

Olympic Area Agency on Aging

Issue Areas and Objectives:

Building Elder Friendly Communities

The Olympic Area Agency on Aging is one of many Area Agencies on Aging (AAA) in Washington to use the Elder Friendly framework in its Area Plan development. The Elder Friendly framework was developed by the AdvantAge Initiative¹, and is based on a comprehensive survey of elders who live at home. Consumer information obtained from the survey is used to ensure planning efforts are responsive to a range of community voices.

The priority areas in the Olympic Area Agency on Aging area plan correspond to the four issue areas below from the **Elder Friendly** framework:

1. Basic needs
2. Optimizing health and well-being
3. Social and civic engagement
4. Independence for frail older adults and people with disabilities

Each issue area is profiled for the O3A region, and contains a broad goal and measurable objectives. In addition, the State Unit on Aging requires that O3A address specific issues relating to Family Caregiver support and services, Aging and Disability Resource Centers (ADRCs), Healthy Aging and Older Native Americans, along with local issues prioritized by O3A. These issue areas are incorporated into the elder friendly framework for this area plan; a state structured administrative policy 7.01 plan is attached specific to Older Native American goals and objectives.

Strategies O3A will use to operationalize the area plan include:

- Developing strategic community and technical partnerships with existing local, regional and state agencies and service providers;
- Targeted information dissemination, public education and advocacy efforts
- Mobilizing additional resources (human, material and financial);
- Building capacity of local community partners (traditional and non-traditional);
- Application of evidence-based program and service models that improve quality of life and enhance the delivery of health services at the community level; and
- Outreach with service delivery responsive to minority populations and those with special needs, as well as the general consumer population.

¹ More information on the AdvantAge initiative may be found on-line at www.vnsny.org/advantage/whatis.html.

Olympic Area Agency on Aging

1. An Elder Friendly Community Addresses Basic Needs

The ability to 'age in place' assumes that we have a safe, secure and familiar place to live; transportation for shopping, social activities and medical visits; information about services in the community, along with assistance to access them; are protected from abuse and exploitation, and can receive assistance in an emergency.

Safe and affordable housing

A significant barrier to remaining at home as we grow older is the cost of housing. Throughout the O3A service region, there is a generally acknowledged lack of affordable housing for all community members,² a situation that is exacerbated for elders, who may face declining or fixed incomes in retirement. Despite an overall increase in the number of subsidized rental units throughout the region, currently, about 35% of senior renters live in housing that costs more than 30% of their annual income.

Property tax relief programs, utility subsidies, reverse mortgages and home equity loans are options for local elders who own their own homes, however, nearly 22% of homeowners still pay more than 30% of their income for housing. The increasing costs of owning and maintaining a home, even one with no mortgage commitment, will continue to make home ownership a challenge. In addition, increasing maintenance costs surpasses the ability for many elders on fixed incomes to keep their properties safe and functional.

As the population of older adults and people with disabilities who are living longer increases, so are rents and property values, as well as costs for other basic items such as food, fuel, medications, and health care. Moreover, housing developers, although responsive to building single family retirement homes, seldom consider rural areas for cost effective projects, further limiting affordable and safe housing to potentially the most isolated, and therefore at risk elders within the O3A region. The growing gap between the demand for and availability of housing means that an affordable place to live will continue to be out of reach for many elders.

In addition to affordability, home safety is an issue as we age and as physical and cognitive abilities diminish. Stairs, doorways, bathtubs, and ovens can present barriers and safety risks not anticipated by people until their specific and special needs increase. Many times, people have to move because their homes are no longer safe or user friendly. Looking at how homes are designed and adapting universal design features, intended for all ages and designed for a lifetime, can go a long way in allowing people to live independently in their own homes as long as possible.

Fortunately, it is possible to make the home environment safer with relatively simple modifications, such as wheel chair ramps, grab bars, and raised toilets. Home modifications can be expensive, however, and many people over the age of 60 with disabilities do not have the modifications they may need to remain safely in their chosen environment. Home modification is a service currently offered for clients through O3A contracted vendors, and a number of local providers, who often provide the service at reduced rates or the cost of supplies.

² Affordable housing is defined as mortgage or rent and utilities that do not exceed 30% of the household's annual income.

Olympic Area Agency on Aging

Transportation

It is not surprising, given the explosive growth in the older population in the O3A service region, that a growing number of vulnerable adults lack access to public or private transportation. Anecdotal evidence from emergency first responders indicates that an increasing number of people are relying on 911 response teams for transportation to emergency facilities for non-emergency care. This includes older adults and adults with disabilities who do not drive; do not have access to a private vehicle; and either cannot afford or may be too frail to access public transportation.

Supporting these older adults to age in place and live independently in their own homes requires an infrastructure that enables access to medical and health care, and supporting services. The rugged geography and rural nature of the service region present significant challenges, including access to adequate medical care -- many older adults with chronic or complex medical conditions must now travel to other counties or states for specialized care that does not exist in the service region. These seniors and people with disabilities are often unable to tolerate multiple transfers and long waits to access the public transit system; may be unable to drive or without access to private transportation. They can easily become isolated and dependent on emergency services and transportation.

Linking older people with goods, supports, services and activities in the community becomes a greater challenge as people outlive their ability to drive. On average, men will live an average of six years and women an average of 11 years after they stop driving.³ Furthermore, only 3% of older people use public transit⁴ due to concerns about safety, schedules and connections to needed destinations. For these elders, living in the rural and often remote communities of the Olympic peninsula, social isolation and the inability to access basic needs becomes a significant risk to their health, well being, independence, and ability to age in place.

A recent change in federal funding guidelines for transit agencies provides an opportunity to improve coordination of transportation services for elders and persons with disabilities. In order to receive federal funds in the next biennium, public transit agencies were required to demonstrate coordination with social service agencies. O3A has participated with regional transportation planning organizations (RTPOs) to develop coordinated plans for Peninsula (Jefferson, Clallam counties) and Southwest Washington (Grays Harbor, Pacific counties) regions.

In addition to identifying unmet needs for public transportation, these planning efforts revealed the need for better support and coordination of volunteer transportation services, as well as responsive services for residents who are unable to access public transportation.

O3A provided technical assistance to the RTPOs to develop a scope of work for the position of Mobility Coordinator, which would be based within a local transit agency, and be responsible to:

³ Foley, D. et al. Driving Life Expectancy of Persons Aged 70 Years and Older in the U.S." *American Journal of Public Health*, August, 2002, vol 92, no 8.

⁴ Rosenbloom, S. "The Mobility Needs of the Elderly," *Transportation in an Aging Society: Improving Mobility and Safety for Older Persons*, Washington, D.C.: U.S. DOT, 1995.

Olympic Area Agency on Aging

- identify existing community resources;
- ensure access to services;
- serve as a key 211 resource link;
- coordinate a uniform volunteer driver training and utilization program; and
- contribute to local emergency preparedness capability by identifying vulnerable, home bound residents, and linking them to appropriate services in an emergency situation.

Grays Harbor Council of Governments included this position in its application to the WSDOT Public Transportation State and Federal Consolidated Grant Program for the next biennium, and Clallam Transit (along with O3A) has received funding from the Agency Council on Coordinated Transportation (ACCT) and Community Transportation Association of America (CTAA) to further explore this concept in Clallam and Jefferson Counties.

Information and assistance to access benefits and services

Information about available services is consistently identified as one of the top needs of older adults. Consumers are concerned about having access to this information, and because of the rural nature and high proportion of older adults in the service area, O3A recognizes information and assistance as a basic need.

General public awareness of O3A's Senior I & A services increased over the last two years, as I & A staff responded to the high demand for assistance with Medicare Part D with group presentations and individual help to navigate the plans. This has resulted in a growing number of people contacting local I & A offices for help with screening for benefit eligibility. O3A maintains a website and has excellent access to media publicity through two weekly radio programs reaching approximately 21,000 listeners throughout the Olympic peninsula, and popular weekly newspaper columns in several local newspapers, with a combined audience of over 42,000 readers.

Accessing human services, including Senior I & A, will become more streamlined as the 2-1-1 service phone line goes into wider use. O3A Senior I & A participates in two regional 2-1-1 programs, 2-1-1 of the Peninsulas serving Jefferson, Clallam and Kitsap Counties, and the South Regional Call Center serving Mason, Thurston, Grays Harbor and Pacific Counties. Although implementation of the 2-1-1 program has been somewhat uneven, and requires that O3A participate in two service regions, the potential for this service to generate smoother access to information on senior issues will eventually benefit elders throughout O3A's four service counties.

