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No. 87483-2
SUPREME COURT OF THE STATE OF WASHINGTON

RESA RAVEN,

Petitioner,

v.

WASHINGTON STATE DSHS,

Respondent.

DECLARATION OF REGAN BAILEY IN SUPPORT OF *AMICI CURIAE* BRIEF IN SUPPORT OF PETITIONER'S PETITION FOR REVIEW

REGAN BAILEY, WSBA #39142
DISABILITY RIGHTS WASHINGTON
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Attorney for *Amici Curiae*

ORIGINAL

I, Regan Bailey, declare as follows:

1. I am an attorney and Director of Legal Advocacy at Disability Rights Washington (DRW), the state protection and advocacy organization.

2. I am familiar with the arguments presented by the parties, and the facts and issues in this case. I have reviewed the existing briefs and the record.

3. I have conducted extensive research into federal and state law, regulations and policy regarding the rights of people with disabilities, including guardianship law.

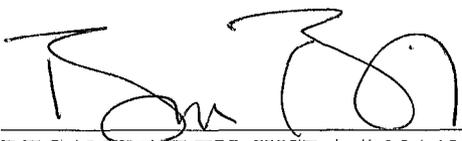
4. Attached as Exhibit A is a true and correct copy of a scholarly article by Thomas J. Mattimore, Neil S. Wenger, Norman A. Desbiens, *et al.* entitled *Surrogate and physician understanding of patients' preferences for living permanently in a nursing home*. J. Am. Geriatric Soc. 1997; 45(7):818-824.

5. Attached as Exhibit B is the Department of Social and Health Services' *Washington's Olmstead Plan, 2005*.

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I declare under penalty of perjury of the laws of the State of Washington that the foregoing is true and correct.

Dated this 3rd day of August, 2012 in Seattle, Washington.



REGAN BAILEY, WSBA # 39142

CERTIFICATE OF SERVICE

I certify, under penalty of perjury pursuant to the laws of the State of Washington, that on August 3, 2012 I caused to be served a true and correct copy of the foregoing document upon counsel listed below by legal messenger:

Catherine Hoover
Assistant Attorney General
7141 Cleanwater Dr SW
PO Box 40124
Olympia, WA 98504-0124

Jeff Crollard
1904 Third Avenue, Suite 1030
Seattle, WA 98101

I declare under penalty of perjury of the laws of the state of Washington that the foregoing is true and correct.

DATED August 3, 2012 at Seattle, Washington.



Mona Rennie

EXHIBIT A

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Surrogate and Physician Understanding of Patients' Preferences for Living Permanently in a Nursing Home

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CLINICAL INVESTIGATION

Surrogate and Physician Understanding of Patients' Preferences for Living Permanently in a Nursing Home

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OBJECTIVE: To evaluate patients' willingness to live permanently in a nursing home and surrogate and physician understanding of that preference.

DESIGN: Evaluation of cross-sectional interview data from a cohort study.

SETTING: Five academic medical centers.

PARTICIPANTS: Seriously ill hospitalized adults enrolled in the Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments (SUPPORT).

MEASUREMENTS: Patients' willingness to live permanently in a nursing home was measured on a 5-point scale ranging from "very willing" to "rather die." Ordinal logistic regression was used to identify patient demographic and clinical characteristics associated with this preference. Surrogate and physician perceptions of patient preferences were compared with patients' responses, and factors associated independently with surrogate and physician understanding of patient preference were identified.

RESULTS: Of 9105 patients, 3262 (36%) provided responses to the study question: 7% were "very willing" to live permanently in a nursing home, 19% "somewhat willing," 11% "somewhat unwilling," 26% "very unwilling," and 30% would "rather die." Older age was associated independently with less willingness to live permanently in a nursing home (odds ratio [OR]= .90 per decade; 95% confidence interval [CI]: 0.85, 0.96). Patients with more education (OR = 1.03 per year; 95% CI:1.00,1.05) and more disabilities (OR = 1.05 per disability; 95% CI:1.01,1.09), and black patients (OR = 1.46 compared with white patients; 95% CI:1.20,1.76) were more willing to live in a nursing home. Surrogates understood 61% of patients' nursing home preferences but identified only 35% of patients who were willing to live permanently in a nursing home. Physicians identified 18% of patients willing

EXHIBIT A

to live permanently in a nursing home.

CONCLUSION: Patient attitudes about living permanently in a nursing home can be elicited, cannot be reliably predicted from demographic and clinical variables, and are frequently misunderstood by surrogates and physicians. Elicitation of patient preferences regarding permanent nursing home placement should be explored before patients become unable to participate in decision making in order to enhance the concordance of patient preference with the way they spend the end of their lives.

Supported by The Robert Wood Johnson Foundation.

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As the population has aged, the number of Americans living in nursing homes has increased substantially. Currently, 10% of Americans older than age 65 are admitted to a nursing home each year, and 5% of this population live in nursing homes. ^[1] It is estimated that 43% of persons who were 65 years old in 1990 will enter a nursing home at some time before death, 55% of those who enter nursing homes will have a total lifetime use of at least 1 year, and more than one-fifth will spend 5 years or more in a nursing home. ^[2]

The decision to refer a patient for long-term nursing home care has important implications for longevity, quality of life, healthcare resource use, and the individual's ultimate financial circumstances. Unfortunately, patients are often unable to participate in the decision when long-term care choices need to be made, leaving surrogate decision-makers, guided by the patient's physician, to decide whether patients will be placed in nursing homes. Although a number of studies have identified factors associated with admission to a nursing home, ^[3] ^[4] ^[5] little is known about patients' preferences concerning long-term nursing home care. The few studies that have examined this question have studied either a special population with little generalizability to most people who will eventually enter nursing homes ^[6] ^[7] or non-hospitalized older persons, ^[8] ^[9] for whom the question may have had little immediacy. In order to understand the preferences of seriously ill persons at risk of nursing home placement, we evaluated willingness to accept permanent nursing home placement, factors associated with these preferences, and surrogate and physician understanding of patient preferences among patients enrolled in the Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments (SUPPORT), a multicenter study of medical decision-making and outcomes for seriously ill patients.

METHODS

Patient Sample and Data Collection

Adult patients admitted to five acute care hospitals participating in SUPPORT and meeting preset admission criteria

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were enrolled in the study between June 1989 and January 1994. Phase I, from June 1989 to June 1991, was a prospective observational study (n = 4301); Phase II, from January 1992 to January 1994, was an interventional trial (n = 4804). Because the intervention had no effect on clinical end-of-life outcomes ^[10] or on preferences regarding living permanently in a nursing home, the focus of the present study, data from the entire cohort of 9105 patients are considered together. Patients with the following diagnoses were enrolled: acute respiratory failure, exacerbation of chronic obstructive pulmonary disease, exacerbation of congestive heart failure, end-stage liver disease, nontraumatic coma, non-small cell carcinoma of the lung stage III or IV, colon carcinoma metastatic to the liver, and multiple organ system failure with sepsis or malignancy. Six-month mortality of the full cohort was 47%. Details of the study entry criteria have been published elsewhere. ^[11]

Patients were approached for participation in the study if they survived at least 48 hours in the hospital, spoke English, were at least 18 years of age, were not pregnant, did not have AIDS, head trauma or burns, and were not admitted with an anticipated discharge within 72 hours. After consent was obtained, the patients, their surrogates (identified by the patient or physician as the person who would make decisions for the patient if the patient were unable), and the physician in charge of the patient's care were interviewed between the second and sixth day after study enrollment (the mean hospital day of the patient interview was day four). Nearly 90% of surrogates in SUPPORT were family members of the patient. All interviews with patients and surrogates were performed by trained interviewers using standardized techniques.

Patients were questioned about demographic information (ethnicity, marital status, educational level, family income, and whether they live alone). Patients were also asked about their functional status (measured as a revised scale of dependencies in Katz's activities of daily

living (ADL) 2 weeks before, whether their plan of medical care focused on prolonging life or providing comfort, and their quality of life (rated on a 5-point scale from excellent to poor). In regard to nursing home preference, patients were asked the following question: "Would you be very willing, somewhat willing, somewhat unwilling, very unwilling, or would you rather die, than put up with living in a nursing home all the time?"

Surrogates and physicians were asked how they believed the patient would respond to the same question about living permanently in a nursing home. Surrogates also were asked their age and educational level, how long it takes to get from the surrogate's to the patient's home, and the patient's functional status and quality of life. If patient responses were missing for functional status and quality of life, the surrogate responses were substituted after calibration to a patient value. For these variables, if both surrogate and patient values were missing, the values were imputed from other variables.^[12] Physicians were asked their age, gender, ethnicity, and how long they had cared for the patient. Because the patient's nursing home preference was asked of physicians early in the study interview only in SUPPORT Phase I, the analysis of physician understanding of patient nursing home preferences is restricted to the subsample in the first phase of the study.

Patients' charts were abstracted for diagnostic information, health insurance status, comorbidities and physiological data, including components of the acute physiology score from APACHE III^[13] and the Glasgow coma score. Based on these data, each patient's chance of 6-month survival was predicted by a model created for SUPPORT.^[14]

Statistical Analysis

Subjects responding to the question about nursing home preference were compared with non-responders in the study sample on demographic and clinical variables, using chi-square or *t* tests as appropriate. We then described the nursing home preferences of study subjects and explored the bivariable relationships of demographic and clinical variables to nursing home preference.

