Office of Hearings and Appeals
3601 C Street, Suite 1322
P. O. Box 240249
Anchorage, AK 99524-0249
Ph: (907)-334-2239
Fax: (907)-334-2285

STATE OF ALASKA
DEPARTMENT OF HEALTH AND SOCIAL SERVICES
OFFICE OF HEARINGS AND APPEALS

In the Matter of)
)
[REDACTED],) OHA Case No. 10-FH-2318
)
Claimant.) Div. Case No. [REDACTED]
__________________________________)

FAIR HEARING DECISION

STATEMENT OF THE CASE

[REDACTED] (Claimant) applied for Medicaid Home and Community Based Waiver services (hereinafter "Medicaid HCB Waiver services").[1] On August 11, 2010 the Division of Senior and Disabilities Services (Division) sent the Claimant notice her application was denied. (Ex. D) The Claimant requested a fair hearing contesting the denial on August 21, 2010. (Ex. C)

This Office has jurisdiction pursuant to 7 AAC 49.010.

The hearing was held on September 29, 2010. The Claimant appeared telephonically; she represented herself and testified on her own behalf. [REDACTED], the Claimant's Care Coordinator, appeared telephonically and assisted the Claimant with her representation. The Division was represented by [REDACTED], Medical Assistance Administrator III, who appeared in person. [REDACTED], a registered nurse employed with the Division, appeared in person and testified on the Division's behalf.

The record was left open after the hearing until October 15, 2010 for the Claimant to present additional documentary evidence and for the Division's optional response. The Claimant did not submit any additional information.

[1] The record does not indicate the specific date of the Claimant's application.

ISSUE

Was the Division correct to deny the Claimant's application for Medicaid HCB Waiver services on August 11, 2010 because she did not require a nursing facility level of care?

SUMMARY OF DECISION

The Division was correct to deny the Claimant's application for Medicaid HCB Waiver services on August 11, 2010 because she did not require either a skilled nursing facility or intermediate care facility level of care as of July 27, 2010, the date she was assessed to determine her eligibility for Medicaid Home and Community Based Waiver services.

FINDINGS OF FACT

The following facts were established by a preponderance of the evidence:

1. The Claimant is a 68 year old woman (date of birth [redacted]) who lives in an assisted living home. (Ex. E, p. 1) The Claimant has anal cancer which has been treated through chemotherapy, radiation, and surgery. (Ex. E, p. 1; Ex. F, p. 1) The Claimant has a colostomy bag. (Erickson testimony)

2. Claimant applied for Medicaid HCB Waiver services. Claimant was assessed for Medicaid HCB Waiver eligibility on July 27, 2010. (Ex. E, p. 1) The person who conducted the assessment was [redacted], a registered nurse. *Id.*

3. The July 27, 2010 Medicaid HCB Waiver assessment (Consumer Assessment Tool) scored the claimant with a "0" and found she did not qualify for Medicaid HCB Waiver services. (Ex. E, p. 30) Specifically, the assessment found that as of July 27, 2010:

   a. The Claimant did not require any professional nursing services (injections, IV feeding, feeding tubes, suctioning/tracheotomy care, treatments or dressing, catheter, coma, ventilator, catheters, uncontrolled seizure disorder). (Ex. E, pp. 13 - 14)

   b. The Claimant did not receive any therapies (physical therapy, speech therapy, occupational therapy or respiratory therapy). (Ex. E, p. 14)

   c. The Claimant did not require any special treatments or therapies performed by or under the supervision of a registered nurse. (Ex. E, p. 15)

   d. The Claimant does not have either short-term or long-term memory problems. (Ex. E, p. 16) She also is not impaired in her daily decision making skills. *Id.* She does not require "professional nursing assessment, observation and management" to manage her decision making skills. *Id.*

e. The Claimant does not exhibit problem behaviors (wandering, verbal/physically abusive, disruptive behavior, resisting care). (Ex. E, p. 17)

f. The Claimant was able to turn and reposition herself in bed (bed mobility). (Ex. E, p. 6) She received a self-performance code of 0 (independent) and a support code of 0 (none required) in this category. (Ex. E, pp. 6, 18)

g. The Claimant had able to get up and down from chairs, bed, etc. (transfers) by herself. (Ex. E, p. 6) She received a self-performance code of 0 (independent) and a support code of 0 (none required) in this category. (Ex. E, pp. 6, 18)

