THE OLYMPIC AREA AGENCY ON AGING

Area Plan

2012- 2015

Olympic Area Agency on Aging

11700 Rhody Drive
Port Hadlock, WA 98339
www.o3a.org
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September 29, 2011

Dear Friend:

It is my pleasure to present the Olympic Area Agency on Aging 2012-2015 Area Plan. As you review the plan, you will find that a wide range of services and programs are available across our region – many of them innovative in their nature and scope. The process to develop the plan involved consumer group and public consultation, research, and community outreach. The major goals in this plan outline steps for the Olympic Area Agency on Aging (O3A) to support older adults, adults with disabilities, and their families to:

- Address basic needs;
- Improve health and well being;
- Provide support for family caregivers;
- Make informed decisions about the support they need to remain independent and access the appropriate services;
- Access quality in home services that support consumer engagement and provide choice; and
- Coordinate with services for Older Native Americans.

Preparation of the 4-year Area Plan is a statutory requirement, and represents considerable time and effort on the part of staff and local community members. O3A would like to express its appreciation to the following persons and groups for their feedback and guidance during this comprehensive process:

To the Council of Governments
County Commissioners:

- David Sullivan, 2011 Chair, Jefferson
- Bud Cuffel, 2011 Vice-Chair, Pacific
- Mike Doherty, Clallam
- Steve Tharinger, Clallam
- Mike Wilson, Grays Harbor
- Herb Welch, Grays Harbor
- Phil Johnson, Jefferson
- Lisa Ayers, Pacific

And To:

- Marti Anthony, 2011 Advisory Council Chair
- Dale Jacobson, 2011 Advisory Council Vice-Chair
- The Advisory Council Planning Committee
- The Advisory Council
- Community members & service agencies
- Bob Nakutin, volunteer, Grays Harbor County

Given the current economic outlook, difficult choices are required for agencies and individuals alike. We look forward with optimism to working together with our neighbors over the next four years to provide as many local services and choices as possible. If you would like some additional information, please do not hesitate to telephone or email me at walkerb@dshs.wa.gov, or visit our agency website: www.o3a.org.

Sincerely,

Roy Walker

Roy Walker
Executive Director

ACRONYMS

AAA	Area Agency on Aging
AC	(O3A) Advisory Council
ADA	Americans Disability Act
ADRC	Aging & Disability Resource Center
ADSA	Aging & Disability Adult Services Administration
ADC	Adult Day Care
ADH	Adult Day Health
AFH	Adult Family Homes
ALF	Assisted Living Facility
AIRS	Association of Information & Referral Specialists
AOA	Administration on Aging
APS	Adult Protective Services
CCM	Chronic Care Management
CDC	Center for Disease Control
CDSMP	Chronic Disease Self Management Program
CE	Continuing Education (Unit)
CG	Caregiver
CGT	Caregiver Training
CLEAR	Coordinated Legal Education, Advice and Referral System
CM	Case Management (Care Management)
CMS	Centers for Medicare& Medicaid Services
COG	Council of Governments
COPES	Community Options Program Entry System
CSO	Community Services Office
DCAP	Dental Care Access Program
DD	Developmental Disability
DDD	Developmental Disability Division of DSHS
DOH	Department of Health
DOT	Department of Transportation
DSHS	Department of Social & Health Services
FCSP	Family Caregiver Support Program
FEMA	Federal Emergency Management Assistance
HC	Home Care
HCS	Home and Community Services
HCRR	Home Care Referral Registry
HIPAA	Health Insurance Portability Accounting Act
HUD	Department of Housing & Urban Development
I & A	(Senior) Information & Assistance
IP	Individual Provider
ILC	Independent Living Center
INS	Immigration & Naturalization Service
IRC	Internal Revenue Code
IRS	Internal Revenue Service
KCSP	Kinship Caregiver Support Program
LGBT	Lesbian, Gay, Bisexual or Transgender, also GLBT

LIS	Low Income Subsidy Program
LTC	Long Term Care
LTCOP	Long Term Care (Volunteer) Ombudsman Program
MB	Management Bulletin
MH	Mental Health
MIPPA	Medicare Improvements for Patients and Providers Act
MPC	Medicaid Personal Care
N4A	National Association of Area Agencies on Aging
NCOA	National Council on Aging
NICOA	National Indian Council on Aging
NS	Nursing Services
NSIP	Nutrition Services Incentive Program
OAA	Older Americans Act
O3A	Olympic Area Agency on Aging (OAAA)
PERS	Personal Emergency Response System; also Professional Emergency Response Services
PSA	Planning and Service Area
RCW	Revised Code of Washington
RFI	Request for Information
RFOC	Revised Fundamentals of Caregiving
RFQ	Request for Qualifications
RFP	Request for Proposals
RSVP	Retired Senior Volunteer Program
SAIL	Stay Active & Independent for Life
SCOA	State Council on Aging
SCSA	Senior Citizens Service Act
SCSEP	Senior Community Service Employment Program
SFMNP	Senior Farmers Market Nutrition Program
SHIBA	Senior Health Insurance Benefit Advisors
SLAC	Senior Legal Advice Clinic
SNF	Skilled Nursing Facility
SSA	Social Security Administration
SSPS	Social Service Payment System
SSA	Social Security Administration
T-CARE	Family caregiver assessment tool
USDA	United States Department of Agriculture
WAC	Washington Administrative Code
W4A	Washington Association of Area Agencies on Aging

SECTION A – Area Agency Planning and Priorities

A – 1 Introduction:

The Olympic Area Agency on Aging, Area Plan 2012- 2015

The Olympic Area Agency on Aging (O3A) is pleased to present its Area Plan for 2012 – 2015. The plan supports O3A's mandate to develop a comprehensive and coordinated system of home and community based services for older adults and people with disabilities. It describes O3A's priorities and provides an overall strategic framework to guide fiscal and human capital investments for the next four years, and was developed through broad-based community consultation, qualitative and quantitative field research, and public input. The area plan document serves as the foundation for work plans, funding priorities and planning efforts to provide services for persons who are older or need long term care in Clallam, Grays Harbor, Jefferson and Pacific Counties.

O3A has provided support to older adults in Clallam, Grays Harbor, Jefferson and Pacific counties since its inception in 1976. Designated by the State Unit on Aging as one of 13 Washington area agencies on aging, O3A is mandated to coordinate services and advocate on behalf of older adults and others in need of long term care throughout its service region.

Service Region

O3A's primarily rural service area comprises 194,993 people dispersed over the rugged mountainous terrain of the Olympic peninsula and extends the entire length of Washington's west coast. The region is generally considered economically distressed, with higher unemployment and lower wages than many areas in the state. The service population within this region includes over 58,664 adults age 60 and older, adults with disabilities, native elders from nine Tribes, and a small but growing minority population (other than Native American).

The Olympic Area Agency on Aging

In order to support people to age in place and live independently in their own homes, O3A has developed a multidimensional approach that includes direct and contracted service delivery; community outreach with information and assistance; disease prevention and health promotion; and strategies to increase access to medical, health care, and supportive services.

To overcome the difficult geographic barriers in its service region, O3A relies on decentralized field office placement, with direct service and support staff situated in the communities they serve; a communications system supported by information technology; and a provider network of contracted and cooperating partners offering support and care to older adults. The provider network includes family and paid caregivers; individual and agency providers of in-home and respite care and support; community action programs providing senior nutrition, transportation, peer counseling and adult day care services; contracted legal services; mental health providers and local

contractors providing home safety modifications and personal emergency response services. Cooperating partners include local area hospitals and clinics as well as local health departments and legal and law enforcement agencies.

O3A direct service staff provides nursing and case management services to nearly 1,400 Medicaid-eligible adults age 18 and older. O3A's Senior Information & Assistance program provides community outreach with information about health insurance, legal issues, long term care options and other senior service programs and benefits to thousands of local residents each year.

Governance

O3A is governed by a Council of Governments, with membership comprising two county commissioners from each of the four service counties. In addition, O3A is guided by an active Advisory Council that includes consumers, providers, health and social service specialists, community representatives, tribal and minority population advocates. The 21 member council includes four representatives from each of the four counties in O3A's service area (16 total); plus four regional representatives in the positions of elected official, representative for younger adults with disabilities, tribal representative, and a representative from minority/ethnic populations in the service area. The remaining position is a regional State Council on Aging Representative, appointed by the Governor's office as a liaison between the State Council on Aging and the region.

Operational Capacity

Approximately 68 direct service, technical and administrative personnel are based in seven offices - one in Grays Harbor, and two each in Clallam, Jefferson and Pacific counties. An administrative office, located in Port Hadlock, houses executive, financial, human resource, planning and contract management staff. Two larger offices in Aberdeen (Grays Harbor) and Sequim (Clallam) comprise direct service provision staff, and senior management for Information and Assistance, Care Management, Family Caregiver Support, Nursing Services and Information Technology.

Two offices in Pacific County, one office in the West End of Clallam County, and one in Port Townsend (Jefferson County) serve as satellite offices for Information and Assistance (I&A) and Care Management Program staff. O3A receives federal and state funding to administer 15 programs, as well as foundation grants and local resources, and has an average annual budget with total revenue of $5.8 million dollars.

O3A supports its direct and contracted service provision with contract management, technical assistance and monitoring, financial oversight, and IT support. O3A maintains a website (www.o3a.org), and access to media publicity through weekly radio programs which reach approximately 12,600 listeners throughout the Olympic peninsula, and weekly columns in local newspapers with a combined audience of over 26,000 readers. O3A also provides outreach through social media outlets.

Contact

For more information about this plan, please contact: Roy Walker, Executive Director, at 360-379-5064, or 1-866-720-4863; 11700 Rhody Drive, Port Hadlock, WA 98339; walkerb@dshs.wa.gov. For more information about the Olympic Area Agency on Aging, please consult O3A's website at www.o3a.org.

A – 2 Mission, Vision and Values:

MISSION

The Olympic Area Agency on Aging exists to help older adults and persons with disabilities maintain their dignity, health and independence in their homes, through a comprehensive and coordinated system of home and community-based services.

The federal Older Americans Act provides O3A with the authority to deploy six broad operational strategies to advance its mission. These strategies include:

- **advocacy,** which encompasses O3A's responsibility to represent the needs and concerns of older people in the policy, program and budget development processes at the local, state and federal levels, as well as their needs and concerns arising from service delivery;
- the dissemination of **consumer information** and the conduct of **public education** activities;
- the **procurement of local services** through performance-based contract mechanisms;
- the **provision of coordination and technical assistance** to community based entities and other stakeholder organizations that affect aging services, policies and programs throughout the service region;
- **planning and program development**, based on local community assessment and including the application of evidence-based program and service models that improve quality of life and enhance the delivery of health and human services at the community level; and
- **oversight** of its programmatic and fiscal responsibilities.

VISION

O3A believes that dignity is inherent to all individuals in our society, and that older adults and persons with disabilities should have the opportunity to fully participate in all aspects of society and community life, be able to maintain their health and independence, and remain in their own homes, supported by their communities, for as long as they choose to do so.

VALUES

O3A is guided by a set of core values in developing and carrying out its mission. These values include:

- Listening to older people, those with a disability, their family caregivers, and our partners who serve them;

- Responding to the changing needs and preferences of our increasingly diverse and rapidly growing older population;
- Producing measurable outcomes that significantly impact the well-being of older people and their family caregivers; and
- Valuing and investing in our staff and provider network.

A – 3 Planning and Review Process:

The Area Plan for 2012--2015 charts the course that the Olympic Area Agency on Aging will follow over the next four years.

The major goals in this plan outline steps for O3A to support older adults, adults with disabilities, and their families to:

- Address basic needs;
- Improve health and well-being;
- Provide support for family caregivers;
- Make informed decisions about the support they need to remain independent, and access the appropriate services;
- Access quality in home services that support consumer engagement and provide choice; and
- Coordinate with services for Older Native Americans.

Within this framework, O3A has specifically addressed issue areas required by the State Unit on Aging: Family Caregivers; Healthy Aging; In Home services; Information and Assistance (I & A) and Aging and Disability Resource Centers (ADRCs); and Native American Elders.

Federal law, the Older American's Act (OAA), requires that every Area Agency on Aging (AAA) engage community partners in the formation of a major planning document every four years. Responding to this requirement, O3A has involved the community in crafting the objectives we plan to achieve. The process to develop the plan has involved consumer and public consultation, qualitative and quantitative field research, and community input and feedback.

The Olympic Area Agency on Aging Advisory Council

The framework for the plan was designed and carried out with guidance from the O3A Advisory Council. The Advisory Council is mandated to identify the needs of older people and of adults with disabilities in our community, to advise on services to meet those needs, and to advocate for local, state and national programs that promote quality of life for these populations. Members of the Advisory Council Planning Committee have worked closely with staff throughout the plan's development, giving guidance on major objectives, with consultation from the entire O3A Advisory Council, the O3A Council of Governments and O3A's local partners and consumers.

Planning activities included:

- A desk review of information and data that have been generated over the previous four years by various local sectors (civic planners, public health, transportation, social services, community action programs, etc.), as well as regional demographic and other data, a literature review of academic study of aging, and Washington State and U.S. census information and projections;
- a consumer survey distributed via O3A's website, stakeholder and provider network;
- a telephone survey of O3A consumers by Advisory Council members;
- a series of meetings and interviews with service providers, community leaders, members of O3A's Council of Governments, and Advisory Council; O3A direct service staff, and tribal elders, and
- Public Hearings in each of O3A's four service counties: Clallam, Jefferson, Grays Harbor, and Pacific counties.

A – 4 Prioritization of Discretionary Funds

The Olympic Area Agency on Aging administers federal and state funds for services for older people and adults with disabilities. Of O3A's budget, about 84% is considered "nondiscretionary" and is designated for specific services like Medicaid Title XIX Case Management and Home Care, the United States Department of Agriculture meals program, and state funded respite care.

The O3A annual budget also includes about 16% in discretionary funds from the Federal Older Americans Act (OAA) and the Washington State Senior Citizens Act (SCSA). "Discretionary" funding is more flexible and can be used to meet O3A-identified priority needs within a range of allowable services in the O3A service region.

The Advisory Council, through the work of two committees, recommends criteria for evaluation and allocation of discretionary funding to service areas. The Planning Committee evaluates service funding priorities based on community assessment data; the Allocations Committee reviews annual performance and recommends allocation levels based on available resources. Both committees have representation from each of O3A's four counties.

With life spans increasing, the baby boom cohort advancing, and a service region that is a significant retirement destination, as well as economically distressed, a major challenge for O3A is the determination of vulnerability in a growing population of older adults, in order to prioritize services in a relatively resource-scarce environment.

