

REPORT TO THE LEGISLATURE

Developmental Disabilities—Residential Habilitation Center Workgroup

Engrossed Substitute Senate Bill 6032 Sec. 205(g)(i)
January 7, 2019

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Introduction: This Report's Origins and Contributors

Engrossed Substitute Senate Bill 6032 Sec. 205(g)(i) (“the proviso”) directed the Department of Social and Health Services to contract with the William D. Ruckelshaus Center to facilitate workgroup discussions about how to support appropriate levels of care for residential habilitation center clients based on the clients’ needs and ages.

The proviso specified that representatives from the following entities must be invited to participate in the workgroup: one member from each of the two largest caucuses in the senate, who must be appointed by the majority leader and minority leader of the senate; one member from each of the two largest caucuses in the house of representatives, who must be appointed by the speaker and minority leader of the house of representatives; one member from the office of the governor, who must be appointed by the governor; one member from the developmental disabilities council; one member from the ARC of Washington; one member from the Washington Federation of State Employees; one member from the Service Employee International Union 1199; one member from the Developmental Disabilities Administration within the Department of Social and Health Services; one member from the Aging and Long-Term Support Administration within the Department of Social and Health Services; and two members who are family members or guardians of current residential habilitation center residents.

The following individuals constituted the workgroup:

- A. Senators John Braun and Karen Keiser;
- B. Representatives Morgan Irwin and June Robinson;
- C. Jason McGill, Senior Health Policy Advisor, Office of the Governor;
- D. Julia Bell, Developmental Disabilities Council;
- E. Sue Elliott, The Arc of Washington State;
- F. Greg Devereux, Washington Federation of State Employees;
- G. Lindsey Grad, Service Employees International Union;
- H. Evelyn Perez, Assistant Secretary, Developmental Disabilities Administration;
- I. Bill Moss, Assistant Secretary, Aging and Long-Term Support Administration; and
- J. Terri Anderson, Friends of Fircrest, and Jeff Carter, Friends of Rainier.

In addition, several others joined the workgroup meetings at varying times, to add staff representation, fiscal guidance or personal experience to the discussions, when appropriate. These others included Debbie Roberts, Charlie Weedon, and Michael Pettersen (DSHS Developmental Disabilities Administration); James Kettel (Senate Ways & Means Committee staff); Mary Mulholland (House of Representatives Committee staff); Bryce Andersen (Office of Financial Management); Matt Zuvich (representing WFSE); a client receiving community-based services; and a client residing at a residential habilitation center.

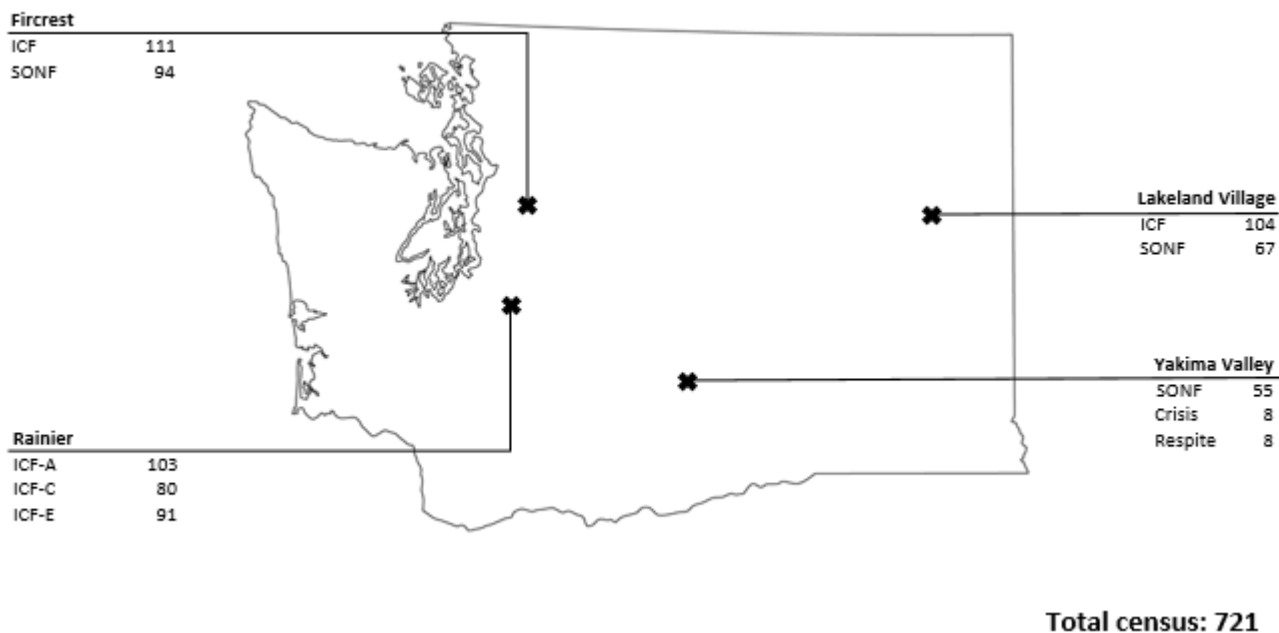
In accordance with the proviso, the workgroup’s discussions included converting Residential Habilitation Center (RHC) cottages from intermediate care facilities to skilled nursing facilities, developing a state-operated nursing facility for eligible clients, and placing RHC clients in state-operated living alternatives (SOLAs).

This report to the Legislature and the Office of Financial Management presents pertinent background on the RHCs and their relationship to the array of paid residential services available to individuals with intellectual or developmental disabilities through the Developmental Disabilities Administration. The report then presents the workgroup’s agreed-upon short-term recommendations, as well as identification of several substantive long-term issues that require further attention.

Background

Washington State’s Department of Social and Health Services operates four large residential facilities for individuals with intellectual disabilities. Each of these four RHCs has a unique campus and composition. Fircrest and Lakeland each contain a state-operated nursing facility and an intermediate care facility; Rainier houses three intermediate care facilities; and Yakima Valley is a single state-operated nursing facility, plus an eight-bed respite facility and an eight-bed crisis stabilization program. In sum, the four RHCs include a total of eight separately certified long-term facilities: three state-operated nursing facilities and five intermediate care facilities. Intermediate care facilities are primarily teaching facilities where the goal is to help clients develop skills they need to live in a less restrictive setting. The primary function of a nursing facility is to provide around the clock nursing care to the elderly or individuals with disabilities.