Aging and Disability Resource Center (ADRC)

The 2006 reauthorization of the Older Americans Act, along with the passage of the Lifespan Respite Bill align with local community assessments calling for a coordinated system to provide comprehensive information on a full range of available public and private long-term care services. Recent national and state initiatives focus on transforming Senior Information and Assistance and the 211 resource into an Aging & Disability Resource Center (ADRC) format to serve a wider population. O3A will evaluate current capacity (internal and external) for potential development of a partnership that can implement a regional ADRC. In the evaluation, O3A will identify

Olympic Area Agency on Aging

challenges in realigning current I&A services into an ADRC; how the challenges can be addressed; what other resources may be needed and community partnerships to meet those needs.

A regional ADRC might include, but not be limited to information and resources on; Personal Care Services, Information & Assistance, and 211, Benefits Check-ups Screenings, Family Caregiver Resources & Services, Kinship Caregiver Resources & Services, Respite Assessments & Services, Case Management Services, Statewide Health Insurance Benefits Assistance, Mental Health Services, Developmental Disabilities Services, Legal Services, Long-Term Care Ombudsman Services, Residential Care Services, Home & Community Services, Transportation Services, Employment Options and Opportunities, with Counseling & Services, Wellness Programs, and a variety of other Community Programs and Services.

Abuse & Exploitation

Elder abuse can include verbal abuse, physical aggression and beatings, psychological trauma (such as being isolated from others or being severely criticized), sexual and financial exploitation and abuse, and self-neglect. Nationally, reported incidents of elder abuse grew by 150% over the past 10 years; some estimates are that between 3 and 4 percent of the aging population have been abused or neglected. In 2003, APS received almost 600,000 reports of abuse nationwide, a 20% increase over 2000 figures. Two-thirds (66%) of elder abuse victims were female. Of the victims aged 60+, 43% were 80 years of age and older.

Some experts believe these numbers are too low, as many cases of abuse and neglect typically go unreported. Neglect can be defined as the failure of a caretaker to provide goods or services necessary to avoid physical harm, mental anguish or mental illness, for example, abandonment, denial of food or health related services.⁵

Self-neglect is regarded as an adult's inability, due to physical or mental impairment or diminished capacity, to perform essential self-care tasks including obtaining essential food, clothing, shelter, and health care; obtaining goods and services necessary to maintain physical health, mental health, or general safety, and/or managing one's own financial affairs. Choice of lifestyle or living arrangement is not, in itself, evidence of self-neglect.

As scarce resources and the increasing population of older adults begin to meet one another, risks to individual safety will increase, leaving the most frail and vulnerable open to abuse, neglect and personal and financial exploitation. Interrupting and decreasing abuse, neglect, and exploitation of vulnerable adults requires consistent public education to raise community awareness about the issue, along with expert advice and counseling for individuals on how to recognize and decrease their risks.

Emergency Preparedness

Residents of the Olympic Peninsula are generally familiar with emergency situations caused by winter storms, including prolonged power outages, road and bridge closures, and damage to buildings caused by flooding and fallen trees. In the wake of September 11th and Hurricane Katrina, local county governments and emergency response

⁵ Administration on Aging, *Fact Sheets, Elder Abuse Prevention*.

Olympic Area Agency on Aging

agencies are actively engaged in community-wide planning to improve readiness especially in major emergencies. O3A's Senior Information and Assistance program is a natural community partner for the dissemination of information. Designated O3A direct service staff currently participate in these planning efforts throughout the service region in order to inform local emergency operations leadership about the needs of older adults and adults with disabilities in emergencies, and to obtain current information on resources and recommendations on steps local seniors can take to improve their own readiness. O3A communicates information on individual and household emergency preparedness via the media (newspaper columns and radio broadcasts), as well as in pamphlet form.

The Older Americans Act recently added new requirements for state and area agencies on aging disaster and emergency planning, and AAAs are required to develop emergency plans for their local offices⁶. Over the next four years, O3A will ensure its emergency preparedness planning meets these criteria as well as those specified in *Standards for Professional Information and Referral*⁷. AAAs must:

- Designate staff to participate in local emergency planning efforts;
- Establish and maintain working relationships with local emergency operations leadership and other local partners, such as the Red Cross, and participate in drills, exercises and other preparedness activities;
- Develop criteria to identify high risk clients and procedures for contacting and referring them to first responders as necessary;
- Ensure subcontractors have emergency preparedness plans in place; and
- Develop an Emergency Operations and Business Contingency plan to ensure the AAA can remain operational and assist local response efforts in emergencies. .

Goal: Basic Needs:

Elders and adults with disabilities are able to meet basic needs. This means that elders and adults with disabilities can achieve the following:

- live in a safe, secure and familiar place;
- access transportation for shopping, social and medical visits;
- receive information about services in the community, along with assistance to access them;
- be protected from abuse and exploitation; and
- receive community assistance in emergency situations.

Objectives

⁶ DSHS, ADSA HCS Management Bulletin, H07 (Draft), August, 2007.

⁷ *Standards for Professional Information and Referral*, Version 5.1, Approved June, 2006. Alliance of Information and Referral Systems.

Olympic Area Agency on Aging

1) Increase safe, affordable housing for elders and people with disabilities

a. Advocate with local civic planners, affordable housing advocates and housing developers to expand and create safe, decent and affordable housing units, as evidenced by:

- Dissemination of information to local civic planners, affordable housing advocacy groups and housing developers on the demographic trends affecting the local market, along with information on elements of safe, affordable housing that supports people to age in place; and
- Develop an Olympic Area Agency on Aging award and publicity for local housing development projects that promote an Elder Friendly environment that supports people to age in place with a focus on universal design and community livability standards.

b. Promote and publicize the benefits of home modifications, and programs to reduce costs associated with housing (e.g., property tax relief, utility subsidies, etc.) in concert with local providers and vendors as evidenced by:

- O3A newspaper columns, radio shows and web sites with information on the benefits of home modifications and programs to reduce costs associated with housing;
- Dissemination of “home safety” flyers through PUD & property tax bills; and
- Vendor / provider participation in events such as O3A Falls Prevention Awareness workshops.

c. Ensure sufficient vendor options for home modification services for clients through contracted service provision, as evidenced by:

- Contract development mechanisms with varied providers in all four-service counties to assure client needs are met;
- Provide ongoing contractor monitoring, evaluation and technical assistance to assure contractors remain in good standing and are able to provide appropriate services to clients; and
- Identify # of clients benefiting from home modifications, their satisfaction with the service, and any needed enhancements to the program services, through assessment of current vendors & services.

2) Increase transportation options for elders to access basic community services

a. Coordinate with local and regional transit coalitions and volunteer agencies to improve access to transportation for elders and people with disabilities throughout the region, as evidenced by

- Support (and funding) for county mobility coordinator position(s) within transit agencies;
- Volunteer agencies providing door-to-door volunteer transportation service improve recruitment and training, including defensive driving and vehicle safety checks;
- Enhanced volunteer agency capacity to increase volunteer driver recruitment and retention; and

Olympic Area Agency on Aging

- O3A continued participation in regional transportation coalitions to provide information and data on needs of rural elders, and advocacy to increase resources and responsive services.

3) Increase access to benefits and services

a. Through Senior Information & Assistance, empower older people, their families, and other consumers to make informed decisions about, and to be able to access, existing health and long-term care options, as evidenced by:

- Partnerships with community based providers;
- O3A participation in rolling out 2-1-1 services;
- Consumers feedback indicating streamlined access to health and long-term care options/services;
- Information dissemination and personal counseling for individuals, including middle-aged individuals, to plan for future long-term care needs;
- Consumer-based service development responsive to consumer preferences and needs, i.e. “wrap around services”;

b. Evaluate capacity (internal and external) for potential development of a regional ADRC

- Development of local and regional Aging and Disability Resource Centers; and
- Increased & targeted outreach to special needs groups to ensure all community members and resources are included in Resource Center Data.

4) Strengthen protection from abuse and exploitation

a. Coordinate local and regional efforts among community agencies and businesses to revive the Gatekeeper Program across the four-county region. Provide support and encouragement for caregivers to increase self-care activities that will promote a positive caregiving environment, as evidenced by:

- Resources (funding, staffing) mobilized to strengthen the gatekeeper program;
- Training provided to appropriate community members, e.g., bus drivers, mail carriers, meter readers, and faith-based and neighborhood communities and businesses, on signs of abuse and what to do about it;
- Public education on warning signs of escalating and potentially abusive situations, and where to turn for help/assistance;
- Public education to raise community awareness about local and national financial exploitation schemes

b. Promote benefits of counseling and respite care for caregivers resulting in:

- Increased awareness among paid and unpaid caregivers of options for respite care, support and counseling services.