RESOURCE ALLOCATION GUIDELINES FOR DISCRETIONARY FUNDS

In order to make well-considered, appropriate choices for the use of resources, decisions must be based on the mandates and regulations that govern the agency and each fund source, as well as on desired future directions that support the agency mission, vision and values. These resource allocation guidelines are reviewed at least every two years to ensure they continue to reflect the most appropriate approach.

FUNDING GUIDELINES

Funds must be allocated in accordance with mandates from each funding source. Services/support must be responsive to the current operating environment. Critical elements to focus on for 2012 – 2015:

- ensuring O3A maintains the capacity and flexibility to respond to emerging local needs through O3A programs (e.g., its I & A and Family Caregiver Support services);
- prevention services and health promotion programs aimed at reducing the burden of chronic disease and injury in the service population;
- greater coordination and support for local service delivery at the community , county , and at regional levels (e.g., leveraging with health providers for opportunities within the Affordable Care Act);
- strengthening the safety net for vulnerable adults through support for traditional (e.g., professional and family caregivers) and non-traditional stakeholders, (e.g., engaging businesses and faith-based organizations in developing services and support); and
- engaging consumers in creating solutions, through technology and development of an integrated service model that supports consumer choice and reflects our diverse and rural communities.
- O3A will consider first for funding those services/supports which are a high priority and which are not and cannot reasonably expect funding by other entities.
- Services will be funded at a level sufficient to make the program viable and responsive to consumer needs. O3A will encourage providers to "leverage" additional funds for joint funding of services, and may assist providers to secure funds from grants and other sources.
- O3A will generally avoid allocating funding to services in which the O3A contribution is less than 15% of the total for that particular service and it appears likely that other funding, or fundraising, could be used to cover the service cost.
- In the case of new services and/or initiatives for which other funding sources may be anticipated, O3A funding may be allocated and considered "seed" money, for a time-limited period.
- Consideration will be given to the needs, resources, and proportion of the target population in each county in developing funding allocations.

STAFF ALLOCATION GUIDELINES

- Staff time must be allocated in accordance with mandates from each funding source and to assure compliance with requirements of each program / service.
- Staff resources will be allocated for program development, quality initiatives, training, coordination, and advocacy efforts that support the agency mission and statement of values and vision for 2012-2015.
- Staff resources will generally be allocated first for those activities that are necessary to support and improve the quality of services funded directly by O3A.

- Staff resources will be allocated next for those efforts for which the agency can expect to have a high level of impact and likelihood of success in achieving the agency's mission, vision, and objectives.
- Staff resources will be allocated to take advantage of opportunities that arise during the course of the next four years, and which will serve to move the agency toward achieving the goals stated in its mission, values and vision statements.
- O3A's staffing model will remain flexible in order to sustain capacity by training and rededicating staff with appropriate skill sets as funding, programs and services change.

PRIORITIZATION OF PROGRAMS & SERVICES

Services planned for 2012 are prioritized according to the following scale, with Level One being highest priority. Please note that the services listed below include both mandated and discretionary services, and are not broken out by fund source. Changes in the fund source may lead to reductions or enhancements to the designated service. Enhancements or reductions will be considered based on these priorities and the funding source requirements.

Level One	Level Two	Level Three
Case Management	Congregate meals	Falls Prevention
Chronic Care Management	Home Repair & Maintenance	Gatekeeper Program
Family Caregiver Support	LTC Ombudsman	Kinship Caregiver Support
Information & Assistance	SCSEP Title V Employment Program	Living Well with Chronic Conditions (1)
In-home Personal Care	Transportation (volunteer mileage)	Senior Legal Services (2)
Nursing Services		
Home-delivered meals		

Notes

1. Some activities in the Living Well with Chronic Conditions program (Chronic Disease Self Management) are subject to grant funding timelines and will phase out in 2013.
2. Funding for legal services is mandated at 11% of the OAA Title III-B funding source, and is budgeted at the required level for 2012.

Section B – Planning and Service Area Profile

B – 1 Population Profile:

O3A's service area is home to approximately 194,993 people widely dispersed over the rugged mountainous terrain of the Olympic peninsula. Of these, 30%, or 58,664 are 60 years old and over. The entire service region is considered to be rural[1], with an average of 30 people per square mile.

The Olympic peninsula has become a significant retirement destination, owing to a natural environment which offers recreational and lifestyle choices that are attracting increasingly large numbers of adults heading into their retirement years. Life expectancy for these older adults has increased dramatically, thanks to improvements in education, medicine, nutrition and general living standards. Individuals who reach the age of 60 today can expect to live almost 25 more years.

As life expectancy rises, the number of "older old" and "oldest old" adults also increases. For this reason, programs and policies directed to the 60 and over population must take into account the needs of up to three generations of older adults. In addition to generational differences, the older population is extremely diverse in health, social and economic status. While most of the older adults between the ages of 60 and 74 are active, healthy and independent, those who are 85 years and older are more likely to face problems of ill health and loss of independence, further straining already overburdened rural health and long-term care systems.

For these elders, as well as for people with disabilities, residence in a rural setting such as the Olympic peninsula can contribute to social isolation and increased risk to well being. Health and income disparities across ethnic groups, which are already pronounced particularly amongst native and minority elders, will have a greater impact on their quality of life as these older adults age.

The aging trend in the O3A service area will continue for the next several decades, according to population growth projections from Washington State's Office of Financial Management. The age distribution places significant stress on the local long-term care systems. As the younger adult population continues to leave the area for better economic opportunities, there is growing concern about who will provide the care needed by older adults and adults with disabilities in the coming years.

DEMOGRAPHIC SUMMARY

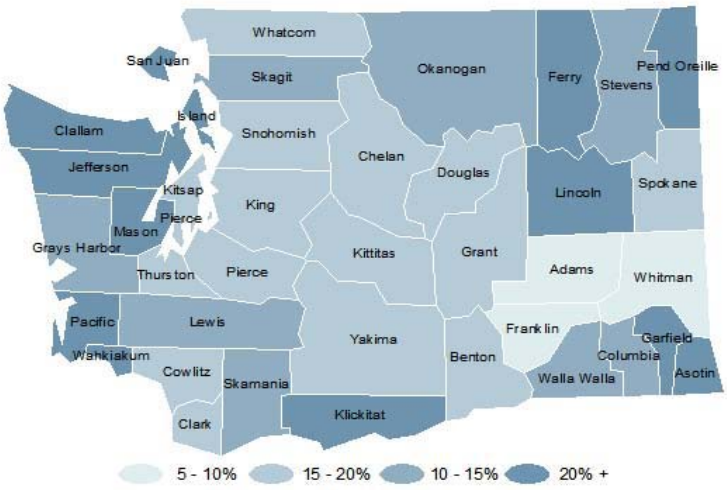
[1] *For the sake of consistency and reporting, the Administration on Aging's definition for rural is used: Any area that is not defined as urban. Urban areas comprise (1) urbanized areas (a central place and its adjacent densely settled territories with a combined minimum population of 50,000) and (2) an incorporated place or a census designated place with 20,000 or more inhabitants.*

Within O3A's four county service region, there is no incorporated area or census designation (smaller than county) with a population over 20,000. The population of each of the two largest towns in the service region, Aberdeen and Port Angeles, is less than 19,000.

Demographic	Total
Total population	**194,993**
60+[2]	**58,664**
60+ Below poverty level[3]	**3,982**
60+ Minority	**2,999**
60+ Minority below poverty level	**470**
60+ Rural Areas[4]	**58,664**
Adults w/ Disabilities(18 & above)	**20,217**
60+ Limited English Proficiency	**1,702**
Tribal Elders (estimated)	**968**
Number of Tribes	**9**
Tribal Nations	Chehalis, Chinook, Hoh, Jamestown S'Klallam, Lower Elwha Klallam, Quileute, Makah, Quinault, and Shoalwater Bay.
Tribes with Title VI (OAA) programs	Chehalis, Jamestown S'Klallam, Lower Elwha Klallam, Quileute, Makah, Quinault, and Shoalwater Bay.

[2] www.factfinder2.census.gov; Profile of General Population and Housing Characteristics: 2010 Census Data.
[3] *Forecasts of the Aging Population, Dementia Prevalence and Use of Long-Term Care Services through 2020 in Washington State: Selected Population and Aging Service Utilization Forecast, Olympic AAA*. Report from DSHS, Planning, Performance and Accountability; Research and Data Analysis Division, August 2011. Please note that these data are based on projections, not on actual 2010 Census Data.
[4] www.factfinder2.census.gov; Profile of General Population and Housing Characteristics: 2010 Census Data.

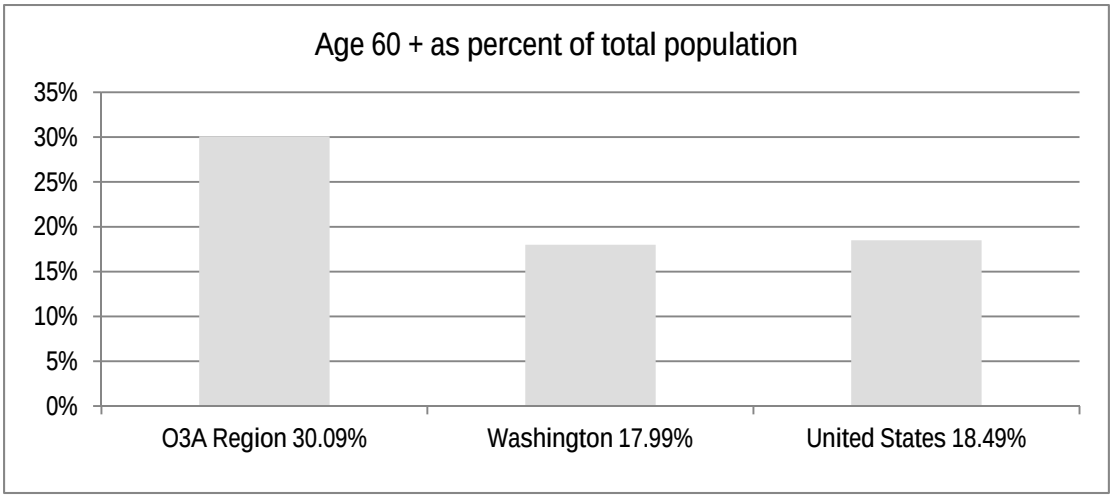
Percent of Washington population age 65 and over by county[5]



65 and older

According to Washington State's Office of Financial Management, "Washington's population age 65 is growing at an increasing rate. In 2010, persons age 65 and over represent 12.4% of the state's population." Three of O3A's four service counties rank among the first five Washington counties with the highest percentage of persons age 65 and over: Jefferson (26.5%); Pacific (25.5%), and Clallam (25.4%).[6]

Percent of O3A Service Region Population Age 60 and over



60 and older

Throughout the O3A service region, 30.09% of the population is 60 or older, compared to Washington State, with 18%, and the United States at 18.5%[7].

[5] *2010 Washington Population Trends*, Office of Financial Management, pg. 51.
[6] *Ibid, pg 50.*
[7] www.factfinder2.census.gov; Profile of General Population and Housing Characteristics: 2010

The proportion of adults aged 60 years or over in Pacific County is 34%; with Jefferson at 37.61%; Clallam at 32.44% and Grays Harbor at 23.54%. That means that the 60+ age group already represents nearly a third of the population in three of the four O3A service counties. As adults continue to age in place and retire to the peninsula, growth in the number of 60+ residents will continue to outpace the rest of the state and nation.

Elders living alone

In a recent O3A survey of the region, 53% of respondents reported living alone; 41% reported living with a spouse or partner, and 6% reported living with a friend or relative.

Minority Populations

Within the O3A service region, 91% of the total population is white. Persons identifying themselves as Hispanic or Latino amounted to 6.13% of the population, the largest minority in the region recorded by 2010 Census data. American Indian/Alaskan Natives comprise the second largest 'minority' community at 5.72% of total population[8].

As of April 2011, approximately 3.5% of American adults identify as lesbian, gay or bisexual, while 0.3% are transgender—approximately 11.7 million Americans. Washington state is one of ten U.S. states with the highest number of adults identifying as lesbian, gay or bisexual, at 5.7% of the total state population.[9]

O3A PSA: White, Native American and Hispanic Populations

County	% White	% American Indian/ Alaska Native	% Hispanic or Latino
Clallam	90.4	7.4	5.1
Grays Harbor	88.5	6.8	8.6
Jefferson	94.2	4.2	2.8
Pacific	90.6	4.5	8
PSA Average	**90.9%**	**5.72%**	**6.13%**

Adults with Disabilities

The percent of adults age 18 and above with disabilities (10+%) exceeds the state percentage of 4.6%. The percentages are particularly high in Pacific County (26.3%) and Grays Harbor County (24%). Only 45% of the 21-64 year old populations with disabilities in the area are employed, compared to the Washington State average of 57.6%.

Seniors with Disabilities

The percent of the 65+ population with disabilities is higher in Grays Harbor and Pacific Counties than the state percentage (42.3%), at 48.6% and 47.8%, respectively. Both

[8] www.factfinder2.census.gov; Profile of General Population and Housing Characteristics: 2010
[9] http://en.wikipedia.org/wiki/Demographics_of_sexual_orientation

Clallam and Jefferson County are below the state average, at 38.4% and 33.9%, respectively.

B – 2 Target Population:

A significant factor in identifying service populations and priorities relates to vulnerability and safety. O3A has identified the following elements that contribute to a person's vulnerability within the service region:

- Frail older adults in need of support to age in place;
- Older adults any age who live in very remote rural settings;
- Older adults any age who live alone, are without family close by or who lack an adequate social support network;
- Older adults with impaired health or at high risk (including chronic medical, dental or mental illness);
- Older and young adults with disabilities;
- Older adults considered low income or in poverty;
- Older adults who do not speak English; and
- Tribal elders and members of minority communities.

All services are first targeted to individuals with the greatest economic and social needs, low-income minority individuals and those living in rural areas. O3A contracted service providers are required to describe in their scopes of work how this will be accomplished prior to entering a contract. Other services provided by O3A, for the most part, have income criteria and/or need eligibility associated with access. O3A also works closely with Native American Elders to assure they are aware of services available.

B – 3 Services provided through the Olympic Area Agency on Aging:

The Olympic Area Agency on Aging funds the following services to older adults and adults with disabilities who live throughout the service region (not all services are available in all counties). The number of clients served and the funds allocated in each of the service areas are listed in the budget attachments to this document.

Service provision in the region is constrained by a limited number of qualified providers, consequently, O3A provides many services directly. Others are provided by a network of community-based organizations located throughout the service region, which contract with O3A to provide services.

