Olympic Area Agency on Aging

Area Plan

2020 – 2023

Picture credits clockwise from top left: Bob Segui, unknown, Tove Martin, Jody Moss

Olympic Area Agency on Aging

11700 Rhody Drive
Port Hadlock, WA 98339
www.o3a.org
Phone: 360-379-5064 or 1-866-720-4863 Fax: 360-379-5074

September 30, 2019

Dear Friend:

It is my pleasure to present the Olympic Area Agency on Aging 2020 - 2023 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 major goals in this new four-year 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 and gaps in services
- Provide resources towards a healthier aging process
- Provide support for unpaid family caregivers and kinship caregivers
- Make informed decisions and access the services required to remain independent
- Access quality in-home services that support consumer engagement and provide choice
- 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:

- Wes Cormier, 2019, Chair, Grays Harbor
- Randy Johnson, 2019, Vice Chair, Clallam
- David Sullivan, 2019, Jefferson
- Lisa Olsen, 2019, Pacific
- Mark Ozias, Clallam alternate
- Vickie Raines, Grays Harbor alternate
- Kate Dean, Jefferson alternate
- Mike (Hawk) Runyon, Pacific alternate

And To:

- Joanne Levine, 2019 Advisory Council Chair
- Denny Evans, 2019 Advisory Council Vice-Chair
- The Advisory Council Planning Committee
- The Advisory Council
- Community members & service agencies
- Bob Nakutin, Community Member

We look forward with optimism to working together with our neighbors over the coming four years of this Area Plan 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

Advocates for Independence, Individual Choice and Quality Community Services
Serving Older Adults and Persons with Disabilities

CONTENTS

Acronyms

AAA	Area Agency on Aging
AC (O3A)	Advisory Council
ACH	Accountable Community of Health
AD	Alzheimer's Disease
ADA	Americans Disability Act
ADRC	Aging & Disability Resource Center
ALTSA	Aging & Long Term Services and Supports Administration
ADC	Adult Day Care
ADH	Adult Day Health
AFH	Adult Family Homes
ALF	Assisted Living Facility
ALTSA	Aging & Long Term Services Administration
AIRS	Association of Information & Referral Specialists
AOA	Administration on Aging
APS	Adult Protective Services
BH	Behavioral Health
CCM	Chronic Care Management
CCO	Care Coordination Organization
CDC	Center for Disease Control
CDE	Consumer Directed Employment
CDSMP	Chronic Disease Self Management Program
CE	Continuing Education (Unit)
CFC	Community First Choice
CG	Caregiver
CGT	Caregiver Training
CLEAR	Coordinated Legal Education, Advice and Referral System
CM	Case Management (Care Management)
CLC	Community Living Connections
CMS	Centers for Medicare& Medicaid Services
COG	Council of Governments
COPES	Community Options Program Entry System
CSO	Community Services Office
CT	Care Transition
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
EVV	Electronic Visit Verification
FCSP	Family Caregiver Support Program
FEMA	Federal Emergency Management Assistance
HAP	Health Action Plan
HC/HCA	Home Care / Home Care Aide
HCS	Home and Community Services
HCRR	Home Care Referral Registry
HH	Health Homes
HIPAA	Health Insurance Portability Accounting Act
HUD	Department of Housing & Urban Development
I&A	(Senior) Information & Assistance
ILC	Independent Living Center
IP	Individual Provider
IPA	In Person Assister
IRC	Internal Revenue Code
IRS	Internal Revenue Service
INS	Immigration & Naturalization Service
KCSP	Kinship Caregiver Support Program

LGBTQ	Lesbian, Gay, Bisexual/ Binary Transgender, Questioning
LIS	Low Income Subsidy Program
LTC	Long Term Care
LTCOP	Long Term Care Ombudsman Program
MAC	Medicaid Alternative Care
MB	Management Bulletin
MCO	Managed Care Organization
MTPD	Medicaid Transformation Project Demonstration
MH	Mental Health (preferred terminology today is Behavioral 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
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	Statewide 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
TJQMBB	Tai Ji Quan Moving for Better Balance
T-CARE	Family caregiver assessment tool
TSOA	Tailored Services for Older Adults
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 2020-2023

Every 4 years, the Olympic Area Agency on Aging (O3A) and every other Area Agency on Aging across the country, (and there are more than 620 located in every state in the nation), develops an Area Plan which charts the path we will follow through the next 4 years in supporting older adults and adults with disabilities in our diverse communities. This plan outlines the needs of older adults and adults with disabilities in each local region and proposes goals and objectives as well as specific programs to address those needs.

The Olympic Area Agency on Aging is pleased to present our Area Plan for 2020 through 2023. 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 framework to guide financial and staffing 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 Washington State Unit on Aging as one of 13 area agencies on aging in our state, 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 **204,403**[1] people dispersed over 8,301 square miles of rugged mountainous terrain, forests

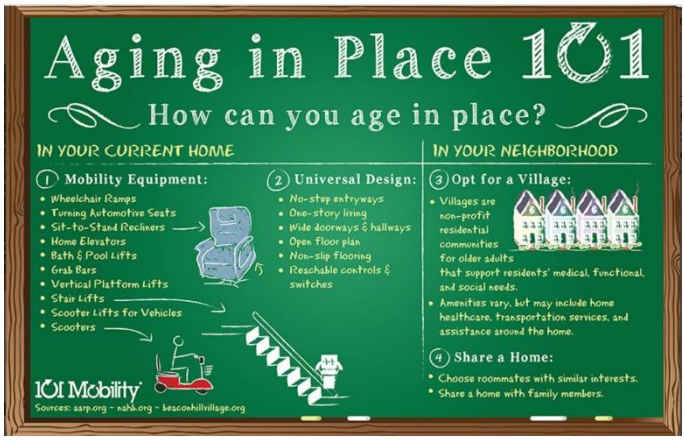
[1] http://worldpopulationreview.com/us-counties/wa/

and farm land, small rural cities, towns and small villages on 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 **76,356[2] adults over the age of 60 with a predicted increase to 83,384 by 2030** – this is termed the Age Wave**.** There are adults age 18 and older with disabilities **- 21,477 growing to 24,977 in 2030**, native elders from eight Tribes **2,207 growing to 2,425,** and a 60+ minority population **(6,574 growing to 8,533**), of which the majority of individuals are Hispanic from a variety of North & Central American countries.

O3A's Approach to Aging in Place

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; strategies to increase access to health care, and supportive services; and, advocacy with the public and legislators on issues affecting older adults and adults with disabilities.



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 that includes family and paid caregivers; individual and agency providers of in home and respite care support; community action programs providing senior nutrition, transportation and adult day care services, contracted legal services; behavioral health service providers, and local contractors proving home safety modifications and personal emergency response systems. Cooperating partners include local area hospitals and clinics as well as local health departments, social service organizations and legal and law enforcement agencies.

O3A direct service staff provides nursing, case management, and other services to approximately **2,078** Medicaid eligible adults age 18 and older in 2018, with that number continuing to grow each year. O3A's Information & Assistance (I&A) program provides community outreach with information about health insurance, legal issues, options for planning

[2] David Mancuso, PhD., Jingping Xing, PhD., Forecasts of the Aging Population, Dementia Prevalence and Use of Long-Term Care Services through 2030 in Washington State; Office of Financial Management, WA State, 2019.

for aging and for long-term care, 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 one county commissioner from each of the four service region counties. In addition,O3A is guided by an active Advisory Council that includes 21 consumers, providers, health and social service specialists, community representatives, tribal and minority population advocates. The member council includes representatives from each of the four counties in O3A's service area (16 total); plus five regional members in the positions of a disability representative, an elected official, a representative for the 8 tribes in our region, 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 80 direct service, technical, and administrative personnel are based in seven offices - one in Grays Harbor, and two in each of Clallam, Jefferson and Pacific counties. An administrative office, located in Port Hadlock, houses executive, financial, human resources, planning, and contract management staff. Two larger offices in Aberdeen, (Grays Harbor) and Sequim (Clallam) comprise direct service provision staff, and management for Information and Assistance, Case management, Family Caregiver Support including MAC & TSOA, Nursing Services and Information Technology.

Two offices in Pacific County (Raymond & Long Beach), one in the West End of Clallam County (Forks), and one in Jefferson County, (Port Townsend) serve as satellite offices for I&A, Case Management Program, and FCSP staff with other staff traveling to serve remote areas as required. O3A receives federal and state funding to administer over 20 programs, as well as foundation grants and local resources, and has an average annual operating budget with total revenue of $8.6 million dollars. O3A also authorizes approximately $40 million of Medicaid services annually.