h. The Claimant is able to walk (locomotion) without assistance. (Ex. E, p. 7) She received a self-performance code of 0 (independent) and a support code of 0 (none required) in this category. (Ex. E, pp. 7, 18)

i. The Claimant was able to dress herself without assistance. (Ex. E, p. 8) She received a self-performance code of 0 (independent) and a support code of 0 (none required) in this category. (Ex. E, pp. 8, 18)

j. The Claimant did not require any hands on assistance with eating. (Ex. E, p. 9) She received a self-performance code of 0 (independent) and a support code of 0 (no assistance required) in this category. (Ex. E, pp. 9, 18)

k. The Claimant required some personal hygiene assistance after toileting. (Ex. E, p. 9) The Assisted Living Home staff help her change her ostomy bag. *Id.* She received a self-performance code of 1 (supervision required) and a support code of 2 (one person physical assist) in this category. (Ex. E, pp. 9, 18)

l. The Claimant did not require assistance with her personal care needs (combing hair, brushing teeth, washing face). (Ex. E, p. 10) She received a self-performance code of 0 (independent) and a support code of 0 (none required) in this category. (Ex. E, pp. 10, 18)

m. The Claimant did not require physical assistance with transferring in and out of the shower, bathing and drying herself. (Ex. E, p. 11) She received a self-performance code of 0 (independent) and a support code of 0 (none required) in this category. (Ex. E, pp. 11, 18)

n. The Claimant requires assistance with her medications three times daily, 7 days per week. (Ex. E, p. 12)

4. On August 10, 2010, ████████, a registered nurse employed by the Division, reviewed the July 27, 2010 assessment and compared it to the factors listed in the State of Alaska *Manual for Prior Authorization of Long-term Care Services* in order to determine whether the Claimant qualified for Medicaid HCB Waiver services. (Ex. F, pp. 2 - 3) Ms. ████ checked a box on the *Manual* form that stated the Claimant required "[a]ssistance with [activities of daily living]." (Ex. F, p. 3) Her written comment was that the Claimant required "[s]upervision with toileting." *Id.*

5. Ms. ████ stated that the Claimant did not qualify for Medicaid HCB Waiver services under the "Skilled Level of Care Factors" listed in the State of Alaska *Manual for Prior Authorization of Long-term Care Services* for her colostomy because the Claimant did not need professional nursing services for her colostomy care. (████ testimony; Ex. F, p. 2 - 3)

6. The Claimant testified as follows:

   a. She does have physical therapy on a drop in basis. Whenever she is able to make it to the hospital, she can have physical therapy.

   b. She was hospitalized several weeks before her September 29, 2010 hearing. While she was in the hospital, she had a nasogastric tube, but it was removed before she was released from the hospital.

   c. She has been falling a lot recently and injuring herself.

   d. She is not currently receiving either radiation treatment or chemotherapy.

   e. It was difficult and took a lot of concentration to complete the physical portion of her August 27, 2010 assessment.

   f. She experiences a great deal of pain and frustration.

PRINCIPLES OF LAW

A party who is seeking a change in the status quo has the burden of proof, by a preponderance of the evidence, in an administrative case. *State, Alcohol Beverage Control Board v. Decker*, 700 P.2d 483, 485 (Alaska 1985); *Amerada Hess Pipeline v. Alaska Public Utilities Comm'n,* 711 P.2d 1170, n. 14 at 1179 (Alaska 1986). "Where one has the burden of proving asserted facts by a preponderance of the evidence, he must induce a belief in the minds of the [triers of fact] that the asserted facts are probably true." *Robinson v. Municipality of Anchorage,* 69 P.3d 489, 495 (Alaska 2003).

An adult 65 years old or older, who requires "a level of care provided in a nursing facility…" is entitled to receive Medicaid HCB Waiver services. 7 AAC 130.205(d)(1)(D) and (d)(2)(iii). [2]

Regulation 7 AAC 130.205(b)(2) states, in relevant part, that an older adult is not eligible for Medicaid HCB Waiver services unless the individual requires the nursing facility level of care as determined under 7 AAC 130.230(b) and under 7 AAC 140.505 - 7 AAC 140.515.