In addition, O3A provides case management to approximately 1,400 clients. The following table indicates current services being provided and the geographic location of each. Service descriptions follow.

O3A Direct and Contracted Services	Clallam	Grays Harbor	Jefferson	Pacific
Case Management ❖ COPES / Medicaid Personal Care	X	X	X	X
Elder Abuse Prevention ❖ Long-Term Care Ombudsmen	X		X	
Family Caregiver Support Program ❖ Unpaid caregiver support services ❖ Kinship Caregiver Support (now *Relatives as Parents*) ❖ Caregiver training ❖ Powerful Tools for Caregivers Classes ❖ Respite Services ❖ Respite Assessment and Coordination ❖ Respite Care	X	X	X	X
Employment Support/Title V Services	X	X	X	X
Gatekeeper Program	X			
Home Care Referral Registry ❖ Independent Provider procurement and placement	X	X	X	X
Information and Referral Services	X	X	X	X
Legal Services ❖ Senior Legal Advice Clinics ❖ Simple Will Services	X	X	X	X
Minor Home Repairs	X	X	X	X
MIPPA Beneficiary Outreach and Enrollment Program	X	X	X	X
Nursing Services ❖ Chronic Care Management ❖ Disease Prevention and Health Promotion o Medication Management Training o Falls Prevention o Food Safety & Nutrition ❖ Chronic Disease Self Management Program	X	X	X	X
Nutrition ❖ Congregate nutrition ❖ Home delivered meals ❖ Senior Farmers' Market	X	X	X	X
Transportation	X	X	X	X
Statewide Health Insurance Benefits Advisors (SHIBA)	X	X	X	X

O3A Direct and Contracted Services:

Adult Day Services

Adult Day Services are provided to adults with medical or disabling conditions in order to prevent or delay the need for institutional care. Case management authorized participants attend State approved day centers and receive care designed to meet their physical, mental, social interaction and emotional needs. Depending on the level of their need and the number of days authorized, participants may enroll in one or combination of the following services: COPES, MPC, and out-of-home respite care.

Adult Day Care programs provide personal care (e.g., body care, eating, positioning, transfer, toileting), social services, routine health monitoring (e.g., vital signs, weight, dietary needs), general therapeutic activities and social (e.g., recreational activities and relaxation therapy), general health education (e.g., nutrition, stress management, preventive care), supervision, assistance with arranging transportation, and first aid as needed.

Adult Day Health programs provide the core services mentioned above, plus skilled nursing services, skilled therapy services (e.g., physical therapy, occupational therapy, or speech therapy), and psychological or counseling services. *There are presently no Adult Day Health services available in the O3A service region.*

Caregiver Information, Support and Training

Caregiver support focuses on both the individual caregiver and the system that supports the caregiver. It includes in-home and out-of-home respite care services for family and other unpaid caregivers who provide the daily services required when caring for adults with functional disabilities. Paid caregivers receive support with training and continuing education, as well as placement with the Homecare Registry and Referral program. Caregivers can receive help with information, training, respite care, translation /interpretation, and specialized transportation. Services are provided to grandparents (age 60+) caring for relatives and caregivers of persons age 18 and over.

Case Management

Case management provides in-depth assistance to persons who have significant health and social needs. O3A's case managers conduct in-home assessments with the client, consultation with the family, health care professionals, and any other support systems that the client has in place in order to develop and implement a service plan that addresses the individual's needs.

Case managers have regular follow-up contact with clients and service providers to ensure that clients obtain and can effectively use necessary support services. Short-term counseling is provided if needed. Case management services also include client advocacy, assistance, consultation, networking, family support, crisis intervention, and follow-up after termination from services.

Screening and referral for case management services are provided through the O3A Information & Assistance program, and the state DSHS Home & Community Services.

COPES / Medicaid Personal Care (MPC)

COPES Personal Care services are provided to disabled Medicaid clients who often live alone. COPES services include:

- Client training by a skilled professional, such as a pharmacist, registered nurse, or dietician;
- Adult day care at a licensed facility that provides personal care, routine health monitoring, and other general therapeutic services;
- Environmental modifications by licensed, bonded construction companies that build or install minor physical adaptations and devices in the homes of clients;
- Home-delivered meals for housebound clients who lack the ability to prepare meals and do not have help;
- Home health aide services to provide intermittent health and other incidental services beyond what a regular caregiver can provide;
- PERS (professional emergency resources services), which include the installation of devices and in-home monitoring and response to personal emergency requests for help;
- Skilled in-home nursing services to meet needs that are beyond the capacity of non-licensed staff; and
- Specialized medical equipment that allows the client to function better in the home and community (such as wheelchairs, special shoes, flashing light doorbells, and aids to assist with standing).

Disease Prevention / Health Promotion

The *Chronic Disease Self Management Program*, titled *Living Well with Chronic Conditions*, is an evidence-based workshop conducted over six sessions that provides participants with information on how to manage their chronic conditions.

The *Fall Prevention Program* educates older adults about the dangers of falls and how they can reduce their own risks. Workshops and clinics provide education and health screenings (individual medication evaluation, tests for blood pressure and blood glucose, vision and depression screening, etc.), to participants at no charge.

Health education on a variety of topics is provided in group settings.

Elder Abuse Prevention

The Residential Long Term Care Ombudsman Program is designed to improve the quality of life for residents of nursing homes, congregate care facilities, boarding homes and adult family homes. With the assistance of trained volunteers the Ombudsman investigates and resolves complaints made by or on behalf of residents, and identifies problems that affect a substantial number of residents. Changes in federal, state and local legislation are also recommended by the LTCOP program.

Employment (Title V Senior Community Service Employment Program)

Job placement assistance is provided to job seekers over age 55. Part time community service employment opportunities are available for low-income residents of Clallam, Grays Harbor, Jefferson and Pacific County age 55 and older.

Gatekeeper Program

The Gatekeeper Program is part of the Information and Assistance program; it recruits and trains "gatekeepers"--employees or volunteers of corporations, businesses and other organizations, who, in the course of daily work activities, come into contact with older adults in the community. Gatekeepers are trained to identify and refer at-risk older adults whose independence, tenure, or survival in the community is in jeopardy because of illness, social isolation, abuse or neglect.

Information and Assistance

Information and Assistance (I&A) connects older adults and their families with the services and information they need. Information is provided over the telephone and in-person, by trained and certified specialists who maintain a current, comprehensive data base of local, state and federal resources for older adults and their families. Assistance in contacting and accessing services is also provided for clients who are unable to do so themselves. AIRS-certified[10] I&A specialists screen clients to determine their need for more extensive services, which are provided by the case management staff.

I&A staff also provide outreach with information, outreach and education via newspaper and radio media, conduct I&A fairs and seminars, e.g., legal wills clinics, Medicare Part D presentations, and other activities designed to reach out to older persons who need services and link them with the most appropriate resources.

Legal Services

Legal services provide individual client services and limited legal representation to enable adults age 60 and over to secure rights, benefits and entitlements under federal, state, and local laws. It also seeks to effect favorable changes in laws and regulations that effect older people. This program also disseminates information about legal issues to older persons, service groups and bar associations through lectures, group discussions, and the media.

Minor Home Repair and Maintenance

This service provides repair or modification of eligible, client-occupied structures that are essential for health and safety of the client (e.g., installation of wheel chair ramps and grab bars). Limited housing counseling and moving assistance may be provided when repairs will not attain reasonable standards for safety and health.

[10] Alliance of Information and Referral Systems is a professional credentialing program for individuals working within the I&R sector of human services. Certification is a measurement of documented ability reflecting specific competencies and related performance criteria, which describe the knowledge, skills, attitudes and work-related behaviors needed by I&R practitioners. The AIRS Certification Program is operated in alignment with national standards for credentialing organizations.

MIPPA11 Beneficiary Outreach and Enrollment Program

MIPPA Beneficiary Outreach and Enrollment program is an enhanced service of Information and Assistance, providing help for people likely to be eligible for the Low-Income Subsidy program (LIS), Medicare Savings Program (MSP), the Medicare Part D Prescription Drug Program, and in helping people apply for benefits.

Nursing Home Diversion Services for Veterans

This program provides a range of consumer-directed, in home services and support to veterans who are at risk of institutional placement, and their family caregivers.

Nursing Services

Nursing services are provided to high risk older people and younger adults with disabilities with medically unstable health conditions, who are enrolled in state-funded programs (COPES, or Medicaid Personal Care). Services provided include client assessment, advocacy, referral and coordination with health care professionals and other community providers to enhance the overall health of the individual client. The frequency and amount of service is based on individual need that is defined by eligibility and client assessment.

Chronic Care Management

Chronic Care Management is provided to eligible clients with multiple severe and multiple chronic conditions, and includes assessment, coordination with medical and health providers, and appropriate referrals.

Medication Management

Medication management training is provided by O3A nurses, who provide adults 60+ with education and information on safe and effective use of medication (prescription drugs, vitamins and herbs) through seminars and presentations in the home and in group settings such as senior centers, assisted living facilities and senior housing.

Nutrition Services

The *Congregate Nutrition* program helps meet dietary needs of older people by providing nutritionally sound lunches in a group setting, along with nutrition education. Two contracted agencies manage nutrition sites located throughout the service region, with settings in senior and community centers, churches and assisted living facilities. Nutrition services are provided directly and through congregate sites to native elders.

Home-Delivered Meals, often referred to as “Meals on Wheels”, provides nutritious meals to older people and adults with disabilities receiving Medicaid services, who are homebound and unable to prepare meals for themselves. Clients receive hot meals delivered to their homes, as well as frozen meals for weekends and days that hot meals are not scheduled for delivery.

[11] Medicare Improvement for Patients and Providers Act

The Senior Farmers Market Nutrition Program provides fresh, locally grown fruits and vegetables to eligible low income seniors in Jefferson, Clallam, Grays Harbor and Pacific Counties to improve nutrition; also provides nutrition education. Fresh produce is available through a voucher exchange at local farmers markets, as well as through bulk purchase and distribution in areas with no participating farmers market.

Respite Services

Respite assessment and coordination includes screening individuals/ care recipients for eligibility; performing an in-home respite care assessment; developing a service plan; authorizing the level and amount of respite care services to be provided; arranging for care with the respite service program; and maintaining contact with client/participant for reassessment and referral to other services.

Respite Care is provided by local agencies through contracts with O3A, affording relief for families or other caregivers of adults with disabilities. Respite care workers provide supervision, companionship, personal care and personal care services usually provided by the primary caregiver of the disabled adult. Respite can be provided in the care recipient's home or in any residential facility contracted to provide this service (adult family homes, adult day care, nursing homes, and assisted living).

Senior Drug Education

Senior Drug Education (6088) is carried out by O3A nursing staff, who provide adults age 60 and over with education and information on safe and effective use of medication (prescription drugs, vitamins and herbs) through seminars and presentations in classroom settings.

Statewide Health Insurance Benefits Advisors (SHIBA)

Through trained volunteers, individuals receive one-on-one consultation on health insurance plans, advocacy on their behalf with health insurance providers, explanations of billings received, and referral to other appropriate services. SHIBA staff and volunteers conduct numerous trainings throughout O3A's service region on health insurance benefits with a particular focus on Medicare Plans.

Transportation

Contracted volunteer services designed to transport older persons who do not drive, and who cannot access or utilize public transportation, to and from medical, health care and social services, meal programs, senior centers, shopping and recreational activities.

Olympic Area Agency on Aging Coordination Services

Service	Description
Advocacy	Coordinates advocacy efforts through Advisory Council and community partners to provide a strong voice for older adults and influence government policy and decision-making about elder issues
Education	Conducts events and activities that address aging issues as a way to promote long-term planning and crisis prevention for older adults and their families
Outreach & Access	Generates publicity through various media to inform the public about available services and provide assistance where services are not easily accessible
Funding to Local Service Providers	Negotiates, funds & monitors contracts with local service providers & provides technical assistance to assure provision of client-centered, quality services
Planning & Needs Assessment	Conducts community assessments, evaluates existing services, identifies gaps and prioritizes resources to improve access to available services
Service Delivery Coordination	Participates in efforts to develop and sustain service delivery systems that optimize available local resources and develops new resources

B – 4 Non-AAA Services Available in the O3A Planning & Service Area:

This section describes services that are available in the O3A service area from providers other than the Olympic Area Agency on Aging or its contractors. Some are provided by for-profit and / or non-governmental agencies. Although this chart should not be considered as an all-inclusive listing of organizations and services, when taken together with the services provided through O3A, it illustrates the range of long term care and supports available for older people, adults with disabilities and their families.

Services Provided	Clallam	Grays Harbor	Jefferson	Pacific
Adult Day Care	1	-	-	-
Alzheimer's / Dementia Services & Facilities	5	3	1	1
Case Management Programs	3	-	3	1
Community Action Programs	1	1	1	1
Councils on Aging or other significant senior organizations	1	1	1	1
Dental Health Programs & Services	3	2	1	3
Department of Social and Health Services (DSHS)	1	1	1	1
• Adult Protective Services (APS)	1	1	1	1
• Community Services Offices (CSO)	3	1	1	2
• Developmental Disabilities Offices (DD)	1	1	1	1
• Food Stamp Offices	1	1	1	1
• Home & Community Services (HCS)	3	1	1	2
• Information & Referral	3	1	1	2
Disability Access Programs	-	1	1	-
Disability Services & Programs (see DSHS Developmental Disabilities)				
Elder Abuse Programs (see DSHS Adult Protective Services)				
Health & Medical Care				
• County Health Departments	1	1	1	1
• Home Health Agencies	4	1	1	1
• Home Care Agencies	9	3	5	3
• Hospice Services	2	1	2	1
• Hospitals	2	1	1	1
• Community Health Clinics	5	3	4	4

Services Provided	Clallam	Grays Harbor	Jefferson	Pacific
Housing				
• Public Housing Authority	1	1	1	1
• Public Housing Facilities	9	8	1	5
• Boarding Homes & Contracted Assisted Living Facilities	5	6	2	3
• Adult Family Homes	7	1	2	6
• Nursing Homes	5	3	1	1
• Home Repair, Energy Assistance, Weatherization Services	1	1	1	1
• Housing for the Homeless Services	2	3	1	-
Information & Referral Services (private or non-profit) (includes 2-1-1)	3	3	3	1
Legal Services				
• Volunteer Lawyer Program	2	1	1	1
Mental Health Services				
• Mental Health Regional Support Network (crisis services)	6	1	5	2
• Mental Health Centers (community)	3	1	1	3
• Substance Abuse Treatment Programs	5	6	3	1
Native Elder & Minority Services				
• OAA Title VI American Elder Nutrition / Cultural Programs	5	2	-	1
• Tribal Health Clinics	4	2	-	1
• Other	5	2	-	1
Nutrition				
• Food Banks (public)	8	11	5	3
• Women-Infant-Children (WIC) Offices	3	1	2	1
Peer Counseling	1	1	-	-
Primary Care Physicians	25	125	13	15
Retired Senior Volunteer Program, other volunteer programs	3	3	1	1
Senior Centers	4	6	6	1
Senior Fitness and Social / Cultural Programs	3	18	3	4
Social Security Offices	1	1	-	-
Spiritual / Faith-Based Organizations (churches, temples, synagogues)	80	120	38	35
Transportation (includes public transit and Para Transit)	1	2	1	1

SECTION C –ISSUE AREAS, GOALS AND OBJECTIVES

Local and State / National Issue Areas

The priority areas in the Olympic Area Agency on Aging Area Plan for 2012—2015 correspond to the five **Aging and Disability Services Administration (ADSA)** issue areas below:

- Family Caregivers and Kinship Caregivers
- Senior Information and Assistance and Aging and Disability Resource Centers (ADRCs)
- In-Home Services
- Healthy Aging
- Older Native Americans

A sixth issue area, specific to the local O3A service region, addresses

- Basic Needs

Each issue area is profiled for the O3A region, and contains a broad goal and measurable objectives. A state-structured administrative policy 7.01 plan is attached specific to Older Native American goals and objectives.

