality of life must be established to provide guidance for policymakers to use as new technologies become available.		10	
14	System Change	Look for ways to partner with the Federal Government to redesign Medicaid programs to allow for different eligibility criteria with a goal of obtaining services earlier and delaying enrollment in the full Medicaid program. (Potentially create a Family Caregiver Program that will allow federal match on services that prevent or delay individuals from becoming Medicaid clients.)	10		
15	Workforce	Respite services and other supports for unpaid caregivers. The needs of unpaid caregivers must be met through respite services and other supports, including the exploration of using Residential Habilitation Centers (RHCs) where available. Currently respite and supports are provided to unpaid LTC caregivers through the Family Caregiver Support Program (See item number 2a above). Through this program, planned respite may be provided in the client's own home, or with a short stay in an adult family home or nursing home. Funding for FCSP may be targeted towards respite, supplemental services (such as equipment), training, and/or counseling. Caregivers of clients with DD can receive respite services through the Individual and Family Support (IFS) program. Respite is currently offered at Yakima Valley School. Other RHCs offer short term emergency admissions for crisis, but not planned respite. *This option is scalable*.		10	
16	Workforce	In-home Respite Providers. Remove barriers for part time respite providers and address the workforce needs (how to address the shortage of qualified workers). Most often, a family feels most comfortable with someone they know providing care in their home to their loved one while the primary caregiver is receiving respite. The respite may be as	10		

	Group	Suggestion	Priority Level		
			Short-Term	Mid-Term	Long-Term
		little as a few hours a week. However provisions of the mandatory training law that require 35 hours of training before that individual can be hired by the client to provide respite care. Beginning July 1, 2016, this requirement increases and the passing of a certification exam will also be required. This is becoming a barrier for part-time respite providers. The law does not take into account any actual previous experience of an individual who the client would like to provide respite. *This option is a policy option and may not require additional funding.*			
17	System Change	Continue the work of the Alzheimer's Plan Work Group which was established through SSB 6124. DSHS is the agency coordinating the efforts of the Work Group which consists of a variety of stakeholders as well as two legislative members (who also serve on the JLEC). The Work Group report is due to the Governor by January 1, 2016 and stakeholder meetings are currently under way.	10		
18	System Change	As Washington's population ages, the number of people who will need guardianship and information about assisted decision making options will grow significantly. The state needs to understand how the formal guardianship system, both public and private, can respond to this need in a way that maintains high standards and public confidence. The state also needs to review how families, seniors, and people with disabilities can access effective decision making options short of full guardianship.		10	

Appendices

Appendix A.....Age Wave Technical Notes
Appendix B.....Inventory of Long-Term Supports and Services
Appendix C.....Community First Choice Option

August 2011 | RDA
Olympia, Washington

Forecasts of the Aging Population, Dementia Prevalence and Use of Long-Term Care Services through 2020 in Washington State

TECHNICAL REPORT

David Mancuso, PhD

In collaboration with the Department of Social and Health Services Aging and Disabilities Services Administration

THIS REPORT provides technical detail about the methods used to produce a series of Area Agency on Aging (AAA) and county long-range forecasts of:

1. Persons meeting selected criteria related to age, income, and race/ethnicity;
2. Prevalence of disability, limited English proficiency, and dementia; and
3. Utilization of Aging and Adult Services in-home, community residential and skilled nursing facility services benchmarked to June 2010 utilization rates.

For these forecasts, we combined new population projection data maintained by the Office of Financial Management (OFM) with other data sources containing county, state or national estimates of prevalence or service utilization, as described in detail more below. The forecasts associated with item 2 were derived using synthetic estimation processes. Synthetic estimation is a statistical technique that produces "small area" population prevalence estimates by using information from larger population areas. For reference, a table containing Washington State level forecasts of the measures developed in this study is presented at the end of this technical report.

OFM County-Level Estimation and Projection Model (the "OFM Projection Model")

The OFM Projection Model provided the detailed "small-area" county-level population estimates and forecasts from 2010 to 2020. OFM contracted with Krupski Consulting LLC in 2010 to develop this new county-level population projection model to augment existing OFM population forecasts with income and health insurance status data from the American Community Survey (ACS). The ACS is administered annually by the United States Census Bureau. The OFM Projection Model integrates OFM long-range population forecasts with data essential for forecasting eligibility for means-tested social and health services, including potential eligibility for Medicaid through the expansion of coverage for low-income adults in 2014 under the Affordable Care Act (ACA). It is anticipated that the OFM Projection Model will be updated on an annual basis following the release of new ACS public use microsample (PUMS) data by the US Census Bureau.

The OFM Projection Model provided county-level population data required to produce synthetic estimates related to disability, English proficiency, dementia and long-term care service utilization. In addition, the OFM Projection Model was used directly to produce the following forecasts:

- Number of persons aged 60 or above,
- Number of persons aged 60 or above with income at or below the Federal Poverty Level,
- Number of persons aged 60 or above and minority,
- Number of persons aged 60 or above and American Indian/Alaska Native, and
- Number of minority persons aged 60 or above and at or below the Federal Poverty Level.

Prevalence Estimates Derived from ACS Data

The prevalence of persons meeting criteria related to disability and English proficiency was derived from PUMS data for Washington State from the 2009 ACS. We extracted ACS data for the population aged 18 and above, including persons residing in institutional group quarters. The following definitions were applied to the ACS source data in developing prevalence estimates:

- **Limited English proficiency** was defined to include persons who reported speaking English "not well" or "not at all." ***Item 14c***
- **Disability** prevalence was based on persons reporting ambulatory difficulty (walking or climbing stairs) or self-care difficulty (dressing or bathing). ***Items 18b and 18c***
- **Cognitive impairment** was based on persons reporting difficulty concentrating, remembering or making decisions. ***Item 18a***
- **Need for assistance with instrumental activities of daily living** (IADLs) was based on persons reporting difficulty doing errands alone such as visiting a doctor's office or shopping. ***Item 19***

We used a regression-based approach to develop ACS-based prevalence estimates for the county-level demographic cells available in the OFM Projection Model data file, and then aggregated estimates up to the county, AAA and statewide level for reporting purposes.

Dementia Prevalence Estimates

Age-specific estimates of dementia prevalence were developed from Plassman, et al.[1] The dementia forecasts represent estimates of the combined prevalence of Alzheimer's disease and vascular dementia. Note that the Plassman study provides estimates of dementia only for persons aged 71-79, 80-89 and 90 and above. The Plassman study did not find statistically significant differences by gender after controlling for age. Therefore, our synthetic estimation process used the reported combined (male plus female) age-specific dementia rates. These rates were applied across all relevant county-level demographic cells in the OFM Projection Model data file. We then aggregated estimates up to the county, AAA and statewide level for reporting purposes.

Long-Term Care Service Utilization

Long-term care service utilization forecasts were developed through the following steps. First, Aging and Adult Services caseload counts for June 2010 were derived from the DSHS Research and Data Analysis Division's Client Services Database (RDA CSDB). These counts were derived within detailed county demographic cells based on the residential and demographic information available in CSDB. Counts were derived for the following service groups:

[1] Plassman, et al. Prevalence of Dementia in the United States: The Aging, Demographics, and Memory Study. Neuroepidemiology 2007; 29:125-132. Age-specific dementia prevalence estimates were derived from Table 2.

- **In-home services** including services provided through the COPES waiver and Medicaid Personal Care;
- **Community residential services** including adult family home, adult residential care and assisted living facilities; and
- **Skilled nursing facilities**.

It is important to note that these counts reflect only services paid for by Medicaid through the Aging and Adult Services component of the DSHS Aging and Disability Services Administration. Similar services paid for through other fund sources (e.g., private pay or Medicare) are not included in these forecasts. Personal care, community residential and ICF/MR services paid for through the Division of Developmental Disabilities are also excluded from these forecasts.

In the next step, caseload counts for June 2010 derived from the RDA CSDB were compared to the June 2010 Caseload Forecast Council (CFC) estimates for the same service categories. Although the caseload counts were found to be quite similar, a global ratio adjustment was performed to ensure that the statewide count of clients by service modality for June 2010 exactly matched the available CFC estimate.