5) Develop Emergency Preparedness role for O3A

a. Coordinate with and inform local emergency preparedness efforts on the needs of local area elders and adults with disabilities, and ensure the

Olympic Area Agency on Aging

infrastructure exists to assist frail and home-bound adults in emergency situations as evidenced by:

- Designated O3A direct service staff participation in planning efforts of local emergency operations leadership, including drills, exercises, and other activities;
- Letters of agreement with local emergency operations leadership (county emergency management, fire department, law enforcement, local transportation providers, and emergency medical services);
- O3A Emergency Operations and Business Continuity Plan exists and staff are trained to understand their roles and responsibilities (both personal and professional) in emergencies;
- O3A's plan includes criteria to identify high risk clients, along with contact and referral protocols in emergencies;
- Subcontractors have emergency plans in place for their programs, and have trained staff in their implementation; and
- Dissemination of local emergency preparedness information to local seniors, including information on what resources will be available should there be an emergency, and how to access them.

Olympic Area Agency on Aging

2 An Elder Friendly Community Optimizes Health and Well-Being

Although life spans are increasing, many older adults are affected by disability or activity limitations due to physical, mental, or emotional conditions. The Centers for Disease Control estimates that nationally about 80% of older adults have at least one chronic condition, and 50% have at least two. These conditions can cause years of disability, pain, and loss of function. Quality of life suffers as a result, and demands on family and caregivers can be challenging.

Overall U.S. health care costs associated with the aging population are projected to increase 25% by 2030,⁸ further straining a national healthcare system that is not prepared to address the geriatric needs that currently exist⁹. With more than a quarter of the population on the Olympic peninsula over the age of 60, the O3A service region is confronting today what the nation will face in 2030. The situation on the peninsula, because of its rural nature, is made worse by the shortage of primary care providers and inadequate transportation options.

Medical and health care in the region is severely limited

Many physicians refuse or limit the number of Medicaid or Medicare clients they see because they are unable to recover the costs of processing the claims. Medical doctors are leaving the community for better financial situations elsewhere and people of any age moving to the region face long wait times to access the limited, non-emergency care options provided by local community health providers.

Preventive services and screening

Medicare pays for some medical screening for older adults including bone density tests, colorectal cancer examinations, glaucoma screens, mammograms, pap and pelvic examinations, prostate screening, and influenza, hepatitis B or pneumococcal vaccinations. Nationally, however, one in three elders do not receive influenza vaccine, fewer receive other vaccinations, and nine of ten do not use their benefit for health screening.

While the health care system is certainly responsible for some of the lack of access to necessary screening, seniors themselves are also reticent to be screened for illnesses because they fear the results, the treatment expense, or believe it is too late to be of any benefit. Some simply cannot access health care providers close to home to receive the benefit.

Problems of mental illness and depression are increasing

The needs of older adults for mental health care remain essentially unmet. Currently, mental health services available on the Olympic Peninsula offer limited outpatient therapy, consultation, client evaluation and education. Within O3A's four county service region population of 185,000, the Washington State Office of Financial Management records an astonishing 70,632 incidences of all types of disabilities across all ages¹⁰. Of these, 11,695 are identified as mental health disabilities; with 3,483 of these

⁸ www.cdc.gov

⁹ Gawande, A. "The Way We Age Now", Annals of Medicine © the Richard Avedon Foundation, April, 2007.

¹⁰ Washington State Office of Financial Management, *Disability Profile*, 2002.

Olympic Area Agency on Aging

identified in people over the age of 65. These data show that a significant proportion of older people in need of mental health services may also be experiencing difficulties with the process of aging and/or other health issues, including debilitating chronic disease, as well as a lack of mobility, transportation, and personal support services.

Depression affects 10-20% of individuals 65 and older,¹¹ however, less than 3% of Medicare reimbursement is for psychiatric care. The onset of chronic illness for people 50 and over often leads to depression, the most common mental health concern for older adults. "The presence of a chronic ailment is closely tied to functional capacity. Age and the presence and duration of chronic disease significantly decrease the ability to perform activities of daily living. Dependence on others in regard to shopping, bathing, and dressing has a negative impact on one's self esteem and self worth."¹²

Many primary care physicians are not trained to screen for mental illness in older people, and, unfortunately, may attribute psychiatric symptoms to 'normal aging' or to chronic physical illness. As a result, close to 90% of depressed older patients in primary care get no treatment or inadequate treatment, despite the availability of effective treatments. Only 3% receive treatment for mental disorders from a mental health specialist.¹³ If left untreated, mental disorders can have significant consequences, including increases in disease, disability and mortality. In fact, men age 85 and older currently have the highest rates of suicide and depression is the foremost risk factor identified. Evidence suggests that up to 75% of older adults who commit suicide have visited a primary care professional within 30 days of their death.

Excessive consumption of alcohol and prescription drugs

Substance abuse by older adults often goes undetected and effective treatment for alcohol and drug abuse in older adults has not been well-studied. Older adults experience many changes, both physically and emotionally as they progress through the aging experience. Some will choose to self-medicate in attempts to cope with loss, physical disability, and loneliness. Those with chronic, painful diseases such as arthritis, osteoporosis and cancer, or psychiatric disorders such as depression or anxiety, are more likely to drink or take substances.¹⁴ About one third of all older substance abusers began taking substances after the age of sixty. Half of emergency room visits by older adults are related to consequences of alcohol or substance abuse.

O3A promotes mental health services through contracted professional mental health counseling services, which serves a limited number of individuals, and a senior peer counseling model that supports seniors in their homes with referral to community resources and one-on-one peer support and assistance.

In line with the current research efforts, the Olympic Area Agency on Aging will evaluate a proactive depression management project / program model designed to (1) reduce

¹¹ Sullivan, M. et.al. "Stepping Out on Faith: Geriatric Mental Health in 2015," Project 2015: The Future of Aging in New York, <http://aging.state.ny.us/explore/project2015/artEld.pdf>, p. 111.

¹² Sullivan, M.et.al. p.112.

¹³ The State of Aging and Health in America, The Merck Institute of Aging and Health, and The Gerontological Society of America, 2003.

¹⁴ Widlitz, Michelle and Marin, Deborah B. 2002. Substance abuse in older adults: An overview. Geriatrics, Volume 57 (12), p 29-34.

Olympic Area Agency on Aging

incidences of depression and (2) increase the quality of life for clients suffering from mild depression that may include:

- A train the trainer model utilizing peer counselors and/or case managers;
- Teaching clients to (a) recognize symptoms of depression and (b) develop structured steps that they can use to help solve problems;
- Helping clients develop plans for increasing levels of social and physical activity; and
- Helping clients to plan for increasing their participation in enjoyable activities.

Oral health care is even more difficult to find in our communities.

Few dentists take Medicaid for adult patients and those who do quickly find their practices full to overflowing. Access to special dental treatments, such as dentures and endodontal care, is limited to seniors who can afford to pay. Many of the elder poor have no teeth at all, which seriously compromises their nutrition. Oral cancer, xerostomia (dry mouth) and other oral health problems go untreated in older adults, often until a serious threat to life and health ensues. Elders living in skilled nursing facilities usually have little or no access to oral health care. Poor oral hygiene and lack of professional assessment put them at risk of serious oral disease and related complications.

Access to prescription drugs is an ongoing problem

Many elders lack medical insurance with drug coverage. The high cost of medications, coupled with the large number of medications taken by older adults, make appropriate use of prescribed medications extremely challenging, and frequently unmet. Assistive devices, such as hearing aides, glasses, and walkers are unaffordable to many elders; Medicaid does not cover all the devices needed by elders, and elders who are ineligible for Medicaid simply do not have access. Elders are often faced with making difficult choices between food, rent, medications, or other health needs.

Palliative care is underutilized and not well understood

Although hospice care is available through Medicare and Medicaid, it is underused. Older adults are generally unaware of all that is involved in planning for end-of-life. Elders may have a 'living will', but be unaware that palliative services, which are not limited to 'terminally ill' people, can also be an effective way to manage chronic pain.

Food insecurity is higher in Washington State.

Washington had poverty rates more than two percentage points below the national average, yet the prevalence of food insecurity was 11.9 percent—well above the national average of 9.7%.¹⁵ Another indicator of food insecurity is participation in the Basic Food Program, a critical source of nutrition assistance for low-income older adults in the U.S. One in five of the 7.3 million food stamp households in the U.S. are headed by an adult age 60 and older.¹⁶

¹⁵ Nord, M., K. Jemison, and G.W. Bickel. 1999. Prevalence of Food Insecurity and Hunger by State, 1996-1998. Food and Nutrition Research Report No. 2, USDA, Economic Research Service, Sept. 1999.