Effects of the Recession and State budget crisis

The worsening state budget crisis, combined with the effect of the recession on the economic security of older adults, yields a bleak picture for at least the near term future of long term care services and supports to vulnerable older adults and those with a disability.

As state revenues continue their decline and Washington state legislators struggle to balance the state budget, they are forced to make difficult decisions regarding funding for services for the state's most vulnerable residents. In this environment, for example, home care clients are likely to face further reductions to service hours that have already been reduced; Medicaid and Medicare beneficiaries are likely to see further reductions to their benefits; and local community agencies have been forced to reduce services and even close programs because of funding reductions.

The effect of the recession on the economic security of older adults has generally eroded their ability to meet basic needs. Older adults are finding themselves out of work and retired seniors who may have depended on retirement income are now finding they need to return to work. In some cases, newly out-of-work adult children or grandchildren may be moving in with their older parents or grandparents, adding to their burden.

Some older adults are experiencing food insecurity, which is resulting in either an increased demand on local food banks and for Senior Nutrition services, or, conversely, in fewer seniors participating because they lack transportation or because providers have been forced by rising costs for food and fuel to reduce service levels.

Newly out-of-work older adults may find themselves without health insurance, causing them to delay or go without necessary medical and dental care. Older adults facing severe economic problems are more likely to abuse alcohol or experience depression.

The recession has increased the need and the demand for community based services that support older adults and those with a disability to stay independent in their homes, even as it has also caused these services and programs to contract, further eroding the safety net for vulnerable adults.

Strategies O3A will use to operationalize the area plan

In the current economic environment, strategies O3A will emphasize to operationalize the area plan include:

- *Prioritizing resources to reach most vulnerable*
- *Maintaining current program & service delivery capacity*
- *Training / rededicating staff as funding, programs and services change*
- *Building new partnerships with local, regional and state agencies & service providers*
- *Applying proven service models*
- *Outreach with service delivery responsive to the consumer*
- *Encouraging new community initiatives*

C - 1 Family Caregivers and Kinship Caregivers

National estimates suggest that nearly one-quarter of all people aged 65 and older have 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.

Millions of caregivers are spouses, siblings, or children who are in their seventies and eighties themselves. Grandparents may also find themselves as the primary caregivers to their grandchildren. Caregiving can take a heavy toll on caregivers, jeopardizing their health and emotional well-being. 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, health and wellness 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.

Particularly Vulnerable Caregivers

Vulnerable caregivers[12] identified by the Older Americans Act or at state level include:

[12] DSHS/ADSA/HCS Management Bulletin: H11-024-Procedure; May 17, 2011; Attach. A.; pg .8.

- Limited English-speaking and ethnic caregivers, including Native American caregivers;
- Caregivers who are in the greatest economic and social need;
- The term, "greatest social need", means the need caused by non-economic factors, which including: physical and mental disabilities; language barriers; and cultural, social, or geographical isolation, including isolation caused by racial or ethnic status, that restricts the ability of an individual to perform normal daily tasks; or threatens the capacity of the individual to live independently.
- Caregivers who provide care to persons (any age but those over 60 are high priority) with Alzheimer's disease and other dementias;
- Caregivers who provide care to persons at risk for institutionalization;
- Non-traditional family caregivers who may not be recognized as family; GLBT (Gay, Lesbian, Bisexual or Transgender) partners and individuals who are not legally married;
- Grandparents and relatives raising children: age 55 and older are eligible for services provided by the National Family Caregiver Support Program and relatives who are adults (age 18 and older) are eligible for the Kinship Caregivers Support Program and the Kinship Navigator Program;
- Older individuals caring for people, including children (of all ages), with severe disabilities (including developmental disabilities); and
- Caregivers providing care to adults under the age of 60.

Caregivers in the O3A Service Region[13]

In 2007, an estimated 21,866 people in the O3A four-county service region reported that they provided regular care or assistance to someone who has a long term illness or disability. Estimated caregivers by county:

Clallam County:	7,775
Grays Harbor County:	9,956
Jefferson County:	2,536
Pacific County:	1,599

In addition to these caregivers, an estimated 2,040 persons in the four county region report that they have been raising a child under age 19 whose parents are unable to care for them. Caregivers enrolled in O3A FCSP and Relatives as Parents programs include Native American caregivers, and meet vulnerability criteria listed above.

In 2010, the majority of caregivers accessing O3A Relatives as Parents services and support were grandmothers (86%) with the following characteristics: 86% white; 14% Native American; 62% are under the age of 60. All are English speakers.

[13] www.doh.wa.gov/brfss Behavioral Risk Factor Surveillance System: 2007 Survey; Washington State.

This compares with the majority of caregivers accessing O3A FCSP services, who are white (100%), female (81%), and over the age of 60 (55%). All are English speakers.

State and National Family and Kinship Caregiver Support Programs

The State and National Family Caregiver Support Programs (FCSP), along with the Kinship Caregivers Support Program and Kinship Navigator Programs provide critical services to unpaid caregivers caring for adults with functional disabilities or relatives who are raising children. These services help delay or avoid entry into the Medicaid system[14].

O3A's Family Caregiver Support and Relatives as Parents Programs

O3A provides both Family Caregiver Support and Relatives as Parents (Kinship Caregiver) programs. O3A has Family Caregiver Support Specialists in each service county. Presently, there are four staff (3 FTEs) assigned to FCSP: one in Grays Harbor, two in Clallam / Jefferson, and one in Pacific County. O3A FCSP and Relatives as Parents program specialists are trained to implement the T-CARE screening, assessment and care planning protocols, enabling them to identify the caregiver's needs and provide tailored support and services.

The T-CARE program helps FCSP specialists understand the caregiving experience and guides the design and targeting of support services for caregivers. Their receptiveness to services shifts as they move through seven caregiving stages: [15]

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.

Outreach to Vulnerable Caregivers

O3A conducts outreach and public awareness through a variety of mechanisms:

- Health and hospital fairs, including O3A Staying Independent Fairs, Tribal health fairs and outreach to Native Americans;
- News media, including newspaper columns, radio and television
- Referrals from local physician's offices
- Outreach to local schools has resulted in referrals for the Relatives As Parents services
- Word of mouth –caregivers who have received assistance spread the word to their friends and family
- Outreach to churches to publicize Powerful Tools classes
- Presentations to providers, including presentations specific to Gay, Lesbian Bisexual or Transgender caregiver issues (by an O3A Advisory Council member)

[14] DSHS/ADSA/HCS Management Bulletin: H11-024-Procedure; May 17, 2011; Attach. A.; pg .8.
[15] Montgomery, R.J. & Kosloski, K.D. "Change, Continuity and Diversity Among Caregivers," Sept. 2001.

Core Family Caregiver Support Services

Family Caregiver Support services available in each county include:

Information services and Group Activities

Information services are provided by:

- O3A FCSP Specialists, in person and by telephone (including a toll free number);
- Information and Assistance staff, who provide information on legal services and benefits;
- O3A Nursing staff, who include caregivers in public education on relevant topics such as medication management, fall prevention and chronic disease self management;
- a variety of written materials, including brochures and pamphlets created by O3A and other agencies, such as National Institutes on Health /Aging, specifically written for family caregivers; materials from Alzheimer's and dementia support agencies; videos; books, and web resources, many of which are linked on the O3A website;
- a caregiver Lending Library located in the O3A Aberdeen office, where caregivers can borrow books and reference materials;
- newspaper columns, articles, radio and TV presentations by O3A staff; and
- O3A social networking and web sites.

Group Activities with outreach to Caregivers include:

- Health and hospital fairs—the TCARE assessment is available at some of these events;
- Caregiver support groups;
- Presentations about both FCSP and Relatives As Parents (see Outreach to Vulnerable Caregivers, above)

One-to-one specialized family caregiver information and assistance, including TCARE Screening and Assessment/Care Planning

- Caregivers receive TCARE screening / assessment and care planning provided by O3A FCSP specialists.
- In response to the caregivers' needs identified by the T-Care screening protocol, O3A FCSP staff have developed a menu of services that can be provided through a purchase order system or in-place contracts with local providers. FCSP specialists report that since the introduction of the T-CARE program, referrals to the FCSP have increased significantly.
- Caregivers benefit from tailored contracted and purchased services, such as counseling for the caregiver, assistive technology, provision of durable medical equipment and respite services for the care recipient.
- Caregivers are also referred to other service providers, including O3A's Information & Assistance program and other local community support services.

Counseling

An estimated 60% of family caregivers are at high risk of depression. O3A's T-CARE assessments have demonstrated that family caregivers feel isolated and sink into depression before they know it, based on the stressful situation they are facing. This information assists O3A FCSP specialists to develop a responsive care plan, which may include:

- Encouraging caregivers to speak to their doctors about the T-CARE results showing high risk of depression, and request that their doctor also follow up with their own depression screening. This can lead to medical intervention by the doctor, including introduction of antidepressants.
- Receiving individualized counseling. If the caregiver does not have a health insurance plan that will cover counseling for depression related to caregiver burden and stress, O3A can cover this expense (to the extent funding is available).

Training

O3A's Family Caregiver Support Program provides one-to-one training as well as group training opportunities, workshops and conferences for caregivers.

- ***Powerful Tools For Caregivers,*** O3A has seven FSCP and I&A staff trained to provide this six-week education program, developed by Legacy Caregiver Services in Portland, Oregon, which focuses on the **needs of the caregiver**, and is designed for family and friends who are caring for older adults suffering from stroke, Alzheimer's, Parkinson's disease or similar long-term conditions. The class provides caregivers with the skills and confidence caregivers need to better care for themselves while caring for others.
-
- O3A staff have been trained to train others to deliver the Powerful Tools Caregiver workshops, with the objective of training other community groups to provide this to their constituencies.

Referral to other training opportunities

FCSP staff also refer caregivers to local training opportunities offered by O3A and other community providers, such as training in caring for persons with Alzheimer's and dementia; and the Chronic Disease Self Management workshops.

- **One-to-one training**—for example, how to communicate with someone who is cognitively impaired; how to effectively communicate with medical providers regarding the care receiver's medical issues; how to recognize possible depression issues based on the situation they are facing; and other self help tools that are available in the O3A resource library and online.
- **Annual Caregiver Conference** O3A Senior I & A and FCSP staff support the Caregiver Coalition of the CARE Partnership, Clallam County, to host an annual Caregiver Conference, which focuses on enhancing tools and resources available to caregivers. A similar conference will take place in Jefferson County in 2011.

Support Groups

O3A FCSP provides support groups for family caregivers in Grays Harbor, Clallam and Jefferson counties, as well as referral to support groups offered by other community agencies, such as hospice and local Alzheimer's Associations.

Respite care services (both in and out of home)

Respite care is the most frequently accessed service to provide the unpaid caregiver with regular breaks from caregiving responsibilities. Respite care is provided through O3A-contracted service providers in each county, including "Encore", in Clallam County, the only Day Care service available; and in the home by contracted agency providers.

Supplemental services

The O3A FCSP also provides durable medical equipment & assistive technology, as well as emergency home repair; "wander guard" technology; such as lifeline (paid via O3A purchase order or by Seniors and Law Enforcement Together), and legal aid from O3A Senior Legal Advice Clinics. All these services are interventions listed on T-CARE.

Core services available to Relatives as Parents (Kinship Care)

The FCSP staff specialists also provide limited direct services to kinship caregivers for minor children. Services provided include:

- **Information** on support and services available locally, frequently including referral to Legal Services.
- A local organization publishes the ***Parenting Again*** newsletter, which is distributed to tribes and most of the schools in the region.
- **Support group** (in Grays Harbor County)
- **Supplemental Services**
- This service is provided directly by FCSP specialists and helps caregivers with urgent basic needs such as housing, food, clothing, and essential supplies; the need for this service generally exceeds O3A's capacity to meet it.

Problem / Need(s) Statement:

In order to expand services and support to family caregivers in the O3A service region, O3A needs to ensure that trained, dedicated staff are supported to conduct outreach and provide targeted support responsive to the needs of family and kinship caregivers. In addition, O3A needs to take advantage of support for family caregivers available from other community groups, and offer training, technical assistance, and referral resources for these groups.

Goal: Family Caregiver Support and Relatives as Parents programs supports more family & kinship caregivers to care for their family members.

Objective 1: Expand FCSP & KC staff capacity for increased service provision.

Key Tasks:

- Rededicate and train I&A staff (up to 2.0 FTE) according to changes in funding & increasing need.

- Orient ten (10) I&A staff to FCSP & KC programs.

Objective 2: Conduct outreach & provide targeted support & services to family & kinship caregivers responsive to their needs.

Key Tasks:

- Promote FCSP & Relatives as Parents as Parents programs with appropriate local community agencies, via presentations & contacts to schools, medical service providers, discharge planners, churches, etc. Target 2 presentations per month.
- Support / facilitate referrals from hospitals, discharge planners, physicians' offices, schools, churches, etc. Target 2-3 referral resources/ year per county.
- Provide T-CARE assessments & customized care plans for family caregivers.
- Provide targeted services & supports to FCSP & Kinship caregivers (e.g., respite, counseling, support groups, help w/children's school supplies, etc.)
- Identify & engage 2-3 new vendors & providers each year utilizing purchase order system to facilitate efficient and timely service provision.