Regulation 7 AAC 130.230(b) requires a level of care assessment to determine eligibility:

> …to determine if the applicant meets the level of care required under 7 AAC 130.205(d)(2), the department will authorized the care coordinator to prepare a complete assessment of the applicant's physical, emotional, and cognitive functioning and need for care and services.

Regulation 7 AAC 130.230(b)(2), which applies to adults 65 years of age and older, requires the department to:

> (A) …determine whether the applicant requires skilled care under 7 AAC 140.515 or intermediate care under 7 AAC 140.510; and
>
> (B) [the] level of care determination under (A) … must incorporate the results of the department's *Consumer Assessment Tool (CAT)*, adopted by reference in 7 AAC 160.900. (Emphasis supplied.)

Regulations 7 AAC 140.505 - 140.515 set out factors the department must consider when determining the appropriate level of care for an individual seeking Medicaid HCB Waiver services.

Regulation 7 AAC 140.505 requires the department to consider:

> (1) the type of care required;
> (2) the qualifications of the person necessary to provide direct care; and
> (3) whether the recipient's overall condition is relatively stable or unstable.

Regulation 7 AAC 140.515, titled "Skilled nursing facility services,"[3] provides that skilled level of care is:

> (a) (1) needed to treat an unstable condition; (2) ordered by and under the direction of a physician; and (3) provided directly by or under the

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[2] There are other eligibility criteria, however, those are not at issue in this case. *See* 7 AAC 130.205(a) and (b).

[3] The acronym SNF refers to "skilled nursing facility." *See* 7 AAC 160.990(b)(80).

supervision of qualified technical or professional personnel, who are authorized by state law to provide that service and who are on the premises at the time service is rendered; technical or professional personnel include a registered nurse, a licensed practical nurse, a licensed physical therapist, a licensed physical therapy assistant, a licensed occupational therapist, a certified occupational therapy assistant, a licensed speech-language pathologist, a registered speech-language pathologist assistant, and an audiologist.

> (b) Skilled nursing services are the observation, assessment, and treatment of a recipient's unstable condition requiring the care of licensed nursing personnel to identify and evaluate the recipient's need for possible modification of treatment, the initiation of ordered medical procedures, or both, until the recipient's condition stabilizes.

Regulation 7 AAC 140.510, titled "Intermediate care facility services," provides that intermediate care services are:

> (a) (1) needed to treat a stable condition; (2) ordered by and under the direction of a physician (except as provided in (c) of this section; and (3) provided to a recipient who does not require the level of care provided by a skilled nursing facility.
>
> (b) Intermediate nursing services are the observation, assessment, and treatment of a recipient with long-term illness or disability whose condition is relatively stable and where the emphasis is on maintenance rather than rehabilitation, or care for a recipient nearing recovery and discharge whose condition is relatively stable but who continues to require professional medical or nursing supervision.
>
> (c) Intermediate care may include occupational, physical, or speech-language therapy provided by an aide or orderly under the supervision of licensed nursing personnel or a licensed occupational, physical, or speech-language therapist.

Regulation 7 AAC 130.230(b)(2)(B) requires the department to incorporate results of the Consumer Assessment Tool (CAT) into the level of care determination made for an older adult applying for Medicaid HCB Waiver services.[4]

The CAT performs this determination by assessing an applicant's needs for professional nursing services, for therapy provided by a qualified therapist, for special treatments

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[4] The Consumer Assessment Tool (CAT) is adopted by reference in regulation 7 AAC 160.900(d)(6) and is specifically included in the eligibility determination for Medicaid HCB Waiver services by regulation 7 AAC 130.230(b)(2)(B). The CAT also is applied to determine if an applicant is eligible for other Medicaid based services and is designed to present a comprehensive picture of an applicant's medical needs.

(chemotherapy, radiation therapy, hemodialysis, peritoneal dialysis), and whether or not an applicant experiences impaired cognition, or problem behaviors. (Ex. E, pp. 13 - 14)

The CAT only assesses an applicant based on their conditions and needs for the 7 day time period immediately preceding the assessment date. (Ex. E, pp. 13 - 14) Each of the assessed items is given a numerical score. For instance, if an individual required 5 days or more of therapies (physical, speech/language, occupation, or respiratory therapy) per week, she would receive a score of 3. (Ex. E, p. 29)