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 radio programs and columns in local newspapers. These two outreach efforts have the potential to reach significant numbers of the population in the 4-county region, listed below (likely reach). In addition, O3A has increasingly used Facebook, a Constant Contact Newsletter, and to a lesser extent Pinterest and Twitter.

Media Organization	Distribution	Region	Likely numbers of readers/listenership	Online
Chinook Observer*	Weekly	GH P	9 1,424	981
Pacific County Press	Weekly	P	1,702	
Willapa Harbor Herald*	Weekly	P	1,964	
Daily World*	3 X/Week	GH	1,355	758
Daily World Saturday Events Column*	1/week	GH	1,520	
Peninsula Daily News*	Daily	C J	3,674 873	1,782 455
Forks Forum*	Weekly	C	1,442	141
Sequim Gazette	Weekly	C	1,171	357
Port Townsend Leader	Weekly	J	2,438	5,205
Senior Sunset Times*	Monthly	C/J GH/P	9,000 1,500	3,500 5,000
Living Well Magazine* (Resource Guide)	Annually	PSA Request	18,000 380	1,100
Radio Program	**NA**	**Region**	**# of listeners / quarter hour**	
KANY		GH	95	
KBKW*		GH	95	
KJET		GH P	165 6	
KONP		C	4,542 (per hour)	
KPTZ*		J/CL	20,000 (estimate)	
KSQM*		C	3,244	
KSWW		GH	259	
KXRO		GH	2,354	
Possible Total Reader/Listenership (Reach)			**33,999**	
*Note: Regular articles/radio shows appear in/on these media outlets. Periodic articles/programs are in/on the others.				

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 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 coordinated system of home and community-based services.

We do this work through the federal Older Americans Act which 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;
- **Procurement of local services** through performance-based contract mechanisms;
- **Provision of coordination and technical assistance** to community-based 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 the 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, 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 is described in Appendix E.

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 69% is considered "nondiscretionary" and is designated for specific services like Medicaid Title XIX Case Management and Home Care.

The O3A annual budget also includes about 31% in discretionary funds from the Federal Older American Act (OAA) and the Washington State Senior Citizens Services Act (SCSA), and several other small funding sources. "Discretionary" funding is more flexible and can be used to meet O3A identified priority needs within a range of allowable services and criteria 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 recommends service funding priorities based on community assessment data; the Allocations Committee 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 both a significant retirement destination and economically distressed, a major challenge for O3A is the determination of vulnerability in a growing population of older adults, in order to prioritize service 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 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 the mandates from each funding source.

Services/support must be responsive to the current operating environment. Critical elements to focus on for 2020-2023:

- Assuring that older adults and adults with disabilities have a one stop shop to help them with planning and to identify resources they may need as they age.
- 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, community-based organizations, faith-based organizations and local coalitions in developing services and supports);

- Prevention services and health promotion programs aimed at reducing the burden of chronic disease and injury in at risk populations and improving unpaid family caregiver resilience;
- Ensuring O3A maintains the capacity to respond to emerging local needs through O3A programs, for example, O3A's I&A, Medicaid Alternative Care, Tailored Services for Older Adults (MAC and TSOA) and the Health Homes Lead work.
- Greater coordination and support for local service delivery at the community, county, and at regional levels (e.g. strengthening partnerships with agencies serving the same population and addressing social determinants of health and leveraging with health providers for opportunities within the current Accountable Communities of Health);
- 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;
- Discretionary funding for those services/supports which are a high priority and which cannot reasonably expect to be funded 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 funding for services and may assist providers to secure funds from grants and other sources;
- O3A will generally avoid allocating funding of 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 period; and
- 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 for program development, quality initiatives, training, coordination, and advocacy efforts that support the agency mission and statement of values and vision for 2020-2023.
- Staff resources will be allocated first for those activities that are necessary to support and improve the quality of service 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.
- Additional staffing resources are needed for the Health Homes program, both for the Care Coordination role and for the Lead role, MAC/TSOA, and Case Management, as well as additional support staff for Contracts Management and Long Term Ombudsman – these needs will be assessed over time and added incrementally.

Prioritization of Programs & Services

Services planned for 2020-2023 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 Services	Congregate Meals	Advance Care Planning
Family Caregivers Support	Dementia Planning	Evidence Based Programs
Health Home Services	Falls Prevention	Housing Issues
Home Delivered Meals	Home Repair & Maintenance	Health Care Access Issues
Information & Assistance	Kinship Caregiver Support	Suicide Prevention
In-Home Personal Care	LTC Ombudsman	
Nursing Services	Senior Legal Services	
Transportation	Statewide Health Insurance Benefits Advisors (SHIBA)	

- Level One represents categories where needs are high and funding sources are present.
- Level Two represents a need but perhaps less critical with a funding source, or a high need but no funding source.
- Level Three represents lower need and /or less funding. This category also recognizes that other organizations may be taking primary responsibility for this issue, and O3A can play a supportive role.

The chart on the next page summarizes O3A's planned allocations of Discretionary funds:

Service Category	**2019 Area Plan Dollars as Basis
LEGAL ASSISTANCE	**$ 66,957**
ACCESS SERVICES	**$745,490**
Transportation	74,000
Information & Assistance	671,490
IN-HOME SERVICES	**$17,500**
Minor Home Repair & Maintenance (OAA)	7,500
Senior Emergency Fund (SCSA)	10,000
NUTRITION SERVICES	**$881,848**
Congregate Meals	370,880
Home Delivered Meals	463,128
Senior Farmers Market Nutrition Program	47,840
SOCIAL & HEALTH SERVICES	**$885,820**
Medication Management for Older Adults	12,612
Disease Prevention/Health Promotion	40,857
Family Caregiver Support Program	**$741,190**
Information Services	3,501
Access Assistance	398,081
Support Services	5,001
Respite Care Services	290,006
Supplemental Service	25,001
Services to Grandparents/Relatives	19,600
Kinship Caregiver Support Program	37,598
Long Term Care Ombudsman	53,563
OTHER ACTIVITIES	**$102,772**
Outreach	993
Coordination	101,779
TOTAL	**$2,700,387**

This chart represents some but not all service areas and funding streams. Some of the funds have limits but allow for discretion on how they are allocated. The chart excludes grants and contracts that require how funding must be used.

****Funding sources included:**

Older Americans Act (OAA)
Senior Citizens Services Act (SCSA)
State Family Caregiver Support Program (SFCSP)
Kinship Caregiver Support Program (KCSP)
Senior Drug Education
Nutrition Services Incentive Program (NSIP)
Senior Farmer's Market (SFMNP)
Expanded Nutrition (SB5736)

SECTION B - PLANNING AND SERVICE AREA PROFILE

There has been an overall increase in the population O3A serves since the 2015 Area Plan by 3% or 6,533.

B – 1 POPULATION PROFILE:

O3A's service area is home to approximately **204,403** people widely dispersed over the rugged mountainous terrain of the Olympic Peninsula. Of these, **37% or 76,356** are 60 years old and over. The entire service region is considered to be rural, and in some regions "Frontier and Remote"[3] with an average of 30 people per square mile[4]. This is significant in relationship to access to health and social services, food resources, socialization opportunities, etc. To travel from one end of the region to the other, one must circle impenetrable mountains often using one accessible highway between regions.

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 increases. For this reason, programs and policies directed to the 60 and over population must consider the needs of up to three generations of older adults.

In addition to generational differences, the older population is extremely diverse in health, social status, and economic status. While most of the older adults between the ages of 60 to 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 an already overburdened rural health and long-term care system.

Retirees with the means to do so tend to relocate closer to children, grandchildren or services once they become frail.

For elders in the region, as well as for people with disabilities, residence in a rural setting such as the Olympic Peninsula can contribute to social isolation and an 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.

[3] John Cromartie, David Nulph, and Gary Hart; Mapping Frontier and Remote Areas in the U.S.; www.ers.usda.gov
[4] https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkmk

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 local long-term care systems. As the younger adult population continues to leave the area for better economic opportunities, there is a growing concern about who will provide the care needed by older adults and adults with disabilities in the coming years.