¹⁶ Gabor, Vivian et al. "Seniors View of the Food Stamp Program and Ways to Improve Participation: Focus Group Findings in Washington State," 2001.

Olympic Area Agency on Aging

Elders who live alone are at greatest risk for food insecurity. Factors which increase an elder's risk include functional impairments, social isolation and poverty. Although nationally about 20% of low-income seniors participate in some aspect of senior nutrition programs, many more seniors are unwilling to accept assistance. In O3A's service region, the home-delivered meals program is an important part of the safety net for frail, homebound elders, and it serves as a referral mechanism to other services, notably Senior I&A and in-home care services. Some elders decline to participate in congregate nutrition programs because 'they are for old people.'

Poor health is not an inevitable result of aging. Preventing health problems is one of the few known ways to stem rising health care costs and help seniors remain independent for as long as possible, which can improve their quality of life and delay the need for costly long-term care. Prevention becomes more important especially in O3A's rural setting, where healthcare services are relatively scarce and unaffordable to many. Studies show that preventive measures such as increasing physical activity, improving nutrition, reducing alcohol consumption, and utilizing health screenings and immunizations can help with managing chronic conditions and reducing associated disabilities as people age.

Goal: Optimizing health and well-being:

Elders and adults with disabilities have the knowledge, support and services to achieve optimal health and well-being. They can achieve the following:

- Manage their chronic illness;
- Prevent disease and injury;
- Obtain health and nutrition education;
- Obtain nutritious food and affordable medications; and
- Access medical, mental and dental health services.

Objectives

1) Provide training to manage chronic illness

Empower older adults and adults with disabilities to manage their chronic illnesses as evidenced by their participation in:

- a. The Intensive Chronic Care Management program for state-designated Medicaid clients; and**
- b. Chronic disease self management program¹⁷ workshops for seniors and adults with disabilities who wish to improve their ability to manage their own chronic conditions.**

2) Provide education and promote disease and injury protection

Raise community and individual awareness on the benefits of preventive screenings and interventions, as evidenced by:

¹⁷ The chronic disease self management program is an evidence –based program developed by Stanford University.

Olympic Area Agency on Aging

- a. Falls prevention workshops and other public education events;
- b. Mini screening clinics, e.g., blood pressure, blood glucose, vision, depression, nutrition, gait, etc.; and
- c. Funding realized and coordination with appropriate partners strengthened to increase influenza and pneumonia vaccination rates.

3) Provide targeted public education on topics important for healthy aging

- a. Conduct public health education and promotion on health topics important to aging adults (including benefits of physical activity and safe and effective medication management), as evidenced by:
 - Provider activities to provide consumer health education directly; and
 - O3A Falls Prevention workshops, and seminars on medication management and other important health topics.

4) Provide nutritious food and nutrition education

Provide nutrition and nutrition education as evidenced by

- a. Participation in O3A-sponsored senior meals programs;
- b. Provider and O3A education and information on healthy eating habits and meal preparation; and
- c. Participation the Senior Farmers' Market Nutrition Program.

5) Increase access medical, mental and dental health services

- a. Conduct advocacy and coordination efforts to increase access to medical, mental and oral health services across the O3A service region, as evidenced by
 - Advocacy for improved Medicare reimbursement rates;
 - Increased local and regional transportation options; and
 - New local resources (e.g., funding, personnel, pilot programs) to increase service delivery options on the Olympic peninsula.
- b. Evaluate a proactive depression management model that reduces depression & increases quality of life for clients suffering from mild depression, that may include:
 - A train the trainer model utilizing peer counselors and/or case managers;
 - Teaching clients to (a) recognize symptoms of depression and (b) develop structured steps that they can use to help solve problems;
 - Helping clients develop plans for increasing levels of social and physical activity; and
 - Helping clients to plan for increasing their participation in enjoyable activities.

Olympic Area Agency on Aging

3 An Elder Friendly Community Fosters Social & Civic Engagement

Social engagement is an important aspect of maintaining mental, emotional, physical health, and independence. Studies have shown that social isolation may be the strongest predictor of premature death. Physical and/or mental decline in older adults happens faster and more frequently in those who have no social ties. It is important for people to have frequent contact with relatives and friends and to participate in regular social activities. Maintaining social contact for older adults does much more than enhancing the quality of life -- it is a basic and critical component to any service strategy that has a goal of fostering health and well being for elders.

Given the economic and geographic constraints facing people on the Olympic Peninsula, the O3A Advisory Council is concerned that many older retired people in our service region are isolated from mainstream society. Older seniors, and those with more significant needs for assistance with activities of daily living, are more likely to become socially isolated and unable to access opportunities for social and civic engagement. Many older seniors have outlived friends and acquaintances, and elders who chose to relocate here when they retired may not have family support close by.

The more rural areas on the peninsula have fewer structured programs and activities than are accessible to seniors living in more urban areas. Frail elders in particular are less likely to be able to travel to activities outside their immediate neighborhoods, especially if they lack access to private transportation. With limited public transportation options for these older rural seniors, access to social and civic activities is quite limited.

O3A recognizes that while retirement can be a time for leisure activities and relaxation, it can also be a time for active engagement within the community, through recreational, social and civic activities, paid employment or volunteering. Most people can expect to live up to 20 years after retirement, almost a quarter of their lives.

Retirement is often interpreted as opportunity for extensive travel, ample leisure activities, and engaging in artistic outlets. Without question, many retirees look forward to leisure time after spending years in the full time work force. However, the transition from productivity to idleness and from being socially connected to being suddenly isolated can be difficult. Many elders effectively adapt to this by re-inventing how they engage with the community after retirement, for example, through service on boards and councils of community service organizations, civic advisory groups, churches, schools and volunteer programs, as well as through second careers. Remaining active within the community is not only beneficial to older adults from social, economic, health, and well-being points-of-view; it is also clear that older people have tremendous talent and experience to contribute to the community and the overall society.

Recent trends point to more seniors interested in remaining in the work force, as they grow older, for a combination of reasons, including the desire to maintain social connections and personal satisfaction, as well as financial constraints that preclude retirement. Many of these seniors face barriers in the workplace, including ageist stereotypes about their productivity and effectiveness. As the work force continues to

Olympic Area Agency on Aging

mature in the O3A service region, it is clear that more local employers will need to look at how to create multigenerational work environments that accommodate older workers.

For many older adults, staying physically active and socially engaged also helps maintain good health. Elders who are isolated, often times leading a sedentary lifestyle, can be prone to depression, physical deterioration, and an earlier death. Older adults should be encouraged to get outside, take long walks, and take part in social interaction. Many communities within our region, such as Sequim in Clallam County, are recognizing the needs of elders and are building miles of walking trails, with exercise stations, that accommodate walkers, runners, bicyclists, and wheelchairs. In Jefferson County, the Disability Awareness Starts Here (DASH) project has advocated effectively with civic, private sector and service groups to enhance access through changes to the built environment, for example in public buildings, businesses, and sidewalks.

A wide variety of community services and programs exist to facilitate social and civic engagement, such as RSVP (Retired Senior Volunteer Program), peer counseling, tutoring or mentoring programs, church programs for elders, volunteer transportation services, and service on boards and advisory councils. Senior and community centers provide social, recreational and educational opportunities, and volunteer centers and intergenerational programs offer ways for elders to share their experience, wisdom and skills for the benefit of the community.

Goal: Social and Civic Engagement:

Elders and people with disabilities participate fully in all aspects of social and community life. Elders and people with disabilities can do the following:

- Obtain volunteer and paid employment;
- Engage in civic, social and cultural community life; and
- Participate in recreational and intergenerational activities.

Objectives

1) Increase opportunities to obtain volunteer and paid employment

a. Promote and expand paid employment options for older adults and people with disabilities through coordination with community partners who provide training, support and employment, as evidenced by:

- promotion activities within the local business community of the benefits of employing older workers;
- promotion of the Senior Community Service Employment Program (SCSEP) at local community events and fairs;
- direct assistance to seniors with job search training and support;
- increase number of seniors employed each year;
- increase in agencies agreeing to host SCSEP participants each year; and
- increase in employers providing on-the-job opportunities for SCSEP participants.

Olympic Area Agency on Aging

b. Build capacity of local institutions, such as faith based organizations, to develop volunteer programs that provide services and volunteer opportunities for seniors, as evidenced by

- increased O3A collaboration, partnership and technical assistance for local agencies to increase volunteers services and opportunities.