Residential Habilitation Center Census by Certified Facility in November 2018



For decades the State’s five intermediate care facilities were stable with respect to continued federal funding—but this is no longer true. The Great Recession resulted in State cuts to RHC staffing and deferral of millions in physical plant maintenance. These cuts might have been survivable, but a stricter enforcement posture from the federal Centers for Medicare and Medicaid Services (CMS) led to broader and more fundamental citations against Washington’s intermediate care facilities, denial of payment for new admissions, and ultimately special agreements in lieu of immediate termination of certification.

As the legal landscape changed, the Department responded with a multifaceted strategy that included hiring two national consulting firms, adding staff, establishing a statewide quality assurance unit, and providing extensive on-site technical assistance. Despite this effort, two of Washington’s state-run intermediate care facilities—both located at Rainier—faced an imminent risk of losing all federal funding.

Table 1 identifies each RHC, its constituent facilities, and their current Medicaid certification status. CMS has declared its intention to conduct unannounced surveys of Rainier intermediate care facilities A and C. If the surveys demonstrate substantial compliance with federal conditions of participation, CMS will permit the facilities to continue participating in Medicaid. If not, CMS will terminate the facilities’ Medicaid provider agreements and stop funding the facilities. The surveys are expected to be completed no later than March 2019.

Table 1

Campus	Facility Type	Certification Status
Fircrest	Intermediate care facility	Certified
	State-operated nursing facility	Certified
Lakeland	Intermediate care facility	Certified
	State-operated nursing facility	Certified
Rainier	Intermediate care facility A	Decertified pending resurvey
	Intermediate care facility C	Decertified pending resurvey
	Intermediate care facility E	Certified
Yakima Valley	State-operated nursing facility	Certified

During the seven-month period in 2018 that the workgroup convened, four of the five state-operated intermediate care facilities—one at Fircrest and three at Rainier—were appealing certification termination actions by CMS. Consequently, the workgroup spent a significant portion of its time discussing the implications of the federal termination actions and their ensuing appeals. The workgroup examined the basis for the federal action, particularly the intermediate care facilities’ noncompliance with “continuous aggressive active treatment” requirements.

Under federal law, intermediate care is available only for individuals in need of, and receiving, active treatment services. Active treatment refers to a continuous, aggressive, and consistently implemented program of specialized and generic training, treatment, and health or related services directed toward helping the client function with as much self-determination and independence as possible.¹ This has resulted in federal citations for gaps in active treatment as short as 20 minutes.

¹ <https://www.medicaid.gov/medicaid/ltss/institutional/icfid/index.html> (Accessed December 12, 2018).

Through the facility resurvey process, CMS agents indicated that numerous individuals residing at Rainier were not in need of or able to benefit from active treatment. This finding carries two important implications:

1. Intermediate care facility residents who cannot participate in active treatment jeopardize the entire intermediate care facility's federal funding.
2. Intermediate care facility residents may "age in place" if—and only if—they consistently participate in continuous aggressive active treatment.

In response to federal findings, DDA assessed Rainier's residents and identified approximately 60 individuals who either persistently refused offers of active treatment or could not participate due to age and infirmity.

The workgroup focused considerable energy on the issues raised by the federal policy that individuals who do not need or cannot benefit from continuous aggressive active treatment may no longer "age in place" in intermediate care facilities (without jeopardizing the facility's federal funding).

Much of the workgroup's discussion focus changed after recognizing that most individuals who can no longer participate in active treatment require nursing services. An aging population less responsive to active treatment over time (as well as those who persistently refuse or are unable to participate in active treatment) led to discussion around nursing service capacity and existing service and staffing gaps.

In addition, the workgroup lent its considerable and varied expertise to improving the experience of moving clients from intermediate care to nursing care, either in another RHC or to a community-based option, depending on each client's needs and preferences. Specifically, workgroup members worked collaboratively with DDA to mitigate the stress of relocation and improve communication between DDA, clients, guardians, and advocates. This planning is ongoing.

Workgroup members, including DDA leadership, intend to use the lessons learned from this collective experience to proactively improve procedures, including the speed, frequency, and accuracy of intermediate-care-facility eligibility reassessments.

Residential Habilitation Centers in Context

Residential care models vary in their cost and RHCs are the most expensive publicly funded care model for adults with intellectual or developmental disabilities in Washington State. Prior to the transfers described above, approximately 503 of DDA's approximately 47,383 clients resided in a state-run intermediate care facility.

The overwhelming majority of DDA's clients—71% as of July 1, 2018—live with and receive support from a parent or other relative. But these individuals, their parents, and other relative caregivers are aging. As clients age, their support needs increase; as the relatives who support them age, the support they can provide declines. Many clients who are presently served in their own home or in a relative's home will therefore require publicly financed residential services later in their lives.

DDA funds an array of out-of-home residential services for individuals with intellectual disabilities. Appendix A, Table 1, *DDA Adult Paid Residential Services*, provides a brief narrative description of the primary paid residential services. Appendix A, Table 2, *DDA Adult Residential Service Information by Setting*, is a simple reference guide that compares variables across settings. Appendix B, Figures 1 and 2, show the distribution of DDA clients by paid residential service.

The Workgroup’s Short-Term Principles and Recommendations

The workgroup reached consensus on the principle that the state must maintain and enhance a publicly provided array of services and supports—including RHC’s intermediate care facilities and state-operated nursing services—for individuals with intellectual and developmental disabilities throughout the next biennium. In addition, the workgroup agreed to the following general principles:

Individuals with intellectual or developmental disabilities who are eligible for residential habilitation services should have an array of options that are:

- Designed to meet their individual preferences and needs;
- Available in their local community, whenever possible; and
- Fully funded to ensure continuity and quality.

The workgroup further agreed that the service system for individuals with intellectual or developmental disabilities should be designed to:

- Address issues related to diverse populations;
- Address specific needs of young people, aging populations, and individuals with mental health diagnoses;
- Expand and support housing and workforce components;
- Expand SOLA availability; and
- Optimize existing RHCs and community-based services to help attain the above noted principles.

To achieve these agreed-to principles, the workgroup offers the following recommendations.

SHORT-TERM RECOMMENDATIONS

The workgroup believes the following consensus-based recommendations are achievable within the upcoming budget cycle.