Demographic Summary

Demographic	Total	
Total Population	**204,403**[5]	**% of Total over 60**
60+	**76,356**	**37.4%***
60+ and a minority	**6,574**	**8.6%**
60+ at or Below Poverty Level	**4,957**	**6.4%**
60+ and a minority at or Below Poverty	**531**	**>1%**
60+ Living in Rural Areas[6]	**30,876**[7] *(estimated)*	**40%**
Adults w/ Disabilities (age 18+)	**21,477**	**10.5%***
60+ w/ Disabilities	**16,128**	**21%**
60+ Limited English Proficiency	**2,749**	**3.6%**
Tribal Elders (55+)	**2,207**	**2.9%**
Individuals with Cognitive Impairment	**12,433**	**16.2%***
60+ w Alzheimer's Dementia, Cognitive	**7,217**	**9%**
60+ at Risk of Institutional Placement[8]	**9,926**	**13%**
Number of Tribes	**8**	
Tribal Nations (with Title VI (OAA) Programs[ŧ]): [ŧ]Chehalis Confederated Tribes, Hoh Tribe, [ŧ]Jamestown S'Klallam Tribe, [ŧ]Lower Elwha Klallam Tribe, [ŧ]Quileute Nation, [ŧ]Makah Tribe, [ŧ]Quinault Nation, and Shoalwater Bay Tribe.		
Note: While Chinook is not a federally recognized tribe, O3A works with the community of Bay Center to address needs of elders in that community.		
Unless otherwise footnoted, Totals are derived from David Mancuso, PhD., Jingping Xing, PhD., Forecasts of the Aging Population, Dementia Prevalence and Use of Long-Term Care Services through 2030 in Washington State. June 2019, and reflect the forecasted numbers for 2020.		
*Percentage of total population.		

[5] David Mancuso, PhD., Jingping Xing, PhD., Forecasts of the Aging Population, Dementia Prevalence and Use of Long-Term Care Services through 2030 in Washington State; Office of Financial Management, WA State, 2019.

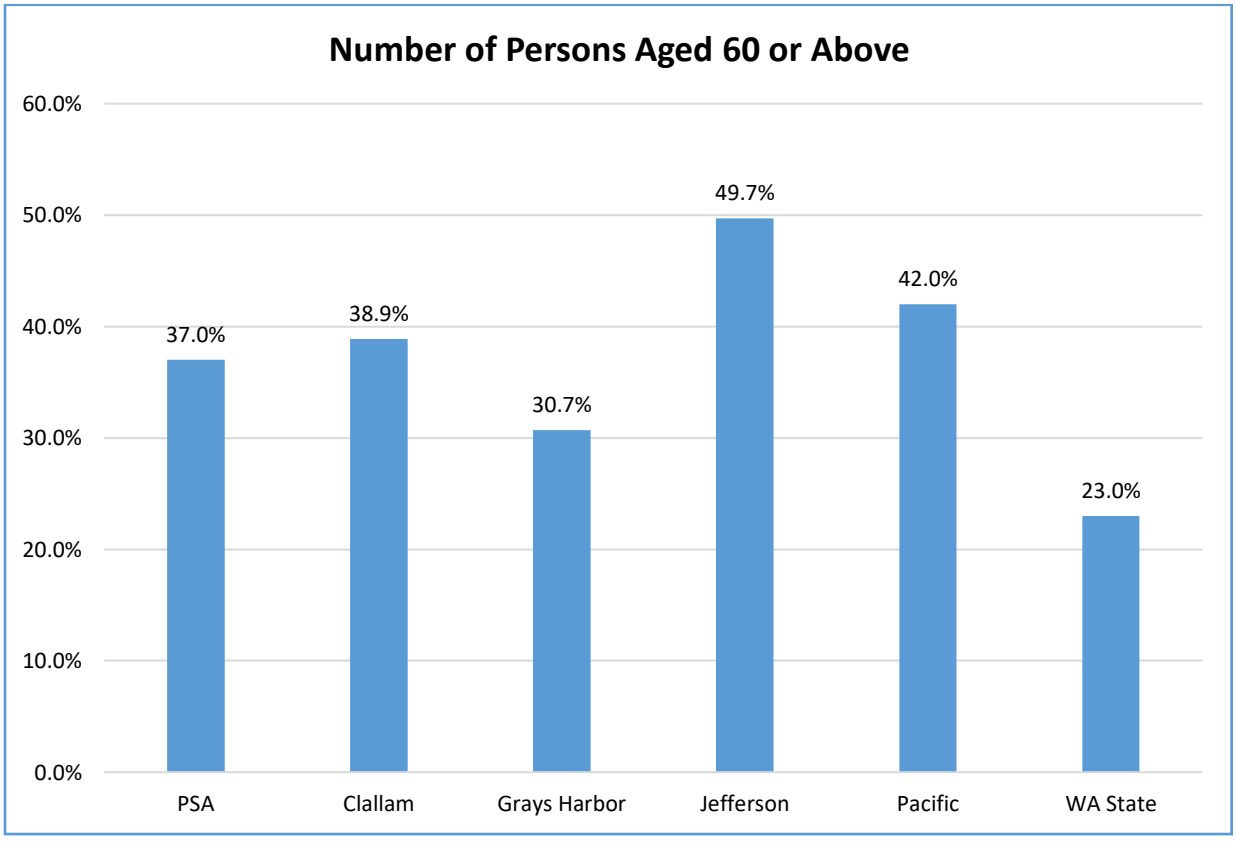
[6] For the sake of consistency and reporting, the Administration on Aging's definition for rural is used: Rural refers to any area that is not defined as urban. Urban areas comprise (1) urbanized areas (a central place and its adjacent densely settled territories with a combined minimum population of 50,000) and (2) an incorporated place or a census designated place with 20,000 or more inhabitants. DSHS RDA data will delineate rural areas by county only. PSAs that include rural areas within a mostly urban county will include data to identify rural towns, cities, or territories in the county to coincide with targeting efforts to serve rural residing older adults.

[7] https://www2.census.gov/geo/docs/reference/ua/County_Rural_Lookup.xlsx estimated using 60+ percentage of total population data.

[8] The term "at risk for institutional placement" means, with respect to an older individual, that such individual is unable to perform at least 2 activities of daily living without substantial assistance (including verbal reminding, physical cuing, or supervision) and is determined by the State involved to be in need of placement in a long-term care facility.

Number of Persons Aged 60 or Above

Throughout the O3A service region, 37% of the population is 60 or older, compared to Washington State as a whole, with 23%. All counties exceed the state averages. All of these percentages have increased since the 2015-2019 Area Plan was written, and this trend is expected to continue for the next decade. The 60+ age group already represents over a third of the population in three of the four O3A service counties and very close to a third in the fourth county. As adults continue to age in place and arrive on retirement 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, 40% of respondents reported living alone; 50.2 % reported living with a spouse or partner, and 9.3% reported living with a friend or relative.[9] This percentage is borne out by Senior Report in the American Health Rankings.

Over one-fourth (26%) of women ages 65 to 74 lived alone in 2018. This share jumped to 39% among women ages 75 to 84, and to 55% among women ages 85 and older.[10] A single elder living alone is not only at risk of social isolation, but also of being priced out of housing while on a fixed income as prices continue to rise. The Elder Index,[11] which measures how much income a retired older adult requires to meet his or her basic needs—without public or private assistance, documents that within our 4 counties single elder renters must have an income of between $21,396 and $23,472; for home owners with a mortgage, $28,968 and $31,440; and for owners with no mortgage, between $19,812 and $20,592. The Elder Index measures basic expenses for elders, age 65+ living in the community, not in institutions.

Minority Populations

Within the O3A service region, 88.9% of the total population is white. Persons identifying themselves as Hispanic or Latino amounted to 7.5% of the population, the largest minority in the region recorded by updated 2018 Census data.[12] American Indian/Alaskan Natives comprise the second largest 'minority' community at 4.1% of total population.

According to the Family Equality Council, approximately 4.3% of American adults identify as gay, lesbian, bisexual, transgender, or queer (LGBTQ) – 10.7 million Americans. Of those percentages 0.6% identify as transgender – 1.4 million American adults. If the same percentages hold true locally, 3,283 seniors in our region identify as LGBTQ. (1,267 - C, 957 - GH, 667 - J, 392 – P)[13]

Washington State is one of ten U.S. States with the highest number of adults identifying as lesbian, gay or bisexual, at 5.2%[14] of the total state population.