Objective 3: Expand Powerful Tools training & make available to wider community.

Key Tasks:

- Train 2-3 community partners each year to provide Powerful Tools training for their constituents.
- Provide support & technical assistance for ongoing classes in all counties.
- Recruit 2 Tribes in 2012 and 1-2 Tribes each subsequent year to receive Powerful Tools training.

ISSUE AREA: FAMILY CAREGIVERS and KINSHIP CAREGIVERS					
GOAL: Family & Kinship Caregivers are supported to care for their family members.					
Measurable Objectives	**Key Tasks**	**Responsible**	**Timeframe**		**Accomplishment or Update**
			Start Date	**End Date**	
1. Expand FCSP & KC staff capacity for increased service provision.	1.a. Orient ten (10) I&A staff to FCSP & KC programs.	Reg I&A Director; FCSP/KC specialist(s)	1/12	6/12	
	1.b. Rededicate and train I&A staff (up to 2.0 FTE) according to changes in funding & increasing need.	Regional I&A Director	7/11	6/15	
2. Conduct outreach & provide targeted support & services to family & kinship caregivers responsive to their needs.	2.a. Promote FCSP & Relatives as Parents programs with community agencies via up to 2 presentations per month to schools, medical service providers, discharge planners, churches, etc.	FCSP/KC specialist(s)	7/11	6/15	
	2.b. Support / facilitate referrals from hospitals, discharge planners, drs' offices, schools, churches, etc. Target=2-3 referral resources per county per year.	FCSP/KC specialist(s)	7/11	6/12	
	2.c. Provide T-CARE assessments & customized care plans for family caregivers.	FCSP/KC specialist(s)	7/11	6/15	
	2.d. Provide targeted services & supports to FCSP & Kinship caregivers (e.g., respite, counseling, support groups, help w/children's school supplies, etc.)	FCSP/KC specialist(s)	7/11	6/15	
	2.e.Identify & engage 2-3 new vendors & providers each year utilizing purchase order system to facilitate efficient and timely service provision.	FCSP/KC specialists; Regional I&A Director; O3A Fiscal Dept	7/11	6/15	
3. Expand Powerful Tools training & make available to wider community.	3.a. Train 2-3 community partners (e.g., churches) each year to provide Powerful Tools training for their constituents.	FCSP/KC specialist(s)	7/12	6/15	
	3.b. Provide support & TA for ongoing classes in all counties.	FCSP/KC specialist(s)	7/12	6/15	
	3.c Recruit 2 Tribes in 2012 & 1-2 Tribes in subsequent years to receive Powerful Tools training.	Regional I&A Director/Direct Service Supervisors	7/13	6/15	

C - 2 Senior Information and Assistance Services and Aging & Disability Resource Centers (ADRCs)

The Olympic Area Agency on Aging's Information and Assistance Program

Information and Assistance (I&A) Services have been critical to older adults and are an integral part of today's Aging Network. O3A's Information and Assistance program is a client-based service model with decentralized service staff responsive to local areas, issues and resources. In addition to serving younger adults with disabilities with case management services, O3A's existing I & A program has achieved broad coverage throughout the region with referral and information about services and benefits for older adults, and has developed solid working relationships with the many state agencies and local community resources providing programs and services to both older adults, as well as younger adults with disabilities.

O3A is able to reach a wide audience with information via the O3A website, social networking sites, and access to media publicity through weekly radio programs reaching approximately 21,000 listeners throughout the Olympic peninsula, a weekly television program, and popular weekly newspaper columns in several local newspapers, with a combined audience of over 42,000 readers.

O3A's I & A participates in the "2-1-1 of the Peninsulas" serving Jefferson, Clallam, Kitsap, Mason, Thurston, Grays Harbor and Pacific Counties, which also provides access to information on service and programs of interest to older adults throughout O3A's four service counties.

Aging and Disability Resource Centers

The ADRC initiative is a collaborative effort of the Administration on Aging (AoA) and the Centers for Medicare & Medicaid Services (CMS) and is designed to streamline access to home and community supports and services for consumers of all ages, incomes and disabilities, and their families. The goal for these centers is to help older adults and individuals with disabilities (physical, mental or developmental) make informed decisions about their service and support options, and serve as a single point of entry into the long term care system.

Through integration or coordination of existing aging and disability service systems, ADRC programs raise visibility about the full range of options that are available, provide objective and trusted information, advice, counseling and assistance, empower people to make informed decisions about their long term supports, and help people more easily access public and private long term supports and services. With the expectation that ADRCs will be expanded statewide, O3A anticipates that the current I & A infrastructure can be systematically realigned into the Aging & Disability Resource Center format in order to serve a wider population.

O3A Transition to ADRC Format

O3A's Information and Assistance program provides an effective platform for transition to an ADRC service format. Information and Assistance now serves as a highly visible and trusted place where people of all ages and incomes can turn for information on a wide range of long term support options, particularly within a framework of a local 'continuum of care' that allows older adults to remain in their community as they age.

Many of the services that can be accessed via an ADRC already exist under the purview of O3A's Information and Assistance program; and/or are provided by established partners. These services include, but are not limited to: Information & Assistance; Benefits *CheckUp* Screenings; Family Caregiver Support; Relatives as Parents Program (Kinship Caregiver Support); Case Management; Veterans programs; Dementia programs; Adult Day Services; Wellness programs; Senior Community Service Employment; Statewide Health Insurance Benefits Assistance; Legal Services; Long-term Care Ombudsman; Volunteer Services; Transportation; Home & Community Services; Residential Care Services; Developmental Disabilities; Mental Health Services; and 2-1-1.

O3A staff participated in the recent ADSA procurement process for a statewide AAA information system, which will support development of the ADRC format. The new system will provide a robust client management system, reports, resource directory, and an online self-service component.

In order to transition to an ADRC format, O3A will conduct an ADRC readiness assessment to identify current strengths and areas of development to become an ADRC. The assessment will assist O3A to

- identify potential new ADRC partnerships and explore strategies for partnering with local organizations, for example, by clarifying roles and responsibilities; developing mechanisms to share knowledge; conduct cross training; prevent duplication of information and services, etc.
- identify existing issues in realigning both funding and I&A services into the ADRC format to meet community needs, including those of the ADRC target populations;
- clarify how challenges will be addressed and what assistance would be needed, and
- identify how best to deploy the AAA statewide information system so that constituents can fully utilize the self-service component.

Following the assessment, and assuming adequate funding, O3A will develop a "Transition to ADRC Plan" that addresses the following ADRC key service components:

- Information, Referral & Awareness (including self-service)
- Options Counseling and Assistance
- Streamlined Eligibility Determination for Public Programs
- Person-Centered Care Transitions Supports
- Continuous Quality Improvement

Senior Legal Advice Clinics (SLACs)

The provision of senior legal assistance services is a federal program authorized under the Older Americans Act. The goal of the program is to improve the independence and welfare of older adults (age 60 and over) by providing access to basic legal services to low-income seniors.

The Olympic Area Agency on Aging contracts with individual practicing attorneys to provide services to seniors in a one-on-one based Senior Legal Advice Clinic format. This unique service format is integrated into the I & A program itself, and supports referral feedback for clients between the attorney and the I & A program staff.

The Senior Legal Advice Clinic provides free legal assessments, referrals, and / or services to individuals who qualify for the program. SLACs typically provide advice in the following legal areas:

- Powers of Attorney and planning for incapacity;
- Family law issues;
- Institutional Medicaid eligibility issues;
- SSI overpayments;
- Consumer problems;
- Wills and Probate questions;
- Private Landlord/Tenant and Real Estate foreclosure problems;
- Long Term Care/Health Care Issues.

Through the O3A Senior Legal Advice Clinics, older adults:

- receive direct one-on-one counseling and assistance in their own community and at no cost for a 30 minute consultation;
- receive education about, and the review and/or preparation of, basic legal documents such as powers of attorney, healthcare directives and wills;
- are assisted to resolve financial situations that may include consumer problems, Medicaid eligibility, and landlord/tenant issues;
- can be referred to other legal service providers, community agencies, and / or back to O3A Information & Assistance staff for any additional services and/or follow-up on an individual basis.

Problem / Need Statement(s):

Information & Assistance and ADRCs

Presently, O3A staff are funded to provide information and referral services to adults age 60 and over only, precluding O3A from embarking on any full scale realignment into an ADRC that could serve younger adults until funding for this becomes available. Recent budget cuts to the Senior Citizens Services Act present an even greater threat, and will necessitate rededicating some I& A staff with appropriate skill sets to other programs (e.g., Family Caregiver Support). Consequently, O3A's current priority is to maintain the staffing expertise and capacity within in its direct services workforce that will be essential to the development of an ADRC service format when funding becomes available.

Legal Services

The recent economic downturn has increased the demand for legal services throughout the region. The SLAC service format is well developed in two of O3A's four service counties (Clallam and Jefferson), and O3A, with current resources, is in process of expanding the model to Grays Harbor and Pacific County.

GOAL: Older adults and people with disabilities are assisted to make informed decisions about and access services they need to remain independent and in their own homes.

Objective 1: Provide information to older people, families, other consumers about existing health and long-term care options, and assistance to access.

Key Activities:

- Maintain capacity to implement Information & Assistance program throughout the region according to program requirements.
- Coordinate with local community partners to provide coverage with responsive services and current information on alternatives

Objective 2: Develop O3A "Transition to ADRC" plan, in order to expand I&A services to people with disabilities and children.

Key Activities:

- Assess O3A I&A readiness to transition to ADRC program format (ADRC assessment tool available on the ADRC Technical Assistance website).
- O3A staff workgroup develops "Transition to ADRC" plan for submission to ADSA.
- Upon approval from ADSA & assuming adequate funding, begin implementation of "Transition to ADRC" plan.

Objective 3: Provide Senior Legal Advice Clinics (SLACs) in all service counties.

Key Activities:

- Recruit & contract local attorneys to provide 30 minute consultation & limited follow up to older adults on relevant legal issues.
- Coordinate legal clinics in I&A offices in each county.
- Provide appropriate follow up for clients referred to I&A for other services.

ISSUE AREA: INFORMATION & ASSISTANCE SERVICES AND AGING & DISABILITY RESOURCE CENTERS

GOAL: Older adults and people with disabilities are assisted to make informed decisions about support and services they need to remain independent and in their own homes.

Measurable Objectives	Key Tasks	Responsible	Timeframe		Accomplishment or Update
			Start Date	End Date	
1. Provide information to older people, families, other consumers about existing health and long-term care options, and assistance to access.	1.a. Maintain capacity to implement Information & Assistance program according to program requirements.	Regional I&A Director	1/2012	12/2014	1.a.
	1.b. Coordinate with local community partners to provide coverage with responsive services and current information on alternatives.	Regional I&A Director; O3A Planner	1/2012	12/2014	1.b.
2. Develop O3A "Transition to ADRC" plan, in order to expand I&A services to people with disabilities and children.	2.a. Assess O3A I&A readiness to transition to ADRC program format (ADRC assessment tool available on the ADRC Technical Assistance website).	Regional I & A Director; O3A Planner	1/2012	6/2014	2.a.
	2.b. O3A staff workgroup develops "Transition to ADRC" plan for submission to ADSA.	Regional I & A Director; O3A Planner	7/2012	3/2013	2.b
	2.c. Upon approval from ADSA & assuming adequate funding, begin implementation of "Transition to ADRC" plan.	Regional I & A Director	4/2013	12/2013	2.c.
3. Provide Senior Legal Advice Clinics (SLACs) in all service counties.	3.a. Recruit & contract local attorneys to provide 30 minute consultation & limited follow up to older adults on relevant legal issues.	Program Development Mgr; Program Manager; Regional I&A Director	1/2012	12/2013	3.a.
	3.b. Coordinate legal clinics in I&A offices in each county.	I&A supervisors	1/2012	12/2013	3.b.
	3.c. Provide appropriate follow up for clients referred to I&A for other services.	I&A supervisors & staff	1/2012	12/2013	3.c.

C - 3 In Home Services

Increasing caseloads & impact on the case management system

In the O3A service region, there are more than 1,400 older adults and individuals with disabilities living at home receiving publicly funded Medicaid personal care and other supportive services. The O3A in-home service caseload is increasing, reflecting pressures from the regional demographic shift towards proportionately more older adults, as well as the toll the recession is taking on them and their families.

Within the O3A Medicaid caseload, the number of younger adults with disabilities (aged 18 and over) is also 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. In addition, younger clients tend to need support for longer periods.

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.

Increasing caseloads, state budget crisis & effect on service delivery

With the state budget crisis, and associated reduction in funding for mental health services state-wide, case management staff has reported that the number of people with disabilities related to mental health issues has increased. They report that although these clients generally qualify for fewer in-home service hours, they present with behavioral issues that tend to require more time from case management staff.

The recent service cuts, along with cuts in funding for mental health services, are resulting in significant pressure on the case management system to respond with sufficient services and supports, and to provide adequate and appropriate options to clients. In the past, it has been possible to link clients and family members with other local services, e.g., offered by churches and community service agencies, however, funding to these agencies has also been affected by the economic downturn, resulting in severe stress on the traditional community safety net.

In Grays Harbor County, one proactive response has been from the National Alliance on Mental Illness (NAMI), which is providing training for law enforcement and emergency first responders in managing encounters with persons with mental health issues.

O3A is also responding with an expansion of the Gatekeeper program—training for community personnel on how to identify older adults who may not be coping due to depression, dementia, or chronic illness, and referring them to Information and Assistance and other community resources.

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;
- the 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,
- reimbursement rates for in-home care services have not kept pace with increasing costs, and
- lack of economies of scale (e.g., caseload size in large rural areas in relation to required administrative structure).

Over half of adults over the age of sixty (54%) on the Olympic peninsula live alone[16], 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. For older adults who need more support than they can receive in their homes, residential facilities can be a good option.

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.

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 concern about who will provide the care needed by older adults and people with disabilities.

Especially for younger case managed clients with disabilities there is a need to integrate other types of services, such as those provided through I & A and SHIBA, as well as other agencies, to support a substantial increase in client-directed service provision. With new support to develop and implement ADRC services in the region, O3A could begin to address the provision of more responsive services to this population. Please refer to Section C-2, Information & Assistance Services and Aging and Disability Resource Centers.

O3A will continue to coordinate with two regional programs, MALLARD, in Grays Harbor, and DASH, in Jefferson (programs to increase access and awareness of issues

[16] Olympic Area Agency on Aging, Consumer Survey; June 2011.

affecting people with disabilities). These programs have successfully raised awareness and fostered change at the community level.