1. Nursing Services

To meet the needs of RHC clients, the workgroup recommends that the Legislature fund:

- Capital investments in the pre-design study² necessary to maintain nursing facility services at Fircrest; and
- Additional state-operated nursing services in community settings.

As noted, the need for nursing services will continue to increase over time and the workgroup recommends that DSHS proactively prepare for this growing need. Specifically, the Aging and Long-Term Services Administration within DSHS should prepare a Request for Information to gauge the nursing home industry’s interest in providing services to individuals with intellectual and developmental disabilities.

² <https://www.dshs.wa.gov/sites/default/files/FSA/capital/Projects/FIRCREST%20NF%20FINAL%20REPORT%202018.pdf>

2. Proactively assessing intermediate care facility residents

The workgroup discussed the importance of improving the experience of moving from intermediate care to nursing care, either in another RHC or to a community-based option. Specifically, workgroup members identified strategies to mitigate the stress of relocation and improve communication between DDA, clients, guardians, and advocates.

The workgroup recommends standardizing these interventions, including assessment for community placement options, for future use across the state's RHCs. The workgroup further recommends that DDA partner with stakeholders to identify and carry forward the lessons learned from this experience and proactively improve procedures, including the speed, frequency, and accuracy of intermediate-care-facility eligibility reassessments. Specifically, the workgroup recommends that DDA:

- Identify individuals who no longer need active treatment as early as possible; and
- Improve communications and transition processes to increase each individual's options and mitigate transition stress.

3. State-Operated Living Alternative Expansion

The workgroup recommends that the Legislature support DDA's decision package to fund the remaining 47 state-operated living alternative placements. Appendix C, Figures 1-4, show state-operated living alternative expansion from 2016 to 2021.

The workgroup recommends that the Legislature also fund increasing SOLA capacity by 100.

4. Supported Living

The workgroup recommends that the Legislature approve wage increases for supported living providers, which will likely attract more providers to meet growing demands for supported living, and also help reduce staff turnover, crisis interventions, hospital stays, and short-term admissions to RHCs. Supported living providers currently make about two percent more than Washington State's minimum wage. Offering a more attractive wage may also improve client quality of care by encouraging qualified staff to remain in the field.

5. Family Mentoring Services

The workgroup recommends that the Legislature continue to fund family mentoring services.

6. Planned Respite

The workgroup would like to continue conversations to reach consensus around the need to increase capacity for respite services. To inform these discussions, the workgroup requests that DDA develop educational materials to help families better understand the processes for accessing planned respite. The workgroup also requests that DDA provide detailed analysis of respite requests and utilization to inform future policy recommendations to address respite capacity needs.

7. Children's Crisis Stabilization (Enhanced Respite)

The workgroup would like to continue conversations to reach consensus around the need to increase capacity for crisis stabilization services available to children on an emergent—as opposed to planned—basis. To inform these discussions, the workgroup requests that DDA develop educational materials to help families better understand the process for accessing crisis stabilization. The

workgroup also requests that DDA provide detailed analysis of enhanced respite requests and utilization to inform future policy recommendations to address capacity.

8. Additional Funding

The workgroup suggests DDA hire a consultant who can help identify opportunities for additional funding through grants or federal financial participation.

9. Continued Workgroup Collaboration

Over the past seven months, the workgroup has achieved consensus around the noted short-term issues, making significant progress compared to prior efforts. The workgroup requests that the Legislature support the group's momentum and authorize it to resume meetings in 2019. Doing so will allow the workgroup to continue to build collaborative capacity, addressing the long-term issues identified below that affect the quality of life and independence of individuals with intellectual and developmental disabilities, as well as other germane topics recommended by the Legislature.

IDENTIFIED LONG-TERM ISSUES

The noted 2018 workgroup focus and relatively short convening timeline prevented the workgroup from developing additional consensus around a longer term vision, as well as critical systemic and cost-related issues that impact those with intellectual and developmental disabilities. The workgroup identified several key issues below that will require further evaluation, discussion and stakeholder consensus.

A. Shifting care and staffing needs

The workgroup recognizes that 'aging in place' is no longer an option for many individuals who reside in an intermediate care facility, and that failure to comply with federal requirements for continuous aggressive active treatment jeopardizes federal funding to the intermediate care facility. Additional workgroup collaboration should address:

- How RHC and community-based services utilization and costs will shift as a result of this policy change; and
- How program capacity and costs should adjust to meet the changing needs of and options for individuals.

In addition, the workgroup suggests exploring strategic options and building consensus that optimize capacity for:

- State-operated living alternatives;
- State-operated nursing facilities;
- Intermediate care facilities;
- Private nursing facilities;
- Respite care;
- Crisis intervention and stabilization;
- Family care; and
- Possible alternatives.

Staffing challenges for these settings and services are expected to change over time. The workgroup would like to consider collaborative solutions that not only improve employee recruitment and

retention, but also increase capacity. Specifically, the workgroup identified the need to create opportunities for younger applicants, or those in the early stages of their career, by offering apprenticeships and collaborating with high schools, universities, and trade programs. These employees could receive training that teaches evidence-based protocols and ensures the use of responses and interventions appropriate for people with intellectual and developmental disabilities.

B. Crisis Stabilization

The workgroup acknowledged a significant need for improvements in crisis stabilization efforts. Providers within the criminal justice system are often unfamiliar with intellectual and developmental disability response and intervention needs. Clients risk inappropriate and traumatic jail time or emergency room utilization. In addition, the workgroup would like to explore more effective crisis intervention and stabilization efforts to address the needs of individuals experiencing both mental illness and an intellectual or developmental disability. The workgroup discussed the need for DDA to engage the mental health and criminal justice systems to approach these interconnections, in a more systematic way to avoid redundant effort and leverage recent and on-going mental health and related initiatives.

C. Alternative uses of RHC campuses

The workgroup recognized Fircrest's ongoing Master Plan process. The Department of Natural Resources is waiting for options to be presented through this process. Only the RHC core of the Fircrest campus is being discussed. It is unclear to what extent the Legislature will address Fircrest's progress in the upcoming legislative session.

Additional collaboration could expand initial workgroup discussions relative to other potential uses of RHC capacity and property.

D. Transforming adult family homes

The workgroup discussed the creation of an enhanced services facility to support individuals who do not require active treatment or medical treatment. Further consensus-building could help to explore viable options, such as transforming adult family homes, which house six people or less.