Finally, the June 2010 caseload estimates (by county demographic cell) were combined with the OFM Projection Model population estimates (by county demographic cell) to produce service utilization estimates, benchmarked to June 2010. These utilization rates were then applied, by county demographic cell, to the OFM Projection Model population estimates through 2020 and aggregated up to the county, AAA and statewide level for reporting purposes.

These estimates are best interpreted as a forecast of monthly caseload counts for June of the year reported. The forecasts assume that future caseload growth is driven by changes in the county's demographic composition (e.g., growth in the population of aged persons), while holding constant the propensity to use long-term care services at the level observed in June 2010 within the detailed demographic cells.

Income relative to Elder Economic Security Standard™ Index

Estimates of the number of persons aged 60 or above and at or below Elder Economic Security Standard™ Index (EESSI) are based on the county-specific EESSI standards for calendar year 2010 for a single elder person who owns their own home without a mortgage.[2]

[2] Gerontology Institute, University of Massachusetts Boston and Wider Opportunities for Women, 2011. The Elder Economic Security Standard™ Index for Washington.

Selected Population and Aging Service Utilization Forecast, Washington State

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Number of persons aged 60 or above	1,199,843	1,243,727	1,291,273	1,342,906	1,394,212	1,449,388	1,502,610	1,556,565	1,612,143	1,663,502	1,719,184
Number of persons aged 60 or above and at or below 100% FPL	89,593	91,093	90,324	85,749	85,111	87,401	89,607	91,735	93,198	93,665	93,856
Number of persons aged 60 or above and at or below EESSI	216,440	222,170	226,986	229,348	234,730	242,902	250,829	259,269	267,537	274,637	282,117
Number of persons aged 60 or above and minority	149,780	159,526	169,910	181,138	192,604	204,851	217,832	231,041	244,759	258,086	272,363
Number of persons aged 60 or above and American Indian/Alaska Native	12,134	12,769	13,452	14,187	14,929	15,716	16,561	17,403	18,265	19,084	19,959
Number of persons aged 60 or above, American Indian/Alaska Native, and Disabled (ACS 18b or 18c)	2,825	2,965	3,119	3,276	3,442	3,626	3,815	4,011	4,216	4,413	4,623
Number of persons aged 60 or above and at or below 100% FPL and minority	21,464	22,350	22,700	22,064	22,391	23,466	24,606	25,786	26,736	27,385	27,965
Number of persons aged 60 or above with limited English proficiency	44,632	46,723	48,992	51,226	53,715	56,548	59,442	62,488	65,583	68,505	71,632
Number of persons aged 60 or above and Disabled (ACS 18b or 18c)	254,222	261,110	268,682	276,604	284,962	294,541	303,874	314,189	325,257	335,701	347,135
Number of persons aged 18 or above and Disabled (ACS 18b or 18c)	468,619	476,030	482,912	487,450	494,571	504,213	513,523	523,418	533,448	543,053	553,296
Number of persons aged 60 or above with cognitive impairment (ACS 18a)	112,902	115,695	118,296	120,683	123,590	127,272	130,895	134,768	138,972	142,873	147,163
Number of persons aged 18 or above with cognitive impairment (ACS 18a)	307,323	309,881	311,003	309,076	310,311	313,915	317,541	321,164	324,529	327,604	330,600
Number of persons aged 60 or above with IADL (ACS 19)	162,717	166,583	170,409	174,335	178,673	183,878	188,982	194,790	201,118	207,105	213,794
Number of persons aged 18 or above with IADL (ACS 19)	306,079	309,912	312,703	313,420	316,530	321,741	326,879	332,470	338,082	343,372	349,030
Number of persons aged 70 or above with dementia	79,628	80,878	82,178	83,696	85,208	87,044	88,877	91,255	94,061	96,854	100,112
Number of persons using SNF services, based on June 2010 CFC utilization calibration	10,518	10,713	10,934	11,169	11,399	11,661	11,915	12,203	12,519	12,829	13,181
Number of persons using in-home services, based on June 2010 CFC utilization calibration	33,643	34,502	35,490	36,552	37,618	38,755	39,900	41,194	42,563	43,919	45,360
Number of persons using community residential services, based on June 2010 CFC utilization calibration	11,382	11,592	11,829	12,075	12,315	12,587	12,853	13,151	13,476	13,799	14,164

Summary of Long-Term Supports and Services in Washington State

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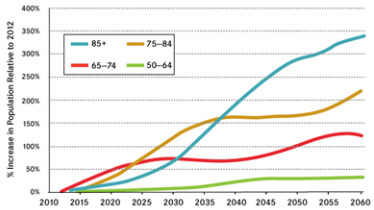
What are Long Term Services and Supports?

A broad array of long-term services and supports are available in Washington for individuals who need assistance with tasks such as bathing, dressing, ambulation, transfers, toileting, medication administration/reminders, personal hygiene, meal preparation, transportation and other personal, household or health-related tasks. Often this type of assistance is needed by individuals who experience functional limitations due to age, physical or cognitive disability. These services and supports allow individuals to choose the setting and services that will best meet their needs and preferences for quality, independence and self-determination.

Currently approximately 37% of the individuals served under the Aging and Long -Term Support Administration's Medicaid program are between the ages of 18 and 64, with 63% ages 65 and older. It is estimated that approximately 70% of people over the age of 65 will need some form of long-term services and supports in their lifetimes.

Projected growth of older population in WA state as percentage of 2012 population



Over 80% of long-term services and supports is provided by unpaid family caregivers. Washington has over 850,000 unpaid family caregivers supporting their loved ones. The care they provide has an estimated economic value of $10.6 billion, almost 5 times what the state of Washington spends annually on Medicaid funded long-term supports and services.

Medicaid is the primary public payer of long-term services and supports, supporting approximately 60% of the state's nursing home residents. Medicaid is also the primary public payer of long-term services and supports provided in community based settings such as an individual's own home, Adult Family Homes and Assisted Living Facilities. Medicare only pays for qualified short-term stays in nursing homes for rehabilitative services. Individuals also use their own private resources and incomes to pay for needed services. Only 50 individuals per 1,000 age 40 or older in Washington have private long-term care insurance policies in effect.

Development of Washington's Array of Long-Term Services and Supports

In the early 1980's Washington was an "early adopter" of new federal opportunities to support people with significant disabilities in their homes and other home-like environments. The premise was simple, individuals when given the choice and quality supports choose to remain in their own homes and communities where they can maximize independence, self-determination and community participation. Community based care on average is also less expensive.

By 1995, Washington's legislature recognized the importance of community-based services in statute that directed further development of a system of supports that provides choice and flexibility and reductions in Medicaid paid nursing home beds. Without that emphasis Washington would be spending over two billion more to support people with disabilities than we are today.

Washington's success in this arena has made us a national leader. 86 percent of individuals receiving Medicaid funded LTSS are served in their own home or community residential setting. According to the 2014 AARP Scorecard on Long-Term Services and Supports for older adults, people with physical disabilities and family caregivers, our LTSS system is ranked 2nd in the nation for its high performance at the same time as its ranking for cost is 34th.

Long-Term Supports Available Through the Aging & Disability Network

Area Agencies on Aging (AAAs) provide a network of community-based services funded through federal Older Americans Act (OAA), state and local funding. The table below provides a summary of these services and programs. A number of programs offered through the Older Americans Act and State funds are required by all AAAs and others are discretionary and decisions about priorities and funding levels are made through the local Area Planning process. The services marked with an asterisk are available statewide.