O3A PSA: White, Native American and Hispanic Populations

County	White	American Indian/Alaskan Native	Hispanic or Latino
Clallam	87.2%	5.6%	4.0%
Grays Harbor	87.2%	5.6%	10.2%
Jefferson	91.4%	2.3%	3.7%
Pacific	89.9%	2.9%	9.8%
PSA Average	**88.9%**	**4.1%**	**6.93%**
Some people identify as from two or more races so numbers can add up to more than 100%			

[9] O3A Area Plan Survey, Conducted May 1 – July 2019, N=433
[10] https://www.prb.org/aging-unitedstates-fact-sheet/
[11] http://www.basiceconomicsecurity.org
[12] US Census, Quick Facts, https://www.census.gov/quickfacts, 2018 update
[13] Family Equality Council, LGBTQ Family Fact Sheet, August 2017
[14] https://williamsinstitute.law.ucla.edu, LGBT Proportion of the Population, January 2019

Adults with Disabilities

The percent of adults age 18 and above with disabilities (11%) exceeds the state percentage of 6.9%. Only 36.8% of adults with disabilities over the age of 18 are employed in our state.[15] The significant fact related to adults with disabilities who are receiving services through the long-term care system, is that they will spend significantly more time requiring services than an older adult. For example, with advances in health care supports, an adult who has a motorcycle accident at 28 and becomes a quadriplegic, can expect a long life and will require a variety of supports and case management for the rest of their life.

Seniors with Disabilities

The percent of the 60+ population with disabilities is similar among all four counties and the state, between 9 and 10%[16].

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 who live in very remote rural settings;
- Older adults 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);
- 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 how this will be accomplished in their scopes of work 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 provides outreach into tribal communities to ensure that Native American Elders are aware of services available.

B – 2 Services provided through the Olympic Area Agency on Aging and Partnerships:

The Olympic Area Agency on Aging funds the following services to older adults with disabilities who live throughout the service region (not all services are available in all counties). The

[15] https://fortune.com/2017/02/28/disability-employment-rank/

[16] David Mancuso, PhD., Jingping Xing, PhD., Forecasts of the Aging Population, Dementia Prevalence and Use of Long-Term Care Services through 2030 in Washington State; Office of Financial Management, WA State, 2019.

number of clients served and the funds allocated in each of the service 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. Other services 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 **2,000 clients each year,** (carrying an average caseload of 1,700), **and this volume is steadily increasing**. 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
Adult Day Care Services	X			
Case Management ❖ COPES / Medicaid Personal Care	X	X	X	X
Elder Abuse Prevention - Long-Term Care Ombudsmen	X	X	X	X
Family Caregiver Support Program - Unpaid caregiver support services ❖ Kinship Caregiver Support/Relatives as Parents ❖ Caregiver training; ❖ Respite Services, Assessment & Coordination ❖ Respite Care	X	X	X	X
Home Care Referral Registry (to be replaced by CDE)	X	X	X	X
Information & Referral Services	X	X	X	X
Legal Services - Senior Legal Advice Clinics	X	X	X	X
Minor Home Repairs	X	X	X	X
Nursing Services ❖ Core Nursing Services ❖ Health Home Services	X	X	X	X
Nutrition ❖ Congregate nutrition ❖ Home delivered meals ❖ Senior Farmers' Market	X	X	X	X
Transportation	X	X	X	X
Senior Drug Education Program	X	X	X	X
Statewide Health Insurance Benefits Advisors (SHIBA)	X	X	X	X

O3A Direct and Contracted Services:

(Direct means that the services are provided by O3A staff or volunteers.)

Adult Day Services (Contracted)

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; *Olympic Community Action Programs Encore* is currently the only *Adult Day Care Service* available in the O3A service region. This program, located in Clallam County, provides core services including personal care (e.g., body care, eating, positioning, transfer, toileting) social services, routine health monitoring (e.g. vital signs, weight, dietary needs), general therapeutic and social activities (e.g. recreational activities and music 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, and psychological or counseling services. *There are presently no Adult Day Health services available in the O3A service region.*

Caregiver Information, Support, and Training (Direct & Contracted)

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 (Direct)

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 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 supports, 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 DSHS Home & Community Services.

Community First Choice/COPES/Medicaid Personal Care (MPC)(Contracted)

Community First Choice (CFC)/COPES/Medicaid Personal Care services are provided to disabled Medicaid clients who often live alone. These services include:

- In-home assistance with activities of daily living provided by a trained homecare aide;
- Client training by a skilled professional, such as a pharmacist, registered nurse, or dietician;
- Environmental modifications by licensed, bonded construction companies that build or install minor physical adaptations and devices in the home 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 (Personal Emergency Response Systems), 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 wheel-chairs, special shoes, flashing light doorbells, and aids to assist with standing).

Elder Abuse Prevention (Direct)

The residential Long Term Care Ombudsman Program (LTCOP) is designed to improve the quality of the life for residents of nursing homes, congregate care facilities, assisted living facilities and adult family homes. With the assistance of trained and certified volunteers, the Ombudsman investigates and advocates to resolve complaints made by or on behalf of residents and identifies facility issues and/or potential issues that affect facility residents. Changes in relevant federal, state, and local legislation are also promoted/monitored by the LTCOP program.

Evidence Based Programs (Contracted)

Evidence Based Programs offer proven ways to promote health and prevent disease among older adults. They are based on research and provide documented health benefits, and should be delivered with fidelity to the model to be effective. Older adults who participate in EBPs can lower their risk of chronic diseases, improve their health if they have one or more diseases, lower their risk of falls or minimize the impact of a fall. Some evidence based programs support unpaid caregivers in their difficult, demanding work. Most programs are offered as multisession workshops. O3A attempts to recruit providers in all parts of the PSA to deliver these programs.

Information and Assistance (Direct)

Information Assistance 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 specialists screen clients to determine their need for more extensive services, which are provided by the case management staff. Staff also provide outreach with information, outreach and education via newspaper and radio media conduct fairs and seminars, e.g. legal will 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 (Contracted)

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 impact 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 (Contracted)

This service provides limited repair of eligible, client-occupied structures that are essential for health and safety of the client, on a first-come, first-served basis.

Nursing Services (Direct)

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

Medication Management (Direct)

Medication management training is provided to adults 60+ with education and information (prescription drugs, vitamins, and herbs) though seminars and presentations in the home and in-group settings, such as senior centers, assisted living facilities and senior housing.

Nutrition Services (Contracted)

The *Congregate Nutrition* program helps meet dietary needs of older people by providing nutritionally sound lunches in a group setting, along with nutrition education. Socialization opportunities are a benefit of this program. Two contracted agencies manage nutrition sites located throughout the service region, with settings in senior and community centers, churches and assisted living facilities.

Congregate Meals Exceptions to the 5 meals per week requirement – One agency has requested/ been granted an exception to the 5 days/week rule due to financial constraints as follows:

- Meals are provide at a minimum, 3 days per week in Forks and often more frequently
- Meals are provide 4 days per week in Chimacum, Port Angeles and Sequim

Home Delivered Meals, often referred to as "Meals on Wheels", provides meals to older people who are homebound and unable to prepare meals for themselves. Adults with disabilities age 18 and older enrolled in Medicaid long-term care service may also receive meals delivered at home. Clients may receive hot or frozen meals delivered to their homes, as well as frozen meals for weekends and days that are not scheduled for meal delivery. This program also includes a socialization and gatekeeper component where the delivery staff or volunteer has some responsibilities to check on the client.

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 in Clallam and Jefferson Counties, as well as through bulk purchase and distribution in areas with no participating farmers markets in Grays Harbor and Pacific Counties. Clients may also receive this fresh produce delivered to their homes along with home delivered meals. This program is limited in scope and is offered on a first come first serve basis to qualified older adults.

Respite Services (Contracted)

One of the services a caregiver may be eligible for is in home or out of home respite care. Unpaid Caregiver assessment and coordination includes screening Individuals / care recipients for eligibility; performing an in-home assessment; and developing a service plan. If the caregiver is eligible to receive respite care, staff will authorize the level and the amount of respite care services to be provided; arrange for care with the respite service program; and maintain 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. 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 (Contracted)

Senior Drug Education (RCW 74.09.660) provides adults age 60 and over education and information on safe and effective use of medication (prescription drugs, vitamins, and herbs) through newsletter articles, and seminars and presentations by pharmacists or similarly qualified individuals. Senior Drug Education articles are also listed on the O3A website and Facebook page.

