

Transforming

REPORT TO THE LEGISLATURE

Redesign State-Operated Intermediate Care Facilities to Provide Short-Term Stabilization and Intervention Services

Engrossed Substitute Senate Bill 5268 Part 3 Sections 11-13

Chapter 219, 2022 Laws PV

Engrossed Substitute Senate Bill 5092 Sec. 203 (1) (G)

Chapter 334, 2021 Laws PV

Engrossed Substitute Senate Bill 5693 Sec. 203 (1) (G)

Chapter 297, 2022 Laws PV

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Executive Summary

Engrossed Substitute Senate Bill 5268 was passed during the 2022 Legislative session relating to transforming services for individuals with intellectual and developmental disabilities by:

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

The Department of Social and Health Services' Developmental Disabilities Administration was asked to submit a report describing the above efforts and to make any necessary recommendations for policy or fiscal changes to the governor and the Legislature for consideration in the 2023 Legislative session.

Transforming the continuum of care for individuals with intellectual or developmental disabilities remains a priority for DDA. As we celebrate successes achieved to begin the redesign of Washington State's Intermediate Care Facilities, there remains a need for continued investment in the on-going transformation of Intermediate Care Facilities. The policy recommendations can streamline multiple systems for DDA eligible clients. Our goal is to reduce the length of time an individual is away from their home in the community.

Recommendation Highlights

- Create teams at each Residential Habilitation Center that follow the client receiving services while at the ICF, back into their community. The teams would be person-centered using a wraparound approach, shifting away from a problem-based focus to a strength-based, needs driven approach. This includes evaluating individual's success and providing comprehensive support. This would require a policy that outlines the process, training and redistribution of funds for staff. It could be done entirely within existing resources at no additional cost.
- Support the re-design of intermediate-care services (see [Ruckelshaus Report](#)) from a congregate care model currently supporting up to 16 individuals in one cottage which provides long-term care, to smaller 4-6 bedroom cottages designed to provide crisis stabilization services. This will allow a person-centered approach to provide short-term, intensive, habilitative services for individuals in crisis, as well as provide an alternative to acute care hospitalizations when an individual no longer has a medical or behavioral health care need. DDA will work with the Centers for Medicare and Medicaid Services, to explore federal funding options in these settings. Fircrest School RHC campus is currently funded for two significant construction projects (development of 120 bed Nursing Facility and relocation of the Adult Training Program building). This recommendation is a long-term goal; however, the smaller cottages are already incorporated into the [Fircrest Proposed Master Development Plan](#).

Legislative Intent

Develop a report which addresses:

1. Developing procedures regarding Intermediate Care Facilities that ensure:
 - Clear information is provided to individuals that ICFs are temporary, what the eligibility requirements are and specifically what constitutes active treatment.
 - Stabilization services in the community are presented prior to presenting an ICF option.
 - If an individual is admitted to an ICF, discharge planning begins upon admission and after 60 days the individuals team convenes to review their stabilization and provide any necessary changes to the plan.
2. Expanding the number of family mentors, subject to funding, and establish peer mentors for clients in an ICF to assist in their transition to the community.
3. Ensuring individuals do not lose their community residential services if the individual is receiving stabilization services at an RHC, which must include:
 - Providing 90-day vacancy payments
 - Use available resources, client or other, to pay the individuals community-based rent to avoid eviction.

Background

In 2019, a stakeholder workgroup facilitated by the William D. Ruckelshaus Center produced a report to the Legislature titled [Rethinking Intellectual and Developmental Disability Policy to Empower Clients, Develop Providers, and Improve Services](#). Recommendations suggested the necessity to redesign state operated ICFs to function as short-term crisis stabilization and intervention facilities by developing infrastructure to ensure no one remains in an ICF longer than necessary. The report states that DDA will continue to transform the developmental disabilities continuum of care. The Ruckelshaus report also recognizes the success of the Family Mentor Program and suggests that it should be expanded to connect each client in a state-operated intermediate care facility with a peer mentor.

In 2020, the Legislature passed ESSB 6419, which created a joint executive/legislative taskforce to implement the 2019 Ruckelshaus report's recommendations. Based on recommendations from developmental disability self-advocates, the joint taskforce endorsed adding a peer mentorship component to the Family Mentor Program and additional funding was appropriated to implement this program. DSHS' Developmental Disabilities Administration produced a report, in collaboration with developmental disability self-advocates and stakeholders, [Designing a Peer Mentor Program For Clients in State-Operated Intermediate Care Facilities](#), to establish the steps necessary to implement a Peer Mentor program.

Deliverables

1. DEVELOP PROCEDURES REGARDING INTERMEDIATE CARE FACILITIES

With the legislative intent to redesign intermediate care facilities from long-term care settings to settings that support short-term crisis stabilization and intervention, DDA has taken the following steps to begin that transformation. DDA has begun building the infrastructure needed, with a long-term goal of supporting individuals to achieve stable, permanent placements in the least restrictive settings. The goals identified below identify the deliverables in meeting the objectives outlined in the 2021 Legislative Report, [Transforming State-Operated Intermediate Care Facilities](#).