Conclusion

In summary, the workgroup made substantial progress throughout the seven facilitated collaborative meetings in 2018. The workgroup reached consensus recommendations around numerous issues impacting RHCs and interrelated community-based services to those with intellectual and developmental disabilities. The group hopes that the Legislature will address these short-term recommendations in the upcoming 2019 session.

The focus and time spent responding to CMS' RHC decertification processes prevented the workgroup from reaching consensus in 2018 around a longer-term vision for RHCs. However, the workgroup was able to identify a list of long-term issues they believe should be addressed in a consensus-building setting. The group included this need for further collaborative efforts in their short-term recommendations section, with a request to the Legislature to provide authorization for this on-going effort.

Appendix A

Table 1: DDA Adult Paid Residential Services

■ **Supported living** occurs in a home owned or leased by up to four clients. Clients receive support from contracted service providers. Support varies from a few hours a month to 24 hours a day, depending on the client's need.

■ **Private nursing facilities** provide 24-hour support to clients who require nursing facility level of care. Clients receive support from contracted service providers.

■ **Assisted living facilities** provide 24-hour adult residential care services in a home-like environment for seven or more clients. Enhanced care includes intermittent nursing and medication administration.

■ **Adult family homes** provide 24-hour care for two to six clients. The provider owns or leases a home in the community and offers meals and personal care, and may also offer nursing or specialized mental health care.

■ **Group homes** provide 24-hour instruction and support to two or more adults. The provider owns the facility and clients pay for room and board.

■ **Alternative living** provides up to 40 hours a month of support to a client living in their own home. The support is provided inside and outside the client's residence.

■ **State-operated intermediate care facilities** provide 24-hour support to promote client independence and teach clients skills they need to live in a less restrictive setting. Support is provided by state employees.

■ **State-operated nursing facilities** provide 24-hour support to clients who require nursing facility level of care. Support is provided by state employees.

■ **Private intermediate care facilities** provide 24-hour support to promote client independence and teach clients skills they need to live in a less restrictive setting.

■ **Community protection** provides 24-hour supervision to clients who live in a supported living environment and pose significant risk to others.

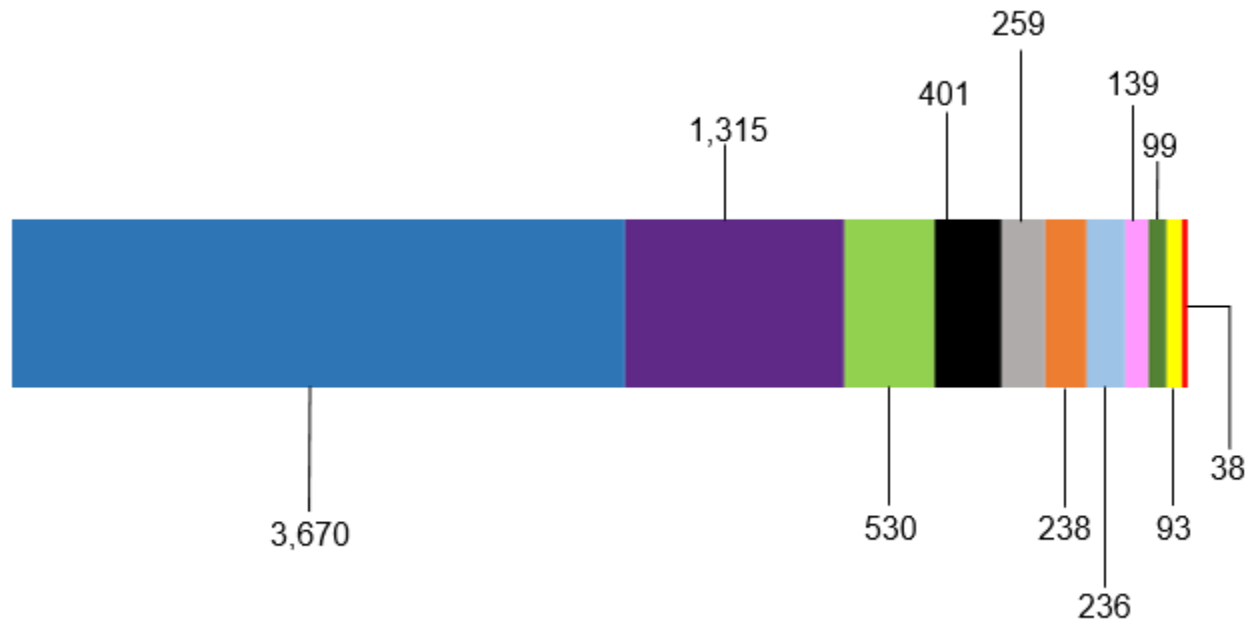
■ **SOLA** is state-operated supported living. It occurs in a home occupied by up to four clients. Support is provided by state employees and varies from a few hours a month to 24 hours a day.

Table 2: DDA Adult Residential Service Information by Setting

Setting	Age	Support available	Funding	How are food, rent, and utilities paid?	Who owns or leases the living space?	How many clients share the living space?	Will the client have a private bedroom?
Adult Family Home	18+	24-hour availability	State Plan	Participation	Provider	Up to 6	Possibly
Alternative Living	18+	40 hours per month	Waiver (Core)	Client funds	Client	1	Yes
Assisted Living (Adult Residential Care)	18+	24-hour availability	State Plan	Participation	Provider	Per license	Possibly
Companion Home	18+	24-hour availability	Waiver (Core)	Room & board	Provider	1	Yes
Group Home	18+	24-hour availability	Waiver (Core)	Participation	Provider	2-12	Typically
Intermediate Care Facility—private	18+	24 hours	State Plan	Participation	Provider	Up to 16	No
Intermediate Care Facility—state operated	16+	24 hours	State Plan	Participation	Provider	Up to 8	Possibly
Nursing Facility—private	18+	24 hours	State Plan	Participation	Provider	Per license	Possibly
Nursing Facility—state operated	16+	24 hours	State Plan	Participation	Provider	Up to 18	Possibly
SOLA	18+	Up to 24 hours	Waiver (Core or CP)	Client funds	Client	Up to 4	Yes
Supported Living	18+	Up to 24 hours	Waiver (Core)	Client funds	Client	Up to 4	Yes
Supported Living—Community Protection	18+	24 hours	Waiver (CP)	Client funds	Client	Up to 4	Yes