Statewide Health Insurance Benefits Advisors (SHIBA) (Direct)

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

Transportation (Contracted)

Contracted volunteer services are 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. This is an area where additional resources beyond volunteer transportation programs are needed. While the volunteer program is an excellent option, it is often under resourced.

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

Partnerships

Partnerships and collaboration are the processes by which all work not directly delivered or funded by O3A is accomplished, and even some of that work requires strong partnership to ensure excellent service delivery. For example, O3A collaborates with a variety of resources (Public Utilities, St. Vincent de Paul, Community Action, faith communities, etc.) to help a client with outstanding utility bills. Partnerships can be loosely developed, as simply a referral network that works to arrange needed services or resources. It can also become a formalized, more closely defined process, with outlined responsibilities and deliverables. The primary types of partnerships in this region are the former, where in the rural environment, the benefits of knowing one another well and working together over years of partnering come successfully to the forefront. The more formal method is used as needed if O3A or the partnering agency encounter problems, or the partnering agency is required to have such agreements in place. Below is a chart listing just a few of the partners/collaborators O3A has worked with, or would consider developing partnerships with as needs arise. (For example, O3A does not partner with all faith communities, but might develop a plan for a particular client need.)

Services Provided	Clallam	Grays Harbor	Jefferson	Pacific
X = Provided in County - = Not Provided in County				
Accountable Communities of Health	X	X	X	X
Adult Day Care	X	-	-	-
Alzheimer's / Dementia Services & Facilities	X	X	X	X
Case Management Programs	X	-	X	X
City & County Paramedic Services	X	X	X	X
Community Action Programs	X	X	X	X
Councils on Aging or other significant senior organizations	X	X	X	X
County Emergency Management	X	X	X	X
Dental Health Programs & Services	X	X	X	X
Department of Social and Health Services (DSHS)	X	X	X	X
• Adult Protective Services (APS) (aka Elder Abuse)	X	X	X	X
• Community Services Offices (CSO)	X	X	X	X
• Developmental Disabilities Offices (DD)	X	X	X	X
• Special Nutrition Assistance Program	X	X	X	X
• Home & Community Services (HCS)	X	X	X	X
• Information & Referral	X	X	X	X
Disability Access Programs	-	X	X	-
Health & Medical Care				
• County Health Departments	X	X	X	X
• Home Health Agencies	X	X	X	X
• Home Care Agencies	X	X	X	X
• Hospice Services	X	X	X	X
• Hospitals	X	X	X	X
• Community Health Clinics	X	X	X	X
Housing				
• Public Housing Authority	X	X	X	X
• Boarding Homes & Assisted Living	X	X	X	X
• Adult Family Homes	X	X	-	X
• Nursing Homes	X	X	X	X
• Home Repair, Energy Assistance, Weatherization Services	X	X	X	X
• Housing for the Homeless Services	X	X	X	-
Information & Referral Services (private or non-	X	X	X	X
Legal Services	X	X	X	X
Local Coalitions (Clallam County Transportation, J and GH Homelessness Task Forces, ACH sub-committees	X	X	X	-
Behavioral Health Services				
• Behavioral Health Organization (crisis)	X	X	X	X
• Behavioral Health Centers (community)	X	X	X	X
• Substance Use Disorder Treatment Programs	X	X	X	X

Services Provided	Clallam	Grays Harbor	Jefferson	Pacific
Native Elder & Minority Services				
• OAA Title VI American Elder Nutrition	X	X	-	X
• Tribal Health Clinics	X	X	-	X
• Other	X	X	-	X
Nutrition				
• Food Banks (public)	X	X	X	X
• Women-Infant-Children (WIC) Offices	X	X	X	X
Peer Counseling	-	-	-	-
Primary Care Physicians	X	X	X	X
Retired Senior Volunteer Program, other volunteer	X	X	X	X
Senior Centers	X	X	X	X
Senior Provider Networks	X	X	X	X
Senior Fitness and Social / Cultural Programs	X	X	X	X
Social Security Offices	X	X	-	-
Spiritual / Faith-Based Organizations (churches, synagogues)	X	X	X	X
Transportation (includes public transit and Para Transit)	X	X	X	X
Utility Providers	X	X	X	X

B – 3 Focal Points also known as Offices for O3A:

Focal Points are locations for comprehensive service delivery supporting older adults in our region. Because of the geographic spread of Olympic Area Agency on Aging, a number of full service offices have been identified across the region. The following chart identifies the designated Focal Points for the Olympic Area Agency on Aging:

Olympic Area Agency on Aging Focal Points				
County	**Office**	**Focal Point Address**	**Public Phone Number & E-Mail* Address**	**Services Coordinated at this Site (Optional)**
Clallam	Sequim Information & Assistance (I&A)	609 W. Washington Suite #16 Sequim, WA 98382	360.452.3221 800.801.0070	All I&A Offices provide: LTCOP I&A Case Management HCRR FCSP KCSP SHIBA MAC/TSOA
Clallam	Forks I&A	481 5th Ave. P.O. Box 1644 Forks, WA 98331	360.374.9496 800.801.0070	
Grays Harbor	Aberdeen I&A	2700 Simpson Ave. Suite 205 Aberdeen, WA 98520	360-532.0520 800.801.0060	
Jefferson	Port Townsend I&A	2500 W. Sims Way Suite 300 Port Townsend, WA 98368	360.385.2552 800.801.0050	
Pacific	Raymond I&A	430 3rd St. Raymond, WA 98577	360.942.2177 888.571.6557	
Pacific	Long Beach I&A	1715-A Pacific Ave. N., Long Beach, WA 98631	360.642.3634 888.571.6558	
Jefferson	Administration Office	11700 Rhody Drive Port Hadlock, WA 98339	360.379.5064 800.801.0070 *mossjm1@dshs.wa.gov	Administrative, HR, Fiscal, Planning, Contracts Management

SECTION C - ISSUE AREAS, GOALS, AND OBJECTIVES

C – 1 HEALTHY AGING

O3A Healthy Aging Programs and Services

Maintaining and improving health for older adults and adults with disabilities requires a broad array of services, advocacy, and programs

The ability to "age in place" also assumes that older adults can afford to do so; are able to access employment, transportation and food; are protected from abuse and exploitation; can receive assistance in an emergency; and can maintain their homes as safe environments. This is often not the case. With a goal of allowing an elder to remain in the place of their choosing, these programs are designed to fill in the gaps that begin to occur as we age.

Employment and Economic Security

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 reason they work 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 play an increasingly important role in our economy and America's leadership in the world marketplace. In 2020, 24.3% of Americans work force is aged 55+ and by 2024, 25% of the U.S. labor force will be an elder population.[17]

The committee on Economic Development indicates that employers rate older workers high on characteristics such as judgement, commitment to quality, attendance and punctuality. However, many older adults work because they have to and may have increasing medical problems they are struggling with, causing employment challenges.

Although the rate of unemployment among mature workers is lower than younger population, older workers who do become unemployed spend more time searching for work. In 2014, 8.9% of the unemployed population were older workers. Nearly half a million older adults aged 55-64 and 168,000 aged 65+ who wanted to work in 2014 were unemployed 27 weeks or longer.[18]

Senior Community Services Employment Program (SCSEP)

This program, formerly a program of O3A, is now managed by the AARP Foundation, which works to match unemployed seniors 55 and older with nonprofits and public organizations so

[17] https://www.bls.gov/careeroutlook/2017/article/older-workers.htm, "Employment and Economic Security"Pg.27
[18] https://www.ncoa.org/news/resources-for-reporters/get-the-facts/mature-workers-facts/

they can gain job skills. In order to assure that this resources remains viable in our region, O3A asks local agencies hosting SCSEP employees to continue to encourage the AARP Foundation to actively support this senior employment program in rural areas.

Food Insecurity and the Threat of Hunger in Older Adults and Adults with Disabilities

Food banks throughout the O3A service region report an increase in the number of all age groups seeking assistance over the last few years. In several communities, the Food Banks have implemented "Senior Saturday" or specific services in order to allow older adults age 55+ more time at the Food Bank and to give them more support.

Food insecurity in older adults can result in:

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

Older adults who live alone are at greatest risk for food insecurity. Factors which increase an elder's risk includes functional impairments, social isolation and poverty.

Senior Nutrition program---Congregate and Home Delivered meals

In the O3A service region about 2,300 older adults participate in some aspect of the senior nutrition programs which include congregate and home delivered meals and the Senior Farmers Market Nutrition Programs. Participation in the congregate and home delivered meals programs enhances the daily nutritional intake, nutritional status, social interactions and functionality of older adults.