2) Increase opportunities to engage in civic, social and cultural community life

a. Incorporate into O3A programs best practice approaches that provide regular contact for elders, particularly those living alone, or living in rural areas where access to social activities is limited or non-existent, as evidenced by:

- resource mobilization to pilot / integrate best practice approaches, such as, for example, the TimeBanks¹⁸ model, a volunteer community service exchange program;
- support for partner efforts, such as peer counseling, to provide regular contact for elders at risk of social isolation;
- promotion, with local partners, of activities designed to pair older adults with younger community members in social or educational settings; and
- promotion with local partners, e.g., in provider meetings, for programs such as NorthWinds Arts Council program to provide elder art classes in residential facilities and Songwriting Works, an evidence-based approach for working with persons with dementia.

3) Increase opportunities to participate in recreational activities

a. Explore opportunities for contribution to local government planning processes that regulate design and construction of neighborhoods, recreational facilities, and exercise trails, as evidenced by:

- dissemination of information on universal design and access to local planning groups.

4 An Elder Friendly Community Maximizes Independence for Frail Older Adults and Adults with Disabilities

In home services

In the O3A service region, there are more than 1,300 older adults and individuals with disabilities living at home receiving publicly funded Medicaid personal care and other supportive services. In spite of the impressive regional demographic shift towards more older adults, the overall in-home caseload within the O3A service region is declining somewhat, reflecting various factors, including declining disability rates for older adults and reluctance of otherwise eligible individuals to accept services, thereby entailing their estate or their family's inheritance. As one tribal program manager put it, "Our elders need services, but they don't want to give up their land."

¹⁸ TimeBanks is a community volunteer service exchange model with active programs in 22 countries, www.timebanks.org

Olympic Area Agency on Aging

Within the O3A Medicaid caseload, the percentage of younger adults with disabilities is **increasing**. Younger clients tend to consume more of the case manager's time to deal with "quality of life" issues such as socialization, education, employment, increased mobility and communication needs, as compared with older consumers. The current per capita funding formula does not respond to these issues, resulting in less client choice and control and increased pressure on the case management system to provide effective services for these clients.

The proportion of people with disabilities who also have self-care limitations increases in the 65-plus age groups, and the prevalence of self-care limitations increases sharply for people in the 75-and-older age group. People in this group are more likely to have physical or sensory limitations or to be unable to get out of the house. Although the rates of disability for older adults have declined overall, older adults with less education and lower incomes have not yet experienced these declines. For these case managed clients there is a need to integrate other types of services, such as those provided through Senior I & A and SHIBA, to support a substantial increase in client-directed service provision.

Medical acuity and complexity of client care is increasing, reflecting a long term care system that has surmounted significant challenges as it adjusts to serve case managed clients to age in place in an environment where institutionalization is not an acceptable option. The increasing medical complexity of client care will present even more challenges in future, requiring successfully blending medical and social support, and statewide advocacy to achieve needed change.

Case-managed clients on the Olympic peninsula face severe gaps in services due to lack of adequate transportation options, inadequate local medical and rehabilitation services, and a lack of available medical care providers.

Nearly a third of adults over the age of sixty on the Olympic peninsula live alone, compared with the state average of about 20%. As this population segment increases with more seniors relocating to the area to retire, it is clear that communities on the Olympic Peninsula need to strengthen their capacity to respond with available, affordable and appropriate services for older adults and adults with disabilities who may be without family, social or personal support.

In the next 20 years, the number of people who need long-term care assistance will double. The increased demand for services will require development and support of a workforce of professional and informal family and kinship caregivers. O3A will work with the State Unit on Aging and our community partners to support family and kinship caregivers, improve career options for professional caregivers, offer chronic care management, encourage patient self-management, and provide home care services that meet required quality standards.

Approximately 80% of caregivers are family members who need support and respite themselves. Approximately 20% of those who need ongoing care to stay at home do not have family members to care for them. These people often receive care from paid home care workers. Home care serves as the foundation for a growing number of people with disabilities and self-care limitations who wish to remain in their own homes.

Olympic Area Agency on Aging

In recent years, the cost of providing in-home services to our communities has increased extensively, due to a number of factors:

- insurance coverage for service providers has become more expensive as insurance companies have associated higher risks with providing services to an aging population;
- a dramatic increase in transportation costs for service providers;
- the high costs to develop and support a decentralized, local structure to meet the needs of frail elders and adults with disabilities living in remote service areas, and
- reimbursement rates for in-home care services have not kept pace with increasing costs.

Not surprisingly, the work force on the Olympic peninsula is older than many other areas in the state, with fewer younger workers owing to limited employment opportunities. In addition, many older workers also find themselves providing care to an elder parent, spouse, sibling or even a child. With younger adults leaving the area to secure employment, there is a growing concern about who will provide the care needed by older adults and people with disabilities.

In an effort to increase the professional caregiver workforce, O3A in 2006 applied for and was awarded a funding contract and support from the Home Care Quality Authority to establish and implement the Home Care Referral Registry throughout the O3A service region. This service supports paid caregivers to receive critical health insurance benefits, training and certification, and can provide support for family caregivers who wish to transition to a paid career in caregiving.

Family Caregiving

National estimates suggest that nearly one-quarter of all people aged 65 and older has a disability that results in their needing some kind of assistance, ranging from infrequent support with activities such as transportation, laundry and housecleaning, to complete physical care around the clock. The majority of older adults also want to remain in their homes with as much independence for as long as possible.

When chronic conditions lead to disability and limitations of activities, many people must rely on family or paid caregivers to provide assistance. The stresses of caregiving, whether by paid or unpaid caregivers, can lead to burnout and potential neglect or abuse. The needs of both caregiver and care recipient must be considered in service development that supports the independence of people with activity limitations wishing to stay in their own homes. Adult Day Services and Respite Care Services, along with Family Caregiver Support Programs, are vital, existing resources that help family caregivers deal with these issues.

- Caregiving can take a heavy toll on caregivers, jeopardizing their health and emotional well-being. Millions of caregivers are spouses, siblings, or children who are in their seventies and eighties themselves. The physical demands, emotional stress, and their advanced age increase their risk for health problems. As a result, it is important to support the caregiver as well as the receiver of care, because caregivers often do not seek medical care nor health or wellness

Olympic Area Agency on Aging

activities for themselves. Many are so involved in caregiving activities, that they are often unaware that services exist, or only seek help when a crisis occurs.

- The economic impact of providing care can be overwhelming for caregivers. Many caregivers make financial sacrifices to support the care of their relative, others give up paid employment to provide care. It is estimated that caregivers miss an average of seventeen days of work each year due to caregiving. This translates into lost productivity for the employer. It is estimated that time off taken by employees to care for a relative with Alzheimer's Disease costs businesses in the U.S. \$7.89 billion a year; when lost productivity is factored in, the loss due to Alzheimer's alone is \$13 billion per year. These estimates do not include the loss to businesses from all types of caregiving.
- More and more employers have started offering flexible schedules, reduced hours, unpaid time off, and other innovative support to accommodate their workers with caregiving responsibilities. This makes it possible for caregivers to remain productive employees while providing care for a relative.
- Understanding the diversity in the caregiving experience can help guide the design and targeting of support services for caregivers. Their receptiveness to services shifts as they move through seven caregiving stages:¹⁹
 1. performance of initial caregiving task;
 2. self-definition as a caregiver;
 3. provision of personal care;
 4. seeking out or using assistive services;
 5. consideration of institutionalization;
 6. actual out-of-home placement; and
 7. termination of the caregiver role.

The order and timing of these stages can help in the design and implementation of caregiver support programs. It is important to create multiple, flexible services that meet a wide range of caregiver needs and to recognize that caregivers use services only when they see the benefits outweighing the monetary, social, emotional or physical costs of using services.

O3A's Family Caregiver Support Program is currently supported by two full time staff in the Aberdeen and Port Angeles. The program currently provides:

- specialized family caregiver information, assistance and counseling;
- support groups for family caregivers;
- support groups for grandparents raising grandchildren;
- respite services; and
- supplemental services, which vary by individual caregiver need.

Given the limited resources currently available for this program, O3A will evaluate the current support, identify strategies to enhance services and outreach, and seek new

¹⁹ Montgomery, R.J. & Kosloski, K.D. "Change, Continuity and Diversity Among Caregivers," Sept. 2001.

Olympic Area Agency on Aging

resource development to strengthen the kinship and family caregiver support programs, including native and minority communities (please reference Issue Area 5).

Goal: Elders and adults with disabilities are able to remain in their own homes with maximum independence for as long as possible, with a coordinated service delivery system that

- Provides support for chronic care management;
- Mobilizes additional resources to support kinship, family and informal, unpaid caregivers;
- Provides training and support for professional caregivers; and
- Expands and strengthens support to unpaid and family caregivers.