Patient nursing home preference was modeled using a set of variables thought to be associated with long-term care preference based on the literature and clinical experience. Ordinal logistic regression was performed on the 5-point nursing home preference variable ranging from 1 = very willing to 5 = rather die. The independent variables were: patient age, gender, years of education, marital status, ethnicity (white vs black vs other), family income (<\$11K, \geq \$11 to \$25K, \geq \$25 to \$50K, \geq \$50K), health insurance status, number of ADL disabilities, and perceived quality of life; whether the patient lives alone; diagnostic group; number of comorbidities; and the model estimated probability of surviving 6 months based on study Day 3 physiology. The ordinal logistic model met the proportional odds assumption that the slopes are equal. In order to incorporate an indication of the patient's preference for aggressiveness of care, the identical model was repeated with the addition of the patient's goal of care preference (asked as whether the patient would prefer to "extend life as much as possible, even if it means having more pain and discomfort" or "relieve pain and discomfort as much as possible, even if it means not living as long"). The logistic model was evaluated using the area under the ROC curve.

The degree to which surrogates understood patients' nursing home preferences was computed as the percent exact agreement between the surrogate and the patient. Then responses were collapsed into willing versus unwilling to accept permanent nursing home placement, and surrogate identification of the patient's preference was evaluated, treating the patient's preference as the gold standard. Surrogate understanding of patient nursing home preference was modeled using ordinal logistic regression of the absolute value of the difference between the surrogate and patient response (0 = perfect understanding, 4 = maximal misunderstanding). Independent variables included all those in the patient preference model with the addition of surrogate age, surrogate educational level, and the time to travel between patient and surrogate homes.

Though restricted only to the patients enrolled in Phase I of the study, physician understanding of patient nursing home preference was computed in a fashion identical to surrogate understanding. As with surrogates, physician understanding of patient nursing home preference was modeled using ordinal logistic regression of the absolute value of the difference between the physician and patient response. Independent variables included all those in the patient preference model with the addition of physician age, gender, and ethnicity, and the length of the physician-patient relationship.

RESULTS

Of the 9105 seriously ill hospitalized patients enrolled in the study, 3262 (36%) provided responses to the question about living permanently in a nursing home. Among the 5843 patients not providing a response, 2680 (46%) were intubated or in coma, 1104 (19%) died or were discharged before the interview could be completed, 717 (12%) were unable to communicate, 493 (8%) failed the cognitive screen, and 299 (5%) refused to be interviewed. Patients who provided a nursing home preference differed from non-responders in that they were younger, less functionally impaired, less acutely ill, and had a better 6-month prognosis. Responders had more comorbidities and were more likely to have cancer, were more likely to be male, and were less likely to have a low family income, though there were no differences in ethnicity, education, marital status, or insurance status. (Table 1) Characteristics of patients in the study sample are described

in Table 1 .

Nursing Home Preferences

Overall, 7% of patients indicated that they would be "very willing" to live permanently in a nursing home, whereas 19% would be "somewhat willing," 11% would be "somewhat unwilling," 26% would be "very unwilling," and 30% would "rather die." (Table 2) In bivariable analyses, older patients and white patients (compared with black patients) were less willing to live permanently in a nursing home. Living alone, short-term survival probability, having a malignancy, gender, and marital status were not related to preferences regarding permanent nursing home placement. (Table 3)

The ordinal logistic regression model predicting patient willingness to live permanently in a nursing home (n = 3027, proportional odds test *P* = .127, ROC area = .57) showed that older age was associated independently with less willingness

TABLE 1 -- Comparison of Study Sample with Nonresponders

	Study sample (n = 3262)	Nonresponders (n = 5843)	P Value
Age (mean years ± SD)	61.8 ± 14.6	63.1 ± 16.1	<.001
Male (%)	59	55	.006
Married (%)	52	54	.400
Living alone (%)	24	21	.001
Ethnicity (%)			
White	79	80	.347
Black	16	15	
Income (%)			.001
<\$11K	50	59	
≥ \$11 to \$25K	23	19	
≥ \$25 to \$50K	17	14	
≥ \$50K	10	8	
Disabilities (mean ± SD)	1.1 ± 1.7	1.8 ± 1.2	<.001
Education (mean ± SD)	11.7 ± 3.3	11.6 ± 3.2	.118
Comorbidities (mean ± SD)	2.1 ± 1.4	1.7 ± 1.3	<.001
Acute Physiology Score, study Day 3 (mean ± SD)	29.2 ± 13.3	41.1 ± 19.8	<.001
6-month survival estimate, study Day 3 (mean ± SD)	0.63 ± 0.20	0.46 ± 0.26	<.001
Intubated or in coma at time of interview (%)	0	46	<.001
Cancer (%)	27	22	.001

TABLE 2 -- Patient Preference for Living Permanently in a Nursing Home (n = 3262)

Preference	n	%
Very willing	237	7%
Somewhat willing	634	19%
Somewhat unwilling	359	11%
Very unwilling	859	26%
Rather die	980	30%

Preference	n	%
Don't know	193	6%

to live permanently in a nursing home (odds ratio [OR]= .90 per decade; 95% confidence interval [CI]: 0.85, 0.96). More education (OR = 1.03 per year of schooling; 95% CI: 1.00, 1.05), and more ADL disabilities (OR = 1.05 per disability; 95% CI: 1.01, 1.09) were associated independently with patients being more willing to live in a nursing home. Black patients were more willing to live permanently in a nursing home (OR = 1.46 compared with whites; 95% CI: 1.20, 1.76). Diagnostic group, gender, model 6-month survival estimate, number of comorbidities, whether the patient lives alone, marital status, family income, insurance status, other ethnicity, and patient perceived quality of life were not significant predictors of nursing home preference. When the patient's preference for aggressive versus comfort care was added to the model, there was no substantive change in the independent relationships of age, education, functional status, or ethnicity to nursing home preference, though a patient preference for aggressive care was associated strongly with preferring to live permanently in a nursing home (OR = 1.56; 95% CI: 1.35, 1.79).

Of the 3082 patients stating a preference about permanent nursing home residence who survived to hospital discharge,

TABLE 3 -- Bivariable Demographic and Clinical Relationships to Preference for Living Permanently in a Nursing Home

	Very Willing n = 237	Somewhat Willing n = 634	Somewhat Unwilling n = 359	Very Unwilling n = 859	Rather Die n = 980	P Value
Age (mean years ± SD)	60.6 ± 15.0	60.6 ± 14.8	60.1 ± 15.4	61.6 ± 14.5	63.6 ± 14.0	<.001
Male (%)	56	57	59	57	60	.649
Married (%)	51	55	52	52	53	.753
Living alone (%)	23	23	21	28	35	.212
Ethnicity (%)						<.001
White	73	77	74	78	83	
Black	22	19	18	16	12	
Other	5	4	8	6	5	
Income (%)						.272
<\$11K	55	50	45	48	51	
≥ \$11 to \$25K	19	25	24	25	24	
≥ \$25 to \$50K	16	16	17	17	17	
≥ \$50K	9	9	14	10	8	
Insurance (%)						.060
Private	30	31	32	29	27	
Medicare	51	51	51	53	56	
Medicaid	13	14	12	15	14	
None	6	4	5	3	3	
Disabilities (mean ± SD)	1.3 ± 1.9	1.1 ± 1.7	1.3 ± 1.7	1.1 ± 1.7	1.1 ± 1.6	.214
Perceived quality of life (%)						.126

	Very Willing n = 237	Somewhat Willing n = 634	Somewhat Unwilling n = 359	Very Unwilling n = 859	Rather Die n = 980	P Value
Excellent	11	8	7	8	8	
Very good	19	23	22	20	19	
Good	11	13	11	13	10	
Fair	27	27	29	29	27	
Poor	31	30	31	30	37	
Education (mean years ± SD)	11.7 ± 3.3	11.8 ± 3.4	12.2 ± 3.2	11.7 ± 3.4	11.5 ± 3.1	.012
Comorbidities (mean ± SD)	2.0 ± 1.3	2.2 ± 1.4	2.0 ± 1.3	2.1 ± 1.4	2.2 ± 1.4	.679
Acute Physiology Score, Day 3 (mean ± SD)	29.0 ± 13.6	28.2 ± 12.9	28.4 ± 12.8	29.7 ± 13.8	29.6 ± 13.2	.110
6-month survival estimate, Day 3 (mean ± SD)	0.64 ± 0.20	0.64 ± 0.20	0.64 ± 0.20	0.63 ± 0.20	0.62 ± 0.21	.122
Cancer (%)	35	38	37	36	36	.692

57 (2%) were discharged to a hospice, 63 (2%) to a rehabilitation facility, and 105 (3%) to a nursing home. During the 6 months after study entry, 1032 (33%) of these 3082 patients died. Among the patients who died, the venue of death was determined for 766: 46 (6%) died in a nursing home, of whom 17 (37%) said they would prefer to die or would be very unwilling to live permanently in a nursing home.

Surrogate Understanding of Patient Nursing Home Preference

Of the 3262 subjects who provided a nursing home preference, 2418 surrogates stated their perception of the patient's preference; 281 (12%) of these surrogates indicated that they did not know. In aggregate, surrogate perceptions of patient willingness to live permanently in a nursing home were similar to patient preferences, with 5% stating that the patient would be "very willing" to live forever in a nursing home, and 29% stating that the patient would "rather die" than live forever in a nursing home. Exact understanding by the surrogate of the patient's preference was 37%. It should be noted that of the 121 patients who stated that they would be "very willing" to live permanently in a nursing home, surrogates indicated that 17 (14%) would "rather die." Of the 694 patients who preferred to die rather than live permanently in a nursing home, surrogates stated that 120 (17%) would be "somewhat" or "very willing" to live permanently in a nursing home. (Table 4)

We collapsed the five preference categories into "willing" (defined as "very willing" and "somewhat willing") and "unwilling" (defined as "somewhat unwilling," "very unwilling" and "rather die") in order to further evaluate surrogate understanding of patient nursing home preference. Evaluating these collapsed categories, surrogates correctly identified patient preferences 61% of the time. Surrogates identified 85% of the patients who were unwilling to live permanently in a nursing home, but they identified only 37% of those were willing to live permanently in a nursing home.