Along with the nutritional benefits of consuming a congregate lunch participants have increased opportunities for social interaction.

In O3A's service region the home-delivered meals program (also known as Meals on Wheels) is an important part of the safety net for frail homebound elders, and it serves as a mechanism to trigger the need for other in-home services.

Senior Farmers Market Nutrition Program

The Senior Farmers Market Nutrition Program (SFMNP) provides low-income older adults with bulk produce or coupons that can be exchanged for fresh, locally grown produce at farmers markets, roadside stands and community-supported agriculture programs. The Senior Farmers Market Nutrition program is a popular program that benefits both older adults, by providing access to fresh vegetables, fruit and honey that enhances their nutrition as well as local framers that are reimbursed for the value of the produce.

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. This has historically registered as a high need in the O3A Area Plan Survey. 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. Other access issues, such as lack of access to medical specialty care may also be driven by the inability to get to and from distant specialist offices.

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 other services.

The rugged geography and rural nature of the service region present significant challenges including access to adequate medical care--many 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 older adults and people with disabilities are often unable to tolerate multiple transfers and long waits to access the public transit system; and 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, and activities in the community becomes a greater challenge as people routinely 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[19]. Furthermore, only 3% of older people use public transit[20] due to concerns about safety, schedules, and connections to needed destinations.

"Currently, there are about 8.4 million senior citizens who depend on others for their transportation. Shortly, the number of older drivers will more than double, making the issue of senior transportation even more critical. In fact, according to the Administration on Aging, by the year 2030 the number of drivers over age 85 will be 4–5 times what it is today.[21]" Some older drivers may continue driving beyond when safety deems they should stop, out of necessity, and a desire to maintain independence.

For these elders living in the rural and often remote communities of the Olympic Peninsula social isolation and the inability to access services and resources becomes a significant risk to their health, well-being, independence and ability to age in place.

Preventing Elder Abuse & Exploitation

Elder abuse refers to intentional or neglectful acts by a caregiver or "trusted" individual that leads to, or may lead to harm of a vulnerable elder. According to the Centers for Disease

[19] 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.
[20] 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.
[21] http://www.caregiverslibrary.org/caregivers-resources/grp-transportation/transportation-and-the-elderly-article.aspx

Control (CDC) 1 in 10 or 10% percent of Americans over the age of 60 reported some form of elder abuse in 2008.[22] Many cases go unreported--for every one case 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 perpetrators are adult children or spouses.

Financial abuse is the most common, yet only 1 out of 25 cases is reported.[23] 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 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. For those elders who have been mistreated, the risk of death is 300 times greater than those who have not been. And an extremely troubling study showed that 47% of patients struggling with dementia have experienced some form of abuse.[24]

Elder abuse can include verbal abuse, physical aggression and beatings, psychological trauma (for example, being isolated from others or criticized, or chemical restraint), sexual and financial exploitation and abuse, and self-neglect. Women and the very elderly at greatest risk; two-thirds or (66%) of elder abuse victims were female. Of the victims aged 60+, 43% were 80 years of age and older. 90% of the abusers are family members, thus leading to lower reporting rates as the elderly do not want to get their loved ones, who are often their only caregivers, in trouble.

Neglect can be defined as the failure of a caretaker, which includes the facilities, 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.

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 and behavioral 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 the vulnerable 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, as well as the knowledge of where to send the victims and or families for help or assistance.

Most O3A employees and contractors are mandatory reporters of abuse.

[22] https://www.cdc.gov/violenceprevention/pdf/em-factsheet-a.pdf
[23] https://www.nursinghomeabusecenter.com/elder-abuse/statistics/
[24] https://www.nursinghomeabusecenter.com/elder-abuse/statistics/

Long-Term Care Ombudsman

The Washington State Long-Term Care Ombudsman Program (LTCOP) protects and promotes resident rights for people living in long-term adult care facilities (e.g. Adult Family Homes, Assisted Living's and Skilled Nursing Homes).

An Ombudsman:

- Advocates for Resident Rights (even if the Ombudsman does not agree with the resident's request, desire or concern).
- Works with Residents, families and facility staff in complaint resolution for residents living in long-term care facilities and provide advocacy during the resolution /mediation process.
- Provides a way to get complaints and concerns heard and resolved at the lowest possible level by mediating issues between residents, residents and families, families and staff etc..
- Assists residents, their families and friends to become more involved in the care and the treatment of the residents (promoting and assisting with Resident and Family Councils), provides companionship and resident education on rights.
- Brokers information to facilities and community agencies related to resident rights and LTCOP Advocacy
- Provides community/agency/facility/hospital presentations and promotion of the Long Term Care Ombudsman Program and resident rights.

The following people can use the Ombudsman Program:

- Residents living in a long-term care facility and his/her relatives or friends
- Administrators & staff of an adult family home, Assisted Living, or nursing home
- Any community member or agency that has a concern or interest in learning about Resident Rights, specific Facility information or resident empowerment

Safe and Affordable Housing

A significant barrier to remaining at home as we grow older is the cost and the difficulty of maintaining housing. Throughout the O3A service region, there is a generally acknowledged lack of affordable housing, defined as mortgage or rent, and utilities that do not exceed 30% of the household budget, for all community members, a situation that is exacerbated for older adults, who face declining or fixed incomes in retirement.

- Nationally, 37% of seniors over 80 years old are paying over 30 percent of their monthly income on housing. Unfortunately, that housing might not even meet their needs for accessibility, comfort, or safety.[16]

- This affects younger seniors as well, as more than one-third of seniors over 50 are spending 30% or more a month on housing.[16]
- Even more shocking is that 23% of senior homeowners, as well as 30% of renters, are spending more than half of their monthly income on housing costs.[25]
- The population of sheltered homeless seniors, age 62 and older, in the U.S. population rose from 2.9 percent to 4.7 percent from 2007 to 2016.[26]
- In 2016, adults with disabilities were about four times more likely to be experiencing sheltered homelessness than were adults without disabilities.[17]
- Anecdotally, housing advocates in our region have noted that seniors, especially senior women, are the fastest rising population sector falling into homelessness.

Home owners have access to property tax relief programs, utility subsides, reverse mortgages, and home equity loans, however many homeowners still pay more than 30% of their income for housing. In addition, struggling seniors often do not know about resources available to help support them in their home.

The increasing costs of owning and maintaining a home, even one with no mortgage commitment will continue to present seniors with a lower income and even modest income growing challenges. At the same time increasing maintenance costs surpass the ability for many elders on fixed incomes to keep their properties safe and functional. In the 2019 Area Plan survey, seniors noted that help with yard work and house work is an unmet need. As seniors age, their housing ages and their ability to maintain the property concurrently decreases.

Concurrent with the growing increase in the population of older adults and people with disabilities who are living longer, so are rents and property values as well as costs for other basic items such as food, fuel, medications and health care. Moreover housing developers, although responsive to building single family retirement homes, seldom consider rural areas for cost effective projects, further limiting affordable and safe housing to potentially the most isolated and therefore at risk elders within the O3A region. The growing gap between the demand for and availability of housing means that an affordable place to live will continue to be out of reach for many 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. Homes that use universal designed features intended for all ages and designed for a lifetime, can go a long way in allowing people to live independently for as long as possible.

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,

[25] https://www.seniorliving.org/care/cost/affordable/

[26] https://files.hudexchange.info/resources/documents/2016-AHAR-Part-2.pdf

however, and many people over the age of 60 with disabilities cannot afford and have not made the modifications they may need to remain safely in their chosen environment.

As the number of older adults within the service region increases, the availability of safe, affordable housing becomes more 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 weather storms, including prolonged power outages, road and bridge closures and damage to buildings caused by flooding and fallen trees. Local county governments and emergency response agencies are increasingly actively engaged in community-wide planning to improve readiness especially in major emergencies.

O3A is a natural community partner for the dissemination of information. Designated O3A staff participate 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 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. In addition, O3A has developed a process to identify the highest priority clients, and in the event of a disaster, work with all home care agencies to be able to find home care workers able to reach clients to check on them or provide critical services.

O3A has developed a comprehensive Emergency Management Plan (See Appendix C), specific to each county, which includes business continuity plans for O3A's business systems and local offices.

The O3A Emergency Management Plan is aligned with "*Standards for professional information and referral"* These standards require AAA's 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 risk clients and procedures' for contracting 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.