Objectives:

1) Expand and enhance long term and chronic care management

a. Advocate for system enhancements that are responsive to needs of people with disabilities, as evidenced by:

- Advocacy activities at state and federal level.

b. Advocate for funding to expand Intensive Chronic Care Management services, as evidenced by:

- Funding and support to provide ICCM services to at least 20 additional case management clients throughout the region.
- Increase training and support to professional caregivers, as evidenced by:
- Caregiver Continuing Education training modules developed that support client chronic care management in the areas of fall prevention, oral health, nutrition and smoking cessation; and
- Home care agencies promote flu vaccination and preventive screenings to caregivers.

2) Increase support for kinship, family and informal (unpaid) caregivers

a. Evaluate current O3A support for kinship, family and informal caregivers by assessing current agency and community resources and the projected needs for service and program development. In particular, O3A will look at how to:

- Structure support services for family & kinship caregivers that integrate current programs; and
- Provide practical information as well as emotional support and emphasize examples of positive coping mechanisms.

b. Identify strategies to enhance outreach and public awareness for caregiver populations with special needs, e.g., caregivers with language barriers; physical and/or mental disabilities; cultural; social or geographic isolation; caregivers of client with dementias; non traditional family caregivers;

Olympic Area Agency on Aging

grandparents & relatives raising children, and caregivers caring for clients with severe impairments. Possible strategies may include:

- Conducting employer / employee seminars to educate about the caregiver role;
- Conducting outreach with medical clinics, home health and hospice personnel to identify at risk caregivers by providing offices with information for referral; and
- Disseminating information on caregiver needs and available support to hospital discharge planners.

c. Mobilize additional resources to strengthen support for kinship caregivers, as evidenced by:

- Advocacy for funding to support Kinship Care navigation program; and
- Additional program and resources developed to support caregivers.

Olympic Area Agency on Aging

5 Outreach and Services for All Elders

Elder friendly communities are inclusive of and responsive to elders from different backgrounds. On the Olympic Peninsula, the predominant demographic configuration for many years comprised a majority of white and minority of tribal people. O3A for many years has worked to increase outreach with service coordination and provision to native elders within the region's nine tribes: Chehalis, Chinook, Hoh, Jamestown S'Klallam, Lower Elwha Klallam, Makah, Quileute, Quinault Nation, and Shoalwater (see attachment, Registered Tribes within the O3A service region).

Though more work is needed, O3A has made progress in developing outreach and service provision within the tribal communities (see attached DSHS Administrative Policy 7.01 plan). In Clallam County, O3A is coordinating with the CARE project, a community partnership effort, funded by the Robert Wood Johnson Foundation, to prepare a Lower Elwha tribal nurse as a Master Trainer in the Stanford University Chronic Disease Self Management Program. The Department of Health has provided Olympic Area Agency on Aging funding to implement this program in both Clallam and Grays Harbor Counties. The training for the tribal nurse in chronic disease self management supports a separate project of the CARE Tribal Healthcare Workgroup, funded by the Washington Health Foundation, to improve chronic disease management for tribal elders in Clallam County. O3A expects to take lessons learned from this effort and adapt as appropriate for other health initiatives benefiting Tribal elders.

Recent years have seen a steady increase of particularly Hispanic and Asian people settling in the region. Although these newer immigrants are still relatively small in number, they do not yet have well-known geographical "bases", such as Tribal affiliations and may not be proficient English speakers. They are not adequately represented by available survey data and community assessments, and therefore it is more difficult to identify and map their service needs and community components.

Another community that is not well represented in community surveys and assessments is the Lesbian, Gay, Bisexual, Transgender (LGBT) community. LGBT elders come from all walks of life -- teachers, postal workers, scientists, ministers, government workers, court judges, business owners, musicians, and lawyers, to name just a few. These elders confront the same barriers to service provision that mainstream populations experience, with the addition of societal biases and social misperceptions that can be addressed through community education, cultural sensitivity and competency training for service providers and others in the community. Washington State recently passed Senate Bill 5336 into law, which protects individuals in domestic partnerships by granting certain rights and benefits, and provides the authority for persons in GLBT and other civic partnerships to participate more equitably in benefits previously available only to spouses.

The Olympic peninsula is home to a large number of veterans, the majority of whom are 60 and older. Many are not able on their own or do not know how to access services that are available to them. O3A conducts outreach activities specifically targeted to this community. In particular, the O3A SHIBA program receives annual updates of changes in Veterans Administration Benefits and makes this information available to community

Olympic Area Agency on Aging

members. As a way to link veterans to employment, SHIBA staff and volunteers refer veterans age 55 and older interested in employment to the O3A's Senior Citizens Employment Program. O3A will continue support opportunities to reach 'hidden' Veterans and link them to benefits for which they are eligible.

Goal: Outreach and Services for All Elders

1) Promote an environment in which elders and people with disabilities from all backgrounds can access culturally appropriate information and services.

Objective:

a. O3A will promote an environment within the mainstream community in which elders, caregivers and persons with disabilities from all backgrounds have access to essential, culturally-appropriate services and support as evidenced by:

- Development of regional mapping for all minority groups;
- Identification of regional and local support systems for each minority group;
- Develop collaborations with identified minority leaders to assist in data collection and community needs assessments;
- Develop targeted outreach strategies specific to each group, designed to meet the needs for information; and
- Incorporate identified services enhancements to assure all minority groups receive culturally appropriate services.

b. Develop targeted awareness effort(s) to support development of culturally-appropriate services as evidenced by:

- Collaboration efforts with minority community leaders, develop effective strategies for information, education and communications (IEC) efforts targeting community at large; and
- Targeting of IEC efforts to enhance local area service providers and agencies.

Olympic Area Agency on Aging

Area Plan Goals and Objectives Matrix

Goal 1 : Elders and adults with disabilities are able to meet basic needs.

Objective 1: Increase safe, affordable housing for elders and people with disabilities

Major Activities	Key Stakeholders	Indicators	O3A Lead	Time Frame	Accomplishment or Update
<p>1.a. Advocate to expand and create safe & affordable housing units.</p> <p>1.b. Promote and publicize home modifications & programs to reduce costs associated with housing (e.g., property tax relief, utility subsidies, etc.) in concert with local providers and vendors.</p> <p>1.c. Ensure sufficient vendor options for home modification services for clients through contracted service provision.</p>	<p>1.a. local civic planners, housing advocates & housing developers & media</p> <p>1.b. local providers & vendors; PUD; local tax assessor; local media</p> <p>1.c. local providers & vendors; O3A direct service staff</p>	<p>1.a. Information provided to stakeholders on demographics & safe housing criteria. Affordable housing award established.</p> <p>1.b. Publicity on home mods & how to reduce housing costs. "Home safety" flyers developed, distributed through PUD & property tax bills.</p> <p>1.c. # Vendor/ provider contracts; # clients w/ modifications</p>	<p>O3A Planning Unit</p> <p>O3A office systems administrator</p>	<p>1.a. 1/2009 – 12/2011</p> <p>1.b. Ongoing</p> <p>1.c. Ongoing</p>	

Objective 2: Increase transportation options for elders to access basic community services

<p>2. Coordinate w/ local & regional transportation coalitions & volunteer agencies to increase options for elders & people with disabilities.</p>	<p>2. State Transport agencies (RTPOs); county transit agencies; local volunteer agencies.</p>	<p>2. Support for county mobility coordinator positions; volunteer agencies able to recruit, train & support more volunteers; O3A participation in RTPOs.</p>	<p>O3A Planning Unit</p>	<p>2. 1/2008 & ongoing</p>	
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Olympic Area Agency on Aging

Objective 3: Increase access to benefits and services					
<p>3.a. Through Senior I & A, provide information to older people, families, other consumers about existing health and long-term care options, and assistance to access.</p> <p>3.b. Evaluate capacity (internal and external) for potential development of a regional ADRC</p>	<p>3.a. Local elders & families & adults w/disabilities; service providers; govt. agencies; I & A staff</p> <p>3.b. Service providers; O3A staff; local elders, local govt agencies</p>	<p>3.a. I&A client data & feedback; provider data base indicates new partnerships</p> <p>3.b. ADRC development plan & partner commitments</p>	<p>O3A Director, Sr I& A</p>	<p>3.a. 1/2008 – 12/2011</p> <p>3.b. 1/2009 – 1/2010</p>	
Objective 4: Strengthen protection from abuse and exploitation					
<p>4.a. Revive Gatekeeper program across the region</p> <p>4.b. Promote benefits of counseling and respite care for caregivers</p>	<p>4.a. community agencies & businesses</p> <p>4.b. paid & unpaid caregivers</p>	<p>4.a. Resources dedicated to Gatekeeper program; training for stakeholders on signs of abuse, how to prevent; public education</p> <p>4.b. # caregivers aware of respite care, counseling options</p>	<p>O3A Planning Unit</p> <p>O3A Director, Sr I& A</p>	<p>4.a 1/2009 – 1/2011</p> <p>4.b. 1/2008 – 12/2011</p>	
Objective 5: Develop Emergency Preparedness Role for O3A					
<p>5. Coordinate w/ local emergency preparedness efforts re: needs of elders & ensure structure exists to assist frail, home bound in emergency.</p>	<p>5. County /local emergency preparedness groups; Am Red Cross; first responders, etc</p>	<p>5. O3A staff participation in local planning efforts; O3A plan exists & staff trained; # subcontractors w/ emergency plans; info to local elders & homebound</p>	<p>O3A Planning Unit</p> <p>Directors, Sr I & A; HR; Nursing Services</p>	<p>5. 1/2008-12/2011</p>	