The ordinal logistic regression model of surrogate understanding of patient nursing home preference met the proportional odds assumption (P = .190) and had a ROC area = .58. A patient perception of "poor" quality of life (compared with "excellent") was associated with better surrogate understanding of the patient's nursing home preference (OR = 1.6;

TABLE 4 -- Surrogate Understanding of Patient Preference for Living Permanently in a Nursing Home (N = 2418 pairs)

Patient Preference	Surrogate Understanding of Patient Preference	Total (%)
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	Very Willing	Somewhat Willing	Somewhat Unwilling	Very Unwilling	Rather Die	
Very willing	45	43	21	51	20	180 (7%)
Somewhat willing	37	128	76	158	100	499 (21%)
Somewhat unwilling	9	45	66	94	65	279 (12%)
Very unwilling	13	77	122	321	166	699 (29%)
Rather die	17	95	83	223	343	761 (31%)
Total	121	388	368	847	694	2418
	(5%)	(16%)	(15%)	(35%)	(29%)	

95% CI: 1.1, 2.4). However, patient and surrogate demographic factors were not associated with surrogate understanding of nursing home preference.

Physician Understanding of Patient Nursing Home Preference

Of the 1206 SUPPORT Phase I cases in which both physician and patient responses about the patient's nursing home preference were obtained, 139 physicians (12%) stated that they did not know, yielding 1067 pairs for evaluation of physician understanding of patients' nursing home preferences (Table 5). Physicians were less likely to perceive that patients were "somewhat" or "very willing" to live permanently in a nursing home (15% vs 29% of patients), but they were also less likely to state that the patient would prefer to die (16% vs 33% of patients). Of the 103 patients with physician responses who stated that they would be "very willing" to live permanently in a nursing home, physicians indicated that 41 (40%) would "rather die" or be "very unwilling" to do so. When patients stated that they would "rather die" than live forever in a nursing home, physicians felt that 13% would be "somewhat" or "very willing." Physician exact understanding of patient preference was 25%.

As was done with the surrogates, we collapsed the five preference categories into "willing" ("very willing" and "somewhat willing") and "unwilling" ("somewhat unwilling," "very unwilling," and "rather die") in order to further study physician understanding of patient nursing home preference. When evaluating these collapsed categories, physicians identified patient preferences correctly 67% of the time and were more successful at identifying patients who were unwilling to live in a nursing home (86%) than those who were willing to live permanently in a nursing home (18%). Physician understanding of patient willingness to live permanently in a nursing home was poorer than that of surrogates.

In the ordinal logistic regression model of physician understanding of patient nursing home preference (proportional odds assumption test: $P = .111$; ROC area = .59), married patients were less likely to be understood by their physicians (OR = .72, 95% CI: 0.53, 0.98), and female physicians were more likely to understand their patients' nursing home preferences (OR = 1.7, 95% CI: 1.2, 2.4). This model included patient prognosis, patient clinical characteristics, and demographics, as well as physician age and ethnicity, none of which was related independently to physician understanding of patient nursing home preference.

DISCUSSION

Seriously ill hospitalized patients often face the prospect of survival in a state requiring long-term nursing home care. The possibility of such an outcome may affect patients' wishes regarding aggressive intervention during hospitalization, though such preferences are rarely elicited. A number of studies have identified factors predictive of admission to a nursing home, including advancing age, female gender, White ethnicity, cognitive and functional impairment, living alone, and having been hospitalized within the preceding year.^{[3] [4] [5] [15]} These studies did not examine patient preference.

TABLE 5 -- Physician Understanding of Patient Preference for Living Permanently in a Nursing Home (N = 1067 pairs)

Patient Preferences	Physician Understanding of Patient Preference					Total (%)
	Very Willing	Somewhat Willing	Somewhat Unwilling	Very Unwilling	Rather Die	
Very willing	11	14	37	29	12	103 (10%)
Somewhat willing	5	27	64	82	28	206 (19%)
Somewhat unwilling	3	19	34	51	21	128 (12%)
Very unwilling	6	32	70	128	47	283 (27%)

Patient Preferences	Physician Understanding of Patient Preference					Total (%)
	Very Willing	Somewhat Willing	Somewhat Unwilling	Very Unwilling	Rather Die	
Rather die	7	37	95	146	62	347 (33%)
Total	32 (3%)	129 (12%)	300 (28%)	436 (41%)	170 (16%)	1067

A small number of studies have evaluated patient preferences regarding living in a nursing home. In one study of long-term care use by frail elders that evaluated whether patients felt that nursing home placement was acceptable or not acceptable, Mui and Burnette found that, among factors associated with nursing home admission, a positive attitude toward nursing home care was the most powerful predictor of nursing home use. [16] A number of studies examining patient preferences concerning nursing home care have provided a hypothetical choice between nursing home care and home care. A 1984 survey by the American Association of Retired Persons found that 80% of members preferred home care to nursing home care. [8] A study of 120 hospitalized AIDS patients in Seattle found that 58% of the patients were willing to accept life in an AIDS long-term care facility, although 73% preferred home care. [6] Although the majority of studies ask about preferences between living in a nursing home and living at home, the latter is usually not a clinical option available to patients who must consider permanent nursing home care. [17] The decision is more likely to be a choice between living permanently in a nursing home or dying earlier -the option posed in our study. Even this choice is an oversimplification; when patients are admitted to a nursing home it may be unclear whether they will improve enough to return to an independent lifestyle. Kulys surveyed 60 elderly persons in the Chicago area and found that most had not planned for future crises and that most found nursing home placement to be an unacceptable option. Yet most of these individuals were resigned to the possibility of ultimately needing nursing home care. [9]

In the present study only 28% of patients indicated that they were "very" or "somewhat willing" to live permanently in a nursing home. Fully 30% stated that they would prefer to die rather than live permanently in a nursing home. These findings suggest that clinicians cannot assume that a patient would want to receive care which would result in a health state requiring permanent nursing home placement. This has clinical relevance for a number of common aggressiveness of care and venue of care decisions. Preference for permanent nursing home life must be considered in initiating and continuing life-sustaining care for acutely ill patients whose pre-morbid functional or mental status did not permit independent living. It must also be considered for patients whose expected post-illness mental and functional status will require institutional care. This preference is particularly important to consider for the chronically ill long-term nursing home resident. Care plans including the treatment of illness and hospital transfer, even including whether to provide nutrition and hydration, may hinge on this preference. These data show that it should not be assumed that patients will prefer to live permanently in a nursing home; most patients will not.

The model of nursing home preferences developed in this study revealed factors associated with patient preferences that were not entirely consistent with the previously identified predictors of nursing home admission. Advancing age, a clear predictor of nursing home admission, [3] [4] [5] [15] was a significant negative predictor of willingness to live permanently in a nursing home, perhaps reflecting the observation that the elderly find nursing home admission undesirable, but often inevitable. [9] Living alone, while a consistent risk factor for nursing home admission [3] [4] [5] [15] was not a significant predictor of preferences for living permanently in a nursing home. Impairment in activities of daily living, a predictor of nursing home admission, [3] [4] [5] was also predictive of willingness to live in a nursing home in this study. Moreover, it should be noted that preferring to live in a nursing home was associated with a preference for aggressive care. Clinicians should not assume that patients transferring to a nursing home have adopted a comfort oriented care plan.

A striking finding in the present study is the role of ethnicity in nursing home preferences. The ordinal logistic regression model, controlling for income and educational level, found that being black was a significant predictor of willingness to live permanently in a nursing home. This effect persisted when the model included the patient's goal for longevity versus comfort care. In contrast, the National Long Term Care Channeling Demonstration found that being black was significantly negatively associated with the risk of nursing home admission ($P < .001$): blacks were 40% as likely to be admitted as whites. [4] Further analysis found that a positive attitude toward nursing home care was the most powerful predictor of nursing home use; the next most powerful was ethnicity, with black and Hispanic elders less likely than whites to use a nursing home. [18] This study did not explore the relationship between ethnicity and attitude toward nursing home care. Similarly, the Longitudinal Study on Aging in 1984 found that black older persons were half as likely to be placed in a nursing home as whites. [5] The current study strongly suggests that patient preference factors do not explain less use of nursing homes by blacks. Cultural factors associated with nursing home care require further investigation. [18]

The failure of surrogates and physicians to understand the preferences of patients for living permanently in a nursing home is not surprising given poor understanding of resuscitation preferences and quality of life perceptions shown in prior studies. [19] [20] [21] However, it has

important implications for surrogate decision making about end-of-life medical care. Both surrogates and physicians tended to underestimate the willingness of patients to live permanently in a nursing home, possibly introducing their own valuation of outcomes in responding to what they thought the patient would wish. Might a surrogate or physician argue against aggressive intervention, anticipating survival in a state requiring long-term nursing home care, when in fact that outcome would be acceptable to the patient? On the other hand, would some patients, knowing that the best outcome they could expect would be to live permanently in a nursing home, choose interventions designed to alleviate pain and forgo aggressive interventions designed to prolong life? This study demonstrates that surrogates and physicians often do not know those preferences. For about one in six patients with strong attitudes about permanent nursing home placement, surrogates believed that patients held the opposite preference. For patients who were willing to live permanently in a nursing home, physicians thought that 40% would not want to do so. Perhaps the most important finding of this study is that patients are capable of and willing to express a preference about living permanently in a nursing home -even a choice that incorporates the option of dying instead of nursing home survival. Of the patients who were capable of being interviewed, only 8% refused to provide a response and only 6% of those providing a response said that they did not know their preference for permanent nursing home life. Rhymes and McCullough note that the long-term care decision has

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important ramifications for both the patient and the family. They suggest that the decision making should be a group process.^[22] However, clinicians recognize that decisions concerning permanent nursing home placement are most commonly made when patients can no longer express a preference. These preferences can -and should -be elicited earlier, before the patient has lost decision making capacity.