Finally, O3A *urges all clients to establish an emergency contact, who is local to their neighborhood*. Unfortunately, this is the biggest area of risk for seniors due to the isolation they have developed in the process of aging and becoming less a part of their local community. They may not know any neighbors, or may live in a very remote area with no neighbors at all. This issue will continue to pose challenges for the population O3A serves and for O3A staff during emergencies. For information on preparedness for seniors, visit the Red Cross website: https://www.redcross.org/get-help/how-to-prepare-for-emergencies/seniors.html

Health Care in the Region

Although more residents have been able to obtain health insurance through Washington State's Health Benefit Exchange, local medical care practices are constrained to meet the increasing demands of an older population, and people of any age moving to region may face long wait times to access the limited, non-emergency care options provided by local community health providers.

In particular, residents in Grays Harbor, (with 1 provider for every 2,980 residents[27]), and Pacific Counties, (with a shocking 4,250 residents for each primary care provider[19]), face significant lack of primary care providers. These ratios compared poorly with the Washington State and US average of 1,200 residents to every provider. As a result, residents without a local primary care provider tend to delay seeking treatment and/or call 911, contributing to an overuse of local EMS services for non-emergency care.

Access to Behavioral Health Care

Accessing comprehensive behavioral healthcare in smaller, rural communities like those in the O3A region, is a growing challenge for older adults. On average, at least 29% or 57,150, of the population in O3A's service region is 65 or better[28]. It is estimated that at least "15% of adults aged 60 and over suffer from a mental disorder"[29] In our four-county region, we then face the possible need of at least 8,573 older adults requiring mental health attention. Other projections

[27] https://www.countyhealthrankings.org/

[28] U.S. Census Bureau (2018, July 1). Retrieved from https://www.census.gov/quickfacts/fact/table/pacificcountywashington,graysharborcountywashington,jeffersoncountywashington,clallamcountywashington/PST045218;

[29] "Mental health of older adults", World Health Organization (2017 December 17). Retrieved from https://www.who.int/news-room/fact-sheets/detail/mental-health-of-older-adults.

show that in our four-county region, between 10.1% and 11.2% of older adults 65+ are diagnosed with Alzheimer's Disease[30].

Additional factors contribute to the pressure for availability of behavioral health care in our region. In 2018, Western State Hospital lost their federal funding (over 50 million). Western State Hospital had up to 850 beds and included serving patients who were involuntarily committed due to psychiatric disorders (many older adults). It's reported that by 2023, "nearly all of the roughly 560 civilly committed patients at Western State Hospital would be placed in community beds"[31]. Washington State has long struggled with inpatient bed availability. Also, in 2017, the 1115 Waiver created new options and eligibilities for long-term services and supports (LTSS). This included a significant move to care for older adults in their own homes, by transitioning older adults who lived in nursing facilities for 3 months or longer (and on Medicaid) to "in-home" care.

Access to Specialty Care

Access to Specialty Care was highlighted repeatedly by respondents to the 2019 Area Plan Survey. 32% of the 407 respondents reported no access or difficulty accessing specialty care. Reasons may include lack of transportation, lack of insurance, or lack of the provider for a particular specialty service available within what individuals consider a reasonable distance. Due to some shortages of specialty care, some individuals may have to wait months to be seen by a specialist.

Oral Health Care is increasingly 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 lower and even modest income elders have challenges with oral health, even lacking any 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 is encountered. Elders living in 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.

[30] Mancuso, David. "Achievements in Long-Term Services and Supports: Rebalancing and the Age Wave", (2017 October 19). Retrieved from: https://www.agingwashington.org/files/2017/10/LTSS-Achievements-Dr.-Mancuso-PPT.pdf

[31] "Western State Hospital loses $53 million in federal funding after failing inspection", The Seattle Times, published 2018 June 25th.

Excessive Consumption of Alcohol, and Prescription Drugs and Increased Cannabis Usage

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[32]. About one third of all older substance abusers began taking substances after the age of sixty. Half of emergency room visits by older adults are related to consequences of alcohol or substance abuse.

Since the legalization of cannabis in Washington State, older adults are the fastest growing population of users. Because cannabis is still illegal at the national level, there are limitations on what research institutions receiving federal grants can study. The following data points are a compilation of data from other studies previously completed:

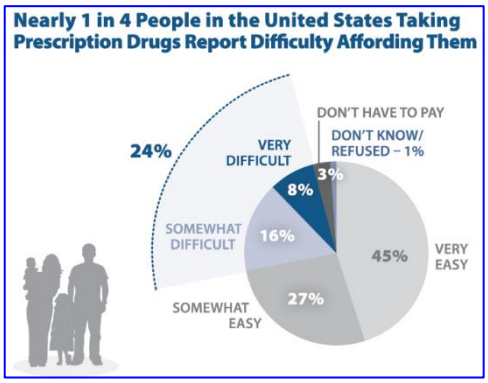
- 57.8% increase among 50-64 year olds from 2006-2013[33]
- 250% increase among 65+ year olds from 2006-2013
- Smoking cannabis can cause airway injury and bronchitis, increased heart rate, cardiac output, supine blood pressure; possible risk of heart attack orthostatic hypotension, may affect blood sugar, may cause drug-drug interactions
- Seniors with complex or sensitive medication regimens could be at risk of adverse reactions
- Some evidence cannabis can increase bleeding risk in those using anticoagulant, antiplatelet drugs
- Using cannabis with anticholinergics or stimulants can magnify its cardiovascular effects
- THC can enhance effects of CNS depressant drugs and alcohol – major concern for accident/fall risk
- Unknown how cognitive effects of cannabis may interact with cognitive effects of aging[34]

Some of retiring boomer population may have used cannabis when they were young. The strains of cannabis in today's cannabis marketplace are very different, much stronger, and can lead to fall risk and medication interactions. Assisted living facilities are providing field trips for seniors to cannabis stores at the residents' requests. It is clear that more research on cannabis use in the older population and its impacts on health are needed.

[32] Widlitz, Michelle and Marin, Deborah B. 2002. Substance abuse in older adul10ts. Geriatrics, Vol 57 (12), p 29-34.
[33] Demographic Trends Among Older Cannabis Users in the United States, Addiction Research Report, Society for the Study of Addiction, dol 10.1111/add.1 3670.
[34] Susan Stoner, PhD., Licensed Psychologist, Research Consultant, Alcohol and Drug Abuse Institute, University of Washington; Presentation to O3A Advisory Council, November, 2018

Access to Prescription Drugs and Assistive Devices

Reference for chart[35]



Many older adults lack medical insurance with sufficient drug coverage; this is true even for adults age 65 and older receiving Medicare. Medicare prescription drug coverage (Medicare Part D) still includes a prescription drug coverage gap (also known as the "donut hole") and different Medicare Part D plans manage this differently, often leaving the older person with significant out-of-pocket expenses during the latter part of the year.

In just the last several years, the cost of many commonly prescribed medications has skyrocketed. 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. 19% of the respondents to the 2019 O3A Area Plan survey reported that they sometimes skip purchasing medication, (or perhaps take medication intermittently to stretch it further).

Assistive devices such as glasses, walkers are unaffordable to many older adults. Medicare has only recently begun paying for hearing aids but not all types are covered. Medicaid covers some but not all the devices needed and older adults who are ineligible for Medicaid simply do not have access.

Skipping Care because of Affordability

Older adults are often faced with making difficult choices between food, rent utilities, medications or other health needs. In the 2019 O3A Area Plan Survey segmented by those who reported their quality of life was okay, poor, or bad, almost half (49%) of the older adult respondents reported they often skipped paying for essentials:

- Dental Care---------49%
- Vision or glasses---41%
- Utilities----------25%
- Food ----------22%
- Medicine----------19%

Palliative Care & Hospice

Palliative care is specialized care for people with serious illnesses. It is focused on addressing what curative treatment may not, including providing people with relief from pain symptoms and stress of a serious illness---whatever the diagnosis. The goal is to support the patient and family with guidance to make informed decisions about difficult or complex treatment and care options and improve the quality of life for both the patient and the family.

