Strategic Lean Project Report

For Reporting Period: July 1, 2016 through December 31, 2016

I. General Information:

Lead agency name: Department of Social and Health Services, Aging and Long-Term Support Administration
Partner agencies: Area Agencies on Aging, Healthcare Authority, DSHS Developmental Disabilities Administration, DSHS Behavioral Health Administration

Improvement project title: Home and Community Based Settings

Date improvement project was initiated: 3/9/2015

Project type: New Project

Project is directly connected to:	**If applicable, specify the alignment:**
☒ Results Washington performance measure	3.2 Increase percentage of long-term services and supports clients served in home and community-based setting
☒ Agency Strategic Plan	2.1 3.2 Increase percentage of long-term services and supports clients served in home and community-based setting
☐ Other	Click here to enter details.

Report reviewed and approved by: Bill Moss, ALTSA Assistant Secretary

II. Project Summary:

The Aging and Long-Term Support Administration improved the percentage of Long-Term Services and Supports clients served in Home and Community Based Settings, resulting in increasing the percentage of people served from 83% in 2013 to 85% in 2016.

III. Project Details:

Identify the problem: ALTSA's mission is to promote choice, independence and safety through innovative services. Ensuring people have the independence to choose where they may safely live. If the service system does not support the mission, we cannot help the people we serve achieve this outcome.

Problem statement: The percentage of people served in Home and Community Based Settings was 83% in 2013 compared to our target of 85% in 2016, which we met five months early.

Improvement description: A team of ALTSA staff from headquarters and the field and partner agencies (Area Agencies on Aging) staff identified barriers to serving more people in home and community based settings. Several Lean tools were utilized over a 3 year period:

First, A3 problem solving was used to identify barriers to serving people in Home and Community Based Settings. One key issue raised was the lack of access to qualified providers. Because the process for becoming a provider has become increasingly complicated over the years, many people start but don't complete the process. A proposed solution was to conduct a Value Stream Mapping event to improve the process by which people become Individual Providers.

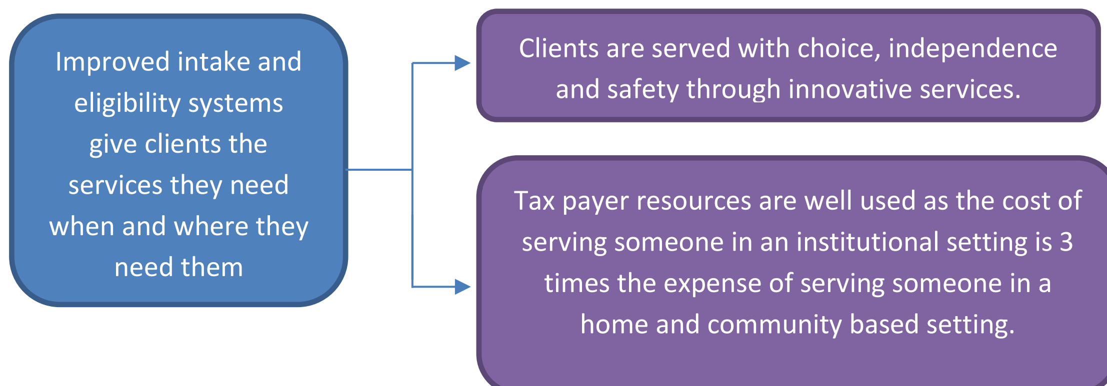
Second, Value Stream Mapping was then used to look at the Individual Provider contracting process. Key improvements were made to the background check process, the process by which providers are trained, and improving communication with our service partners such as the Social Security Administration and the Area Agencies on Aging.

Third, A3 problem solving was used again to look specifically at transitioning clients from Nursing Homes to Home and Community Based Settings. Key improvements included maximizing use of technology by providing staff with remote access to databases for real-time flow of work, improving understanding and acceptance of these services by Nursing Home staff through enhanced training and outreach, and reassessing ALTSA staff skills and workloads, which resulted in redistribution of staff doing this work.