A patient's preference not to live permanently in a nursing home may have great relevance for acute care choices and post-discharge placement. However, such a preference may not be consistent with clinical or social realities or constraints. We are not suggesting that patients who state that they would prefer to die than live in a nursing home be given carte blanche to home care by unwilling or incapable family. Nor are we suggesting that assisted suicide should be considered for such individuals. Not infrequently patients' preferences cannot be followed. However, concerning permanent nursing home placement, these can be elicited to help guide care.

This study is limited in several ways. The study question invites a negative response, and the Likert scale is weighted toward the negative. This may have contributed to the finding that 72% of patients expressed unwillingness to live permanently in a nursing home. In addition, the study question does not ask about other possible situations, such as would subjects be willing to live permanently in a nursing home if they were severely disabled or if they had no one to care for them. Data on physician understanding of patient preferences are available only for Phase I of the study; data from Phase II might have showed some improvement in physician understanding of patient preferences, although this is unlikely based upon other results of the trial.^[10] Evaluation of patient nursing home preferences, as well as surrogate and physician understanding of that preference was based on a single item at one point in time. Decisions about long-term care placement likely evolve over time with consideration of factors including prognosis, quality of life and financial capabilities as well as patient preference. The study also is unable to account for changes in preference perception over time. Furthermore, these data may not be generalizable to all hospitalized patients and may not apply to patients in other venues or the outpatient setting. While, for many of the seriously ill patients we studied the nursing home placement decision was likely quite relevant, the patients in this study were not as old or as chronically ill as the population admitted to a nursing home. Finally, few patients were discharged to nursing homes, so it was not possible to evaluate the impact of patient preferences on the ultimate decision to place a patient permanently in a nursing home.

Patients' attitudes toward living permanently in a nursing home can be elicited. If patients' preferences were discussed and if the health care system provided the types of long-term care for which frail elderly patients express a preference, then decisions about nursing home care could better reflect the health states and situations in which elderly and ill patients would prefer to live. Further work is needed to evaluate the factors resulting in a disparity between black attitudes toward and use of nursing homes. A clinical trial should investigate whether elicitation of patient nursing home preferences enhances the concordance of patient preferences with the way they spend the ends of their lives.

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References

1. National Center for Health Statistics, Hing E, Sekscenski E, Strahan G. The National Nursing Home Survey: 1985 summary for the United States. Vital and Health Statistics. Series 13, No. 97. (DHHS Publication no. (PHS) 89-1758.). Washington, DC:Government Printing Office, 1989. (DHHS Publication no.
2. Kemper P, Murtaugh CM. Lifetime use of nursing home care. *N Engl J Med* 1991;4:595-600.

3. Branch LG, Jette AM. A prospective study of long-term care institutionalization among the aged. *Am J Public Health* 1982;72:1373-1379.
4. Greene VL, Ondrich JI. Risk factors for nursing home admissions and exits: A discrete-time hazard function approach. *J Gerontol B Psychol Sci Soc Sci* 1990;45:S250-258.
5. Wolinsky FD, Callahan CM, Fitzgerald JF, Johnson RJ. The risk of nursing home placement and subsequent death among older adults. *J Gerontol B Psychol Sci Soc Sci* 1992;47:S173-182.
6. McCormack WC, Inui TS, Deyo RA, Wood RW. Long-term care preferences of persons with AIDS. *J Gen Intern Med* 1991;6:524-528.
7. Fogel BS, Mor V. Depressed mood and care preferences in patients with AIDS. *Gen Hosp Psychiatry* 1993;15:203-207.
8. AARP Long Term Care Survey. Washington, DC: American Association of Retired Persons, 1984.
9. Kuls R. Future crises and the very old: Implications for discharge planning. *Health Soc Work* 1983;8:182-195.
10. The SUPPORT Principal Investigators. A controlled trial to improve care for seriously ill hospitalized patients: The Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments (SUPPORT). *JAMA* 1995;274:1591-1598.
11. Murphy DJ, Cluff LE (eds.). SUPPORT. Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments study design. *J Clin Epidemiol* 1990;43(suppl):1-108S.
12. Wu AW, Damiano AM, Lynn J et al. Predicting future functional status for seriously ill hospitalized adults. *Ann Intern Med* 1995;122:342-350.
13. Knaus WA, Wagner DP, Draper EA et al. The APACHE III prognostic system. *Chest* 1991;100:1619-1636.
14. Knaus WA, Harrell FE, Lynn J et al. The SUPPORT prognostic model: Prediction of survival for seriously ill hospitalized patients. *Ann Intern Med* 1995;122:191-203.
15. Vicente L, Wiley JA, Carrington RA. The risk of institutionalization before death. *Gerontologist* 1979;19:361-367.
16. Mui AC, Burnette D. Long-term care service use by frail elders: Is ethnicity a factor? *Gerontologist* 1994;34:190-198.
17. Harrington C, Cassel C, Estes CL et al. and the Working Group on Long-Term Care Program Design. Physicians for a National Health Program. A national long-term care program for the United States: A caring vision. *JAMA* 1991;266:3023-3029.
18. Belgrave LL, Wykle ML, Choi JM. Health, double-jeopardy, and culture: The use of institutionalization by African-Americans. *Gerontologist* 1993;33:379-385.
19. Uhlmann RF, Pearlman RA, Cain KC. Physicians' and spouses' predictions of elderly patients' resuscitation preferences. *J Gerontol A Biol Sci Med Sci* 1988;43:M115-121.
20. Starr TJ, Pearlman RA, Uhlmann RF. Quality of life and resuscitation decisions in elderly patients. *J Gen Intern Med* 1986;1:373-379.
21. Seckler AB, Meier DE, Mulvihill M, Crammer Paris BE. Substituted judgment: How accurate are proxy predictions? *Ann Intern Med* 1991;115:92-98.
22. Rhymes JA, McCullough LB. When the bill comes due for the autonomy of demented older patients, who pays? *J Am Geriatr Soc* 1995;43:1437-1438.

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EXHIBIT B

Washington's Olmstead Plan

**Department of Social and Health Services
State of Washington**

June 2005

**STATE OF WASHINGTON
WASHINGTON'S OLMSTEAD PLAN**

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WASHINGTON'S OLMSTEAD PLAN

INTRODUCTION

Olmstead refers to a lawsuit brought against the state of Georgia by two people with disabilities in a state psychiatric hospital. They were approved for community placement but faced long waiting lists. The suit challenged their being placed in an institutional setting rather than in community-based treatment programs. The claims of the plaintiffs were upheld in lower courts and the state of Georgia ultimately appealed to the U.S. Supreme Court.

In June 1999, the Supreme Court upheld the lower courts decisions and ruled that, under Title II of the American Disabilities Act (ADA), states must place persons with disabilities in community settings rather than in institutions whenever:

- The state's treatment professionals determine it's appropriate;
- The individual doesn't oppose it; and
- The placement can be reasonably accommodated, taking into account the resources available to the state and the needs of others with disabilities.

The Olmstead Decision does not require states to stop serving people in institutions if they are unable to handle or benefit from community settings.

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

INSTITUTIONS IN WASHINGTON STATE

Institution types and responsible agencies in the state of Washington include:

- State Psychiatric Hospitals – Mental Health Division, Department of Social and Health Services (DSHS)
- Residential Habilitation Centers – Developmental Disabilities, DSHS
- Nursing Facilities – Aging and Adult Services, DSHS

- State Veterans Homes – Department of Veterans Affairs
- Children’s Behavioral Rehabilitation Group Homes – Children’s Administration, DSHS

PLANNING

On March 27, 2000, Governor Gary Locke designated DSHS as the lead state agency for Olmstead planning in Washington State. Since DSHS has been emphasizing community placement since 1990, Washington’s Olmstead Plan is intended to be a living document, subject to continuous planning and change.

Initial planning activities included setting up the workgroup, meeting with consumers and stakeholders, assessing current policies and services, and developing budget requests for the 2001 - 2003 biennial budget. DSHS established an Olmstead Workgroup to coordinate planning and accelerate on-going processes and programs.

THE OLMSTEAD WORKGROUP

The Olmstead Workgroup is headed by the Washington State Olmstead Coordinator*, and includes representatives from the following DSHS programs:

- Aging and Disability Services Administration, including Aging and Adult and Developmental Disabilities
- Mental Health Division
- Division of Alcohol and Substance Abuse
- Division of Vocational Rehabilitation
- Deaf and Hard of Hearing Services
- Children’s Administration
- Economic Services Administration
- Medical Assistance
- Office of Indian Policy and Support Services
- Division of Access and Equal Opportunity
- Budget & Finance Office
- Office of Research and Data Analysis.

Extended Workgroup partners include:

- Disability Initiative Advisory Committee
- The Department of Transportation;

* Olmstead contact can be reached at, PO Box 45021, Olympia, WA 98504-5021. Phone 360-902-8271. TTY 1-800-833-6388. FAX 360-902-7848. .

- The Agency Council on Coordinated Transportation;
- Community, Trade and Economic Development; and
- The Department of Veteran's Affairs.

The DSHS Executive Cabinet serves as the Workgroup's Steering Committee.