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 Home Care Referral Registries throughout the O3A service region. This service supports paid caregivers to receive health insurance benefits, training and certification, and can provide support for family caregivers who wish to transition to a paid career in care giving. There is a need to ensure that training for caregivers includes continuing education on client chronic care management that reflects the increasingly complex medical needs of their clients.

Chronic Care Management

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.

The Washington state Chronic Care Management program is a proven model which has demonstrated improved health outcomes for clients and reduced costs from fewer hospitalizations and emergency department visits. The O3A Nursing Service department has provided Chronic Care Management to eligible clients since 2007, and is presently expanding services to additional eligible clients.

The O3A Nursing Services Department has a team of nurses trained and experienced in Chronic Care Management (CCM) protocols; O3A's CCM nurses currently provide CCM services to a caseload of clients dispersed throughout O3A's four county service region.

The Chronic Care Management Program is embedded within O3A Nursing Services Department; CCM nurses are co-located with O3A case management staff, which supports service integration and coordination, efficient use of appropriate staff, and helps prevent duplication of effort.

The O3A CCM Nurse Care Manager works closely together with the individual client's Case Manager to coordinate authorization of appropriate supports and services, and with O3A contract management staff to secure any necessary ancillary services as they are identified.

Community Outreach with Evidence-Based Prevention & Health Promotion

To overcome resource and geographic barriers, O3A has developed a targeted, multi-dimensional approach that emphasizes prevention and consumer engagement, and relies on collaborative partnerships with multiple local community providers for hospital

/medical, health care, and supportive services. The CCM staff facilitate access to these programs and services for the CCM client as appropriate.

On the Olympic peninsula, where access to medical and specialized care is particularly limited, O3A has developed community outreach with evidence-based prevention programs that support older adults with chronic illnesses in the most remote communities and tribes on the peninsula to access tools to help them manage their health issues. O3A has formed partnerships with 11 local agencies—local hospitals and clinics, tribes, community action programs, even an athletic club; provided the tools and support these organizations need to carry out workshops in their own communities, facilitated training for people to lead the workshops, and supported partners to conduct workshops throughout the peninsula. Today, a CCM client, along with older adults in the general community, can attend a Chronic Disease Self Management Workshop in larger communities such as Port Angeles, Aberdeen, Sequim and Port Townsend, and also in smaller, more remote communities such as Neah Bay, Forks and Taholah. CCM clients and other older adults can also benefit from O3A's Fall Prevention program, which aims to provide direct consumer education and individual risk assessment; facilitate introduction of local community exercise classes for older adults to improve strength, balance and flexibility, and build capacity of local stakeholders for a coordinated response.

Expanding coverage with CCM

O3A in 2011-12 is expanding coverage with CCM. In developing this expansion plan, the O3A Director of Nurses, together with the O3A Chief Fiscal Officer, considered current and projected staff levels, geographic coverage, and the historical percentage of clients choosing to participate (about 60%).

O3A's current CCM case load is 44 clients. ADSA previously projected a total of 164 eligible clients for the O3A service region. Assuming an estimated 60% participation, O3A anticipates a total expanded case load of 100 clients, or an expansion goal of 56 new clients.

CCM Program Expansion Staffing and Requirements

O3A projects it will require nine months to expand CCM services to 56 new clients. Currently, five O3A nurses are trained and experienced in delivering CCM and direct nursing services to O3A's Medicaid clients. By adding hours for current staff, O3A can increase the CCM client case load from 44 to 60 before adding new staff. To meet the expansion goal, O3A will recruit and hire one new Nurse Care Manager at approximately 25 hours per week, increasing to 40 hours as needed. Total nursing staff hours will increase as required to meet case ratios.

Clients served by the O3A Chronic Care Management program are high risk, high cost Medicaid clients, often called the 5/50 population, i.e., responsible for 50% of total expenditures. These very vulnerable clients typically have serious impairments caused by disability, mental illness and/or chemical dependence, which complicates delivery of their care. These clients also tend to see multiple medical providers, which leads to

additional complexities for medication management and therapy coordination, for example, between primary care providers and behavioral specialists.

Providing the optimal care to these clients requires that the O3A CCM Nurse Care Manager have a thorough working knowledge of and good relationships both with local community service providers, as well as the client's Case Manager, in order to ensure that appropriate services and supports are made available to support client care.

Adult Family Homes

Adult Family Homes are regular neighborhood homes where staff assumes responsibility for the safety and well-being of the adult. A room, meals, laundry, supervision and varying levels of assistance with care are provided. Some provide occasional nursing care. Some offer specialized care for people with mental health issues, developmental disabilities or dementia. The home can have two to six residents and is licensed by the state. The Adult Family home is an appropriately sized residential option for rural and tribal communities.

Promoting the AFH as a potential model for the O3A service region will require consultation with appropriate stakeholders, including state and regional representatives, local community and tribal representatives, and O3A staff, along with the facilitation of technical assistance to these and other community stakeholders.

Problem /Needs Statement:

In the next 20 years, the number of people who need long-term care assistance will double; older adults with complex chronic illnesses will require specialized medical and social support to age in place. Older adults no longer able to live at home will require residential options that are not always available in their communities. The increased demand for services will require continued 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 promote the development of residential options suited to the environment for individuals who are no longer able to live at home.

GOAL: Elders and adults with disabilities are able to remain in their own homes with maximum independence for as long as possible.

Objective 1: Procure services that meet identified client needs (average caseload >1,400 clients)

Key Tasks:

- Recruit and contract local agencies & providers to meet client needs identified by care managers for TXIX services.
- Recruit and contract with individual providers through the O3A Home Care Referral Registries; ensure caregiver requirements are met, including certification and training.

Objective 2: Increase the number of clients receiving chronic care management.

Key Tasks:

- Recruit, orient and train new Nurse Care manager to accommodate increased # clients
- Increase hours for Nurse Care managers as new clients are enrolled.
- Nursing department provides ongoing program monitoring & evaluation.

Objective 3: Promote new Adult Family Home development in remote and tribal communities.

Key Tasks:

- Consult with state, regional representatives and community stakeholders to identify feasibility and implementation issues.
- Review current information on AFH business model development, and make available to potential providers.
- Identify and facilitate technical assistance to potential providers interested in establishing AFHs.

Objective 4: Participate in pilot programs that support consumer engagement and flexibility.

Key Tasks:

- Identify and explore feasibility for new pilot programs as appropriate for implementation in the PSA.
- Respond to RFPs and other requirements for new program development.

ISSUE AREA: IN HOME SERVICES

GOAL: Older adults & people w/ disabilities are able to remain in their own homes w/ maximum independence as long as possible.

Measurable Objectives	Key Tasks	Responsible	Timeframe		Accomplishment or Update
			Start	End	
1. Provide in-service training for direct service staff to meet increasing client acuity & behavioral needs,& support institutional transitions.	1.a. Convene workgroup to identify appropriate training opportunities responsive to agency & client needs (e.g., Care Transitions Coaching; Motivational Interviewing; PEARLS, etc).	O3A Planner; Nursing Services Director; Regional I&A Director	9/2011	Ongoing	
	1.b. Identify resources available for training.		9/2011	Ongoing	
	1.c. Develop & implement staff training plan.		1/2012	Ongoing	
2. Expand # clients receiving intensive chronic care management per O3A's 2011 CCM expansion plan.	2.a. Recruit, orient & train new Nurse Care Mgr to accommodate expanded # clients.	O3A Nursing Service Director	1/2012	12/2013	
	2.b. Increase hours for Nurse Care Mgrs as new clients are enrolled.		1/2012	12/2013	
	2.c. Provide ongoing program monitoring & evaluation.		1/2012	12/2013	
3. Promote new Adult Family Home development in remote & tribal communities.	3.a. Consult with state, regional representatives & community stakeholders to identify feasibility & implementation issues.	O3A Planner; Regional I&A Director	TBD	TBD	
	3.b. Make current information on AFH business model development available to potential providers.		TBD	TBD	
	3.c. Identify & facilitate technical assistance to potential providers interested in establishing AFHs.		TBD	TBD	
4. Ensure sufficient providers for contracted services that meet identified client needs.	4.a. Recruit and contract local providers to meet client needs identified by CMs (for COPES programs, etc).	O3A Program Mgr CM Supervisors & CMs O3A HCRR staff	1/2012	12/2015	
	4.b. Recruit and contract with individual providers through HCRR; ensure caregiver requirements are met, including certification & training.		1/2012	12/2015	
5. Participate in pilot programs that support consumer engagement and flexibility.	5.a. Identify & explore feasibility for new pilot programs as appropriate for implementation in the PSA, e.g., New Freedom, Nursing Home Diversion, RCL, etc.	O3A Exec Director Reg I&A & Nursing Svcs Directors O3A Planner	9/2011	12/2015 Ongoing	
	5.b. Respond to RFPs & other requirements for new program development.		9/2011	12/2015 Ongoing	

C – 4 HEALTHY AGING

Effects of the recession

Effects of the recession on the economic security of older adults have generally eroded their ability to meet their health and nutrition needs. Some older adults are experiencing food insecurity, which is resulting in either an increased demand on local food banks and for Senior Nutrition services, or, conversely, in fewer seniors participating because they lack transportation or because providers have been forced by rising costs for food and fuel to reduce service levels.

Newly out-of-work older adults may find themselves without health insurance, causing them to delay or go without necessary medical and dental care. Older adults facing severe economic problems are more likely to abuse alcohol or experience depression. In general, the current economic downturn is exacerbating constraints affecting older adults, particularly related to food security and access to affordable medical, dental and mental health care.

In the O3A consumer survey conducted in 2011[17] , the following percentages of older adults reported they often skipped paying for essentials:

Dental Care	28%
Vision or glasses	18%
Medicine	13%
Food	10%
Insurance	9%
Transportation	8%
Housing or utilities	6%

O3A Healthy Aging programs and services

O3A dedicates Older Americans Act and grant funds to support the implementation of evidence-based health promotion/disease prevention programs, including: promoting influenza and pneumonia vaccination of seniors; chronic disease management workshops and programming; active/healthy lifestyle promotion (physical activity) and a robust fall prevention program; the appropriate use of assistive technology to prevent secondary disabling conditions; and nutrition access and education.

Chronic Illness

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.

[17] O3A consumer survey, conducted from March to June, 2011; n= >400.

Overall U.S. health care costs associated with the aging population are projected to increase 25% by 2030,[18] further straining a healthcare system that is not prepared to address the geriatric needs that currently exist[19]. With 30% percent 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 of low reimbursement rates. 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.

In response, O3A has taken a proactive approach to assisting older adults to prevent and manage illness and improve their health, with targeted interventions related to chronic disease management, fall prevention and increasing physical activity.

Living Well with Chronic Conditions Workshops

O3A has implemented the evidence-based Chronic Disease Self Management Program (CDSMP) since 2007 as *"Living Well with Chronic Conditions".* Currently, the O3A Living Well Program is part of the Washington State Living Well with Chronic Conditions program being implemented state-wide. The program features a six week workshop for older adults who wish to learn how to better manage their chronic illness, and for caregivers of people with chronic illness.

The six week *"Living Well"* workshop teaches practical skills for living a healthy life for participants with an ongoing condition such as asthma, diabetes, high blood pressure, heart disease, obesity, or arthritis. Developed by Stanford University's Patient Education Department, the workshop is designed to help people learn to manage their chronic conditions and improve the quality of their lives. Family members, friends and caregivers can also participate. By participating in the workshop, people increase their confidence and motivation needed to manage the challenges of living with a chronic health condition.

O3A has carried out, or supported local community partners to carry out, *"Living Well"* workshops throughout the four county service region: Clallam, Grays Harbor, Jefferson and Pacific Counties; and within Tribal communities in three counties. Today, it is possible to find a *Living Well with Chronic Conditions* workshop in even remote rural and tribal communities within the O3A service region.

[18] www.cdc.gov

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

Fall Prevention and Staying Independent Program

There are more people age 65 and older in Washington hospitalized for injuries due to falls than the number of people, of all ages combined, hospitalized due to motor vehicle crashes[20].

The major risk factors for falling are diverse, and many of them can be addressed. The likelihood that an older adult will experience a fall depends on a unique set of factors related to an individual's age, health and environment. An effective fall prevention approach requires a community-based response that is broad-based, coordinated, and involves multiple community stakeholders.

Since 2006, O3A has implemented a proactive fall prevention program, with well-developed internal and community partnerships; outreach with information and education; preventive services and screening for risk factors; and facilitation and support of evidence-based exercise programs for older adults.

The O3A Fall Prevention /Staying Independent Program Interventions:

- provide opportunities for older adults to evaluate their risk for falling in clinics offered at annual ***Staying Independent Fairs***, conducted by the O3A Nursing and I & A departments to provide practical information to older adults on how to reduce individual risks for falling;
- provide public education through seminars and raising general community awareness through the media about the risks of falling;
- support local health and medical professionals, and service providers with older adult clients, to incorporate fall prevention strategies into the overall health and wellness plans for their patients, and
- facilitate the development of new Stay Active and Independent for Life (SAIL) fitness programs throughout the service region with training, publicity and promotion.

O3A is a member of the Washington State Fall Prevention Coalition, and has received technical assistance and support from national, state and local fall reduction programs, including CDC and US Dept. of Health; Washington State Dept. of Health:" Falls Among Older Adults" Ilene Silver MPH /Sally York, RNC BSN; Dr. Elizabeth Phelan, University of Washington; Grays Harbor Community Hospital; National Center for Injury Prevention and Control; Farewell to Falls Program from Stanford University Medical Center; and Northwest Orthopedic Institute of Tacoma.

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

[20] http://www.doh.wa.gov/hsqa/emstrauma/injury/#EMS; June 2011

vaccinations. Nationally, however, one in three elders do not receive influenza vaccine, fewer receive other vaccinations, and nine in ten often 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.

O3A supports older adults to obtain screening and preventive services through a variety of mechanisms:

- Coordinating with providers to make screening and preventive services available at no cost to the consumer, at O3A I&A Health & Staying Independent Fairs in all counties;
- Publicizing vaccinations via O3A media outreach, particularly during flu season;
- Encouraging local Senior Nutrition providers to coordinate with their local health departments to make vaccinations available at congregate meal sites;
- Encouraging home care agencies to support caregivers to receive an annual flu vaccination to reduce the risk of contagion to the care receiver.