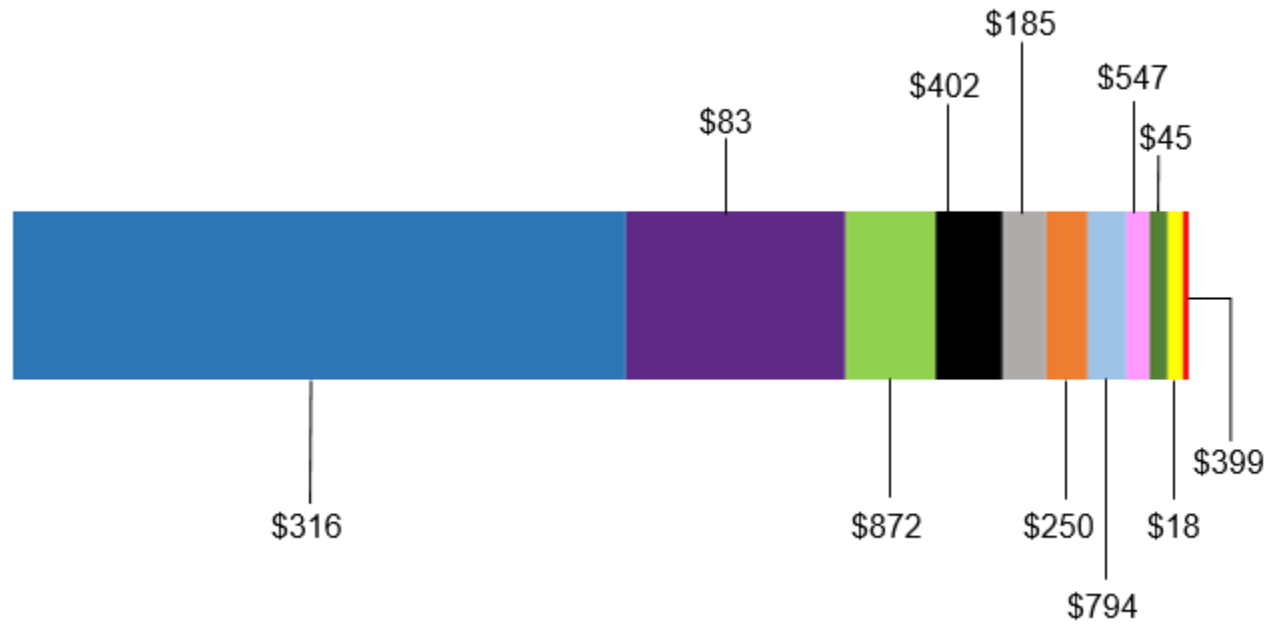
Appendix B

**Figure 1: Distribution of DDA Clients by Paid Residential Service
Showing Average Number of Clients in Fiscal Year 2018**



- Supported living
- Adult family homes
- State-operated intermediate care facilities
- Community protection
- Private nursing facilities
- Group homes
- State-operated nursing facilities
- SOLA
- Assisted living facilities
- Alternative living
- Private intermediate care facilities

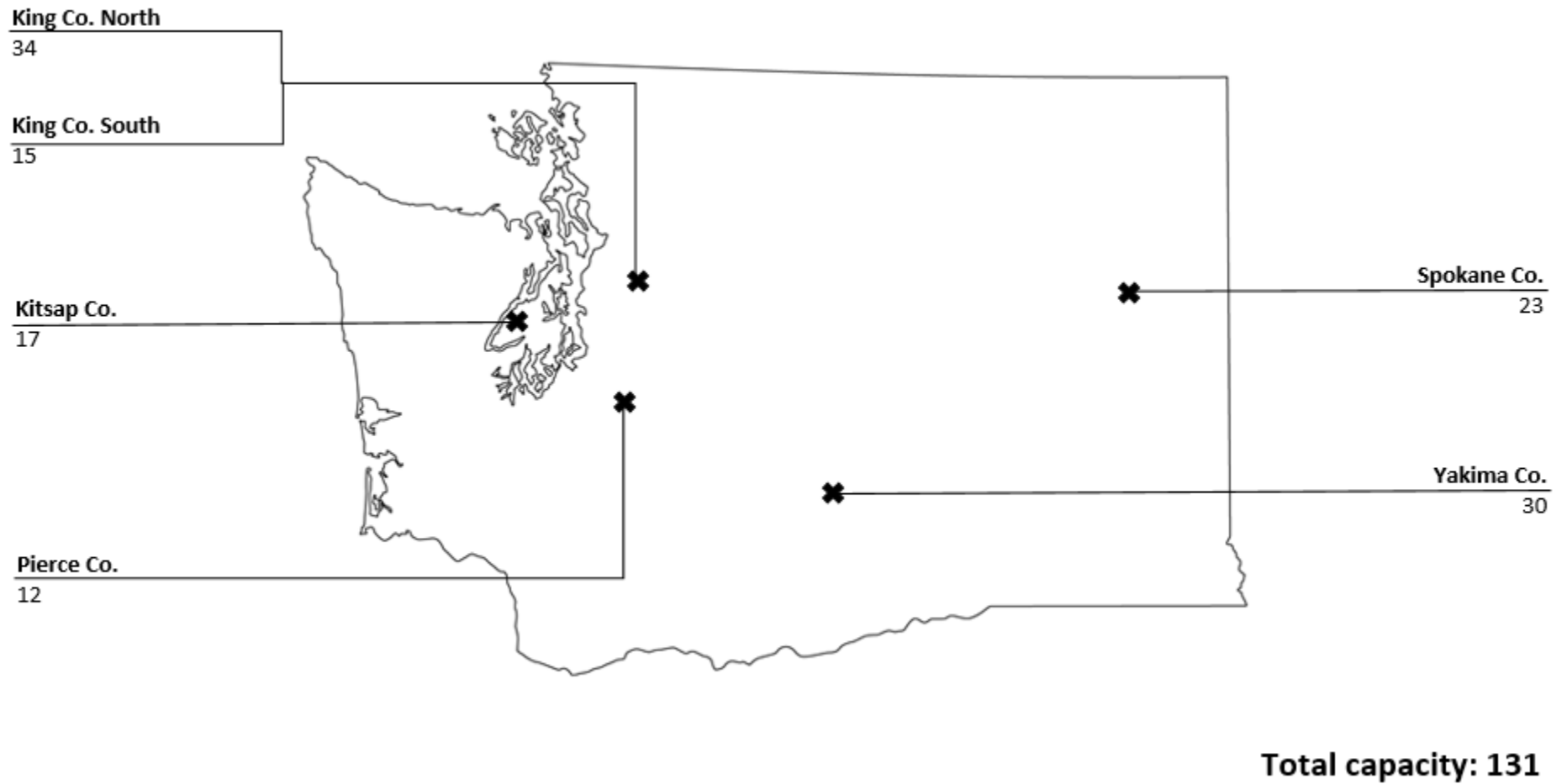
**Figure 2: Distribution of DDA Clients by Paid Residential Service
Showing Average Daily Rate in Fiscal Year 2018**