The purpose of the Olmstead Workgroup is to further Washington State's response to the Olmstead decision by:

- Seeking and responding to input from consumers and stakeholders;
- Expediting and coordinating existing processes and programs;
- Proposing modifications or new processes, programs, or tools to expedite the appropriate placement of institutionalized persons in the community;
- Proposing tools and methods to better evaluate placement options; and
- Coordinating across agency lines to improve access to services and supports necessary for designated individuals to live successfully in the community.

Workgroup activities focus on the population identified in the Olmstead decision, specifically people with disabilities who are:

- Currently in institutions, and:
 - Want to move to the most integrated settings; and
 - Can be appropriately served in the most integrated settings (according to state treatment professionals and the person with a disability);
- At risk of inappropriate institutionalization (as demonstrated for a group by data showing inappropriate admissions to an institution).

COMMUNITY INTERACTION

The Disability Initiative Advisory Committee (DIAC) is the workgroup's conduit for public input. The DIAC provides comments and input, meets routinely with the Olmstead Coordinator, and initially hosted a community forum and a statewide videoconference to gather input for the Olmstead Plan.

In addition, the DIAC and the Olmstead Workgroup members participate in a variety of community meetings and receive input on a one-to-one basis via mail, email, telephone, FAX and TDD. They have advised on Plan updates and provided information on services and issues related to individuals with disabilities.

INITIAL PLANNING INCLUDED FISCAL YEAR 2001 – 2003 BIENNIAL BUDGET

A budget totaling \$16.3 million for direct Olmstead activities and an additional \$189.6 million in new funds for existing community programs was approved for Fiscal Year (FY) 2001 – 2003. Since that time, budgets have included funding for a variety of transitional and community services and programs throughout Washington.

ABOUT THE OLMSTEAD PLAN

Washington's Olmstead Plan includes:

- An overview of current services and activities that further the intent of Olmstead, such as housing, transportation, integration, employment, and systems change initiatives;
- Identification of activities, within the DSHS agency reports, to divert individuals from institutional admissions, to transition individuals from institutions to community settings, and to collaborate on the integration and coordination of grants to increase community options.

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WASHINGTON STATE DEPARTMENT OF SOCIAL AND HEALTH SERVICES

DSHS has a long-standing policy of emphasizing community services and reducing institutional services. DSHS served approximately 70,000 more people in the community and 9,000 fewer people in institutions in 1999 than in 1990, and continues to move in that direction.

Overview of Activities and Services That Further the Intent of Olmstead

HOUSING

Stakeholder Comments: *The workgroup has received more comments about housing than any other single topic. For example:*

- *The supply of safe, affordable housing is insufficient to meet the demand.*
- *Wheelchair accessible housing is difficult to find.*
- *The process of finding and securing housing is confusing and burdensome.*
- *People need a diversity of housing, including single-family, co-living arrangements, adult family homes, etc.*
- **Department Activities:** As people are increasingly served in the community, DSHS recognizes the need to collaborate with agencies, individuals and advocacy groups to link services with housing organizations. In order to address the need for linkages between housing and services, DSHS has:
 - Dedicated a portion of the Olmstead Coordinator's time to promote partnerships and act as a resource between housing and social services
 - Participated in ongoing housing policy discussions that affect affordability, availability, and access for individuals served by DSHS
 - Identified areas that DSHS staff currently work directly or indirectly with housing providers and organizations to build on existing efforts
 - Implemented an executive-level initiative called Integration, including No Wrong Door, to improve cross-system collaboration to achieve community living goals
 - Collaborated with other state and local partners to write the Washington State Homeless Families Plan; participated in two federally-sponsored Policy Academies and numerous statewide

committees to address issues for homeless families and individuals experiencing chronic homelessness in Washington State

- Participated in multiple cross-system efforts to link services with housing organizations, including grant opportunities and collaboration that supports community living

TRANSPORTATION

Stakeholder Comments:

- *DSHS needs to support ACCT's recommendations on transportation.*
- *Transportation services are not adequate, and are crucial for people with disabilities to live successfully in the community.*

Department Activities: DSHS administrations worked with partners to develop the Coordinated Special Needs Transportation Services, Administrative Policy No. 8.09. As required by RCW 47.06B.030 (5), the policy supports special needs coordinated transportation for people with disabilities. Administrations work to see that DSHS clients have access to covered services through a coordinated transportation system. This is an ACCT recommendation. In addition, individual members of the Olmstead Workgroup are members of the staff-level workgroup to coordinate with the Agency Council on Coordinated Transportation (ACCT) to improve transportation services that support community living.

EMPLOYMENT

A DSHS cross-agency workgroup, originally formed to participate in Medicaid Infrastructure Grant activities, has been working with multiple partners including the Social Security Administration and employment providers to plan for the implementation of the Ticket To Work and Work Incentives Improvement Act (TWWIIA) in Washington. The Division of Vocational Rehabilitation is leading the Ticket To Work effort.

The Medical Assistance Administration chose to implement the Medicaid Buy-In program to support the competitive employment of individuals with disabilities. Under the Healthcare for Workers with Disabilities (HWD), persons with disabilities are able to earn and save more money and purchase healthcare coverage for an amount based on a sliding income scale. The availability of HWD benefits enhances the ability of persons with disabilities to use the Ticket To Work and other work incentive opportunities to improve the quality of their lives.

INTEGRATION

DSHS has many programs and projects that provide coordination and collaborative client services that bring together partners from throughout the department, from other levels of government, and from non-government organizations.

DSHS has been building on those efforts with the No Wrong Door Initiative. This includes projects that coordinate services and share information for three specific groups who use multiple services: long term TANF families, individuals with multiple disabilities, and troubled children, youth and their families.

In order to successfully develop integration efforts and to maintain and build upon No Wrong Door, the broader Integration Initiative has been established. The goals of the Integration Initiative are to:

- Improve client outcomes and satisfaction
- Increase cost effectiveness of services, especially for high risk, high cost clients
- Improve community partnerships, including development of innovative pilot projects and models
- Increase employee satisfaction

A variety of strategies and projects have been implemented throughout the department to facilitate integration, including multi-disciplinary teams for case staffing, development of shared data bases, streamlining policies, and other such activities to promote the delivery of services from a client-centered perspective.

STAKEHOLDER INTERACTION

Stakeholder Comments:

- *No system will work if it doesn't have true, meaningful input by the people who use it.*
- *Provide a method whereby the public can post questions and comments on a web page for DSHS' response.*

Department Activities: DSHS designed Internet pages, posted the Olmstead Plan and related documents and updates, and provided a means of web-based communication between DSHS and stakeholders. This is in addition to participation in multiple consumer and stakeholder meetings where input is given, seeking advice from numerous consumer task forces and advisory groups, and hiring an Olmstead Coordinator who works

specifically with individuals with disabilities, families and advocates, and activities that promote community living.

COORDINATION

Stakeholder Comments:

- *Divisions and programs within DSHS need to coordinate better to serve clients who need to access services across division lines.*
- *The plan should incorporate more cross-system collaboration to address the needs of those individuals who fall through the cracks.*

Department Activities: Activities emphasize coordination between DSHS administrations and divisions, as well as between DSHS, the Department of Transportation, the Department of Community, Trade and Economic Development, the Department of Corrections, the Department of Health, the Superintendent of Public Instruction, the Health Care Quality Authority, the Department of Veterans Affairs, and others.

SYSTEMS CHANGE GRANTS

Stakeholder Comment: *DSHS should aggressively seek additional funding to promote "Olmstead".*

Department Activities: DSHS continues to apply for federal grants to fund system changes that promote the intent of the Olmstead decision. In addition to the following grants, individual agency reports describe a number of related grant-funded projects:

- \$50,000 Start-up Award. DSHS was awarded this grant in June 2001 and extended in March 2002 to use for planning purposes in the application of the Systems Change grants.
- Medicaid Infrastructure Grant. This grant was awarded in 2001 to support the competitive employment of persons with disabilities. This grant lead to the Medicaid Buy-in program, Healthcare for Workers with Disabilities (HWD), in addition to many other initiatives that support the Ticket to Work and Work Incentives Improvement Act of 1999.
- Nursing Home Transition Grant. The Aging and Disability Services Administration was awarded this grant in 2001 to transition younger people with disabilities, including developmental disabilities, from nursing facilities to the community.

- Coming Home Project. The Robert Wood Johnson (RWJ) Foundation awarded a three-year grant with a goal of building affordable assisted living facilities for low-income, frail seniors and adults with disabilities. The Aging and Disability Services Administration, DSHS, and the RWJ Coming Home Program, working in partnership with local community sponsors, have collaborated to fund two affordable assisted living facilities and nine more are in the pre-development stage. The majority of these facilities (9) are located in hard to develop rural areas and two are in underserved urban areas. Additional funding is being sought to develop new models of housing with services for adults with disabilities.

- The Real Choice Systems Change Grant. DSHS and a consumer task force worked together to develop a proposal for this grant. The grant, called the Community Living Initiative, has been awarded in 2002 in the amount of \$1,385,000 to improve community services by changing the systems that help people move from institutions to community-based settings.

- Money Follows the Person, Real Choice Grant. This grant was awarded in 2003 to allow Washington State to add the capacity to provide assessments for children and persons with developmental disabilities to the CARE tool for community-based options. }

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AGENCY REPORTS

AGING AND DISABILITY SERVICES ADMINISTRATION

The Aging and Disability Services Administration is made-up of the former Aging and Adult Services Administration and the Division of Developmental Disabilities. The following are descriptions of current services and activities by Aging and Adult and by Developmental Disabilities.

AGING AND ADULT

Aging and Adult services include long-term care programs and services for people over the age of 18 with functional disabilities. These programs and services are offered in a variety of settings. The Aging and Disability Services Administration (ADSA) has spent the last ten years developing alternatives to nursing facility placement for the people they serve.