Olympic Area Agency on Aging

Goal 2: Elders and adults with disabilities have the knowledge, support and services to achieve optimal health and well-being.					
Objective 1: Provide training to manage chronic illness.					
Major Activities	Key Stakeholders	Indicators	O3A Lead	Time Frame	Accomplishment or Update
1.a. Implement the Chronic Disease Self Management program in Clallam and Grays Harbor counties. 1.b. Expand CDSMP to Jefferson and Pacific counties.	1.a. & 1.b. local (& Tribal) health clinics & providers; Stanford Univ; CARE project;	1.a. & 1.b. # participants; # master trainers; # volunteer leaders trained; # workshops held; PAM scores 1.b. New funds for expansion.	O3A Director, Nursing Services O3A Planner	1.a. 1/2008-12/2011 1.b. 1/2010 – 12/2011	
Objective 2: Provide education and promote disease and injury prevention.					
2.a. Provide workshops on preventing falls. 2.b. Promote preventive screenings. 2.c. Promote flu vaccinations	2.a-c. Health depts, clinics, hospitals & providers; Costco; Home Care agencies; senior centers; sponsors	2.a-c. # workshops; # participants; # providers/vendors Publicity in local media Promotion in local media & home care agencies	O3A Director, Nursing Services O3A Planner	2.a. –c. 1/2008-12/2011	
Objective 3: Provide targeted public education on topics important for healthy aging.					
3. Conduct public education & promotion on health topics, e.g., falls prevention, increasing physical activity, nutrition, medication management.	Senior centers & facilities; nutrition programs, local health experts & tech resources	3. # seminars, presentations, workshops # health topics, # participants, # providers conducting education on health topics	O3A Director, Nursing Services	3. 1/2008-12/2011	

Olympic Area Agency on Aging

Objective 4: Provide nutrition and nutrition education.					
<p>4.a. Increase # elders in congregate & home delivered meals programs & receiving education</p> <p>4.b Increase # elders who consume fresh vegetables & fruit</p> <p>4.c Increase # elders at high nutritional risk referred to Sr I & A</p>	<p>Senior nutrition providers; Sr Farmers Mkt partners; Sr I & A staff</p>	<p>4.a # participants in congregate & home delivered meals programs</p> <p>4.b voucher redemption rate ; # recipients w/fresh produce</p> <p>4.c # referrals to Sr I & A</p>	<p>O3A OAA Program Manager, Sr Nutrition Programs</p> <p>Director, Sr I&A</p>	<p>4.a.-c. 1/2008 -12/2011</p>	
Objective 5: Increase access to medical, mental and oral health care.					
<p>5.a. Conduct advocacy and coordination efforts to increase access to health care</p> <p>5.b. Evaluate a proactive depression management model that reduces depression & increases quality of life for clients suffering from mild depression</p>	<p>Local medical, mental and oral health agencies & providers</p> <p>Legislators</p>	<p>5.a&b. Advocacy at federal level</p> <p>Increased transportation options</p> <p>5.a&b. New resources (funding, pilot programs)</p>	<p>O3A Executive Director & Advisory Council</p> <p>Planning Unit</p>	<p>5.a. 1/2008 - 12/2011</p> <p>5.b. 1/2009 – 12/2010</p>	

Olympic Area Agency on Aging

Goal 3: Elders and adults with disabilities are able to participate fully in all aspects of social and community life.					
Objective 1: Increase opportunities for elders and adults with disabilities to obtain volunteer and paid employment					
Major Activities	Key Stakeholders	Indicators	O3A Lead	Time Frame	Accomplishment or Update
<p>1.a. Promote and expand paid employment options for older adults and people with disabilities through coordination with community partners who provide training, support and employment.</p> <p>1.b. Build capacity of local institutions such as faith based organizations, to develop volunteer programs that provide services and volunteer opportunities for seniors.</p>	<p>1.a. SCSEP program; Worksource Centers; community service agencies; hosts of local business and community events.</p> <p>1.b. local community service agencies, churches, local providers, etc.</p>	<p>1.a. # Presentations to local businesses ; Promotion at # local community events/fairs; # seniors benefiting from job search training; # seniors w/direct assistance in job search training and placement; # seniors in unsubsidized employment; # new SCSEP host agencies.</p> <p>1.b. New resources (funding, pilot programs, partnerships) to support increased volunteer services/opportunities.</p>	<p>O3A Program Mgr Title V</p> <p>O3A Planning Unit</p>	<p>1.a. 1/2009 – 12/2011</p> <p>1.b. 1/2009 – 12/2011</p>	
Objective 2: Increase opportunities for elders and adults with disabilities to engage in civic, social and cultural community life.					
<p>2. Incorporate into O3A programs best practice approaches that provide regular contact for elders, particularly those living alone or living in rural areas where access to social activities is limited or non-existent.</p>	<p>2. local community and faith based organizations; O3A providers; senior centers; local volunteer agencies.</p>	<p>2. New resources (funding, pilot programs) connecting seniors to community life in multigenerational settings;</p> <p># partner agencies engaging seniors in cultural & social activities.</p>	<p>O3A Planning Unit</p>	<p>2. 1/2009 - 12/2011</p>	
Objective 3: Increase opportunities for elders and adults with disabilities to participate in recreational activities.					
<p>3. Explore opportunities for contribution to local government planning processes that regulate design and construction of neighborhoods, recreational facilities and exercise trails.</p>	<p>3. State, county & municipal government agencies & boards who promote and/or develop recreational facilities and trails.</p>	<p>3. Dissemination of information on universal design and access to local planning groups.</p>	<p>O3A Leadership; Planning Unit</p>	<p>3. 1/2009 – 12/2011</p>	

Olympic Area Agency on Aging

Goal 4: Elders and people with disabilities are able to remain in their own homes with maximum independence for as long as possible.					
Objective 1: Expand and enhance long term & chronic care management					
Major Activities	Key Stakeholders	Indicators	O3A Lead	Time Frame	Accomplishment or Update
1.a. Advocate for system enhancements that are responsive to needs of people with disabilities 1.b. Advocate for funding to expand intensive chronic care management services	1.a & b ADSA, State Unit on Aging; elected officials, legislators	1.a. Advocacy activities conducted @ state & federal levels 1.b # additional clients receiving chronic care management services (target: 20)	O3A Advisory Council & Leadership	1.a & b 1/2008 – 12/2011	
2. Develop Caregiver Continuing Education modules on client chronic care management	2. Caregiver training subcontractor & providers; tech resources.	2. # caregivers receiving training in chronic care management topics	O3A Planning Unit	2. 1/2008-12/2011	
Objective 2: Increase support for kinship, family and informal (unpaid) caregivers.					
1. Evaluate current O3A support for kinship, family & informal caregivers.	1. Caregivers, O3A direct service staff; ADSA; local providers	1. Evaluation w/ recommendations	Director, I&A Planning Unit	1. 1/2008 – 12/2008	
2. Identify strategies to enhance outreach & public awareness for caregiver populations with special needs.	2. Caregivers, O3A direct service staff; ADSA; local providers	2. Plan for expanding community outreach to ensure five core elements for FCSP are addressed.	Director, I&A Planning Unit	2. 1/2009 – 12/2009	
3. Mobilize additional resources to strengthen support for kinship and family caregivers	3. Govt funding agencies; private foundations, etc.	3. New funding to support kinship care navigation & support New funding to support family caregivers	Director, I&A Planning Unit	3. 1/2010 – 12/2011	

Olympic Area Agency on Aging

Policy 7.01 Implementation Plan

for

Olympic Area Agency on Aging (O3A)

Biennium Timeframe: January 1, 2008 to December 31, 2009

Plan Due Dates:

October 1st of each odd numbered year a complete Implementation plan is due for the coming biennium.