Service/ Program	Target population	Description/Limitations
Memory Care & Wellness Services (MCWS)	Unpaid family caregivers who care for a person with diagnosis of Alzheimer's disease or other dementia (care receiver). Funded through the Family Caregiver Support Program (FCSP) when certain criteria are met, including: The care receiver must live at home (not in a licensed care setting), and either live with the primary family caregiver or be receiving 40+ hours per week of care/supervision from the family caregiver. The caregiver must meet certain FCSP eligibility based on TCARE® assessed levels of burden, depression, etc. (See more on TCARE® in the Appendix, under the FCSP).	MCWS is an evidence-informed dementia specific day program for individuals with dementia and their family caregivers. MCWS offers a blend of health, social and family caregiver supports and integrates a structured, specialized exercise program called *EnhanceMobility.* A MCWS study, by the University of Washington, demonstrated that for participants with dementia, quality of life improved and the frequency of behavior problems decreased. For family caregivers, distress over behavior problems decreased in treatment caregivers while increasing in comparison group caregivers. Depressive symptoms, stress and burden also decreased.[8] Access limitations: Available in 3 of 13 Area Agency on Aging (AAA) service areas. King County and Northwest WA AAAs are now supporting MCWS through limited MCWS-funding within FCSP budget; Pierce County grant will end Aug. 31, 2014 and may need additional funding to sustain.
Reducing Disability in Alzheimer's Disease (RDAD)	Persons with Alzheimer's disease or other dementia with an available family caregiver to assist.	RDAD is an evidence-based in-home exercise program. The program consists of nine home visits by a trained/certified RDAD "coach" over a six-week period. The coach teaches the caregiver how to encourage and safely supervise the care receiver while doing the exercises, and teaches caregivers how to handle some of the problems that occur with older adults who have memory problems or dementia. RDAD research, at the University of Washington, demonstrated significant short- and long-term benefits for people in the treatment group. Physical functioning improved and fewer participants ended up in nursing homes due to behavioral disturbances. Access limitations: Available in 5 of 13 AAA service areas, RDAD is currently funded by a National Institute on Aging grant (2012-17).

Care Transitions	Persons of all economic backgrounds, ages, and payors; however, different geographical areas have garnered different funding sources that target specific populations and may not support serving others.	Care Transition services are a set of actions designed to ensure the coordination and continuity of health care as patients transfer between different locations or different levels of care within the same location. Washington State's *Aging & Disability Resource Center* project, is concentrated on patient-centered hospital-to-home care transitions using an evidence-based coaching model, Care Transition Intervention® (CTI), developed by Eric Coleman and his team at the University of Colorado at Denver. 11 of 13 AAAs have trained coaches. The AAAs without trained coaches are Yakama Nation AAA and Colville Indian AAA.
Family Caregiver Support Program (FCSP)	Unpaid family caregivers of adults (18+) with functional disabilities.	FCSP offers an evidence-based caregiver assessment/ consultation and care planning process (TCARE®) in addition to other supportive services, including: help in finding and accessing local resources & services, caregiver support groups and counseling; training on specific caregiving topics (including Alzheimer's/dementia); education (e.g., Powerful Tools for Caregivers); respite care; access to supplies/equipment; and support/practical information and caregiving suggestions. Several evidence-based services, mentioned above, are supported through FCSP funding. See Appendix for more information on FCSP and TCARE®). FCSP is available statewide.
Chronic Disease Self-Management Program (CDSMP)	Individuals who are over the age of 18 have one or more chronic conditions in Washington. Family, friends, and caregivers of people with chronic conditions are welcome to attend CDSME workshops.	The CSDMP is a collaboration between the ALTSA, HCS, Washington State Department of Health (DOH), thirteen Area Agencies on Aging (AAA), and People First of Washington. This program is funded by a three year federal grant which ends August 31, 2015. By the end of the funding period, ALTSA will disseminate, design infrastructure, and plan sustainability for Stanford University's evidence-based Chronic Disease Self-Management Education (CDSME) programs. The specific types of CDSME program that Washington State is implementing are: 1) Chronic Disease Self-Management Program; 2) Tomando Control de su Salud; 3) Diabetes Self-Management Program; 4) Chronic Pain Self-Management; 5) Better Choices, Better Health (Online CDSMP).

Kinship Caregivers Support Program (KCSP)	Grandparents or other relative raising a child age 18 or younger who are at risk of not being able to continue kinship caregiving without additional financial support services.	The Kinship Caregiver Support Program covers the cost of emergent needs incurred by grandparents or other relatives (kinship caregivers) who are raising children whose parents are unable to care for them. Basic needs (such as food, clothing, and supplies) are the most frequent service requests.
Legal Services	Individuals 60 years of age or older with a focus is on socially and economically needy older individuals who are experiencing legal problems.	Legal Services Programs foster a cost-effective, high quality service that is integrated into the aging services network. The Legal Services Program provides access to the justice system by offering representation by a legal advocate (attorney, paralegal, or law student). Services provided include legal advice; brief legal services such as phone calls, letter writing, document review and drafting, or negotiation; representation at administrative hearings; representation in court; referral to other legal resources. Other services that may be provided are education and training; backup and training for the Information and Assistance Program, Case Managers, and the Long-Term Care Ombudsman Program volunteers; resource development to expand services; and organizational representation of elder citizens' organizations, groups and coalitions who work on priority areas of the law and on issues and advocacy affecting low-income seniors. <u>Access Limitations:</u> Targeting of services to the most vulnerable adults is necessary due to funding limitations. This results in waiting times for services such as the CLEAR Senior legal hotline.
Veteran Directed Home Services (VDHS)	Veteran's receiving their primary care at a VA Puget Sound Health Care System hospital or clinic who have significant cognitive impairment, need assistance with three or more ADLs, and are receiving hospital services.	VDHS provides eligible Veterans the opportunity to receive home and community-based services to enable them to continue to live in their homes and communities. This program offers a Veteran access to an assessment that will identify his or her needs and preferences. An individual budget and spending plan is developed based on the Veteran's assessed needs and preferences and includes goods and services (including hiring and managing employees) that will best meet the identified needs. This spending plan must be approved by the Area Agency on Aging and the VA Puget Sound Health Care System. <u>Access Limitations:</u> This program is limited to serving 20-50 veterans statewide.

Minor home repair and modification	Low-income older adults with a medical or disabling condition that requires her/him to make adaptations to safely stay in the home.	Modifications are made to adapt the home to fit an individual's changing needs safely. Common modifications include ramps, grab-bars, or widened doorways for a wheelchair.
Case management*	Individuals age 18 and older who are receiving ALTSA-funded community-based services in their home. Adults age 60+ who reside in the community, and are not receiving Medicaid funded Long-Term Care Core Services.	Case management services include assisting clients to develop a plan of care, educating the client, family members, and other support systems about resources and options available for care, and supporting/maximizing client independence and self-direction. The AAAs provides case management to clients who are not receiving Medicaid funded Long-Term Care Core services. If a client is not eligible for Core services, he/she may qualify for non-core services such as respite care, nutrition programs, exercise programs, or other locally available services.
Senior farmer's market Nutrition Program (SFMNP)*	Lower-income seniors	The Senior Farmers Market Nutrition Program operates June through October and provides fresh fruit and vegetables to lower-income seniors. Participants purchase fresh produce from farmers markets, roadside produce stands community supported agriculture (CSA) shares, or have produce delivered directly to their home. <u>Access Limitations:</u> This service is in high demand; many seniors are turned away each season due to a limited number of vouchers available for distribution.

Medicaid State Plan and Medicaid Waiver Services

The table below provides a summary of state plan and waiver services and programs that support individuals with care needs related to functional limitations. Programs provide services that meet the care needs of individuals with dementia, cognitive impairments, and physical limitations in community-based settings.