Re-Designing DDA's ICF/IID System of Care			
GOAL	OBJECTIVE	TARGET AUDIENCE	STATUS
Develop a NEW Admissions for Intermediate Care Facility Services Policy	<ul style="list-style-type: none"> Reinforces the goal to provide stabilization services and support the client to return to their long-term residence in the community Identifies the temporary nature of the ICF service Clarifies services provided in the ICF Defines eligibility requirements of the ICF Sets parameters for discharge planning prior to and at the time of ICF admission Sets standard timelines for the duration of ICF admissions (180 days as recommended by the 2019 Ruckelshaus Legislative Report) 	DDA Field Services staff RHC staff Clients Legal representatives	Completed
Create RHC ICF/ IID Brochure	<ul style="list-style-type: none"> Provides clear plain talk on ICF services provided by the RHC Identifies the temporary nature of the ICF service Defines active treatment 	NPS referrals and requests for assessment and service are prolonged due to field services backlogs.	Completed
Update RHC Frequently Asked Questions	<ul style="list-style-type: none"> Provides clear plain talk on ICF services provided by the RHC Identifies the temporary nature of the ICF service Defines active treatment Identifies obligations of legal representatives 	Clients Legal representatives	Completed
Amend RHC Admission Checklist	<ul style="list-style-type: none"> Allows a consistent approach for all admissions Requires a discharge discussion to occur as part of the ICF admission process 	RHC admission coordinators Clients Legal representatives	Completed

Re-Designing DDA's ICF/IID System of Care			
GOAL	OBJECTIVE	TARGET AUDIENCE	STATUS
Develop and Execute a Training Plan	<ul style="list-style-type: none"> • Provides training to case resource managers that clearly explains the temporary nature of ICFs and the eligibility requirements necessary for admission • Provides a consistent message for consumers of DDA services 	DDA Field Services staff	Completed
Update IT systems	<ul style="list-style-type: none"> • Allows internal assessment platforms to accurately reflect ICF services provided at the RHCs 	DDA Field Services staff	In process
Communication Plan	<ul style="list-style-type: none"> • Updates both internal and external stakeholders regarding the new policy and available communication tools 	DDA Field Services staff RHC admission coordinators Clients Legal representatives Advocates	In process

DDA's new comprehensive [RHC Admissions for Intermediate Care and Nursing Facility Services Policy](#) requires DDA staff to ensure that clients requesting state-operated ICF services are informed that services in state-operated ICFs are temporary and are given a clear, thorough explanation of the legal and practical requirements of continuous aggressive active treatment, including its implications for continued ICF eligibility.

DDA created a comprehensive suite of accessible communication tools, including brochures for [Intermediate Care](#) services, and an FAQ that will complement conversations between case managers, clients, guardians and family members to achieve the legislative intent in transforming DD services.

As part of the new admission policy, DDA requires that a client's interdisciplinary team meet no more than 60 days after admission and again every 120 days thereafter, to evaluate whether the client meets discharge criteria. If the client does not meet discharge criteria, the team will make necessary changes to the plan and continue services. If the client does meet discharge criteria, the team will begin working with the client to identify appropriate service settings outside the ICF and begin the discharge process. Meeting these deadlines requires the treatment team to begin the discharge planning discussion with the client immediately upon admission. Under the new model, the goal of discharging the resident to an appropriate setting will begin during the admissions process and continue throughout the client's admission at the state-operated ICF. Clients and guardians will be presented with appropriate home and community- based service options. During these conversations, staff will explain the nature of each alternative service, including the relevant requirements for each setting. This direction is outlined in the new RHC Admissions policy, as well as the Admission Checklist used by the RHCs.

2. EXPAND FAMILY MENTORS AND ESTABLISH A PEER MENTOR PROGRAM

Family Mentors

As the state transforms its system of residential services and supports for individuals with I/DD, the voice of self-advocates remains essential to fostering partnerships that empower people to live the lives they want to live. The Family Mentor Program succeeds by supporting families and guardians during a family member's transition from an institutional setting to the community. Each family mentor is a relative of an individual with I/DD. The family mentors are independent contractors, not state employees. Family Mentors all have the personal experience of transitioning their loved ones from an institutional setting such as an RHC or skilled nursing facility, to any community-based setting. They use their experience to provide emotional support and offer guidance and assistance to help other families and individuals make informed decisions about transitioning to the community. Services offered are individualized to the needs of the person and their family.

Family Mentor Project Staff		
NUMBER	AREA OF FOCUS	REGION
1	Supports RHC transitions at Lakeland Village	1
1	Supports RHC transitions at Fircrest	2
1	Supports RHC transitions at Rainier School	3
1	Supports community nursing facility transitions	3

Services provided by Family Mentors:

1. Listen to families and their stories.
2. Explain community services and programs.
3. Suggest strategies for making the process successful.
4. Offer a [checklist](#) of assurances for vigilant involvement.
5. Are available to all eligible families in any location.
6. Are available by phone, text, email, Zoom and in-person.
7. Are available after the move for on-going questions and support.

