

<b>Goal: SE/ALTC will advocate and support quality in-home care services that emphasize choice and optimize effective and efficient service delivery.</b>					
Measurable Objectives	Key Tasks	Lead Position & Entity	Timeframe for 2014-2015 (By Month & Year)		Accomplishment or Update
			Start Date	End Date	
SE/ALTC, in conjunction with W4A, will advocate for community based in-home care programs to maintain these valuable services.	Advisory Board Members (ACM's) will advocate for needed services	Program Mgr. (CB) & ACM's	Jan 2014	Nov 2014	The Clarkston ACM's met with the local Senator and representatives on 11.5.14. ACM's participated in the legislative phone tree.
SE/ALTC will work with its case management staff to ensure a good client to CM ratio in our region, as long as funding allows and as models change.	We continue to monitor caseload ratio throughout our direct service offices. We remain within the allowable window provided by AL TSA. We monitor this closely to ensure that we have adequate staffing to best meet the needs of clients in these communities. The Title XIX vendor rate has not been increased in a decade placing the LTSS system at great risk. This is a specific area of advocacy during the 2015 Legislative session.	Program Manager (CB), ALTC Mgt., W4A, & LPC's	Jan 2014	Dec 2015	The 2014 CM to client ratio was 1:85. In 2015 it is 1:78. LPC's are maintaining the CM to client ratio by hiring staff as necessary
SE/ALTC will continue to emphasize preventative care planning and resource development via training new employees, file review, and education on effective local resources at staff meetings	Presentations will be scheduled with community service providers to train ALTC staff. Training webinars are available to staff and the LTC Manual QA process is reviewed.	LPC's	June 2014	Sept 2015	WA Behavioral Healthcare conference on Motivational Interviewing Ethics & End of Life issues by Memorial Physicians Identify issues of abuse with individuals with disabilities, Dementia Research & Referrals, Deaf & Hard of Hearing, etc. Local resources are inputted in the CLC directory.
SE/ALTC will work on the implementation and continuation of Health Homes throughout Health Home Service Area 7.	Employ sufficient Health Home Coordinators (HHC) throughout the ALTC region.	Program Mgr. (CB & EB) & LPC's		Sept 2015	As of Sept 2015 a health home coordinator position was filled at the Clarkston ADRC office.
SE/ALTC will assist to enroll 250 Dually Eligible Clients into SE/ALTC Health Home Services.	Health Home Coordinators will work to identify & recruit dually eligible clients into health home services.	Program Mgr. (EB)	Jan 2014	Dec 2015	HHC has steadily increased the number of clients served while helping other offices to recruit new clients. Clarkston currently has approx 45

					clients in 2015.
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SE/ALTC will continue to educate Case Management staff in DDA, HCS and SE/ALTC about the benefits of the Home Care Referral Registry (HCRR) via frequent presentations, and outreach to CMs. 10% increase in registry names per biennium.	I&A/ADRC staff will remind folks at ALTC, DDA & HCS of the availability of the HCRR via presentations, email and phone.	LPC's	Jan 2014  Feb 2015	Sept 2014  Feb 2015	This activity is performed throughout the year in each community. HCS & DDA presentations were done in Kennewick, Yakima, & Sunnyside. DDA & HCS staff routinely refers clients to ALTC for info on HCRR. ALTC staff are encouraged use of the HCRR during staff mtgs.
SE/ALTC will work with local hospitals to better coordinate care transitions for our T XIX Medicaid clients. ALTC will develop MOU(s) with these hospitals	Keep MOU current and maintain working relationship with the local hospitals.	LPC's	Jan 2014	Dec 2015	MOU renewed with Kittitas Valley Hospital in Feb. 2014. SW's routinely update ALTC staff on hospital census & make referrals. MOU's are current with TRIOS Hospital in Kennewick & Kadlec Regional Medical Center. Care Transitions/Bridges program with Kadlec & Regional Medical Center. Attendance at WA Safe Table Mtg. in June 2014.