Service/ Program	Target population	Description/Limitations
Specialized Dementia Care Program in Assisted Living Facilities (SDCP)	Individuals who are both COPES and SDCP eligible with Alzheimer's disease or other dementia receiving care in a SDCP contracted facility. SDCP eligibility is in WAC 388-106-0033. In 2013 the SDCP served more than 880 clients. See Appendix for more information.	SDCP offers specialized dementia care services within Assisted Living Facilities that are either dedicated solely to the care of persons with dementia or provide care within a separate unit of a larger facility that is dedicated solely to the care of persons with dementia. The ALF must be contracted with DSHS to provide specialized dementia care services, which include: care, supervision, and activities tailored to the specific needs, interests, abilities, and preferences of the person; coordination with the person's family to ensure the person's routines and preferences are honored; dementia-specific training for staff; awake staff twenty-four hours a day; a safe outdoor environment with walking paths and access to a secure outdoor area; intermittent nursing services, help with medications, personal care, and other support services. Available statewide, based upon availability of qualified providers.
Community Options Program Entry Services (COPES) waiver	To be eligible for COPES, clients must be age 18 or older and blind, aged, or disabled per Social Security criteria; meet Nursing Facility Level of Care (NFLOC) criteria and income requirements. See Appendix.	COPES provides personal care services in the consumer's own home, a licensed adult family home or a licensed assisted living facility. Additional services for in-home clients include: personal emergency response systems, home delivered meals, specialized medical equipment, home modifications, nurse delegation, adult day care, client support training, adult day health, skilled nursing, transportation, community transition services, and home health aides. Additional services for clients living in a licensed facility include: specialized medical equipment, nurse delegation, client support training, adult day health, transportation, and skilled nursing.
New Freedom Consumer Directed	Individuals who are 18+ and blind, aged, or disabled per Social Security criteria; live in their own homes; meet Nursing Facility Level of Care	New Freedom is a voluntary budget-based program that provides participants who are eligible for home and community-based services through the Medicaid waiver the opportunity for increased choice and

Services Waiver	criteria and income requirements. See Appendix.	control over their services and supports. Service categories include personal assistance services, treatment and health maintenance, individual directed goods, services and supports , environmental or vehicle modifications, and training & educational supports. Access limitations: Is currently operating in King and Pierce Counties.
Residential Support Waiver (RSW)	To be eligible for RSW, clients must be age 18 or older and blind, aged, or disabled per Social Security criteria; meet Nursing Facility Level of Care (NFLOC) criteria and income requirements. See Appendix.	This waiver is designed for individuals with mental health disorders, and/or chemical dependency disorders; organic or traumatic brain injuries; and/or cognitive/developmental impairments who are relocating from a psychiatric hospital as acute inpatient treatment is no longer medically necessary or the individual cannot benefit from active treatment. Clients enrolled in this waiver receive services in a licensed Enhanced Service Facility or a licensed Adult Family home with a specialized behavior support service contract. The RSW offers behavioral supports, personal care assistance, medical or habilitative treatment, dietary services, security, chemical dependency treatment and supervision in a specialized residential facility.
Enhanced Service Facility (ESF)	ESFs are designed for individuals with mental health disorders, and/or chemical dependency disorders; organic or traumatic brain injuries; and/or cognitive/developmental impairments who are relocating from a psychiatric hospital as acute inpatient treatment is no longer medically necessary or the individual cannot benefit from active treatment. To be eligible, clients must meet NFLOC and ESF criteria. This new Medicaid program will be funded through a 1915(c) waiver.	ESF offers behavioral supports, personal care assistance, medical or habilitative treatment, dietary services, security, chemical dependency treatment and supervision in a specialized residential facility. The first ESF bed will open in 2015. The budget assumes forty two (42) beds will be filled by June 2015. Expansion would require additional funding.
Expanded Community Services (ECS)	ECS are designed for clients with exceptional care needs due to behavioral or mental health issues when current services are not adequate for successful placement due to significant behavioral challenges.	The ECS program offers an enhanced rate to specifically contracted COPES residential providers or ECS contracted skilled nursing facility (SNF) providers; and behavioral support services that are provided through contracts with COPES ECS Behavior Support providers or through the SNF enhanced rate.

	To be eligible, clients must meet COPES and ECS criteria.	
Health Home Services	Individuals with chronic illnesses who are eligible for Medicaid or both Medicare & Medicaid. Individuals must also be at significant risk for health problems that can lead to unnecessary use of hospitals, emergency rooms, and other expensive institutional settings. See Appendix for more information.	Health Home Services provide integration or close coordination of primary, long-term services and supports, and behavioral health/substance use services. They are most commonly focused on serving individuals with one or more chronic health conditions. A health home provides six specific services beyond the clinical services offered by a typical primary care provider: Comprehensive care management, Care coordination and health promotion, Comprehensive transitional care and follow-up, Patient and family support, Referral to community and social support services, and use of information technology to link services, if applicable.
Medicaid Personal Care (MPC)	Individuals who meet the functional criteria based on the social service assessment and financial eligibility based on eligibility for a non-institutional categorically needy or Alternative Benefit Plan (ABP) Medicaid Program. Functional eligibility for this program is based on Chapter 388-106 WAC.	Medicaid program allowed under Washington State's Medicaid State Plan that provides assistance with activities of daily living to eligible individuals. Medicaid personal care services are available in the client's own home, Adult Family Homes (AFH), or Adult Residential Center (ARC). Activities of daily living include tasks such as bathing, dressing, eating, toileting, transferring, ambulating, etc. Clients in their own home receive MPC services from contracted individual providers and/or licensed home care agency providers.

Long-Term Services, Supports Settings, and Provider Types

Long-Term Services and Supports are provided in a number of settings and by many different types of providers. The table below provides a summary of the types of long-term care settings, providers, and non-Medicaid services.

Service/ Program	Target population	Description/Limitations
Assisted Living Facilities (AL) **543 in WA State as of November 2014**	ALFs are available to individuals who are age 18 and older requiring support and supervision. Services vary depending on the type of contract the ALF obtains from the Aging and Long-Term Support Administration (ALTSA).	An assisted living facility (ALF), formerly called a boarding home, is a community setting licensed to care for seven or more residents. The majority are privately owned businesses. The facility provides housing, basic services and assumes general responsibility for the safety and well-being of the resident. The majority of residents pay for their care privately. ALFs allow residents to live an independent lifestyle in a community setting while receiving necessary services from staff. ALFs can vary in size and ownership from a family operated 7-bed facility to a 150-bed facility operated by a large national corporation. Some ALFs provide intermittent nursing services or may serve residents with mental health problems, developmental disabilities, or dementia. ALFs that contract with ALTSA provide one or more of the following service packages: **Assisted Living:** • Private apartments, with an emphasis on privacy, independence, and personal choice • Intermittent nursing services • Medication administration and personal care services **Adult Residential Care (ARC)** • Medication assistance and personal care services • Residents may need/receive limited supervision **Enhanced Adult Residential Care (EARC)** • Medication administration and personal care services • No more than two people will share a room • Intermittent nursing services
Adult Family Homes (AFH) **2,750 in WA State as of November 2014**	AFHs are available to anyone over age 18 requiring support and supervision.	Adult Family Homes (AFHs) are regular residential homes licensed to care for two to six residents. The homes are private businesses and provide the residents with a room, meals, laundry, supervision, assistance with activities of daily living, and personal care. Some provide nursing or other special care and services. Primary authority for adult family homes can be found in Chapter 388-76 WAC and Chapter 70.128 RCW. Residents can pay privately or be funded through DSHS. AFH residents have the right to exercise

		reasonable control over life decisions. See http://www.aasa.dshs.wa.gov/Professional/afh/AFHinfo.htm for additional information on Resident Rights and more.
In-Home Care Service Agencies **509 in WA state as of November 2014**	Individuals who may be ill, disabled, or vulnerable, and wish to remain in a community-based setting.	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 or clients 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 in a place of 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 noninstitutional facility, services may include continuous care, general inpatient care, inpatient respite care, and routine home care.
Skilled Nursing Facility Care (SNF) **237 in WA State as of**	Individuals whose conditions are complex and/or medically unstable and who require frequent medical or nursing intervention.	Skilled nursing facilities have nursing services available 24-hours a day. They provide at least daily nursing supervision to residents needing health services and restorative or maintenance assistance with medications, eating, dressing, walking, and other personal care needs.