- Supported living
- Adult family homes
- State-operated intermediate care facilities
- Community protection
- Private nursing facilities
- Group homes
- State-operated nursing facilities
- SOLA
- Assisted living facilities
- Alternative living
- Private intermediate care facilities

Appendix C

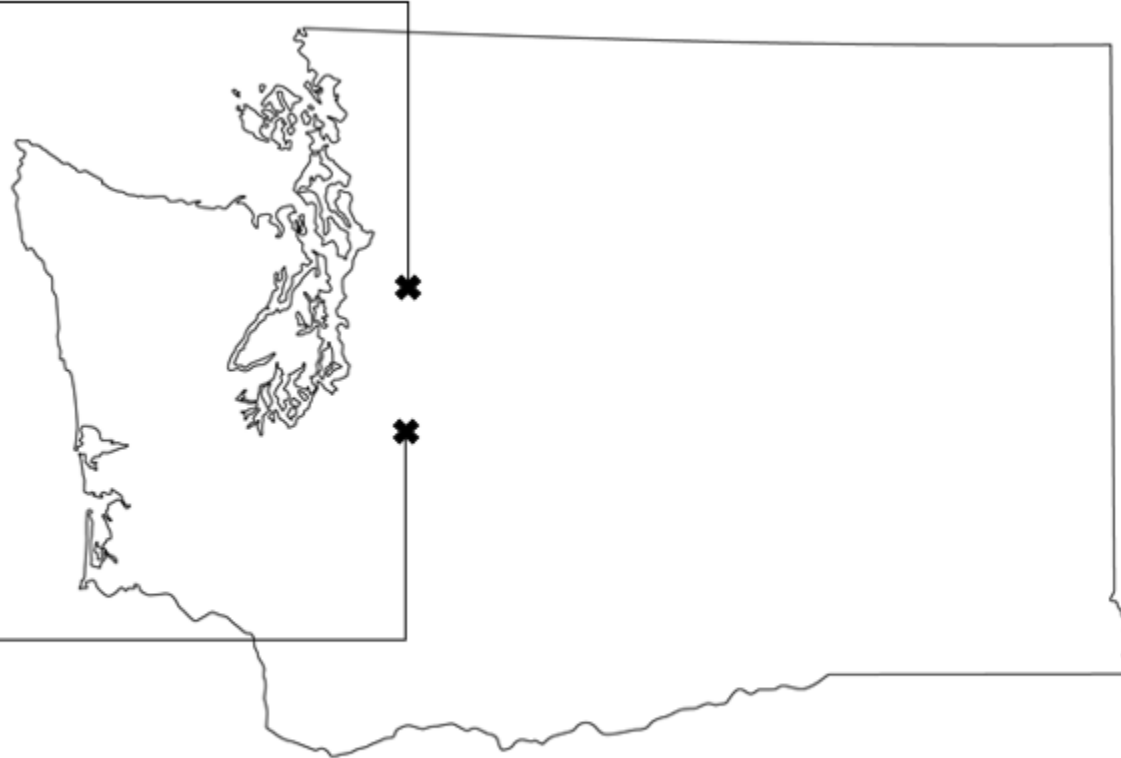
Figure 1: SOLA Beds by County in 2016



**Figure 2: SOLA Mental Health Expansion 2017-2019
New Beds by County**

King Co. South

6



Pierce Co.

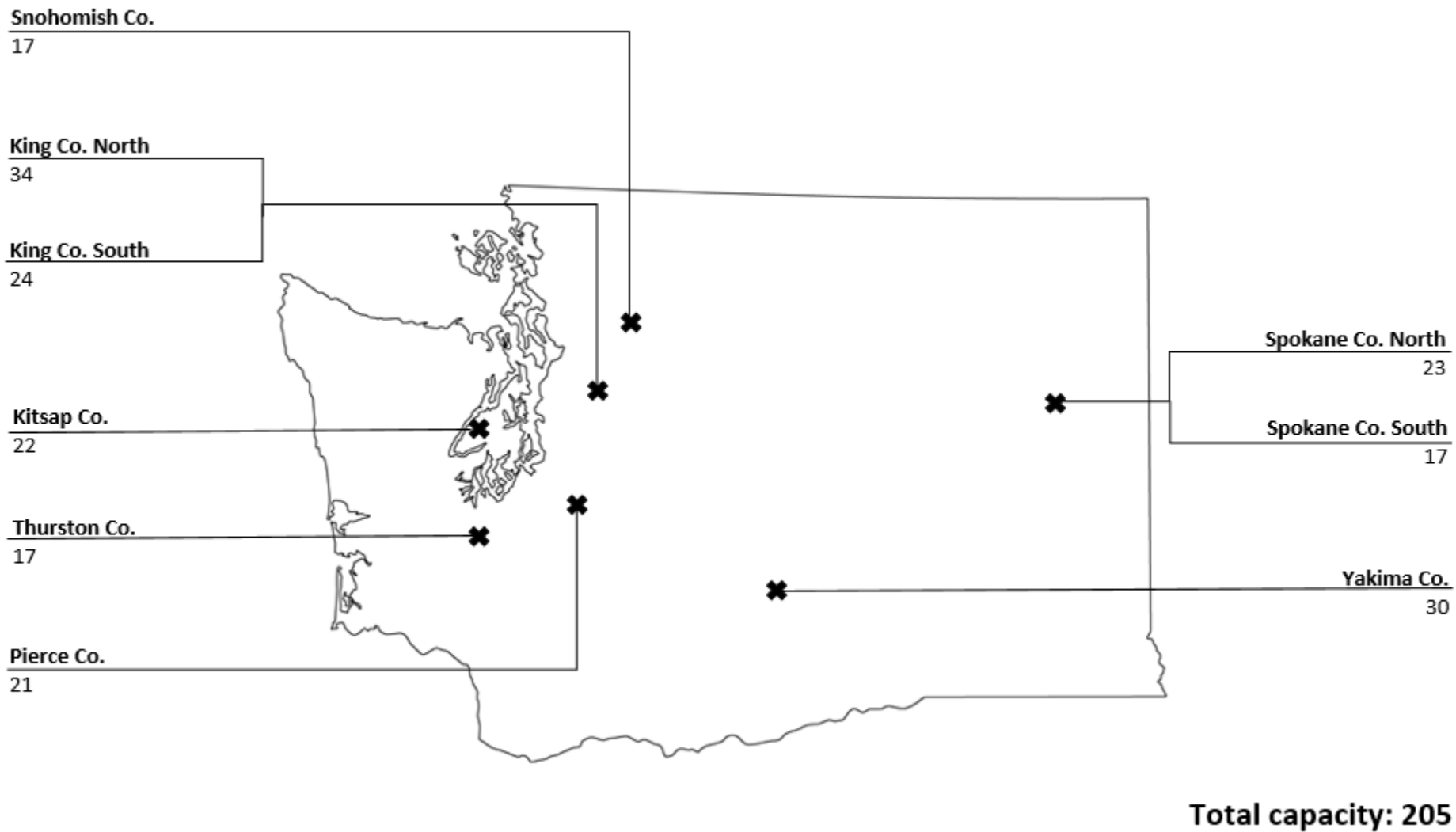
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Total expansion: 15