October 1st of even numbered years a progress report is due.

Implementation Plan				Progress Report
(1) Goals/Objectives	(2) Activities	(3) Expected Outcome	(4) Lead Staff and Target Date	(5) Status Update for the Fiscal Year Starting Last January 1
<p>1. Continue current outreach assistance w/ expansion to all interested area tribes :</p> <p>Chehalis, Chinook Hoh, Jamestown S'Klallam, Lower Elwha Klallam, Makah, Quileute, Quinault Nation, & Shoalwater.</p>	<p>a. Ensure current outreach assistance is continued and explore expanding support and coordination assistance with all area Tribes as available resources allow.</p> <p>b. Hold regular meetings with individual Tribes or tribal groups to discuss elder issues as requested.</p> <p>c. Expand activities in this area through grants available.</p> <p>d. Include Tribal Outreach staff in agency planning, training and project development.</p>	<p>a. Enhanced access to culturally relevant services for tribal elders.</p> <p>b. Increased collaboration with local tribes and community partners to assure appropriate services.</p>	<p>Mark Harvey Designated O3A Service Delivery staff O3A Planning & Program Mgmt staff</p> <p>2007 -2008</p>	<p>O3A currently provides outreach assistance with the following services:</p> <p>Senior Farmers Market Nutrition program (6 tribes): Hoh, Jamestown, Lower Elwha, Makah, Quileute and Shoalwater Tribes</p> <p>Coordination Title III and VI (Senior Nutrition): Jamestown S'Klallam; Lower Elwha, Quileute, Hoh, Chinook, Quinault.</p> <p>Case management: for individual Tribal elders throughout region.</p> <p>Service coordination, training, and support provided through requests from individual Tribal elders for service; typically on a one-to-one basis.</p>

Olympic Area Agency on Aging

<p>2. Improved caregiver training and support options for interested Tribes.</p>	<p>a. Improve coordination between AAA Title III and Tribal Title VI Caregiver Support Programs</p> <p>b. Identify Tribal caregivers through O3A IP & family caregiver support programs and</p> <p>c. Include Tribal caregivers in referral workforce resource center (Registry) training and referral activities</p>	<p>a. Coordinated Title III and VI resources are maximized, resulting in improved dissemination of best practices, available resources, information sharing and provision of technical assistance.</p> <p>b. Increased Tribal capacity for accessing and/or providing training to Tribal members interested in becoming caregivers.</p> <p>c. Increased number of Tribal caregivers</p>	<p>O3A Planning & Program Mgmt staff Mark Harvey</p> <p>2007 - 2008</p>	<p>a. O3a has established relationships with Jamestown, Makah, Quinault, Quileute, Hoh, Lower Elwha and Chehalis Tribes, and connections have been made with the Shoalwater Bay and Chinook Tribes. In 2005, O3A and ADSA sponsored a Native Caregiving Conference at the Jamestown Community Center. Family and kinship caregivers from 7 of the 9 Tribes participated and received counseling, massage therapy, training and education around the following caregiver topics: self-care & traditional healing; the Indian Child Welfare Act and legal options for kinship caregivers; Elder abuse in Indian Country; elder law – advanced directives, wills, powers of attorney; eating nutritiously and traditionally; intergenerational grief and loss; state family and kinship care initiatives; traditional decision-making – family group conferencing; family caregiver support programs ‘best practices;’ prescription drugs and Medicare Part D; and fitness activities to stay healthy. Over 160 Indian people participated from all over the state.</p> <p>b. State contracted tribal caregivers are included in O3A’s contracted caregiver training system, which provides orientation and continuing education.</p> <p>c. O3A’s registry manager will include tribes in marketing and outreach efforts to recruit, train and support current and new tribal caregivers.</p>
<p>3. Enhanced services / support for Tribal grandparents / other elders raising children</p>	<p>a. Increase outreach efforts, particularly with remote communities and Tribal reservations, to inform families of the resources now available for relatives raising children.</p>	<p>Anticipate that Kinship Care Support Program will be of major benefit in enhancement of services for Tribal grandparents & other elders raising children.</p>	<p>Designated O3A Service Delivery staff</p>	

Olympic Area Agency on Aging

<p>4. Improved Tribal access to health and nutrition education and program services to the extent resources allow.</p>	<p>a. Include tribal elders in nutrition education & training offered by O3A health promotion and education staff.</p> <p>b. Through nutrition contracts with local providers, promote inclusion of local tribal elders in nutrition programs.</p>	<p>a. Tribal nutrition program managers & elders receive education on food safety, menu planning, etc.</p> <p>b. Tribal elders participate in programs implemented by local health / nutrition education providers.</p>	<p>O3A Planning & Program Mgmt staff</p> <p>O3A Nursing service staff</p>	<p>Senior Farmers Market Nutrition program (6 tribes): Hoh, Jamestown, Lower Elwha, Makah, Quileute and Shoalwater Tribes</p> <p>Coordination Title III and VI (Senior Nutrition): Jamestown S’Klallam; Lower Elwha, Quileute, Hoh, Chinook, Quinault. Services provided include provision of congregate and home delivered meals. In the previous 12 months, O3A nurses have participated as resources in tribal health fairs on an ongoing basis: Jamestown, Neah Bay, La Push, Queets, the lower Hoh, Shoalwater, Quinault Tribes. O3A nurses provided educational work shops at these fairs, addressing Food Safety, Medication Management under the 6088 bill and Falls Prevention.</p>
<p>5. Improved access to transportation for Tribal elders with special needs.</p>	<p>a. Facilitate Tribal representation in local planning and coordination efforts and regional transportation coalitions.</p> <p>b. Promote increased options for transportation for Tribal elders with special needs.</p>	<p>a. Local planning efforts are responsive to transportation needs of Tribes.</p> <p>b. Through improved coordination of transit resources & services, Tribal elders are better able to access transportation for special needs.</p> <p>c. Situational events for individuals needing special transportation.</p>	<p>O3A Planning & Program Mgmt staff</p>	<p>a. Coordination is taking place at county and regional levels through regional transportation coalitions mandated to coordinate transportation services with local human and social service agencies. O3A is a member of transportation coalitions in two counties, & a member of the regional coalition for Jefferson, Clallam counties. Area tribes represented on these coalitions are: Quinault, Hoh, Makah, Skookum, Quileute, Jamestown S’Klallam& Lower Elwah.</p> <p>b. Through the regional transportation coalition, O3A is supporting development of county mobility coordinator positions, with responsibility to increase access to transportation for all persons with special needs.</p>

Olympic Area Agency on Aging

<p>6. Improved access to health and support services for Tribal elders.</p>	<p>a. Increase coordination between the Area Agency on Aging and Tribal representatives to facilitate access to local services—especially health care-- for Tribal Elders. b. Through CARE partnership in Clallam county, pilot approaches leading to improved access to services.</p>	<p>a. Tribal issues are represented in local community, county planning efforts. b. Tribal needs are considered and addressed by local service providers, resulting in increased access to services.</p>	<p>Mark Harvey O3A Planning & Program Mgmt staff</p>	<p>O3A is coordinating with the CARE project, funded by Robert Wood Johnson, to prepare a Lower Elwha nurse as a Master Trainer in the Stanford University Chronic Disease Self Management Program. O3A is funded by WA DOH to implement this program in Clallam and Grays Harbor Counties. The training for the tribal nurse in chronic disease self management supports a separate project of the CARE Tribal Healthcare Workgroup, funded by the Washington Health Foundation, to improve chronic disease management for tribal elders in Clallam County.</p>
<p>7. Strengthened O3A infrastructure to respond to tribal needs.</p>	<p>a. Ensure tribal representation on O3A staff & Advisory Council. b. Routinely consult with tribal outreach (O3A direct service) staff re: O3A response to tribal issues. c. Train outreach staff in culturally appropriate communication techniques. d. Establish a formal relationship with each Tribal Council that respects and honors individual Tribal protocols.</p>	<p>a. Communication between O3A and area tribes results in more responsive service and program development. b. Consultation with Tribes results in identification of tribal needs & priorities & possible solutions, for incorporation into this plan.</p>	<p>AC Tribal Representative Designated O3A Program Management and Service Delivery staff O3A leadership 2008 -2010</p>	<p>The position of Tribal Representative on the Advisory Council is currently held by a member of the Choctaw Tribe. This 7.01 plan is part of the O3A Area Plan; native elder goals /objectives are integrated into the work plans of each O3A program department. These include Senior I & A and Case Management, Nursing Services, and OAA program services. O3A service delivery to tribal elders is decentralized through out the region through local O3A case management / outreach staff providing a continuous O3A presence.</p>

Olympic Area Agency on Aging

October 1, 2007