Current Services that Further the Intent of Olmstead

In 2004, less than 12,500 clients lived in nursing facilities statewide (down from 17,500 in 1994) and approximately 34,000 clients were served in the community.

Personal Assistance Services

Personal assistance services are provided through agencies or individual providers. The individual provider services are flexible, and people with disabilities have the ability to hire and fire the provider. Family members may be paid as individual providers. Trainings are mandatory for all providers, including a two-hour orientation training, 28 hours of basic personal assistance services training paid for by ADSA, and 10 hours of continuing education. Background checks are mandatory for all providers. There are approximately 10,075 clients using agencies and 15,019 clients using individual providers.

Adult Family Homes

Adult family homes are licensed to care for up to six people in a private home setting with staff available 24 hours a day. They provide room, board, laundry, necessary supervision, personal care, social services, and

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assistance with activities of daily living. Some provide nursing care. There are approximately 3,309 clients statewide in adult family homes.

Adult Residential Care

Adult residential care facilities are licensed boarding homes. They provide room and board and help with medications and personal care. Residents may have limited supervision. Enhanced Adult Residential Care facilities offer these services as well as limited nursing care. Approximately 1,597 clients reside in Adult Residential Care facilities.

Assisted Living Facilities

Assisted living facilities are small studio-like apartments with a private bath and small kitchenette. Congregate meals, laundry, personal assistance services, and limited nursing services are offered. There are approximately 4,502 clients receiving services in assisted living facilities.

Program of All-inclusive Care for the Elderly

The Program of All-Inclusive Care for the Elderly (PACE) is currently provided by Providence ElderPlace to approximately 220 King County residents who require nursing facility level of care. The PACE team delivers a comprehensive service package which includes all medical and long-term care services. Most of these services are provided in the PACE day center or in the client's home.

Assistive Technology Program

The Assistive Technology Program, a limited state funded program, began five years ago to assist clients who have no other funding source to obtain assistive technology. This program funds evaluations, short-term training, and assistive technology services and devices.

Nurse Delegation

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

Case Management Services

Case Management Services are provided for all eligible clients in all settings, and include:

- Comprehensive Adult Assessments and at least an annual reassessment to identify the needs of clients, and inform clients of available options; and
- A plan of care developed by the case manager and client/family to assist the client in transitioning from a nursing facility, or to maintain services in other settings, such as their own homes.

Self-directed Care

Self-directed care was implemented in home settings in February 1, 2000. It provides an opportunity for people with functional disabilities who live in their own homes to direct health-related tasks they could do for themselves if they were physically able. Case management staff informs clients, regardless of their current living setting, of this option during assessments and reassessments. This gives the client and the social worker the opportunity to put a plan together for the client to stay in, or transition back to, his/her own home. Currently, there are approximately 1,200 clients statewide who self-direct their care.

Additional Services

Services, in addition to personal assistance services provided under the COPES Medicaid Waiver, include minor home modification, specialized medical equipment, adult day care, home delivered meals, client training, case management, limited transportation, personal emergency response system and nursing expertise.

Current Proposals

The Aging and Disability Services Administration (ADSA) is striving to develop programs and services that optimize choice and increase independence for people with disabilities.

COPES Waiver – Medically Needy Program

Stakeholder Comments:

- *Expand COPES to cover independent living.*
- *Nursing homes should be treated as institutions.*

Department Activities: ADSA implemented a program for people who qualify for the Medically Needy program to receive COPES services in community settings. Currently the Medically Needy program serves 216 people in community residential settings and 12 people in in-home settings.

COPES Waiver – Expanding Service Settings

Stakeholder Comments: *People with disabilities want choices, including the choice to fully participate in their community.*

Department Activities: ADSA renewed the COPES waiver and amended rules to allow personal assistance services to be provided outside the home setting. This will allow people with disabilities to receive services at school, the workplace, and during recreational outings. The Administration will draft a management bulletin to formally notify staff that COPES personal care services are available outside the home, as long as these services are documented in the service plan.

Personal Assistance Recruitment and Retention Program

Stakeholder Comments: *For many people, the biggest barrier to living in the community is the shortage of reliable, trained caregivers.*

Department Activities: ADSA developed and implemented the Personal Assistance Recruitment and Retention (PARR) project to build a work force of qualified, ready to work individual providers for DSHS clients living at home. In three years, over 500 consumers used this recruitment and referral service to locate pre-screened personal care workers and improve skills as employers. PARR filled more than 1,100 vacancies, and assisted employers to obtain back-up services (substitutes) over 200 times. PARR has informed the plans of the Home Care Quality Authority (HCQA) to implement a statewide referral registry. HCQA continues recruitment and referral activities in Snohomish County and Eastern Washington, and will expand to three more counties in 2005.

Aging and Adult Collaboration with Mental Health Division

Stakeholder Comments: *The programs within the department need to work together effectively to serve clients with needs that cross division lines.*

Department Activities: ADSA, in collaboration with the Mental Health Division, manages the Expanded Community Services (ECS) program in order support long term state hospital patients in moving to community settings. The ECS program has supported more than 90 individuals who moved from geriatric wards at the two state hospitals into less restrictive settings and has supported more than 70 individuals who have been at risk for institutionalization. Components of the ECS program include:

- Regional committees, made up local ADSA staff, members of Regional Support Networks, and mental health providers, that coordinate the services for individuals in the ECS program.
- Adult family homes, nursing homes, and boarding homes in every region of the state that are willing and able to provide care for individuals who would otherwise be at risk for psychiatric hospitalization.
- Mental health programs in each region of the state that can offer outreach and staff training to residential providers in order to help stabilize individuals who are at risk for losing their residential placements.
- Studies out of Washington State University and the University of Washington that track the potential benefits of providing pharmacist consultation to residential programs that serve individuals with both medical and behavioral challenges.

Within the scope of the Real Choices Systems Change grant, staff from ADSA and the Mental Health Division conducted an assessment of the system of care for long term state hospital patients or those at risk for hospitalization who have both medical and behavioral challenges. The assessment included recommendations that might improve the chances for individuals to remain in community settings. The following recommendations have already been implemented:

- Creation and distribution of training modules for residential providers, "Understanding Mental Health and Behaviors: Guidelines for Serving Older Adults/Adults with Behavioral and Medical Challenges in Residential Settings."
- Creation and web posting of "A Guide to Medicare Home Health Psychiatric Care in Washington State."
- ECS program managers in ADSA and at MHD continue meet on a regular basis to provide technical assistance to specialized regional geriatric mental health teams through out the state.
- ADSA staff participate in the Cross System Crisis Taskforce.

You can find more information on long-term care and services at: <http://www.aasa.dshs.wa.gov/> or call (360) 902-7797.



DEVELOPMENTAL DISABILITIES

Current Services that Further the Intent of Olmstead

Residential Habilitation Centers (RHCs)

The Developmental Disabilities staff met with each person currently living in an RHC and their family or guardian, to determine if the person would prefer living in a less restrictive setting. A total of 1,100 people were interviewed.

Approximately 80 people wanted to transition to the community initially and 54 people remained interested and wanted to complete the planning process. Individuals, families and guardians, who want to move were offered the opportunity to self-direct their services if they would like to. Each person contemplating a move had an opportunity to visit residential and employment options prior to moving.

During 2000, Olmstead coordinators were appointed and trained at each state institution and at each regional office to coordinate the Olmstead process. Procedures were in place to help assure that a consistent process was used for each person moving. The first moves took place in November 2001.

The Developmental Disabilities staff has implemented a quality assurance process to follow up with people who move to the community, determine their satisfaction with the move, and see that health and safety issues are being met. This process includes volunteers including self-advocates, parents and others.

Housing

The Developmental Disabilities program currently supports over 4000 people in its residential programs. About 86 percent live in homes that they rent or lease. Developmental Disabilities services do not provide housing for these individuals – the individuals are paying for their own residence. If a person is unable to pay rent for a short time due to unforeseen circumstances, the program pays a non-facility allowance so the person can continue to maintain and live in his/her home.

The legislature has been providing special trust housing funds for people with disabilities for the past three biennium. These funds are administered by the Department of Community, Trade and Economic Development (DCTED). At the state level, the Developmental Disabilities

residential program manager works closely with DCTED and the Department of Housing and Urban Development (HUD) to allocate these funds. Locally, the Developmental Disabilities resource managers work with local housing authorities and developers to increase interest in applying for funding to develop affordable, accessible housing.

Current Proposals

Transitioning from Residential Habilitation Centers (RHCs)

Stakeholder Comments:

*Everyone deserves the opportunity to live in the community.
People who want to stay in the RHCs should not be forced to move.*

Department Activities: The legislature funded the Aging and Disability Services Administration (ADSA) for 14 community placements during the current biennium (FY03-05) for both moving people from the institutions and diverting people from going into the institutions. Additionally, the legislature funded the consolidation of RHCs and downsizing of Fircrest. There are 38 community beds funded under the downsizing and consolidation legislation. Thirty-two people have moved out of the RHCs to date – three under Olmstead funding and the others under downsizing funds. Plans for others to move are currently underway. The RHCs will continue to use the protocols developed earlier to determine if RHC resident, as well as parents/guardians, would prefer to live in the community. This will be done annually as each Individual Habilitation Plan (IHP) is reviewed and revised.

Transitioning from Nursing Facilities

Stakeholder Comments:

- *Help those who want to get out of institutions, nursing facilities and group homes. They have the right to live on their own.*
- *DSHS needs to address how nursing home residents with developmental disabilities will be asked if they desire to move, who will conduct the assessments, and how services will be provided if it is determined the person wants to move.*
- *The lack of cross-system collaboration is a barrier to people with disabilities.*

Department Activities: The Aging and Disability Services Administration (ADSA) is identifying people with developmental disabilities who live in nursing facilities and wish to move to less restrictive settings.