November 2014		
Independent or Individual Provider	Individuals who need assistance with personal care or respite services .	Independent or Individuals Living Providers provide personal care or respite services in the home. The individual who requires care hires the Independent or Individuals Living Provider; providers are paid privately or through DSHS.
Day Centers	Individuals who have an unmet need for personal care services, routine health monitoring with consultation from a registered nurse, general therapeutic activities, or supervision and/or protection.	**Adult Day Care** (ADC) 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 or supervision/protection. **Adult Day Health** (ADH) 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.
State-Funded Volunteer Services	Adults age 18+ living at home and unable to perform certain personal care tasks due to a functional or cognitive impairment and not receiving services under Medicaid long-term services and supports.	Volunteer services provide assist with general household tasks. Tasks may include housekeeping, laundry, shopping, cooking, moving, minor home repair, yard care, and transportation.
Transportation *Public Transportation* *Dial-a-Ride* *Paratransit*	Individuals who need transportation to medical and health services, social services, meal programs or for shopping assistance and cannot provide or arrange their own transport because they do not have a car, are unable to drive, cannot afford to drive, or require assistance to access public transportation.	Transportation services assist eligible clients with getting to and from social services, medical and health care services, meal programs, senior centers, essential shopping, and some recreational activities. Transportation services may include personal assistance for those with limited physical mobility, door-to-door service, individually scheduled rides to appointments, and reduced fares.
Homecare Referral Registry (HCRR)	Medicaid eligible clients and families receiving Long-Term Supports and Services through HCS/AAA or DDA who choose to hire and supervise their own in-home individual providers of respite or personal care.	The Home Care Referral Registry supports consumers and families by providing a list of pre-screened, work-ready providers using web-based matching-logic programing. Local support and educational materials are available from Registry Coordinators positioned across the State. Pre-screened providers are assisted by Registry Coordinators to initiate an Individual Provider contract with the department, meet and maintain training and certification requirements, and get matched with interested consumers.

		Access Limitations: Personal assistance matching services offered are not available in Chelan, Douglas and Okanogan counties.
Personal Emergency Response Systems PERS	Individuals living independently who are at risk of falling or having a medical emergency that would make it difficult to call for help.	Although there are a wide variety of products PERS (also called Medical Alert Systems) typically consist of a small button-sized transmitter that may be carried or worn, a receiving console that is connected to a telephone, and a monitoring center which may be nationally or locally based. A number of 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, or providing paid monthly services. In some cases the cost of the device may be subsidized by another program. Depending on the type of system used, service provided may include storing relevant medical information with a monitoring center, GPS location, 24/7 monitoring, direct communication with an monitoring center dispatcher, fall detection, an auto call to the identified the emergency contact, or an auto call to 911.
Senior Centers	Individuals who would benefit from supplemental meals, a service point connection, or the social support of a communal setting.	Senior centers are facilities in a community where older people can meet, share a meal, get services, and take part in health, wellness, and recreational activities. Senior centers also serve as a referral hub, providing information about and referrals to services that may benefit older individuals.
Senior Nutrition	Individuals not able to prepare nutritious meals due to limited mobility, cognitive impairment, lack of knowledge or skills, or lack of incentive to prepare and eat meals alone.	Nutritious meals are provided in community (congregate) settings or through home-delivery for individuals who have difficulty leaving their homes. Meals provided in a congregate setting meet at least one-third of the current Recommended Dietary Allowance and allow for special dietary needs. Home-delivered meals are provided at least once a day, five or more days a week. Meals may be hot, cold, frozen, dried, canned or supplemental foods with a satisfactory storage life. Additional senior nutrition services include outreach, case management, and referral to other types of services individuals may benefit from.

		Access Limitations: Due to federal sequestration for Older American's Act funds, services have been reduced in many regions as the cost to provide a meal rises.
Office of Deaf and Hard of Hearing (ODHH)	Individuals who are deaf, hard of hearing, deaf-blind, or speech disabled.	ODHH provides services to facilitate equal access to effective communication. Services are designed to be person-centered and recognize the wide range of communication preferences among various individuals. Telecommunications services provided by ODHH may include relay services, distribution of specialized equipment, videophone services, sign language interpreter services, assisted listening devices, and communication access real-time translation (CART) services . Other services provided may include case management, education and training, information and referral, outreach, and independent living assistance.
Department of Social and Health Services (DSHS)	Individuals in need of multiple types of social services in order to meet their basic needs and attain life stability.	DSHS act as a resource network with individuals frequently accessing services and supports across administrations and divisions. ***Economic Services Administration*** Service areas include food assistance (food stamps) and financial assistance. ***Division of Behavioral Health and Recovery*** Service areas include mental health, substance abuse and problem gambling prevention and treatment. ***Developmental Disabilities Administration*** Service areas include residential supports, personal care, employment supports, respite care, and case management. ***Aging and Long-Term Support Administration*** Service areas include community living and residential care supports, personal care supports, dementia care, family caregiver support, and case management.

Protective Services

Protective services safeguard the right of vulnerable adults to live a life free from mistreatment and abuse, financial exploitation, self-neglect, neglect by others, and abandonment. The table below provides a summary of these services and programs.

Service/ Program	Target population	Description/Limitations
Adult Protective Services (APS)	Any adult 60+ who cannot care for him or herself; or adults 18+ that have a legal guardian; have a developmental disability, etc. (see full definition of target population/eligibility in Appendix).	APS receives and investigates allegations of abuse (physical, mental, sexual, and exploitation of person), abandonment, neglect, self-neglect, and financial exploitation of vulnerable adults living in their own homes and in facilities where there is an allegation of mistreatment by someone outside of the facility. APS is available statewide to individuals of all income levels. To make a report: **Call 1-866-ENDHARM** (1-866-363-4276) to report suspected abuse or neglect of a child or a vulnerable adult.
Long-Term Care Ombudsman	Residents living in a care facility and his/her relatives or friends.	The Long-Term Care Ombudsman Program protects and promotes quality of life for people living in licensed, long-term adult care facilities (e.g. adult family home, Assisted Living Facility, nursing home). Services provided in advocacy for the rights of clients in adult care facilities; working with clients, families, and facility staff to meet the needs and concerns of the people living there; as well as mediating and resolving complaints.
Office of Public Guardianship	Low-income individuals age 18+ that are receiving long-term care services; have been determined to the superior court to be incapacitated to make personal, medical, or financial decisions; and do not have a qualified or willing guardian.	A guardian is a surrogate decision-maker, appointed by the court to make either personal and/or financial decisions for a minor or adult, who the court has determined has a significant risk of personal and/or financial harm based on a demonstrated inability to adequately provide for his/her nutrition, health, and physical safety or to manage their financial affairs and/or personal property. The Office of Public Guardianship provides public guardianship services to incapacitated individuals who do not have family a member to serve as a guardian or the have financial resources to pay for a guardian. <u>Access Limitations:</u> Currently the program is only available in Clallam, Grays Harbor, King, Okanogan, Pierce, Snohomish, Spokane, Clark, Kitsap and Thurston Counties.

Federally Funded Information and Resources

Federally funded information and resources assist individuals to find information and/or gain access to the services and programs available to meet their needs. The table below provides a summary of these services and programs.

Service/ Program	Target population	Description/Limitations
Statewide Health Insurance Benefits Advisors (SHIBA)	Individuals age 65+ who need help understanding Medicare and other healthcare coverage options.	Volunteer advisors provide information about the latest Medicare and health care coverage information. Assistance includes understanding health care coverage options and rights, finding affordable health care coverage, as well as evaluating and compare health insurance plans.
Independent Living Centers	Individuals with disabilities	Independent Living Centers assist with obtaining access to the resources and services needed for individuals with disabilities to live independently and participate fully in their communities. Services provided may include Information and referral, independent living skills training, peer counseling, and advocacy.
Benefits Check-up	Adults age 55+ who need help finding information about federal, state and private benefits programs available to them.	Benefits Check Up is a service provided by the National Council on Aging to assist older Americans to find information about federal, state and private benefits programs benefits that could help them cover the costs of everyday expenses such as prescriptions, health care, food, utilities. Benefits Check-up creates a customized report for that describes programs and services the individual may eligible for.
Aging and Disability Resource Centers (ADRC) *and* **Information & Assistance (I & A)**	Older adults (60+) or individuals with disabilities (18+) and/or their family/caregivers.	I & A is available statewide for older adults, caregivers, families and professional assisting or advocating on behalf of older adults. ADRCs are designed to broaden services to individuals of all ages with long-term service and support needs. These services are integrated points of entry into the long-term and home or community-based service and support system and are designed to address the frustrations many consumers and their families experience when they need to obtain information and access to services and supports. These programs raise visibility about the full range of support and service options that are available; provide objective information, advice, counseling and assistance; empower people to make informed decisions about their long-term and other supports;