Finally, two more Value Stream Mapping events were conducted to look at the processes used to assess functional and financial eligibility for Home and Community Based Services. While the teams found improvements in both processes, most dramatic was the difference in cycle time for initial functional assessments (from the point of intake to provision of the client's first contracted service), decreasing from approximately 120 days down to 60 days

Customer involvement: Customer involvement came through reviewing responses to the DSHS Client Survey and the Roads to Community Living Survey, both of which show clients prefer to be served in the least restrictive setting of their choosing.

IV. Impact to Washingtonians:



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V. Project Results:

Improved process as measured by:	Specific results achieved:	Total Impact:	Results status:
☒ **Time**	Decreased the amount of time it takes to complete initial assessments **from** 120 days **to** 60 days.	50% time reduction	Preliminary
☒ **Employee Engagement**	Increased percentage of staff who reported they feel ALTSA is making improvements to make things better for our customers **from** 61% in 2013 **to** 67% in 2015, which is a statistically significant increase of 6%.	6 % increase	Preliminary

In 2016, we achieved our target of having 85% of clients served in the community both through supporting individuals to remain in community settings and assisting individuals to relocate from institutional settings back to their communities. In 2016, Home and community services staff assisted 3,814 people to relocate from nursing homes (313 were in low acuity groups), 94 people relocate from Western State Hospital, 20 people divert from WSH, and 115 relocate from Eastern State Hospital.

VI. Contact information:

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Phone number: 360-480--2435

VII. Optional Visuals: See next page

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RESULTS WASHINGTON

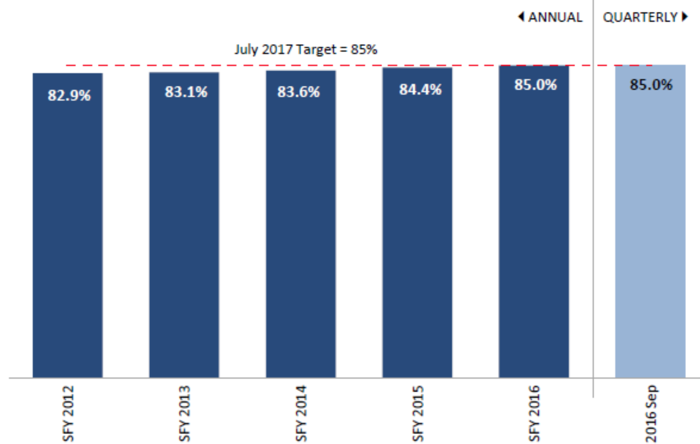
Aging and Long-Term Support Administration

Effective · Efficient Accountable Government
Jay Inslee, Governor

Goal 4: Quality of Life - Each Individual in Need will be Supported to Attain the Highest Possible Quality of Life

Percent of long-term services and support clients served in home and community-based settings

Statewide



SUMMARY

- **Update: this measure has reached its target early and discussions about next steps (new target, etc.) are ongoing.**
- **This measure supports ALTSA Strategic Objective 2.1: Ensure seniors and individuals with a disability who are in need of long-term services and supports (LTSS) are supported in their community.**
- **Background: Washington State is a leader in maintaining LTSS clients in the home and community. We top the nation in measures that look at the proportion of expenses spent on home and community care.**
- **Importance: Developing home and community-based services has meant Washingtonians have a choice regarding where they receive care, and has produced a more cost effective method of delivering services.**
- **Success Measure: Increase the percentage of clients served in home and community-based settings to 85% by July 2017.**
- **Action Plan: The updated action plan for this measure is located in the ALTSA Strategic Plan.**

DATA SOURCE: EMIS reports using SSPS and ProviderOne/BarCode; supplied by Rina Wikandari, Management Services Division.

MEASURE DEFINITION: Statewide percentage of ALTSA long-term care clients living in home and community settings, as defined by the average monthly caseload of clients living in home and community settings divided by the sum of the same and the average monthly caseload of clients living in nursing facilities. This measure focuses on clients of ALTSA and in most cases does not include the caseload residing at the nursing homes operated by the Washington State Department of Veteran's Affairs

DATA NOTES: 1 The count of clients living in nursing facilities excludes clients at the State Veteran's Homes at Retsil, Orting, and Walla Walla, facilities run by the Washington State Department of Veteran's Affairs. Approximately 50 clients living at the Spokane Veteran's Home may be included.

TO DATA: http://www.dshs.wa.gov/data/metrics/AAH.1.xlsx

Updated: December 2016