- Staff will continue to identify the people in nursing facilities who are served by the Division of Developmental Disabilities.
- Developmental Disabilities and Aging and Adult staff will work together to determine which of these people, according to their treatment teams, may benefit from moving to less restrictive environments.
- Case managers will use the protocols developed in the initial planning to ask the people identified, and/or their families/guardians, if they are interested in moving to a less restrictive community residence.
- Once funding is available, the people planning to move and/or their families/guardians will be given an opportunity to visit different residential and employment opportunities. After a person chooses where he/she wants to move, and the move is complete, there will be a series of quality assurance follow-ups.

Reducing State Hospital Stays and Diverting Admissions

Stakeholder Comments:

Needs may change over time, so the system needs to support the person where he/she is at the time without institutionalization or re-institutionalization.

The lack of cross-system collaboration is a barrier to people with disabilities.

Department Activities: Currently, the Aging and Disability Services Administration (ADSA) is continuing to work with the Mental Health Division (MHD) to transition people with a dual diagnosis of developmental disability and mental illness from state hospitals to less restrictive settings. Each person must be deemed ready to move by his/her treatment team.

Working collaboratively, ADSA and MHD will provide clinical cross-system training for the Developmental Disabilities residential providers. Training will focus on developing cross-system crisis plans with multiple steps to support individuals in the community, and using assessment tools for indicating major mental illness in persons with developmental disabilities.

Further, ADSA will work to divert admissions to state hospitals by:

- Continuing to contract with the Regional Support Networks (RSNs) and/or providers for enhanced crisis services, diversion beds, and medication management; and
- Collaborating with MHD and the RSNs to review state hospital admissions of people with a dual diagnosis to determine what, if any, additional community services might have diverted the admission.

Housing and Transportation

Stakeholder Comments:

- *Affordable housing and reliable, accessible transportation are crucial to living successfully in the community.*
- *DSHS needs to assess access to shopping, church, etc. and include transportation in assessment checklists.*

Department Activities: Olmstead coordinators and case managers will help each person transitioning to the community to evaluate proposed residences for affordability and accessibility as well as the availability of transportation. The person moving must be able to afford their new residence and be able to carry out their normal activities of going to work, shopping and visiting friends.

Staff will continue to participate with DCTED in bi-annual sessions to review housing applications involving the Housing Trust Fund. Staff will review the supportive service plans submitted by sponsors who are requesting HUD funding through the Section 811 program to develop housing for people with developmental disabilities.

In addition, ADSA will continue to participate in the cross program transportation planning committee. This committee develops state level transportation policy and works to influence local planning and policy development.

Self-directed Services

Stakeholder Comments:

- *Give people a choice about how to spend support money. People with disabilities and/or their families need to determine priorities.*
- *Treat people with respect in the decision-making process. Appreciate what people have to offer. Encourage their decision-making abilities.*
- *Make training in decision-making and problem-solving accessible in order to increase the person's ability to manage their own services and funding.*
- *Think about priorities, take the dignity of risk and change the system.*

Department Activities: For the past few years, consumers, stakeholders, and the Developmental Disabilities programs have worked together to create a vision for an improved service system. The outcome is a system that puts people with disabilities in control of their services.

The Administration plans to offer people who transition to the community as a result of the initial planning an opportunity to participate in managing

and self-directing their services. The Developmental Disabilities program has identified four main steps to help participants succeed in a consumer-driven system:

- Provide information and training so consumers and their representatives know how to choose and direct their own services, and have the necessary systems to do so.
- Develop and implement a quality assurance system that is responsive to consumer needs.
- Change the internal structure of how the system responds to consumer choice.
- Create a method for teaching and helping people to manage their own budgets.

This process is in the early stages of planning but will give people additional control over spending and services. This is one step the Administration is taking to test the mechanisms of self-directed services and is a major piece of the system change envisioned.

Quality Assurance

Stakeholder Comments: *DSHS needs to address quality assurance and consumer protections available to those moving from institutions to the community.*

Department Activities: The Aging and Disability Services Administration has developed a quality assurance (QA) process that will be implemented for people transitioning as a result of Olmstead planning. The process includes using a QA team, including at least one volunteer/peer, to review consumer satisfaction with the placement. QA follow-ups will occur at intervals determined by the case manager, but not less than 30 days, 90 days, and one year after placement; and annually thereafter.

You can find more information on programs for persons with Developmental Disabilities at:
<http://www.aasa.dshs.wa.gov/> or call (360) 902-7797.



HEALTH & RECOVERY SERVICES ADMINISTRATION

MENTAL HEALTH DIVISION

The Mental Health Division (MHD) operates a system of care for people with mental health needs of all ages.

Current Services that Further the Intent of Olmstead

Regional Support Networks

MHD contracts with 14 Regional Support Networks (RSNs) for community-based services. The RSNs offer an array of services including assessment, service definition and planning, support, and monitoring. RSNs manage the local resources for crisis assessment and intervention, treatment, housing, medication management, and other needed services. The RSNs also provide authorization for inpatient services.

Plan of Care

The RSNs are responsible for crafting a plan of care and services to meet the mental health needs of the people in their local communities. This includes pairing mental health resources with the resources of other community systems into an organized plan that addresses all aspects of an individual's life. These partnerships occur with other DSHS divisions and administrations including Developmental Disabilities, Alcohol and Substance Abuse, Vocational Rehabilitation, Children and Family, Aging and Adult, Juvenile Rehabilitation, and others. Outside of DSHS, partnerships occur with the Department of Corrections, Department of Health, local schools, local juvenile facilities, advocacy groups, and others. The aim is to combine efforts and resources to help people recover and succeed in their home community.

Improved Coordination

MHD has been working to improve services for people with a dual diagnosis of developmental disability and mental illness by:

- Completing working agreements between Developmental Disabilities Regions and fourteen RSNs to improve crisis/treatment/discharge planning between the Aging and Disability Services Administration and MHD.
- Designing a data cross-system that allows Western State Hospital staff and the Aging and Disability Services Administration to share

information about clients. Hospital staff can quickly determine if new admissions are enrolled with the Developmental Disabilities program and, if needed, start the eligibility process for individual services.

- Negotiating enhanced crisis contracts with RSNs and mental health providers to develop cross-system crisis plans that include multiple steps prior to calling the crisis line.
- Participating with the Aging and Disability Services Administration in the development of 18 statewide diversion beds.

Current Proposals

Transition from State Hospitals

Stakeholder Comments:

- *People with disabilities deserve the opportunity to live and take part in their community.*
- *The plan should incorporate more cross-system collaboration to address the needs of those individuals who fall through the cracks.*

Department Activities: MHD has worked with ADSA to transition approximately 180 people from state psychiatric hospitals to community living. MHD continues to:

- Develop, train and operate community support teams to work with long-term state hospital residents before and after their return to the community. This team of professionals works to:
 - Become familiar with the people who may move from the state hospital program to the community;
 - Assess their strengths, preferences and needs;
 - Arrange a safe, clinically appropriate, and stable place for them to live;
 - See that medical, behavioral, and social services are in place; and
 - Monitor individual progress on an on-going basis.
- Provide choices and arrange for community residential, mental health, and other support services for long-term state hospital patients whose treatment needs would be better served by community placement.
- Develop support strategies to reduce the use of state and local hospitals for short-term crisis stabilization services. Strategies may include training and technical assistance for community long-term care and substance abuse providers, developing diversion beds and stabilization support teams.

Reduce Stays and Divert Admissions

Stakeholder Comment:

The plan should incorporate more cross-system collaboration to address the needs of those individuals who fall through the cracks.

Department Activities: MHD collaborates with staff from other programs within DSHS in an effort to lessen or divert institutionalization of people with multiple disabilities to:

- Explore the development of diversion beds and stabilization support teams with the Aging and Adult staff, RSNs and Western State Hospital (WSH) staff.
- Meet regularly with Developmental Disabilities staff, RSNs and WSH staff to review hospital admissions of people with a dual diagnosis to determine what, if any, additional community services might have diverted the admission. Meetings may also include staff from Home and Community Services, Aging and Disability Services Administration, Community Services Offices (financial eligibility), DASA, providers, advocates and family members.
- Work with the Aging and Disability Services Administration to devise and implement strategies to reduce the use of state and local psychiatric hospitals for short-term stabilization of people with dementia and traumatic brain injuries.
- Meet with the MHD/Developmental Disabilities cross-system committee every other month to review issues regarding state hospital admission, treatment and discharge of patients with developmental disabilities.

Increase Community Services

Stakeholder Comments:

- *RSNs need adequate funding to do the job.*
- *The mental health system has an institutional revolving door. People are often unsuccessful in the community after leaving hospitals.*

Department Activities: MHD negotiates performance-based incentive contracts with RSNs that have the most viable plans for providing appropriate community support services for significant numbers of people from their area who would otherwise be served in the state hospitals.

Cross-system Training

Stakeholder Comments:

- *A person's needs may change over time, so the system needs to support the person where he/she is at the time without institutionalization or re-institutionalization.*
- *Systems in the state need to work together toward one goal - to help those in need and one another.*
- *Improve crisis response for people with disabilities to avoid institutionalization and re-institutionalization.*

Department Activities: MHD collaborated on clinical cross-system training with the Developmental Disabilities program for residential providers. Training focused on developing cross-system crisis plans that provide multiple steps to support individuals in the community, and use assessment tools for indicating major mental illness in persons with developmental disabilities.

In addition, MHD and the Aging and Disability Services Administration have collaborated to develop a training curriculum for long-term care providers to avoid and manage behaviors that might otherwise result in psychiatric hospitalizations.

For services and contact information, see:
<http://www1.dshs.wa.gov/mentalhealth> or call (360) 902-0790.