**Figure 3: SOLA RHC Expansion 2019-2021
New Beds by County**



Figure 4: SOLA Expansion by County in 2021



APPENDIX D

GLOSSARY

Active Treatment

A continuous, aggressive, and consistently implemented program of specialized and generic training, treatment, and health or related services directed toward helping the client function with as much self-determination and independence as possible.

Centers for Medicare and Medicaid Services (CMS)

The federal agency within the Department of Health and Human Services (HHS) chiefly responsible for Medicare and Medicaid policy.

Crisis Stabilization

Short-term support to a person experiencing behavioral health issues that may put them at risk of hospitalization or institutionalization. A client may receive crisis stabilization services in a state facility or a specialized community setting.

Intermediate-Care Facility

A residential teaching facility where clients develop skills they need to live in the least restrictive setting possible.

Residential Habilitation Center (RHC)

A residential facility for individuals with intellectual disabilities or other conditions similar to intellectual disability operated by DDA. Each RHC campus may contain separately certified intermediate care facilities, a state-operated nursing facility, or a combination of the two.

Respite Care

Short-term, intermittent care to provide relief for a person who lives with a client or is the client's primary care provider. A client may receive respite care in their home or another setting.

State-Operated Living Alternative (SOLA)

A state-operated supported living service. Typically this model involves multiple people sharing a residence with additional support provided based on each individual's assessed need.

State-Operated Nursing Facility (SONF)

A nursing facility operated by DDA for DDA clients.

Supported Living

Residential services occurring in a home owned or leased by up to four clients. Clients receive support from contracted service providers. Support varies from a few hours a month to 24 hours a day, depending on the client's need.

ADDENDUM

THE WILLIAM D. RUCKELSHAUS CENTER

UNIVERSITY OF WASHINGTON

Intellectual/Developmental Disabilities – Residential Habilitation Center Workgroup Workgroup Process Summary and Neutral Recommendations

The William D. Ruckelshaus Center is a neutral resource for collaborative problem solving in the State of Washington and the Pacific Northwest, dedicated to assisting public, private, tribal, non-profit, and other community leaders in their efforts to build consensus and resolve conflicts around difficult public policy issues. It is a joint effort of Washington State University hosted and administered by WSU Extension and the University of Washington hosted by the Daniel J. Evans School of Public Policy and Governance. For more information, visit:

www.ruckelshauscenter.wsu.edu

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DISCLAIMER

The following summary was prepared by the William D. Ruckelshaus Center, a joint effort of the University of Washington and Washington State University whose mission is to act as a neutral resource for collaborative problem solving in the State of Washington and Pacific Northwest. University leadership and the Center's Advisory Board support the preparation of this and other reports produced under the Center's auspices. However, the key observations contained in this Addendum are intended to reflect the statements and opinions of the DD-RHC workgroup, and the recommendations are those of the Center's team. Those observations and recommendations do not represent the views of the universities or Advisory Board members.

Summary - Background, Process and Workgroup Progress

In 2018, the Legislature requested that the DSHS/Developmental Disabilities Administration engage the William D. Ruckelshaus Center (the Center) to structure a collaborative workgroup process and provide neutral facilitation services around pressing Residential Habilitation Center (RHC) and intellectual/developmental disability (I/DD) issues. Many of those issues are identified in the authorizing proviso language, and described in the main body of this report.

The Center conducted an initial set of live or phone interviews with each of the organizations identified in the proviso language, to gauge individual's backgrounds and history, positions and interests, and willingness to participate collaboratively and in good faith. In addition, participants were asked of their expectations of proviso requests, given the relatively short time period (workgroup convening to be completed during calendar year 2018). All participants expressed hope that successful collaboration could potentially lead to a series of short-term recommendations to the Legislature. Participants voiced different opinions and skepticism regarding proviso issues perceived to require longer-term attention, but several participants noted that a longer-term strategy might be outlined during the 2018 work.

Workgroup participants (and their respective organizations) have deep experience and expertise around I/DD issues, including support and care needs, integration goals and challenges, policy differences, and systemic successes and failures over time in Washington and other states. This experience is both professional and personal – stories of family members and history were generously shared with the workgroup, which often added to a profound collective experience. In addition, two I/DD clients were invited to and participated in the workgroup, describing their experience living in RHC and community-based settings.

These organizations – including RHC advocates, community-based advocates, unions and government have a long shared history in Washington state. Many workgroup participants have worked and lived through many decades of I/DD program challenges – through periods of shared collaboration and conflict. Many workgroup members participated in prior groups and studies, relating stories of mixed success.

Facilitated workgroup meetings began in May 2018. The workgroup desired monthly meetings, each lasting seven hours, and met seven times between May and November. The Center used traditional collaborative processes to help the workgroup build capacity towards consensus, including workgroup engagement rules, shared principles, productive inquiry, diverse thinking exercises, data evaluation and subgroup discussion. In addition, components of design thinking were implemented to help the workgroup move from their initial inventory of categorized issues, to stages of questioning and discussion – including transitions from experience to insights, to questioning, to option vetting, to consensus.