		and help people more easily access public and private long-term supports and services programs. By linking consumers with services and supports that match their individualized priorities and preferences, these programs have the ability to assist individuals to remain at home or in their communities and thereby support individual self-empowerment and quality of life. Access Limitations: ADRCs, are operating in 4 of 13 Area Agency on Aging (AAA) service areas expansion to additional areas is based upon additional funding.
Traumatic Brain Injury (TBI) Resource Line *and* **Tbiwashington.org**	Individuals with a traumatic brain injury and their families	The TBI Resource line (1-877-TBI-1766) and tbiwashington.org provide information about TBI prevention, recovery, referral to services that may individuals with a traumatic brain injury.
Employment	Individuals who need specialized assistance to enter the workforce or to maintain employment.	Employment services are provided by a number of different organizations with specialization in employment for seniors, dislocated workers, dislocated homemakers, and individuals with disabilities. ***Senior Community Service Employment Program (SCSEP)*** SCSEP is a community service and work-based job training program that provides training for low-income, unemployed seniors. Program participants have access to employment assistance as well as placement supports. This program serves as a bridge to unsubsidized employment opportunities for participants. Access Limitations: There are only 421 SCSEP participant slots funded for Program Year 2014. ***Division of Vocational Rehabilitation (DVR)*** DVR assists individuals with a disability to obtain employment in their community. Services provided may include assessment, vocational counseling, training, assistive technology, benefits planning, and specialized counselors for Deaf and Hard of Hearing clients. ***One-Stop Career Centers (WorkSource)*** WorkSource centers offer employment services that include training, referral, career counseling, and case-managed employment and training programs. Many WorkSource programs prioritize services for veterans and their spouses, individuals

		with disabilities, older individuals, and low-income individuals.
Housing	Individuals in need of low-income of specialized housing	***HousingSearchNW.org*** HousingSearchNW.org is an online property-search service that links people with available housing. Individuals can search by rent, size, and property location. Property listings include low-income and subsidized housing options. Other services provided include calculators to plan for the moving costs and a resource list that includes specialized housing such as Adult Family Homes. Limitations: this service is still under development. ***Nursing Home Locator, Adult Family Home Locator, Assisted Living Facility Locato***r The Nursing Home, Adult Family Home, and Assisted Living Facility locators are web-based services available to help individuals find specialized long-term care housing in their local community. Individuals can search by county, city, zip code, license number or long-term care specialization. Search results provide contact information as well as information about the number of placements a facility can take, if the facility is Medicaid contracted, as well as any history of enforcement action taken against the facility.
Washington Health Benefits Exchange	Individuals seeking information about health insurance options	The Washington Health Benefits Exchange is responsible for creating the Washington health plan finder website. Using this website, individuals can shop for and choose the insurance plan that best meets their healthcare needs.

Appendix

Adult Family Home (AFH) – is a residential home in which a person or persons provide personal care, special care and room and board to more than one but not more than six adults who are not related by blood or marriage to the person or persons providing the services. Adult family homes may also be designated as a specialty home (on their AFH license) in one or more of the following three categories: Developmental Disability, Mental Illness, and Dementia if they meet all certification and training requirements. See Chapter 388-76 WAC for more on adult family home licensing requirements.

Adult Protective Services (APS) target population - A vulnerable adult is: any adult 60+ who cannot care for him or herself; or adults 18+ that have a legal guardian; have a developmental disability; live in a facility licensed by DSHS/ALTSA; receive services from a DSHS-contracted individual provider; receive in-home services through a licensed health, hospice or home care agency; or have a personal care aide who performs care under his/her direction for compensation, per 74.39.050 RCW. More on APS can be found at: http://www.adsa.dshs.wa.gov/APS/

Aging & Disability Network Services - The National Aging Network (the Aging Network) was established in 1965 with the passage of the Older Americans Act (OAA) and is one of the Nation's largest provider networks of home and community based care for older persons, adults with disabilities and their caregivers. The Administration on Aging (AoA), an agency in the U.S. Department of Health and Human Services (HHS), is a lead partner of the Aging Network which consists of 56 State Units on Aging, 629 Area Agencies on Aging (AAAs), 246 Tribal organizations, 20,000 service providers, and thousands of volunteers.

Aging and Disability Resource Centers (ADRCs) - The National Aging and Disability Resource Center Program (ADRC), is a collaborative effort of the Administration for Community Living (ACL), the Centers for Medicare & Medicaid Services (CMS), and the Veterans Health Administration (VHA), and is designed to streamline access to home and community supports and services for consumers *of all ages*, incomes and disabilities, and their families. Washington State has received federal grants to assist in the development, implementation, and statewide expansion of a sustainable system of fully functional ADRCs.

ADRCs serve as integrated points of entry into the long-term and home or community-based service and support system and are designed to address the frustrations many consumers and their families experience when they need to obtain information and access to those services and supports. Through integration or coordination of existing aging and disability service systems, ADRC programs raise visibility about the full range of options that are available, provide objective information, advice, counseling and assistance, empower people to make informed decisions about their long-term and other supports, and help people more easily access public and private long-term supports and services programs. These timely supports can also prevent or delay the need to access government paid services. By linking consumers with services and supports that match their individualized priorities and preferences, ADRCs have the ability to assist individuals to remain at home or in their communities and thereby support individual self-empowerment and quality of life. ADRCs rely on strong partnerships with other social services organizations; healthcare providers; and aging and disability advocates to create integrated networks. Thus far, Washington State has received federal grants to assist in the development, implementation, and statewide expansion of a sustainable system of fully functional ADRCs.

Area Agency on Aging (AAA) - Area Agencies on Aging (AAAs) are local organizations that develop and promote services and options to maximize independence for elders, adults with disabilities, and family caregivers. Washington has thirteen AAAs comprising county governments, regional councils, and tribes. A citizen advisory council guides the work of each AAA. The Washington Association of Area Agencies on Aging (W4A) is a membership organization made up of 13 Area Agencies on Aging (AAA) in Washington State. The organization seeks to enhance the effectiveness of each AAA through a strong agenda of information, debate, advocacy and education.

Assisted Living Facility - is a facility, for seven or more residents, with the express purpose of providing housing, basic services (assistance with personal care, activities of daily living and room and board) and assumes the general responsibility for safety and well-being of the resident. See Chapter 388-78A WAC for more on assisted living licensing requirements.

Care Transitions - The term *Care Transitions* refers to the movement patients make between health care practitioners and settings as their condition and care needs change during the course of a chronic or acute illness. Care Transition services are a set of actions designed to ensure the coordination and continuity of health care as patients transfer between different locations or different levels of care within the same location. Washington State's *Aging & Disability Resource Center* project, now called *Community Living Connections*, has primarily concentrated its efforts on patient-centered hospital-to-home care transitions using an evidence-based coaching model, Care Transition Intervention® (CTI), developed by Dr. Eric Coleman and his team at the University of Colorado at Denver. This model translates well with both patients and their informal support systems as well as to other care transition modalities. During a 4-week intervention, patients with complex care needs receive specific tools, are supported by a Transitions Coach®, and learn self-management skills to ensure their needs are met during the transition from hospital to home. Patients who receive this program are: significantly less likely to be readmitted and more likely to achieve self-identified personal goals around symptom management and functional recovery. Findings are sustained for as long as six months after the 30-day intervention.

ALTSA subcontracts with Qualis Health (QH), the Medicare Quality Improvement Organization (QIO) to provide ongoing technical assistance, mentoring, and shadowing to each of the AAA entities providing care transitions in the state. QH also working with the Washington State Hospital Association (WSHA), a CMS-designated Hospital Engagement Network (HEN) to provide additional support to Hospital/AAA partnership development around care transitions.