For Fiscal Year 2022 (July 1, 2021 – June 30, 2022)

- Family Mentor Project assisted 71 families with transitions to the community
- Work accomplished includes
 - 10 RHC transitions completed.
 - 2 hospital transitions completed.
 - 22 RHC transitions supported in process.
 - 5 hospital transitions in process.
 - 32 Skilled Nursing Facility transitions completed.
- Conducting this work included

- 848 service contacts with individuals transitioning.
- 977 service contacts with families and client representatives.

Peer Mentors

The Peer Mentor Services contract was developed to support clients residing at an RHC who are interested in learning more about community-based services. This includes assisting clients throughout the duration of the decision-making process from understanding community-based services and supports, selecting a qualified provider to meet their individualized needs and discharging from the RHC. The contractor of Peer Mentor Services must be a neutral party who works only at the request of and benefit to the client residing at the RHC. The contractor must be an organization or agency with experience supporting individuals with I/DD and their families in the areas of self-advocacy, parent support and community services.

DDA solicited bids for a Request for Proposal in May 2022. Only one proposal was received; however, the applicant withdrew their request, and the RFP was canceled. DDA conducted a post RFP survey sample to explore additional insight which concluded that the predominant reason the RFP failed was a general lack of interest in performing the required work. In the 21-23 biennial budget, DDA was appropriated \$46,000 annually to implement the Peer Mentor program. To seek additional applicants, DDA will be using Roads to Community Living Reinvestment money to augment the annual reimbursement for the contract with a goal to reach a larger network of national and statewide qualified contractors during the new RFP solicitation in spring 2023.

3. MAINTAINING COMMUNITY RESIDENTIAL SERVICES

DDA clients who receive community residential services are supported in a manner that meets their residential support needs and preferences. Clients assessed as needing 24-hour daily support typically live in households with one to three other clients. Contracted Residential Service providers who are supporting a client approved for temporary admission to an RHC for ICF services fall within the scope of [DDA Policy 6.11, Residential Allowance Requests](#). This policy establishes procedures for providers to submit a request for reimbursement for a portion of the expenses (rent and shared utilities) on behalf of the client accessing stabilization services (or other Medicaid services taking them away from their home) for up to six months. This policy and established procedures ensure clients are not evicted from their residence while receiving stabilization services at an RHC.

Additionally, under Section 1611 of the Social Security Act, recipients of Supplemental Security Income who are temporarily institutionalized can get benefits during the first three full months of institutionalization. This SSI benefit can be used to pay expenses to maintain a client's home where they may return upon discharge. DDA will work with the client, their legal representative and responsible fiduciary entity to ensure the client accesses all benefits available to them, to maintain their residence while receiving stabilization services at an RHC.

Recommendations

1. Develop wraparound discharge teams at each ICF that follows the progress of the individual during their ICF admission and continues to follow the individual with support to their community-based service. This would require a policy that outlines the process and

redistribution of funds for staff but could be done entirely within existing resources at no additional cost. If enacted, it would support:

- ✓ Continuation of successful outcomes for the client’s transition to the community.
- ✓ Alleviate concerns of stakeholders on transition to the community.
- ✓ Community providers may be more willing to support the individual.
- ✓ Increase and continue the collaboration of providers after the change in provider.
- ✓ Prevent repeat cycles of ICF admissions and avoid other institutional settings.
- ✓ Require in-person client and provider check ins, which may include review from facility-based professional(s).

2. Washington state’s current ratio of one case manager to 75 clients (1:75) for most caseloads is far higher than the national average identified in the Ruckelshaus report to the Legislature, as well as [NASDDDS Medicaid and Case Management for People with Developmental Disabilities](#) and the [Case Management Workforce Supporting People with ID/DD](#) reports. The Legislature has recognized that many DDA clients have unique needs or circumstances and has already provided funding for specialized, reduced caseload ratios for six caseload types. Monitoring of these lower caseloads has shown positive impacts to client outcomes with reduced caseload sizes. The chart below shows DDA’s current caseload ratio based upon the caseload type in relation to the national average. Clients receiving services at the RHC do not maintain their case manager following their admission.

CASELOAD	RATIO	BELOW NATIONAL AVERAGE
Children's Intensive In-Home Behavior Support	18	✓
Enhanced Case Management	30	✓
Mental Health	30	✓
Out-of-Home Services	30	✓
Transition	35	
Community Protection Program	40	
PASRR	50	
Community First Choice	75	
Waivers	75	
Non-Waiver Paid Services	105	
No-Paid Services	300	

Summary

The Department of Social and Health Services' Developmental Disabilities Administration was tasked with developing procedures regarding Intermediate Care Facilities, expanding the number of family mentors and establishing peer mentor services, and ensuring individuals do



not lose their community residential services while receiving stabilization services at an RHC. As the 2019 Ruckelshaus Report to the Legislature indicates, Washington state's current practice of operating ICFs as a long-term care model imperils their Medicaid certifications and leaves many individuals dependent on a costly service. The information detailed throughout this report represents progress made towards transforming our system of care. With future work outlined in the recommendations above, we can continue to support clients to live successfully in less restrictive settings while we continue to transform our system of care.