The workgroup worked remarkably well together – especially considering past history and conflict. They responded positively to the challenges and patience required to engage in a collaborative process, recognized 'quick wins' and were able to build consensus around a series of important short-term (they defined as the upcoming budget biennium) issues and legislative recommendations that impact people with I/DD. They were unable to construct a consensus strategic outline around the longer-term issues, due to the constraints outlined in the report; however, they did focus

substantial collective effort to identify many of the most important long-term issues, and recommended that the Legislature authorize continued collaborative efforts to attempt further consensus and policy recommendations.

Neutral Observations and Recommendations

Several ‘acute’ and ‘chronic’ factors helped the workgroup focus their efforts during their seven months of meetings:

- The Center for Medicare and Medicaid Services (CMS) had engaged in decertification termination actions related to four of five intermediate care cottage facilities at both Rainier and Fircrest RHCs. As noted in the report, DSHS’ appeals took place throughout the seven months of workgroup meetings. The shared threats of closure, transition trauma and lost federal funding gave the workgroup a sense of urgency around several key issues. For example, DSHS’ transition of intermediate care-based I/DD clients to skilled/nursing settings in or at other RHCs or community-based settings helped to focus the workgroup around nursing care capacity and gaps, intermediate care active treatment requirements, related demographic changes and other workforce gaps. CMS’ termination actions also gave the workgroup a chance to work directly with DSHS/DDA to improve processes to mitigate client transition trauma, and improve government/family-guardian communications through periods of program stress.
- Workgroup member expertise and trended RHC data continue to demonstrate that the I/DD population in RHCs is aging. Aging populations require additional physical/medical care and supports – layered onto more complex I/DD supports, and requiring providers who are trained in I/DD, as well as co-diagnosed mental health issues. The noted client transitions from intermediate care within RHCs to nursing levels of care for an aging I/DD population may further stress capacity limits. Family caregivers represent the largest share of support and residential care. As family caregivers continue to age, additional long-term supports and service needs to supplement or supplant family caregivers will also stress capacity limits.

The workgroup not only worked together collaboratively to suggest eight categories of short-term legislative recommendations – but they have also expressed a willingness to engage forward in the more difficult discussions around longer term issues to address individuals with I/DD needs and integration goals. These issues include workforce capacity/recruiting/training/retention, optimizing RHC and community-based supports and care (including costs), crisis intervention and stabilization, respite care needs, I/DD nursing care needs and provider capacity, and others identified throughout their 2018 workgroup convening.

As noted, the meeting discussions in 2018 were coordinated to move through a series of sequential steps – from issue identification to consensus recommendations. This process encouraged the workgroup to move through a broad array of RHC and I/DD-related issues throughout each of the meetings. One of the powerful byproducts of this type of sequential process is a group recognition of issue connectivity from varying perspectives, which impact both the scope of the workgroup’s recommendations, as well as the need for additional group evaluation of important longer-term issues.

For example, co-diagnosed mental health disorders impact the discussion around crisis intervention and stabilization. This helps the workgroup think about how they might pursue future options (or is impacted by) RHCs, community services and emergency service providers, psychiatric inpatient or outpatient facilities, or community diversion and care coordination programs. Which programs are already being pursued by the Health Care Authority, DSHS or others, to avoid duplication and leverage existing initiatives and efforts? What types of additional data, information or subject matter input could help inform the workgroup to suggest practical crisis policy recommendations to the Legislature?

In addition to the workgroup's recommendations described in the report, the Center suggests the following, assuming the Legislature supports the workgroup's request to continue and to leverage the collaborative I/DD efforts gained in 2018:

1. **Transition from 2018 workgroup meetings that were based on sequential process steps to include more focused topical meetings.** The workgroup has already identified through consensus many of the difficult long-term issues to address moving forward. The workgroup would benefit from dedicating one (or more) future meetings to each long-term issue, to pursue more in-depth discussion and consensus-building, including prepared data, other evidence (including cost information) and subject matter opinion. Solicit university and/or other external expertise and opinion by including guest presenters in structured topical meetings. The long-term issues require more challenging and sensitive conversations – additional perspectives will help expand options and mitigate organizational positions.
2. **Research other state's successes and failures related to I/DD (facility and home and community-based care) program and process improvements.** Many states and local communities, including some in Washington have demonstrated care coordination, case management or crisis diversion models that could impact those with I/DD or co-diagnosed behavioral health conditions. Some states have begun to import long-term supports and services program concepts into I/DD supports. For example, New York has piloted existing PACE (Program of All Inclusive Care for the Elderly) programs to apply to I/DD dual eligibles (those who are both Medicare and Medicaid eligible). Colorado has piloted a Cross-System Response for Behavioral Health Crises program for those with I/DD co-diagnoses. In late fall 2018, CMS announced their intention to explore changing long-standing federal law to relax the barrier between Medicaid and housing supports, which could have significant impact on I/DD programs and funding. Such types of program ideas may help to optimize facility and community-based services, as well as potentially improve federal match.
3. **Prepare detailed RHC and community-based service cost information to support future workgroup meetings.** DSHS/DDA, fiscal Legislative staff and Office of Financial Management staff were able to consistently provide utilization, demographic and basic cost data to the workgroup during their 2018 meetings. I/DD data is not easy to provide, given the inherent limitations and lack of standardized cost reporting (compared to hospital and nursing home reporting standards). Some detailed RHC cost reporting was provided by one of the workgroup's advocates towards the end of the 2018 meeting schedule. That may be a useful starting point to refine data to add context to future topical meeting discussion. It may also be helpful to compare cost impact 'before' and 'after' the noted transition of RHC

intermediate-care clients to skilled/nursing-based care in other RHCs or community-based supported living services.

4. **Continue to improve communication and collaboration with elected officials and appointed staff around I/DD issues and challenges.** Our four workgroup legislative team members (Senators Karen Keiser and John Braun; Representatives June Robinson and Morgan Irwin), Governor's Office staff (Jason McGill), and DSHS leaders (Evelyn Perez, Bill Moss, Debbie Roberts and Charlie Weedin) were all active and engaged participants throughout this collaborative process. Each expressed an appreciation and respect for both the workgroup experience and their personal education, based on the depth and diversity of all participant's expertise and opinions. Please continue to engage and include this variety of interested elected officials and staff in this process. These issues are complex –the collective creativity needed to reach consensus on practical solutions to enable client choice benefit greatly from this type of workgroup diversity and support.