Issue Area: In-Home Services   Office: SE WA ALTC COG

Goal: SE/ALTC will advocate and support quality in-home care services that emphasize choice and optimize effective and efficient service delivery.					
Measurable Objectives	**Key Tasks**	**Lead Position & Entity**	**Timeframe for 2014-2015 (By Month & Year)**		**Accomplishment or Update**
			Start Date	**End Date**	
SE/ALTC will present information on the referral registry to CMs, social workers, and clients to ensure LTC clients are made aware of all provider options available.	The HCRR process is reviewed at staff meetings and HCRR staff and Supervisor attend HCS and DDA staff meetings to educate them on the use of the registry	LPC's & I&A/ADRC, staff & HCRR Coordinator	Sept 2014 Feb 2015	Feb 2015	CM regularly reminds ALTC, DDA, & HCS staff of HCRR & regularly receives referrals. Presentations were completed with HCS and DDS staff in Kennewick, Yakima, & Sunnyside. HCRR brochures included in new case packets. Choice of provider discussed at every face-to-face assessment.
SE/ALTC will continue to advocate for ancillary services supported by Senior Citizen's Services Act (SCSA) funds and State Family Caregiver dollars that help leverage and augment a variety of non-Medicaid services to help elderly persons who are in failing health and might otherwise fall through the cracks, or otherwise go onto Medicaid services as their health diminishes.	CM staff will maintain awareness of non-Medicaid ancillary resources & use them when appropriate	CM staff	Nov 2014	Dec 2015	Clarkston ACM's invited Senator & both Reps to Meet and Greet discussing needs of program on 11.5.14. Several Board members attended Legislative Day in Olympia. CM staff will utilize FCSP funds for DME, emod, etc for qualified individuals. CM staff will refer people to equipment loaning programs (i.e. CWDR & Hospice Friends). CM staff will utilize VCS & other volunteer groups (i.e. KVF&R) for building ramps, installing grab bars, etc. **Goal Met**

Issue Area: In-Home Services   Office: SE WA ALTC COG

Goal: **SE/ALTC will partner with local medical and community based partners to ensure higher levels of integrated care and care transitions that enhance health outcomes for clients.**					
Measurable Objectives	**Key Tasks**	**Lead Position & Entity**	**Timeframe for 2014-2015 (By Month & Year)**		**Accomplishment or Update**
			Start Date	**End Date**	
SE WA ALTC will work on establishing Memorandums of Understanding with local hospitals to develop protocols that will better identify with an in-home T-XIX client is hospitalized and Case Managers and CCM nurses will work on care transitions with these clients.	Maintain MOU & working relationship with local hospitals. Kittitas Valley Hospital (KVH) Kennewick General Hospital (KGH) Kadlec Regional Medical Center (KRMC) Trio Health – formerly KGH hospital (TRIOS) Tri-State Memorial Hospital & Medical Campus (TSMH)	LPC's & ALTC Admin staff	Feb 2014		2/21/14—Renewed MOU w/KVH. KVH staff regularly updates ALTC on hospital census so CMs know when Title XIX clients are hospitalized. MOU's w/TRIOS & KRMC, Care Transitions/Bridges program w/KRM & TRIOS. LPC attends monthly staffing mtgs w/consistent care prog. team to include hospital staff & community partners in Kennewick. CM's work w/hospital discharge staff to consider care transition referral. Contact is maintained w/TSMH.
SE WA ALTC will work with community Accountable Care Organizations within their local communities in an attempt to better partner and assist with community plans to reduce non-emergent ED visits.	LPC to work with entities & groups on readmission issues Participated in Community Health Improvement Plan meetings. Hospitals: Yakima Valley Memorial Hospital (YVMH) Tri-State Memorial Hospital & Medical Campus (TSMH)	LPC's	Jan 2014 June 2014 Sept 2014 March 2015	Jan 2015 Oct 2014	LPC participated in Communities of Health, attends Community Paramedicine mtgs. Staff work w/KVF&R & KVH on frequent EMS/ER users & clients who readmit as referrals are made. Participate in the YVMH monthly ER overutilizer's mtg., WA Safe Table, & Consistent Care. Met

					w/Discharge Planner Sup. at TSMN on two occasions discussed protocols for discharge planning & CTI.
SE WA ALTC will expand its Chronic Care Management (CCM) program from 45 clients up to 370 clients adding additional clients monthly.	Twenty workshops were available with 187 clients enrolled, of that 154 clients completed 4 of the 6 workshops. Thirty-three completed less than 4 workshops.	Program Mgr. & LPC's		June 2013	Workshops were made available to clients & the majority completed the series.
ALTC will continue to work with W4A at the State level to ensure the highest level of stakeholder input as the State forges ahead with health care reform.	SE WA ALTC has been involved in W4A endeavors to help develop and provide input on ACH, 1115 Global Waiver and Health Homes, providing legislative advocacy, attending local ACH, providing input to HCA and DSHS on ACA and other initiatives	Director	On-going	On-going	Retained Health Home through the biennium, with positive results. Part of the Regional ACH Governing Board and Leadership Committee
ALTC will continue to meet with State Legislators from districts within PSA 09 to ensure that they are informed of stakeholder concerns and to advocate for quality in-home care.	Alzheimer's Town Hall Meeting	LPC	Nov 2015	Nov 2015	LPC attended the Alzheimer's Town Hall in Yakima.