The CAT also assesses the degree of assistance an applicant requires for activities of daily living (ADL), which specifically include bed mobility (moving within a bed), transfers (i.e. moving from the bed to a chair, or a couch, etc.), locomotion (walking), eating, and toilet use, which includes transferring on and off the toilet. (Ex. E, p.18) These are broken down into self-performance codes and support codes as explained below:

The self-performance codes rate how capable a person is of performing a particular ADL:

0 Independent, no help/oversight, or help/oversight provided two times or less during the last seven days.
1 Supervision, which consists of encouragement/oversight/cueing provided three or more times during the last seven days or supervision plus non-weight bearing physical assistance provided one or two times during the last seven days.
2 Limited Assistance, which consists of non-weight bearing physical assistance three or more times during the last seven days, or limited assistance plus weight bearing assistance one or two times during the last seven days.
3 Extensive Assistance, which consists of weight bearing support three or more times during the past seven days, or the caregiver provides complete performance of the activity during a portion of the past seven days.
4 Total Dependence, which consists of the caregiver performing the activity for the applicant during the entire previous seven day period.
5 Cueing, which is spoken instruction or physical guidance for a particular activity required seven days per week.
8 Activity did not occur during the previous seven days.

The support codes rate the amount of assistance a person receives for each ADL:

0 None.
1 Setup assistance only.
2 One person physical assistance.
3 Physical assistance from two or more people.
5 Cueing required seven days per week.
8 Activity did not occur during the previous seven days.

(Ex. E, p. 18)

If an individual receives a self-performance code of 2 (limited assistance), 3 (extensive assistance required) or 4 (total dependence) in 3 or more of 5 specified activities of daily living (bed mobility, transfer, locomotion, eating, and toileting), the Claimant receives a score of 3 on the CAT. (Ex. E, p. 29) Alternatively, a person can receive points for combinations of required nursing services, therapies, impaired cognition (memory/reasoning difficulties), or difficult behaviors (wandering, abusive, etc), and required assistance with the 5 specified activities of daily living. (Ex. E, p. 30)

The results of the assessment portion of the CAT are then scored. If an applicant's score is a 3 or higher, the applicant is medically eligible for Medicaid HCB Waiver services. (Ex. E, p. 30)

In addition to use of the CAT in its determination of an applicant's level of care, the Division also uses the factors contained in the *Manual for Prior Authorization of Long-term Care Services* to determine if an applicant qualifies for Medicaid HCB Waiver services.[5] The specific factors contained in the Division's checklist measure whether a Claimant requires either a Skilled Level of Care or an Intermediate Level of Care.[6]

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[5] The Division was required by prior regulation 7 AAC 43.190 (repealed effective February 1, 2010) to "make a level-of-care evaluation in accordance with the guidelines established in the Criteria for Placement section of the *Manual for Prior Authorization of Long Term Care Services."* The current regulation, found at 7 AAC 140.505 (effective February 1, 2010) no longer requires consideration of those criteria, which are referred to as the "*Manual* factors." However, the Division utilized those factors in this case to evaluate the Claimant's eligibility for Medicaid HCB Waiver services.

[6] The *Manual* contains two sets of factors. The *Skilled Level of Care* factors are: 1) whether a patient requires 24 hour observation and assessment by a registered nurse or licensed practical nurse; 2) whether a patient requires intensive rehabilitative services, which is defined as 5 days or more per week of physician ordered physical, occupational, respiratory or speech therapy; 3) whether a patient requires 24 hour performance of direct services that must be furnished by a registered nurse, licensed practical nurse or someone acting under their supervision; 4) does the patient require medications that are administered either intravenously or by naso-gastric tube; 5) does the patient have a colostomy-ileostomy; 6) does the patient have a gastrostomy; 7) is the patient on oxygen; 8) does the patient have a tracheostomy; 9) is the patient undergoing either radiation therapy or cancer chemotherapy; 10) does the patient have sterile dressings that require prescription medication; 11) does the patient have decubitus ulcers; or 12) does the patient have unstabilized medical conditions requiring skilled nursing, such as a new stroke, new fractured hip, new amputation, being in a coma, terminal cancer, new heart attack, uncompensated congestive heart failure, new paraplegia or quadriplegia. (Ex. F, pp. 2 - 3)