Screening services available at the O3A Staying Independent Fair typically include:

- Serum glucose testing, with referral to a physician, if necessary
- Hypertension and orthostatic hypotension testing
- Gait and balance evaluation
- Depression screening, with support of a counselor
- Medication interaction evaluation by a pharmacist (“brown bag” assessment)
- Individual fall risk assessment
- Evaluation and recommendation of footwear
- Nutrition counseling

The O3A Information and Assistance staff regularly promote and publicize screening services for older adults offered by local health and medical providers and community agencies.

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 194,993, the number of persons age 18 and over with cognitive impairment is projected at 12,673; of these, 5,823 are age 60 and older, or approximately 10% of adults age 60 and older in the O3A service

region. The number of persons age 70 and older with dementia is projected at 4,307[21], nearly 8% of adults age 60 and over in the PSA.

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,[22] 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."[23]

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.[24]

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.[25] About one third of all older substance abusers began taking substances

[21]

[22] 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.

[23] Sullivan, M.et.al. p.112.

[24] The State of Aging and Health in America, The Merck Institute of Aging and Health, and The Gerontological Society of America, 2003.

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

after the age of sixty. Half of emergency room visits by older adults are related to consequences of alcohol or substance abuse.

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 endodontic 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 aids, 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 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%.[26] 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.[27]

Consequences of food insecurity in older adults

- Poor intakes of protein, carbohydrate, niacin, riboflavin, vitamins B6 and B12, magnesium, iron and zinc;
- Poor overall health status and compromised ability to resist infections;
- Deteriorating mental and physical health;

[26] 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.

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

- Greater incidence of hospitalizations and extended hospital stays;
- Increasing care-giving demands and national health care expenditures.

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.'

Lack of transportation options affects access to services

It is not surprising, given the impressive 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.[28] Furthermore, only 3% of older people use public transit[29] due to concerns about safety, schedules and connections to needed destinations.

[28] 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.

[29] 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.

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.

Problem / Need Statement:

The rapid growth in the elder population on the Olympic peninsula is associated with an increase in the burden of chronic disease and increasing pressure on available medical and health care services. In addition, geographic isolation coupled with insufficient transportation options can further limit access to health and medical services and increase the likelihood that seniors with chronic illness and adults with disabilities will not be able to obtain optimal care and support.

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

Objective 1: O3A Living Well with Chronic Conditions Workshops are available in communities throughout the PSA.

Key Tasks:

- Implement one CDSM workshop/year in main population centers (Sequim; Port Angeles; Port Townsend; Forks; Aberdeen; East Grays Harbor Co; Raymond & Long Beach);
- Contract local community partners in remote communities to provide CDSMP via COPES contract;
- Assist one local community partner/year to implement Lay Leader training.

Objective 2: Provide disease prevention, health promotion activities to help older adults, adults with disabilities evaluate fall risk; obtain information to prevent disease & increase physical activity.

Key Tasks:

- Conduct annual disease/injury prevention workshops: one each in Pacific County & Grays Harbor County;
- Coordinate w/County Health Depts. to provide vaccinations at annual workshops;
- Integrate prevention activities into at least one existing health event in Clallam and/or Jefferson counties;

- Provide presentations to older adults on medication management; nutrition; increasing physical activity, etc.;
- Facilitate local fitness centers to obtain training & incorporate Stay Active & Independent for Life programs.

Objective 3: Provide OAA Senior Nutrition & Senior Farmers Market programs; refer older adults at high nutritional risk to I&A.

Key Tasks:

- Ensure OAA service contracts prioritize home delivered meals & Senior Nutrition providers offer congregate meals services that are within their capacity to sustain;
- Implement Senior Farmers Market program w/existing Senior Nutrition providers;
- Utilizing SAMS reports on at least quarterly basis, refer older adults at high nutritional risk to I&A staff for follow up.

Objective 4: Support volunteer transportation options for older adults to access health services.

Key Tasks:

- Contract local volunteer transportation agencies to provide transport to health services;
- Advocate at state, local levels to improve coordination of transportation services

ISSUE AREA: HEALTHY AGING

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

Measurable Objectives	Key Tasks	Responsible	Timeframe		Accomplishment or Update
			Start	End	
1. O3A Living Well With Chronic Conditions (CDSM) Workshops are available throughout PSA. *Please note: some activities are grant funded only through 2013.*	1.a. Implement one CDSM workshop/year in main population centers (Sequim; Port Angeles; Port Townsend; Forks; Aberdeen; East Grays Harbor Co; Raymond & Long Beach).	O3A Director Nursing Services	1/5/2012	12/31/2013	
	1.b. Contract local community partners in remote communities to provide CDSMP via COPES contract	O3A Program Mgr	1/5/2012	12/31/2015	
	1.c. Assist one local community partner/year to train Lay Leaders.	O3A Dir Nurse Svcs	1/5/2012	12/31/2013	
2. Provide disease prevention, health promotion activities to help older adults, adults w/ disabilities evaluate fall risk; obtain information to prevent disease & increase physical activity.	2.a. Conduct annual disease/injury prevention workshops: one each in Pacific County & Grays Harbor County.	O3A Director Nursing Services	1/5/2012	12/31/2015	
	2.b. Coordinate w/County Health Depts. to provide vaccinations at annual workshops.	O3A Director Nursing Services	1/5/2012	12/31/2015	
	2.c. Integrate prevention activities into at least one existing health event in Clallam and/or Jefferson counties.	O3A Director Nursing Services	1/5/2013	12/31/2015	
	2.d. Provide presentations to older adults on medication management; nutrition; increasing physical activity, etc.	O3A Director Nursing Services	1/5/2013	12/31/2015	
	2.e. Facilitate local fitness centers to obtain training & incorporate Stay Active & Independent for Life programs.	O3A Director Nursing Services	1/5/2012	12/31/2013	
3. Provide OAA Senior Nutrition & Sr Farmers Market programs; refer older adults w/ high nutritional risk to I&A.	3.a. Ensure OAA service contracts prioritize home delivered meals & Sr Nutrition providers offer congregate meals services that are within their capacity to sustain	O3A Planning Dir	1/5/2012	12/31/2015	
	3.b. Implement Senior Farmers Market program w/existing providers.	O3A Planning Dir	1/5/2012	12/31/2015	
	3.c. Utilizing SAMS reports on at least quarterly basis, refer older adults @ high nutritional risk to I&A staff for follow up.	O3A Planning Dir	1/5/2012	12/31/2015	
4. Support volunteer transportation options for older adults	4.a. Contract local volunteer transportation agencies to provide transport to health services.	O3A Planning Dir	1/5/2012	12/31/2015	
	4.b. Advocate @ state, local levels to improve coordination of transportation services	O3A Exec Director; Planning Director	1/5/2012	12/31/2015	

C - 5 Older Native Americans

Policy 7.01 Implementation Plan

Olympic Area Agency on Aging (O3A)
Biennium Timeframe: January 1, 2012 to December 31, 2013

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) Current Status
1. Continue current outreach assistance w/ expansion to all interested area tribes : Chehalis, Chinook Hoh, Jamestown S'Klallam, Lower Elwha Klallam, Makah, Quileute, Quinault Nation, & Shoalwater.	a. Ensure current outreach assistance is continued &explore expanding support and coordination assistance with all area Tribes as available resources allow. b. Meet w/ individual Tribes or tribal groups to discuss elder issues as requested. c. Expand activities in this area through grants available. d. Include Tribal Outreach staff in agency planning, training and project development.	a. Enhanced access to culturally relevant services for tribal elders. b. Increased collaboration with local tribes and community partners to assure appropriate services.	Mark Harvey Designated O3A Service Delivery staff O3A Planning & Program Mgmt staff O3A AC Tribal Rep 2010-2013	Outreach to and communication with tribes is well-integrated into the fabric of I & A activities, characterized by multi-layered relationships with tribal members (elders, families, tribal program staff) responsive to individual inquiries & emerging issues. As these relationships deepen, I&A staff are better able to provide services that are acceptable & relevant; with the result that in the last year, 1:1 interactions between I& A staff & tribal members have increased significantly. I&A staff participate in tribal health fairs & other outreach events & frequently confer with tribal program staff & Tribal Councils on various topics.

2. Improved caregiver training and support options for interested Tribes.	a. Improve coordination between AAA Title III and Tribal Title VI Caregiver Support Programs b. Identify Tribal caregivers through O3A individual provider & family caregiver support programs and support Tribal caregivers to understand and utilize new Caregiver Training protocols of the Training Partnership. c. Include Tribal caregivers in referral workforce resource center (Registry) training and referral activities	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. b. Increased Tribal capacity for accessing and/or providing training to Tribal members interested in becoming caregivers. Tribal caregivers are able to access training in a timely manner c. Increased number of Tribal caregivers	O3A Planning & Program Mgmt staff Mark Harvey 2012-2013	a. O3A improved coverage for caregiver support in Clallam, Jefferson & Pacific Counties by redistributing staff time, and increased outreach in Grays Harbor with new coordination efforts with local agencies. b. O3A provided training in "Powerful Tools for Caregivers" for 2 Jamestown staff people (they were offered to all Tribes on North Peninsula). Tribal caregivers are accessing training through the Training Partnership. I & A staff are assisting tribal caregivers to obtain the required training, however, there are still reported difficulties with the TP system to access training, e.g., availability of classes, difficulty accessing on line training in a timely fashion, etc. c. O3A's registry staff includes tribes in marketing and outreach efforts to recruit, train and support current and new tribal caregivers.
3. Enhanced services / support for Tribal grandparents / other elders raising children	a. Increase outreach efforts, particularly with remote communities and Tribal reservations, to inform families of the resources now available for relatives raising children.	a. Relatives as Parents Support Program will benefit Tribal grandparents & other elders raising children.	O3A Relatives as Parents Service Delivery staff 2012-2013	a. Particularly in Grays Harbor Co. new coordination efforts resulted in tribal caregivers and their family members benefiting from Relatives as Parents services. The number of tribal grandparents accessing services increased in 2010. b. 2011/12: QuinTANF in Aberdeen worked w/I&A on children as wards of state, DSHS has access to a fund to support child while case disposition is being determined. QuinTANF was referring to I&A for KCSP services. KCSP unable to help since children were wards of state; FCSP (Eric) investigated, learned about this fund, issue was kicked up food chain to state level (i.e., Hilari H) to access fund.

4. Improved Tribal access to health and nutrition education and program services to the extent resources allow.	a. Include tribal elders in nutrition education & training offered by O3A health promotion and education staff. b. Through nutrition contracts with local providers, promote inclusion of local tribal elders in nutrition programs.	a. Tribal nutrition program managers & elders receive education on food safety, menu planning, etc. b. Tribal elders participate in programs implemented by local health / nutrition education providers.	O3A Planning & Program Mgmt staff O3A Nursing service staff 2012-2013	a. Senior Farmers Market Nutrition program is active in 6 tribes: Hoh, Jamestown, Lower Elwha, Makah, Quileute and Shoalwater Tribes Coordination Title III and VI (Senior Nutrition) takes place with Jamestown S'Klallam; Lower Elwha, Quileute, Hoh, Chinook, Quinault. Services provided include provision of congregate and home delivered meals. b. In the previous 12 months, O3A nurses have participated as resources in tribal health fairs on an ongoing basis: the lower Hoh, Shoalwater Bay, Makah, Quileute, Chehalis, Quinault Tribes. O3A nurses provided educational workshops at these fairs, addressing Food Safety, Medication Management under the 6088 bill and Falls Prevention.
5. Improved access to health and support services for Tribal elders.	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. Engage tribes as local community partners in the "Living Well with Chronic Conditions" program	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.	Mark Harvey O3A Planning & Program Mgmt staff Jessie Stopsen, O3A Nursing Services Director 2012-2013	a. In 2011, the American Indian Health Commission for Washington State and I & A are convening a meeting for tribal and local program managers to examine health and medical coordination issues. b. O3A has signed MOUs with 3 tribes: Quinault, Makah, Quileute, & is providing support to implement the Chronic Disease Self Management workshop in each community. Tribes are reimbursed for participants who complete the workshop, & are able to apply for a COPES CDSMP client training contract. c. Tribal members from 4 tribes attended CDSMP workshops. 2012 Mark rec'd referral re non native living on Makah res, no bathing, no clothes, diapers. Makah provided info, supported I&A to get help to this person.
6. Strengthened O3A infrastructure to respond to tribal needs.	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.	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	AC Tribal Representative Designated O3A Program Management and Service Delivery staff O3A leadership	The Advisory Council Tribal Representative, a tribal elder from the Lower Elwha Tribe, is coordinating with area tribes to enhance communication between O3A and area tribes. The AC Tribal Rep and O3A program and direct service staff attended the Tribal/AAA/ADSA meeting in Auburn in 2010. This 7.01 plan is part of the O3A Area Plan; native elder goals /objectives are integrated into the work plans of

	c. Ensure contracting mechanisms support productive tribal partnerships.	incorporation into this plan. c. Contract instruments are responsive to tribal administration capacity.	2012 - 2013	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 throughout the region through local O3A case management / outreach staff, providing a continuous O3A presence.

C - 6 Basic Needs

The ability to 'age in place' assumes that older adults can afford to do so; are able to access employment; are protected from abuse and exploitation; can receive assistance in an emergency; and can maintain their homes as safe environments.

Employment and Economic Security

The effect of the recession on the economic security of older adults has generally eroded their ability to meet basic needs. Older adults are finding themselves out of work and retired seniors who may have depended on retirement income are now finding they need to return to work. In some cases, newly out-of-work adult children or grandchildren may be moving in with their older parents or grandparents, adding to their burden.

While many people think of older adults as retirees, the truth is many adults aged 55+ work full or part-time jobs every day. The reasons they work are varied, but for many it's a matter of necessity to remain financially secure and independent. Others work to stay active and engaged in their communities.

As the population ages, older Americans will play an increasingly important role in our economy and America's leadership in the world marketplace. By 2019, over 40% of Americans aged 55+ will be employed, making up over 25% of the U.S. labor force. The Committee on Economic Development indicates that employers rate older workers high on characteristics such as judgment, commitment to quality, attendance, and punctuality.

Employment

- In 2009, 27.1 million Americans aged 55+ were employed, and 1.9 million were actively seeking work.
- In 2009, older workers represented 19% of the U.S. workforce, a significant increase from 1999 when they accounted for just 12%.
- Weekly earnings vary by age and gender. In the 55-64 age group, men have the highest weekly earnings at $953, while women earn $730. Median weekly earnings for men aged 65+ are $686 and $534 for women. (Bureau of Labor Statistics, 7/20/10).
- The unemployment rate for job seekers aged 55+ has more than doubled since December 2007. On average, 1.5 million workers aged 55-64 and 421,000 workers aged 65+ were unemployed each month in 2009. (Urban Institute, 3/10/10).
- In May 2010, 60% of unemployed older workers had been out of work for six months or longer, and 43% had been without a job for more than a year. (CNN, 7/2/10).