Different geographical areas have garnered different funding sources that target specific populations and may not support serving others. Some of these funding sources are not directly under the purview of ALTSA, but may come directly from CMS, through the HealthPath WA Health Home and fully capitated strategies, or local funders. Additional funding used by AAAs has come from Medicaid HCBS Waivers, Older American Act Title IIIB and IIID, and also a 3-year federal ADRC Enhanced Options Counseling grant.

Only the four pilot ADRCs (PSAs 2, 5, 9, and 11) receive funding under the ACA Section 3026, *Community Care Transitions Partnership* (CCTP) demonstration: this funding serves Medicare beneficiaries. Several of the AAAs receive Affordable Care Act (ACA) Health Home funding to serve the target high cost/high care dually eligible beneficiaries. All those that are using TIIIB or TIIID can serve persons 60+, regardless of the health insurance payer, but their capacity may be limited. All

those using ADRC EOC grant funds or local funds can serve persons of all ages, but their capacity may be limited in some areas written agreements with hospitals to share protected health information and to clarify referral processes may still be pending.

Community Options Program Entry System (COPES) Waiver - The COPES waiver was implemented in 1982 and is one of the oldest waivers in the nation. COPES services are funded with a combination of state dollars and with Title XIX (Medicaid) federal dollars. Aging and Long-Term Support Administration (ALTSA) partners with Centers for Medicare and Medicaid Services (CMS) and the Area Agencies on Aging (AAAs) to implement the COPES waiver.

COPES provides personal care services in the consumer's own home, a licensed adult family home or a licensed assisted living facility. Additional services include: personal emergency response systems, home delivered meals, specialized medical equipment, home modifications, nurse delegation, adult day care, caregiver/recipient training, adult day health, skilled nursing, transportation, adult dental services, community transition services, and home health aides.

COPES services are an effective alternative to nursing home placement and are an integral component of Washington State's successful rebalancing of services from institutional to community based settings.

Family Caregiver Support Program – The Family Caregiver Support Program (FCSP) services unpaid family caregivers. It integrates an evidence-based caregiver assessment/ consultation and care planning process known as TCARE® - Tailored Caregiver Assessment & Referral® (see below). Coordinated through Washington State's 13 Area Agencies on Aging, the FCSP provides also provides the following services and assistance for unpaid family caregivers:

- Help in finding and accessing local resources & services
- Caregiver support groups and counseling
- Training on specific caregiving topics (including Alzheimer's/dementia)
- Education (e.g., Powerful Tools for Caregivers)
- Respite care
- Access to supplies/equipment
- Support/practical information and caregiving suggestions

The *Tailored Caregiver Assessment and Referral (TCARE®)* system was created by Rhonda Montgomery, PhD and colleagues at the University of Wisconsin-Milwaukee. The TCARE® protocol is designed to tailor services to the unique needs of each caregiver thereby reducing stress, depression and burdens associated with caregiving. TCARE® provides a consistent, objective and reliable screening and assessment process that identifies at-risk caregivers and targets resources to those most in need and determines whether support and services make a measurable difference to caregivers. TCARE® also helps inform policy through the collection of state-wide data. The effectiveness of TCARE® is documented in published research articles based upon a national randomized control study, in which Washington State participated. For more information, visit the national TCARE® website at www.TCARE.uwm.edu.

The FCSP is funded through federal ($2,807,974) and state ($11,424,000) funds (2013).

Health Home Services - Health Homes provide integration - or close coordination of primary, long-term services and supports, and behavioral health/substance use services. They are most commonly, but not always, focused on serving individuals with one or more chronic health conditions. As defined by the Centers for Medicare and Medicaid Services, a health home provides six specific services beyond the clinical services offered by a typical primary care provider:

- Comprehensive care management
- Care coordination and health promotion
- Comprehensive transitional care and follow-up
- Patient and family support
- Referral to community and social support services
- Use of information technology to link services, if applicable

Health Home services will be available to individuals with chronic illnesses and who are eligible for Medicaid or both Medicare and Medicaid. Individuals must also be at significant risk for health problems that can lead to unnecessary use of hospitals, emergency rooms, and other expensive institutional settings such as psychiatric hospitals and nursing homes. Washington uses a predictive risk modeling system called PRISM to identify individuals who are at significant risk.

Individuals receiving Health Home services will be assigned a Health Home coordinator who will partner with beneficiaries, their families, doctors, and other agencies providing services to ensure coordination across these systems of care. In addition, the health home coordinator will make in-person visits and be available by telephone to help the individual, their families, and service providers. For more information, go to: http://www.hca.wa.gov/Pages/health_homes.aspx

Information and Assistance - Connects people to available resources in their community by providing general information, support, and advocacy.

Memory Care & Wellness Services - A supervised daytime program for individuals with dementia and their family caregivers. Memory Care & Wellness Services (MCWS) offers a program that is a blend of health, social and family caregiver supports – it is defined and requirements specified the "Memory Care & Wellness Services Standards of Care, December 2010" (currently under refinement).

Memory Care & Wellness Services build upon the core services listed under Adult Day Care and add the following: A program day of five hours, offered two days per week; Staffing that accommodates increasing functional and behavioral support needs of participants as they progress in their dementia, including: 1:4 (vs.1:6) staff to client ratio; Skilled nursing and/or therapy and social services available during program hours for the participant, with targeted education and support of the family caregiver as needed. A structured, specialized exercise program, *EnhanceMobility* is integrated into the program.

Started through federal Alzheimer's demonstration grants, this program has demonstrated that for individuals with dementia, quality of life improved and the frequency of behavior problems decreased. For family caregivers, distress over behavior problems decreased in treatment caregivers while increasing in comparison group caregivers. Depressive symptoms, stress and burden also decreased.[8]

MCWS is currently available in 3 of 13 Area Agency on Aging (AAA) service areas. Original service areas (King County and Northwest WA AAAs) are now supporting MCWS through limited MCWS-funding within Family Caregiver Support Program budget; a federal Pierce County demonstration grant will end Aug. 31, 2014 and may need additional funding to be sustained.

New Freedom - New Freedom is a voluntary budget-based program that provides participants who are eligible for HCBS services through the Medicaid Waiver the opportunity for increased choice and control over their services and supports. Funded through 1915(c) waiver from Centers for Medicare and Medicaid Services and state general funds.

Individuals who reside in King or Pierce Counties; are 18+ and blind, aged, or disabled per Social Security criteria; have functional disabilities based on medical issues or chronic illness; live in their own homes; meet nursing facility level of care and income up to the special income level (SIL) or more than the SIL but less than the NF average state rate plus medically needy income level (MMIL).

Nursing Facility Level of Care (NFLOC) criteria – The individual must: require care provided by or under the supervision of a registered nurse or a licensed practical nurse on a daily basis; Have an unmet or partially met need with at least ADLs as defined in WAC 388-106-0355; Or have cognitive impairment and require supervision due to one or more of the following: disorientation, memory impairment, impaired decision making, or wandering and have an unmet or partially met need with an ADL as defined in WAC 388-106-0355.

Reducing Disability in Alzheimer's Disease (RDAD) - RDAD is an evidence-based in-home exercise program. The program consists of nine home visits by a specially trained/certified RDAD "coach" over a six-week period.

RDAD research, at the University of Washington, demonstrated significant short- and long-term benefits for people in the treatment group. Physical functioning improved and fewer participants ended up in nursing homes due to behavioral disturbances.

During the one-hour in-home sessions, the coach teaches easy-to-follow exercises to both the caregiver and care receiver (i.e., the person with dementia). The coach teaches the caregiver how to encourage and safely supervise the care receiver while doing the exercises. The coach also teaches caregivers how to handle some of the problems that occur with older adults who have memory problems or dementia.

RDAD is currently being translated through a National Institute on Aging grant (2012-17), with Washington (and Oregon) AAAs in the following Washington areas – Olympic, King County, Pierce, Snohomish, Southwest WA and Southeast WA. The federal grant is in operation from 2012-2017.

Specialized Dementia Care Program (SDCP) – Initiated as a partnership with providers, stakeholders and UW (1999), the SDCP demonstrated the ability to accept and retain individuals with greater cognitive impairment and behavioral disturbances than traditional assisted living programs. For more information, see the University of Washington's final outcome report on the Dementia Care Pilot Project, 2003.