The *Intermediate Level of Care* factors are: 1) whether a patient requires 24 hour observation and assessment by a registered nurse or licensed practical nurse; 2) whether a patient requires restorative services, which include encouraging, assisting or supervising the patient in self-care, transfers, ambulation, positioning and alignment, range or motion, handrail use; 3) does the patient require a registered nurse to perform services; 4) does the patient require nursing assistance with medications; 5) does the patient require assistance with activities of daily living, including maintaining Foley catheters, ostomies, special diet supervision, or skin care with incontinent patients; 6) does the patient have a colostomy-ileostomy; 7) does the patient require oxygen therapy; 8) does the patient require either radiation or chemotherapy treatment; 9) does the patient have skin conditions such as decubitus ulcers, minor skin tears, abrasions, or

ANALYSIS

Because this is an application, the Claimant has the burden of proof by a preponderance of the evidence.

A Medicaid HCB Waiver services eligibility determination is based upon an assessment performed by the Division or its designee. 7 AAC 130.205(d)(2). The Consumer Assessment Tool (CAT) is the assessment tool used to determine if an applicant satisfies the regulatory requirement that an applicant requires either skilled care or intermediate care. 7 AAC 130.230(b)(2)(B). In addition, the Division determines if an applicant requires skilled care or intermediate care using the factors listed in the *Manual for Prior Authorization of Long-term Care Services* (Manual factors).[7] Eligibility for Medicaid HCB Waiver services is therefore based on the CAT and Manual factors.

A. Consumer Assessment Tool (CAT)

The Claimant may qualify for Medicaid HCB Waiver services if she meets the scoring requirements set out in the CAT. The Claimant's position is that the July 27, 2010 assessment wrongly assessed the Claimant's level of care.

The evidence shows the Claimant has anal cancer, for which she has been treated in the past by surgery, chemotherapy and radiation. She has a colostomy bag. Per her testimony, she is in a great deal of pain, and has been falling recently and injuring herself. She is not currently being treated by either chemotherapy or radiation. She had a nasogastric tube during her recent hospitalization, but the tube was removed prior to her hospital discharge. In addition, the Claimant receives physical therapy on a drop in basis. However, there was no evidence in the record of her having regular physical therapy.

1. Activities of Daily Living

The Claimant did not disagree with the scored activities of daily living, i.e. bed mobility, transfers, locomotion, eating, and toilet use. Accordingly, the scores in the assessment are accepted. The Division scored the Claimant with one "1" in the area of toileting, because of the assistance the Claimant receives in cleansing and with her colostomy bag. If the Claimant had received scores of "3" in three of the scored activities of daily living, bed mobility, transfers, locomotion, eating, or toilet use, she would have qualified for Medicaid HCB Waiver services. (Ex. E, p. 30) However, because she only received one "1" in the area of toileting, she does not qualify for HCB Waiver services based solely on her scored activities of daily living.

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chronic skin conditions; 10) is the patient a diabetic who needs daily supervision of diet or medications; or 11) does the patient have behavioral problems such as wandering, verbal disruptions, combativeness, verbal or physical abusiveness, or inappropriate behavior. (Ex. F, p. 3)

[7] *See* fn. 5 above.

It must be noted that the Claimant testified that she has been falling and injuring herself lately. However, this would not qualify her for a score on the CAT of "3" unless she required weight bearing physical assistance while walking. The record does not contain any evidence that she requires such assistance. Further, in order to qualify for Medicaid HCB Waiver services, she would require extensive assistance (score of "3") with two other of the scored activities of daily living (bed mobility, transfers, eating, and toilet use). However, the record does not contain any evidence showing that the Claimant requires extensive assistance in any of the scored activities of daily living.

2. Professional Nursing Services

This portion of the CAT deals with items such as professional nursing services required for various items, such as nasogastric tubes. Claimant did not present evidence showing that she required any such professional nursing services at the time of her July 27, 2010 assessment.

The Claimant, however, testified that during her recent hospitalization, she had a nasogastric tube, which was removed before her discharge from the hospital. Regardless, there was no evidence presented the Claimant had a nasogastric tube at the time of her assessment. Since her nasogastric tube was removed before her discharge from the hospital, she does not require professional nursing care for a nasogastric tube. As a result, the fact the Claimant had a nasogastric tube while hospitalized does not invalidate the scoring under the CAT and does not qualify her for Medicaid HCB Waiver services.