SERVICES THAT SUPPORT COMMUNITY LIVING

Most people receive health care and social services in community settings. There are many other administrations and divisions throughout DSHS that provide programs to support and increase options for living in the community.

DIVISION OF ALCOHOL AND SUBSTANCE ABUSE

The Division of Alcohol and Substance Abuse (DASA) develops and conducts a comprehensive program of alcohol and other drug prevention, treatment, and shelter services for residents of Washington State.

People with chemical dependency are at greater risk of institutionalization due to the behaviors caused by intoxication and withdrawal. People diagnosed with both chemical dependency and mental illness are at special risk. Between 40-60 percent of the patients admitted to state psychiatric hospitals have a substance abuse diagnosis.

Residential treatment services to adults, youth, and pregnant women are contracted directly with certified agencies to provide services on a statewide basis. Outpatient treatment services are contracted through counties. Funds are allocated to counties according to agreed-upon formulas, which are based largely on population. Each county submits a biennial plan for services in that county before receiving a contract.

Continuum of Care

DASA's objective is to provide a continuum of care at minimum cost and acceptable effectiveness in rehabilitating people with alcoholism and drug addiction. The program is designed so that clients can access services at many points in the continuum, appropriate to their level of need. Basic treatment services include:

- Diagnostic evaluation
- Alcohol/Drug detoxification
- Outpatient treatment
- Methadone treatment for drug addicts
- Intensive inpatient treatment
- Recovery house
- Long-term residential care
- Involuntary treatment of alcoholics
- Youth residential treatment
- Youth outpatient treatment

You will find a complete range of services and contacts for DASA at: <http://www1.dshs.wa.gov/dasa> or call (360) 438-8200.



DIVISION OF VOCATIONAL REHABILITATION

The Division of Vocational Rehabilitation (DVR)'s mission is to enable people with disabilities to obtain and keep employment.

While DVR staff are not directly involved in securing appropriate housing or residential placement for its participants, they work closely with other agencies and programs that are directly responsible in this area. For example, many of DVR's participants may need assistance finding housing or transportation or independent living services, and DVR serves as an information and referral point in the process. DVR may help with transportation, independent living, training, or other services that are included in a participant's Individual Plan for Employment.

DVR works collaboratively with other programs within DSHS, such as the Aging and Disability Services Administration, Mental Health Division, and DASA, since they frequently have participants in common.

The Independent Living Program

In addition to the Vocational Rehabilitation program, DVR has a small, separately funded Independent Living program that serves people who are not candidates for employment, but may be in the future. A goal of this program is to work closely with the Aging and Disability Services Administration to identify qualified Independent Living vendors, as well as to provide Independent Living services to people with disabilities for whom employment is not an option. These services include leveraging other public or private resources, providing assistance in hiring and training personal assistants, purchases of devices and services that help people live more independently, and diverting people from nursing home placement if it is possible for them to live in the community with support services.

Local Community Partnerships

In addition to providing direct services, DVR also collaborates with community vendors who provide vocational and independent living services to program participants. DVR has contracts and agreements with state, county, and local programs and organizations to expand and enhance services for participants.

DVR has information on specific programs and services at:
<http://www1.dshs.wa.gov/dvr> or call (360) 438-8008.





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INTRODUCTION TO PROGRAMS

There are approximately 529,686 individuals with a hearing loss in Washington, including 10,594 individuals who are deaf. ODHH is organized under the Health and Rehabilitative Services Administration (HRSA) located within the Department of Social and Health Services, in Olympia, Washington. ODHH provides an array of services to the deaf, hard of hearing and deafblind communities throughout Washington State.

PROGRAM DESCRIPTION

Telecommunication Relay Service (TRS)

The Telecommunication Relay Service eliminates barriers to the telecommunication infrastructure, achieving functionally equivalent access to the telephone as a person with normal hearing and clear speech would. Telephone calls are typically conducted through a communication assistant who facilitates the telephone conversation. A contract with a telecommunication relay provider provides an array of relay features matching the consumer's degree of hearing loss or speech disability and preferred communication method. Outreach activities are conducted to heighten public awareness and promote consumer self-sufficiency to utilize relay services effectively. Consumers may file complaints or submit

feedback with ODHH which is reported to the Federal Communications Commission. ODHH works with the relay vendor to resolve consumer complaints.

Telecommunication Equipment Distribution (TED)

Per regulations, eligible consumers apply to receive specialized telecommunication equipment and receive training to effectively utilize the equipment. Specialized telecommunication equipment distributed matches the consumers' degree of hearing loss or speech disability and preferred communication method. The equipment enables the consumer to access the telecommunication relay services or to make direct telephone calls with other parties having similar equipment.

Social and Human Services (SHS)

Contracts with several Regional Service Centers on Deaf and Hard of Hearing throughout the state provide an array of social and human services. Currently the scope of services includes: information and referral, outreach, education and training, advocacy for communication access. Advocacy typically focuses on communication access to products, services and employment in the private, public and nonprofit sectors. The centers play a vital role in providing educational, cultural, recreational and social opportunities and making their facilities available to local and regional grassroots community-based nonprofit organizations.

Communication Access Network (CAN)

There is an infrastructure of videoconferencing sites being established on an ongoing basis throughout Washington State within DSHS agencies, the regional service centers, and service providers. Each site includes a workstation utilizing the latest videoconferencing technologies. The functionality of these sites will be refined to include access to video relay services, remote sign language interpreting, remote real-time captioning and face-to-face interpersonal communications. Technical assistance, outreach and training activities are provided to DSHS and other agencies.

Assistive Communication Technology (ACT)

This new program benefits the hard of hearing and deafblind communities with the goal of providing auxiliary aids including assistive listening device systems, captioning, deafblind telecommunication equipment and other assistive technology. The provision of existing and emerging technologies will fulfill the reasonable accommodations mandate to ensure equal communication access to DSHS agencies, programs and services.

Information and Referral, Advocacy (IRA)

The provision of general information and referral services is currently conducted by regional service centers. The information and referral function within the regional service centers may be phased out and transitioned to ODHH within the next several years. Information and referral provide national, US regions and state-wide information resources and referrals to appropriate organizations.

Advocacy services on behalf of individuals will continue to be under the purview of the regional service centers. The role of the ODHH is to advocate for systematic transformations through revised regulations, policies and contracted services on a statewide or regional basis. ODHH may be requested to intervene for individuals needing access to a state government program or service.

Outreach and Training (OT)

Outreach and training are designed toward different target audiences including professionals, organizations, and deaf, hard of hearing and deafblind communities. Outreach and training comprise activities such as diversity initiatives, exhibits at community events and conferences, publications and presentations. Outreach activities heighten the public profile and awareness of ODHH programs, deaf culture, and other issues pertaining to hearing loss. Training activities instill sensitivity awareness with the knowledge and skills to DSHS staff, interested agencies and vendors to effectively serve the deaf, hard of hearing and deafblind individuals. The training curriculum includes TTY training, deaf culture awareness and legal reasonable accommodation obligations to provide auxiliary aids.

- **Sign Language Interpreter Management (SLIM)**

This program administers the statewide contract to purchase sign language interpreter services. State of Washington agencies are obligated to provide sign language interpreters upon request to deaf or hard of hearing individuals who are seeking accessible government services. The program monitors contractual compliance including quality of services, certification of interpreters and best practices.



ECONOMIC SERVICES ADMINISTRATION

The Economic Services Administration (ESA) helps low-income families, children, pregnant women, persons with disabilities, older adults, refugees, and immigrants. ESA also serves children who need child support, paternity establishment, child care, and medical services.

ESA programs provide such diverse services as: cash grants, Basic Food, housing assistance, child support enforcement, child care subsidies, repatriation assistance, domestic violence referrals, and telephone subsidies. ESA staff also determines eligibility for state and federal medical programs.

Community Service Offices (CSOs) are located throughout the state with staff to work with individuals, families, and children to determine program eligibility, to issue benefits, and to assist people to achieve self-sufficiency.

You can locate your CSO, get contact information, and apply for public assistance at: www.onlinecsos.dshs.wa.gov or call (360) 902-7808.



CHILDREN'S ADMINISTRATION

The Children's Administration (CA) provides services that promote children's safety, permanency, well-being and access to quality child care.

CA has a variety of services available to families before an institutional placement is considered, including: crisis intervention to keep youth at home when there is a conflict in the family; contracted services to help families resolve the issues in their family that have led to a crisis between family members; foster care to provide a safe and stable living situation for children unable to live in their family home due to abuse and neglect or to the inability of the parent to manage the child's behavior; and many projects with other DSHS divisions, state partners and community organizations to blend resources from multiple systems to serve children with high needs.

For more information about the services available through the Children's Administration, see: <http://www1.dshs.wa.gov/ca> or call (360) 902-7820



MEDICAL ASSISTANCE

The Health and Recovery Services Administration, HRSA (formerly Medical Assistance Administration), administers a variety of medical programs with various funding sources, eligibility standards and service coverage. HRSA also administers the disability determination program for social security.

In addition, HRSA continues to work collaboratively with other administrations of DSHS to implement policy decisions and to integrate services. This includes planning and developing programs with consumers, stakeholders and partners that support community living by improving access to services, supplies, and equipment.

Washington Medicaid Integration Project

Washington Medicaid Integration Project (WMIP) is a managed-care consolidation of services now handled by separate administrations within DSHS. This project currently brings together Medicaid funding for medical and chemical dependency services, with plans to incorporate mental health and long-term care services. The object is not only to integrate the Medicaid-funded health services, but to put the individual at the center of a more effective, more efficient and higher quality delivery system.

For more information, see: <http://www1.dshs.wa.gov> or call (360) 902-7807.