Participation in SCDP has shown to significantly delay nursing home placement. Based on the positive pilot project findings, Standards of Care were adopted and placed into WAC 388-110-220(3) in 2003. SDCP eligibility is in WAC 388-106-0033.

STAR-C - An evidence-based dementia consultation program designed to help caregivers reduce or eliminate behaviors that are difficult to manage, such as anxiousness, resistance to care, wandering, or verbal or physical aggression.

This in-home education/consultation program, developed at the University of Washington, has proven to improve care receiver quality life, reduce the frequency of problem behaviors, and lower caregiving depression, burden, and distress over care receiver behavior changes. STAR-C is implemented in the caregivers' homes by skilled consultants who are certified by the University of Washington (UW) to deliver STAR-C. It is now delivered over a six-week period, with four home visits and additional phone support.

STAR-C was first translated in Oregon through a federal demonstration grant and then modified into a condensed version in Oregon and Washington (2012-2014). It is now being continued in two service areas in Oregon and implemented the following Washington areas – Central WA, King County, Lewis/Mason/Thurston AAA, Northwest WA, Southwest WA and Southeast WA.

Funding to pilot a translation of STAR-C into Washington's Family Caregiver Support Program occurred through Older Americans Act (OAA) Title III administrative funding in partnership with the UW, ALTSA and participating AAAs (using local FCSP funds to support service delivery). While the pilot has resulted in positive feedback from participating caregivers and AAAs along with the development of basic processes for certification of community consultants and integration into the FCSP, further expansion would require additional infrastructure for ongoing sustainability and fidelity to this evidence-based practice.

Washington State Department of Social & Health Services

ALTSA Aging and Long-Term Support Administration

For more information, contact:

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APPENDIX C. Community First Choice Option

The Community First Choice Option (CFCO) is an optional entitlement program offered under the Affordable Care Act (ACA). To be eligible, clients must be assessed as needing nursing facility level of care, and must have income that falls below 150 percent of the federal poverty level. States may also choose to include individuals who have higher incomes if those individuals receive medical assistance under certain waiver eligibility groups.

Services offered under the CFCO must include (1) assistance with Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs), and health related tasks, (2) acquisition, maintenance, and enhancement of skills to complete ADLs, IADLs, and health related tasks, (3) back-up systems that ensure the continuity of care and support, and (4) voluntary training on how to select, manage, and dismiss attendant care providers. Other services, such as transition assistance and employer training, may be included under the CFCO at the discretion of each state. Federal Medicaid matching funds would cover 56 percent of the cost for services provided under the CFCO, instead of the current 50 percent matching rate.

The 2014 Legislature passed SHB 2746 and SSB 6387. SHB 2746 directed the Department of Social & Health Services (DSHS) to refinance personal care services through the CFCO. SSB 6387 reinvested some of the savings from CFCO into paid services for individuals with a developmental disability. SHB 2746 further directed the Joint Legislative Executive Committee on Aging and Disability to explore the costs and benefits for additional investment in home and community based services.

Item Description	2015-17 GF-State	2017-19 GF-State
SHB 2746 savings	-$79 million	-$80 million
SSB 6387 investments	$22 million	$36 million
Available for further investment	***-$57 million***	***-$44 million***
Potential Investment Options:		
1. LTC Insurance Study	$0.2 million	-
2. Family Caregiver Support Program	$9.0 million	$9.0 million
3. 1% wage increase (Individual Providers)	$5.0 million	$5.0 million
4. 1% rate increase (Agency Provider)	$2.0 million	$2.0 million
5. 1% rate increase (Adult Family Homes)	$2.0 million	$2.0 million
6. 1% rate increase (Nursing Homes)	$6.6 million	$6.6 million
7. 1% rate increase (Assisted Living)	$1.0 million	$1.0 million
8. 1% rate increase (Adult Residential Care)	$0.4 million	$0.4 million
9. 1% rate increase (DD Community Residential)	$3.8 million	$3.8 million
10. 1% rate increase (DD Employment Programs)	$0.6 million	$0.6 million
11. 1% rate increase (Adult Day Health)	$0.1 million	$0.1 million
12. 1% rate increase (PACE)	$0.1 million	$0.1 million
13. Hours restoration for home care clients (1%)	$10 million	$10 million
14. Pre-Medicaid Services (i.e. counseling, memory care)	$11 million	$11 million
15. APS – financial exploitation and self-neglect (9 FTE)	$1.5 million	$1.5 million
16. RCS – complaint investigations and intake (23 FTE)	$3.9 million	$3.9 million
17. Lower staffing ratio for Area Agencies on Aging	$14 million	$14 million
18. Strategy 2 of the dual eligible project	$4.6 million	$4.6 million
TOTAL	$75.8 million	$75.6 million

Personal care refers to support with routine activities that people tend to complete without needing assistance, called activities of daily living (ADL). Common ADL needs include dressing, bathing, eating, toileting, transferring, and continence. Personal care may also refer to support with activities performed by a person living independently

in a community setting, called instrumental activities of daily living (IADL). Common IADL needs include shopping, cooking, laundry, meal preparation, and housework.
Clients may receive personal care in their own home from a contracted individual provider, or from an employee working for a licensed home care agency. Clients may also receive personal care within a residential setting, such as an Adult Family Home or an Assisted Living facility. In Fiscal Year 2013, approximately 60,000 clients within the Department of Social and Health Services (DSHS) received personal care services.

Currently, clients may access personal care through an optional state plan service, called Medicaid Personal Care (MPC), or through programs that provide home and community based services to individuals who would otherwise require institutionalization, called Medicaid waivers. Medicaid state plan services are an entitlement. Medicaid waivers are not an entitlement. Federal Medicaid matching funds cover 50 percent of the cost for personal care services under MPC, or a Medicaid waiver.

Over the past several years there have been variations in state payments to providers of different long-term services and supports. The following chart shows the recent history of state payment rates.

Rate Adjustments	FY08	FY09	FY10	FY11	FY12	FY13	FY14	FY15
a. Individual Provider (1)	-	-	-	-	-	-	-	-
b. Agency Provider (2)	-	-	-	-	-	-	-	-
c. Adult Family Home	3.2%	2%	-4%	-	-	-	-	-
d. Nursing Home (3)	-	-	-	-	-	-	-	-
e. Assisted Living	6%	2%	-4%	-	-	-2%	-	-
f. Adult Residential Care	6%	2%	-4%	-	-	-2%	-	-
g. DD Community Residential	5%	2%	-3%	-	-1%	-	-	1.8%
h. DD Employment Programs	1.6%	1%	-3%	-	-	-	-	-
i. Adult Day Health (4)	2%	2%	-	-	-	-	-	-
j. PACE	2%	2%	-	-	-	-	-5%	-

Notes:

(1) Wages and benefits for individual providers are collectively bargained. The cost of contract changes have varied. For example, the biennial cost of contract changes in 2013-15 was approximately $110 million GF-State. Individual providers have not received reductions in wages and benefits, but hours of care for in-home clients were reduced (on average) by 4% in FY10 and 10% in FY11.

(2) The hourly rate for agency providers is adjusted to match contract changes for individual providers. The cost of "agency parity" has varied. For example, the biennial cost in 2013-15 was approximately $30 million GF-State. Homecare agencies received a $0.13/hr reduction in the 2010 Supplemental budget. Also, hours of care for in-home clients were reduced (on average) by 4% in FY10 and 10% in FY11.

(3) Nursing home rates were last rebased in FY10. However, revenue generated from the nursing home Safety Net Assessment has allowed for investment in nursing home rates. For example, new rate add-ons were established in FY15, which raised the statewide average rate from $187/day to $199/day in FY15.

(4) Adult Day Health was eliminated as an available service for clients living in residential settings in FY10. Due to litigation, ADH was restored for both in-home and residential clients. However, in FY12, the legislature prohibited clients from receiving both employment services and ADH, which resulted in roughly 40% drop in the ADH caseload.