3. Therapies

This portion of the CAT deals with items such as physical therapy and occupational therapies. The Claimant testified that she receives physical therapy on an intermittent basis when she can make it to the hospital, i.e. it is elective on her part and not a routine part of her medical care. In order for the Claimant's physical therapy to count toward her scoring on the CAT, she would need to receive physical therapy at a minimum of 3 times per week. (Ex. E, p. 30) There is no evidence in the record showing that the Claimant receives physical therapy occurring 3 or more times per week, only that she receives physical therapy on an elective intermittent basis. As a result, the Claimant's intermittent physical therapy does not invalidate the scoring under the CAT and does not qualify her for Medicaid HCB Waiver services.

4. Special Treatments or Therapies

This portion of the CAT deals with items such as chemotherapy and radiation treatment. The Claimant has undergone both in the past. The Claimant, however, presented no evidence that she was undergoing such treatment at the time of her July 27, 2010 assessment, and testified that she was not currently receiving either chemotherapy or radiation treatment. As a result, the CAT correctly scored the Claimant as not receiving any special treatments or therapies.

5. Cognitive Impairments/Behavioral Problems

The CAT scores persons who experience declines in mental functioning and behaviors. The CAT scored the Claimant as having no difficulty in these areas. No evidence was presented challenging that scoring. As a result, the CAT is deemed to have correctly scored the Claimant as not experiencing any cognitive impairments or behavioral problems.

In summary, the Claimant presented minimal evidence challenging the Division's July 27, 2010 assessment, as recorded and scored on the CAT. That limited evidence consisted of her receiving drop in physical therapy services and having a nasogastric tube in place during her recent hospitalization. Neither of those items, as discussed above, were sufficient to result in her receiving an improved score on the CAT. As a result, the CAT correctly found the Claimant did not qualify for Medicaid HCB Waiver services.

B. Manual Factors

The *Manual for Prior Authorization of Long-term Care Services* contains a factor that is not addressed in the CAT. That factor relates to the Claimant's colostomy. (Ex. F, pp. 2 - 3) However, there was no evidence presented that the Claimant requires nursing assistance with her colostomy, merely that she receives help from the Assisted Living Home staff to change the bag. (Ex. E, p. 9) As explained by Ms. Erickson's testimony, assistance with her colostomy bag is not professional nursing assistance. It does not qualify her for Medicaid HCB Waiver services.

Summary

The Claimant had the burden of proof in this case. She did not establish either that the July 27, 2010 CAT was not correct or that she qualified for Medicaid HCB Waiver services based upon the factors contained in the *Manual for Prior Authorization of Long-term Care Services.* Consequently, she did not meet her burden of proof showing that she qualified for Medicaid HCB Waiver services at the time of her July 27, 2010 assessment. The Division was therefore correct when it denied the Claimant's application for Medicaid HCB Waiver services on August 11, 2010, based upon the July 27, 2010 assessment.

CONCLUSIONS OF LAW

1. The Claimant failed to meet her burden of proof by a preponderance of the evidence; she did not demonstrate she required either a skilled nursing facility or intermediate care facility level of care as of July 27, 2010, the date she was assessed to determine her eligibility for Medicaid Home and Community Based Waiver services.

2. The Claimant therefore did not qualify for Medicaid Home and Community Based Waiver services.

DECISION

The Agency was correct to deny the claimant's application for Medicaid Home and Community Based Waiver services on August 11, 2010.

APPEAL RIGHTS

If for any reason the Claimant is not satisfied with this decision, the Claimant has the right to appeal by requesting a review by the Director. To do this, send a written request directly to:

Duane Mayes, Director
Division of Senior and Disability Services
4501 Business Park Blvd., Suite 24
Anchorage, AK 99503-7167

If the Claimant appeals, the request must be sent within 15 days from the date of receipt of this Decision. Filing an appeal with the Director could result in the reversal of this Decision.

DATED this 13th day of December, 2010.

__*/Signed/*________
Larry Pederson
Hearing Authority

CERTIFICATE OF SERVICE

I certify that on this 13th day of December, 2010,
true and correct copies of the foregoing were sent to:

Claimant, USPS First Class Certified Mail, Return Receipt Requested.

And to the following by email:
[redacted], Agency representative
[redacted], Director
[redacted], Policy & Program Development
[redacted], Policy & Program Development
[redacted], Staff Development & Training

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Larry Pederson