Although the rate of unemployment among mature workers is lower than younger populations, older workers who do become unemployed spend more time searching for work. (Bureau of Labor Statistics, 3/10). Older workers also are unemployed for a longer

time —11 months on average in July 2010 compared to 8 months for younger workers. (Bureau of Labor Statistics, 9/3/10).

- Mature workers make up 14.2% of the unemployed population in the U.S.
- Unemployment in 2009 was more common among older men than older women. Over 14% of construction workers aged 55+ and 10% of older manufacturing workers were unemployed—well above the overall 2009 unemployment rate of 6.5% for adults aged 55+. (Urban Institute, 3/10/10).
- Nearly two-thirds of unemployed older men had careers in construction, manufacturing, or trade and professional services in 2009. Among women aged 55+, two-thirds of the unemployed came from trade, professional and business services, health care, manufacturing, and education. (Urban Institute, 3/10/10).
- On average, laid-off male workers aged 50-61 who become reemployed earn 15% less on the new job than the old job, and those aged 62+ earn 21% less. By contrast, reemployed laid-off men aged 35-49 average only 3% less per hour. For reemployed laid-off women, hourly pay cuts average 11% at age 35-49, 16% at age 50-61, and 23% at age 62+. (Urban Institute, 3/10/10).

Part-Time & Multiple Jobs

Part-time work is appealing to many older workers who want to scale back but still remain in the workplace; however, nearly 1.2 million older workers work part-time because of the weak job market or because they cannot find full-time work. These "involuntary" part-time workers represent 5% of the employed mature workforce. (AARP Public Policy Institute, 8/10).

In August 2010, almost 4% of workers aged 55+ held more than one job. Doing so may indicate an inability to find a job that pays enough hours.

Discouraged Mature Workers

- Discouraged mature workers are not looking for work because they believe that none is available, employers will find them too old, they lack the necessary schooling/training, or they face other types of discrimination.
- In August 2010, discouraged mature workers represented nearly 20% of older persons not in the workforce. (AARP Public Policy Institute).
- Low-skilled older men are especially likely to report this status and age discrimination - 29% of men who did not complete high school and 20% of high school graduates claimed their employers preferred younger workers, compared to 13% of men who had attended college. (Urban Institute, 7/1/10).

Persistent Unemployment Threshold[30]

Two of O3A's service counties, Grays Harbor and Pacific counties meet the persistent unemployment threshold, indicating that the unemployed older worker "lives in an area with persistent unemployment and has severely limited employment prospects."

[30] Persistent Unemployment Table for 2008-10; Washington State information. Email communication from DebbieO. Bennet, DSHS/HCS, April 21.2011.

Senior Community Services Employment Program (SCSEP)

O3A contracts with the State of Washington to provide SCSEP services throughout our region. Funded under Title V of Older Americans Act (42 U.S.C 3056), the SCSEP "Title V" program provides paid on-the-job training for low income individuals who are over the age of 55 and need to re-enter the work force.

The program is designed to support individuals with the lowest prospects for employment, and has three goals:

1. To foster and promote useful part-time opportunities in community service activities for unemployed, low-income persons who are age 55 and over and who have poor employment prospects;
2. To foster individual economic self-sufficiency; and
3. To increase the number of older persons who may enjoy the benefits of unsubsidized employment in both public and private sectors.

National organizations receive 78% of the Title V SCSEP appropriation. The states receive the other 22% of the appropriation. The State of Washington sub-contracts its allocation with Area Agencies on Aging and other governmental and nonprofit entities.

Eligibility for the Title V program is based on the following factors: age (55+), residency, need for job readiness training, financial eligibility (125% of Federal poverty guidelines), and employment status (unemployed). Participants have a maximum of 48 months in the program, and are required to continue an active search for work to remain enrolled.

Priority for enrollment is afforded to individuals who are 65 years or older, or who:

- have limited English proficiency or low literacy skills;
- reside in a rural area;
- are veterans or the spouse of a veteran;
- have low employment prospects;
- have failed to find employment, or
- are homeless or at risk for homelessness.

The Title V program design results in many positive community outcomes. Participants are placed for on-the-job training with community host agencies, which must be non-profits, governmental entities or other community service organizations (libraries, schools, etc.).

Host agencies contribute supervision, training and work space, and are reimbursed by O3A for the participant's wages. Participants receive minimum wage for part-time employment, obtain current skills, and recent employment for their resume.

Title V wages play an important role in the economic viability of the low-income participant and his or her family. Participants also receive supportive services such as

eyeglasses, a health exam, tuition and supplies for classes such as computer training, resume development, interview clothing, etc.

Finally, the community benefits from the program as the enrolled participants are performing community service in their Host Agencies, and spend their Title V wages locally.

The SCSEP program has experienced budget reductions. At the same time, O3A has seen increased demand for employment assistance under the program. Enrollment has been reduced to meet available funding. There are now waiting lists in all four counties.

Preventing Elder Abuse & Exploitation

Elder abuse refers to intentional or neglectful acts by a caregiver or "trusted" individual that lead to, or may lead to, harm of a vulnerable elder[31]. According to the Department of Justice, a minimum of 1 in 9 or 11% percent of Americans over age 60 have experienced some form of elder abuse in the past year. Many cases go unreported--for every one case of elder abuse, neglect, exploitation, or self-neglect reported to authorities, at least five more go unreported.

In almost 90% of the elder abuse and neglect incidents with a known perpetrator, the perpetrator is a family member, and two-thirds of the perpetrators are adult children or spouses.

Financial abuse is common; elder financial abuse is regarded as the third most commonly substantiated type of elder abuse, following neglect and emotional / psychological abuse. While underreported, the annual financial loss by victims of elder financial abuse is estimated to be at least $2.6 billion dollars.

As the number of elders increases, so does the problem. Adult Protective Services (APS) found that elder abuse reports have increased by 16% comparing data from 2000 with that of 2004. For those elders who have been mistreated, the risk of death is 300 times greater than those who have not been.

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. Women and the very elderly are at greatest risk: two-thirds (66%) of elder abuse victims were female. Of the victims aged 60+, 43% were 80 years of age and older.

Neglect

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.[32]

[31] *"Elder Abuse Fact Sheet",* National Council on Aging; www.ncoa.org; June 2011.
[32] Administration on Aging, *Fact Sheets, Elder Abuse Prevention*.

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.

The Gatekeeper & Long Term Care Ombudsman Programs

The Gatekeeper Program

In 2009, O3A dedicated resources to developing an O3A Gatekeeper program that is imbedded within the Information and Assistance program. The Gatekeeper Program is designed to coordinate with and support the Information and Assistance program in the identification and referral of community-dwelling adults 60 years and older whose independence, tenure, or survival in the community is in jeopardy because of a serious and persistent mental illness, emotional or behavioral problems, poor health, social isolation, abuse or neglect, substance abuse problems, and reluctance or inability to seek help on their own behalf or the absence of someone to seek help for them.

The Gatekeeper Program model is designed to identify at-risk older adults who do not typically come to the attention of the mental health and aging service delivery systems. These individuals do not self-refer; early identification of at-risk elders can prevent premature institutionalization, abuse and neglect.

The Gatekeeper Program recruits and trains nontraditional, community “referral resources” to serve as Gatekeepers in the community. Gatekeepers are employees or volunteers of corporations, businesses and other organizations, who, in the course of their daily work activities, come into contact with older adults in the community. Examples of Gatekeepers may include: postal workers, utility meter readers, police officers, firefighters, senior and recreation center personnel and bank tellers.

Effective Gatekeeper Programs include three core elements: Recruitment and Training of Community Gatekeepers; a Referral System; and a Community Response System.

Gatekeepers receive training at their work sites to recognize signs and symptoms that an elderly person is in need of assistance, and to refer that person to the Gatekeeper Program. Gatekeepers are not expected to assume the role of social workers or counselors. All that is requested of Gatekeepers is to keep a watchful eye while conducting daily work activities and make a simple referral for those people in need.

To date, Gatekeeper training has been carried out for personnel from community agencies in Clallam County, with expansion planned to the remaining service counties.

Long-Term Care Ombudsman

The Washington State Long-Term Care Ombudsman Program protects and promotes quality of life for people living in licensed, long-term adult care facilities (e.g. adult family home, boarding home, nursing home). An ombudsman:

- Advocates for the rights of clients in adult care facilities;
- Works with clients, families and facility staff to meet the needs and concerns of the people living there; and
- Provides a way to get complaints and concerns heard and resolved.

The following people can use the Ombudsman Program:

- residents living in a care facility and his/her relatives or friends;
- administrators & staff of an adult family home, boarding home or nursing home.

Safe and affordable housing

A significant barrier to remaining at home as we grow older is the cost and difficulty of maintaining housing. Throughout the O3A service region, there is a generally acknowledged lack of affordable housing for all community members,[33] a situation that is exacerbated for older adults, 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 adults 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 a disability 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

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

between the demand for and availability of housing means that an affordable place to live will continue to be out of reach for many older adults.

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.

As the number of older adults within the service region increases, the availability of safe, affordable housing is critical; as adults age, the safety of their homes affects their ability to age in place. Education is needed for elders about the availability of programs and benefits that can assist them with home maintenance and needed modifications to make their home environment safer.

Emergency Preparedness

Residents of the Olympic Peninsula are generally familiar with emergency situations caused by severe winter storms, including prolonged power outages, road and bridge closures, and damage to buildings caused by flooding and fallen trees. In the wake of the severe winter storm that struck the area in 2007, local county governments and emergency response agencies are actively engaged in community-wide planning to improve readiness especially in major emergencies.

O3A's 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.

O3A also ensures its contractors, e.g., home care agencies, have plans in place with staff designated to check on the welfare of vulnerable clients in an emergency.

O3A has developed an emergency operations and business contingency plan for its business systems and local offices, as well as a plan to address a pandemic flu emergency. In general throughout the agency, emergency planning is localized, i.e., direct service staff based in each of the four service counties are responsive to local and agency emergency guidelines.

Emergency planning framework(s) are updated according to local guidelines as well as those specified in *Standards for Professional Information and Referral*[34]. These standards require AAAs to:

- 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.

Problem / Needs Statement:

The ability to 'age in place' assumes that older adults can afford to do so; are able to access employment; are protected from abuse and exploitation; can receive assistance in an emergency; and can maintain their homes as safe environments.

GOAL: Older adults & adults with disabilities are able to meet basic needs for housing, economic security, and safety.

Objective 1: Provide employment options for adults 55 & older each year.

Key Tasks:

- Provide employment/ training placements for 14-15 participants in 2012;
- Retain current host agencies (presently 10 agencies throughout region);
- Coordinate w/ local service agencies to provide training, job skills development for older adults.

Objective 2: Provide Gatekeeper program training for at least two new stakeholders (each year) & one staff person in all service counties.

Key Tasks:

- Identify stakeholders in each service county to receive Gatekeeper training;
- Train stakeholders on signs of self-neglect / abuse, where to report & how to refer / access resources for vulnerable clients;
- Train AIRS certified I&A staff person to continue training & support stakeholders in each county.

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

Objective 3: Maintain current coverage in LTC Ombudsman Program.

Key Tasks:

- Realign available funding to ensure current level of effort /staff capacity is maintained.

Objective 4: Publicize programs to reduce costs associated with housing (e.g., property tax relief, utility subsidies, maintenance, safety modifications etc.).

Key Tasks:

- Maintain (or expand, if possible) current level of effort to provide information via O3A media outlets (newspaper, O3A web site, including facebook, radio & TV) & I&A staff about programs offered through local providers and state/federal programs related to housing maintenance & security.

Objective 5: Coordinate w/local emergency preparedness efforts re: needs of elders & ensure structure exists to assist frail, home bound in emergency; maintain O3A emergency plan, w/ contingency systems developed & staff trained.

Key Tasks:

- Designated I&A staff in each service county participate in local emergency preparedness efforts, with designated O3A & contractor staff assigned to follow up with frail, home bound elders in emergencies.
- Update and revise O3A emergency preparedness plan as necessary; implement system backups, and ensure appropriate staff are trained in emergency system contingencies.

ISSUE AREA: BASIC NEEDS

GOAL: Elders & adults with disabilities are able to meet basic needs for housing, economic security, and safety.

Measurable Objectives	Key Tasks	Responsible	Timeframe		Accomplishment or Update
			Start	End	
1. Provide employment options for adults 55 & older each year.	1.a. Provide employment/ training placements for 14-15 SCSEP participants in 2012;	O3A SCSEP Coordinator	1/2012	12/2015	1.a.
	1.b. Retain current host agencies (currently 10 agencies throughout service region).		1/2012	12/2015	1.b.
	1.c. Coordinate w/ local service agencies to provide training, job skills development for older adults.		1/2012	12/2015	1.c.
2. Provide Gatekeeper program training for at least two new stakeholders each year & one staff person in all service counties.	2.a. Identify stakeholders in each service county to receive Gatekeeper training during this timeframe.	O3A Program Development Manager	1/2012	6/2012	2.a.
	2.b. Train stakeholders on signs of self-neglect / abuse, where to report & how to refer / access resources for vulnerable clients.		6/2012	6/2013	2.b
	2.c. Train AIRS certified I&A staff person to continue training & support stakeholders in each county.		6/2012	12/2015	2.c.
3. Maintain current coverage in LTC Ombudsman program.	3. Realign available funding to ensure current level of effort /staff capacity is maintained.	Exec Dir; CFO; I & A Director	1/2012	12/2015	3.
4. Publicize programs to reduce costs associated with housing (e.g., property tax relief; utility subsidies, maintenance and safety modifications, etc.)	4.Maintain (or expand, if possible) current level of effort to provide information via O3A media outlets (newspaper, O3A web site, including facebook, radio & TV) & I&A staff about programs offered through local providers and state/federal programs related to housing maintenance & security.	Regional I & A Director	1/2012	12/2015	4.
5. a. Coordinate w/local emergency preparedness efforts re: needs of elders & ensure structure exists to assist frail, home bound in emergency	5.a.. Designated I&A staff in each service county participate in local emergency preparedness efforts, with designated O3A & contractor staff assigned to follow up with frail, home bound elders in emergencies.	Regional I & A Director	1/2012	12/2015	5.a.
5.b . O3A emergency plan is in place, w/ contingency systems developed & staff trained.	5.b. Update /revise O3A emergency preparedness plan as necessary; implement system backups & train staff in emergency system contingencies.	O3A IT Coordinator	1/2012	12/2015	5.b.