Palliative care is a formal discipline provided by a team of doctors, nurses, counselors and other specialists such as social workers, massage therapists and pharmacists, who work together with a patient's other doctors. Medical professionals who are part of the palliative care team

[35] https://jamanetwork.com/journals/jama/fullarticle/2510894

undergo special training with emphasis on communication with and among the patient family and medical team. It is appropriate at any age and at any stage in a serious illness, and can be provided along with curative treatments. It is also appropriate for persons with a chronic illness whose symptoms, such as pain, fatigue or medication side effects may not be adequately addressed. The care team works with the patient and their family and the patient's physicians to provide symptom management, extra time for communication, and help navigating the healthcare system. In addition, the care team provides the patient and family the opportunity and guidance to initiate often difficult conversations about end-of-life concerns related to the prognosis of the patient's illness.

Palliative care is provided in a variety of settings including the hospital, outpatient clinics, home, hospice and long-term care facilities, and is covered by most insurance plans including Medicare and Medicaid.

Hospice Care is similar in that it is a team approach towards addressing comfort measures for the patient and family with the difference being that it is provided at the end of life, typically when the person is expected to live for 6 months or less. Many people think accepting hospice is something not to be considered, that it is "giving up". Yet research shows that palliative care, hospice care, and advanced care planning (described several sections below), can contribute to increased patient and family satisfaction with care and a sense of peace in difficult circumstances, reduced costs to the family, and even increased medical provider satisfaction.

Palliative Care for Dementia

Palliative care can be an appropriate approach to meeting the needs of persons diagnosed with dementia and their families. The median survival for a person newly diagnosed with dementia is eight years. Predicting the course that dementia will take can be challenging and other concurrent medical conditions can play a big role.

The needs of a person with dementia are often poorly addressed. Symptoms of dementia are often under-treated, while intensive medical treatments for other conditions with poor or futile outcomes can degrade quality of life and result in unnecessary pain and suffering. Persons with dementia and their families need the type of support that the palliative care approach can provide. Instead of under treatment or over treatment, an individualized treatment plan that balances disease modifying therapy (e.g. antibiotics to treat infection and dementia-specific drugs) and provides palliative support is a better alternative.

This approach focuses on:

- Quality of life
- Symptom management
- Psychosocial support to patient and family
- Communication; and
- Coordination of care

Advance Care Planning

Advance Care Planning is a process of thinking about and sharing your wishes for future health care. It is for all adults 18 and older. Advance care planning includes deciding who you would want to make health care decisions for you if you cannot (called a health care agent) and sharing your values and goals. These are your decisions to make, regardless of what you choose for your care, and the decisions are based on your personal values, preferences, and discussions with your loved ones.

It is important to write down your wishes using documents called advance directives. These documents should be updated regularly and shared with your loved ones and your medical providers.

Talking about future health care decisions and naming a health care agent makes sure that the treatments you want, happen – and the treatments you don't want, don't happen.

Your health care agent and advance directive would only guide your medical care if you are not able to make decisions. As long as you are capable of making decisions, then you remain in control of your medical care.

Advance care planning includes:

- Getting information on the types of life-sustaining treatments that are available.
- Deciding what types of treatments you would or would not want should you be diagnosed with a life-limiting illness.
- Sharing your personal values with your loved ones.
- Completing advance directives to put into writing what types of treatment you would or would not want – and who you chose to speak for you – should you be unable to speak for yourself.

Death with Dignity Act

Many people have become concerned about being able to make difficult but very personal choices at the end of their lives. The Death with Dignity Act (Initiative 1000 codified as RCW 70.245) passed in November 2008 and went into effect on March 9, 2009. This Act allows terminally ill adults seeking to end their life to request lethal doses of medication from medical and osteopathic physicians. These patients must be Washington residents who have less than 6 months to live. Resources and information are available through End-of-Life Washington (www.endoflifewa.org, info@endoflifewa.org or 206-256-1636)

Aging and 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 and Prevention (CDC) estimates that nationally about 60% of all adults have 1 chronic condition

and 40% have 2 or more[36]. The situation on the peninsula with 37% of the population age 60 and older, is made worse by the shortage of primary care, specialty care (and particularly geriatrics), dental and behavioral health providers as well as inadequate transportation options.

Evidence Based Programs

Evidence Based Programs offer proven ways to promote health and prevent disease among older adults. They are based on research and provide documented health benefits, and should be delivered with fidelity to the model to be effective. Older adults who participate in EBPs can lower their risk of chronic diseases and falls—or improve long-term effects of chronic diseases or falls.[37] There are evidence based programs for caregivers as well.

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, falls prevention, and increasing physical activity. Falls for an older adult can be a life ending experience, causing harm to the individual, their families, and costing millions both to the family, private insurance, and in public Medicaid / Medicare / VA tax funded dollars. As older adults age, they may become less active or may be limited by chronic disease or even one illness which impacts overall fitness.

- One in three Washington residents over age 65 fall each year

[36] https://www.cdc.gov/chronicdisease/pdf/infographics/chronic-disease-H.pdf
[37] https://www.ncoa.org/center-for-healthy-aging/basics-of-evidence-based-programs/about-evidence-based-programs/

- Falls and fall-related injuries account for more than half of all injury-related deaths of adults aged 65+ in Washington State, and 70% of all injury-related deaths for adults aged 85+
- From 2011-2016, Washington State had the 14th-highest rate of fall-related deaths in the nation for adults age 65+, and the 5th highest rate of self-reported falls.
- The total number of deaths from falls and fall-related injuries has more than doubled in the last 15 years, from 393 in 2000 to over 943 in 2017
- In 2016 there were 19,060 hospitalizations for falls among adults age 65+.
- 25% of all fall-related hospitalizations for adults age 65+ are for people with a diagnosis of dementia
- The cost of health care and rehabilitation can be financially debilitating for an individual, as well as a community. Direct medical costs for falls in the U.S - what patients and insurance companies pay - totaled $50 billion (CDC). In 2014, the lifetime cost for falls in Washington State was $451 million.[38]

O3A uses Older Americans Act funds to contract for many different evidence-based programs. Community members interested in developing an evidence based program are encouraged to contact the O3A administrative offices for information. Listed below are just a few of the many evidence based programs that are eligible for this fund source:

- Chronic Disease Self-Management Program (CDSM) also known as *Living Well with Chronic Conditions."* The program features a six week workshop for older adults who wish to learn to better manage their chronic illness, and for caregivers of people with chronic illness. These programs include a variety of alternatives such as Wisdom Warriors – a Native American adaptation which is culturally relevant; Diabetes Self Management, Chronic Pain Self-Management, etc.
- Staying Active and Independent for Life (SAIL) is a strength, balance and fitness program for adults 65 and older. Performing exercises that improve strength, balance and fitness are the single most important activity that adults can do to stay active and reduce their chance of falling. The entire curriculum of activities in the SAIL program can help improve strength and balance, if done regularly. SAIL is offered 3 times a week in a one hour class. SAIL exercises can be done standing or sitting.[39]
- Tai Ji Quan Moving for Better Balance is a research-based balance training regimen designed for older adults at risk of falling and people with balance disorders. Fuzhong Li, Ph.D., a Senior Scientist at Oregon Research Institute, developed the program. Although its origin can be traced to the contemporary simplified 24-form Tai Ji Quan routine, TJQMBB represents a significant paradigm shift in the application of Tai Ji Quan, moving the focus from its historical use as a martial art or recreational activity to propagating health by addressing common, but potentially debilitating, functional impairments/ deficits. This unique training approach is the culmination of a systematic series of scientific studies to improve efficacy, utility, and community and clinical relevance.[40]

[38] https://www.doh.wa.gov/YouandYourFamily/InjuryandViolencePrevention/OlderAdultFalls
[39] https://www.ncoa.org/wp-content/uploads/SAIL-Summary-2016.pdf
[40] https://tjqmbb.org/

- Powerful Tools for Caregivers (PTC) provides classes which help caregivers take care of themselves while caring for a friend or relative. Research shows that PTC helps improve self-care behaviors with increased exercise, relaxation and medical checkups; emotional management with reduced anger, guilt and depression; increased self-confidence in coping with caregiving demands; and, increased knowledge about and use of community resources so the caregiver is not so isolated.[41]
- Savvy Caregiver is another caregiver support program introducing family caregivers to the caregiving role, providing them with the knowledge, skills, and attitudes needed to carry out that role and alerting them to self-care issues, and resulting in improved caregiving as well as a healthier caregiver. https://www.caregiver.org/savvy-caregiver-program[42]
- ABC4PD – Aerobics, Balance and Coordination for those with Parkinson's Disease and their Caregivers – ABC4PD is a falls prevention program locally developed by two physical therapists following the criteria for evidence based falls prevention.

In addition to contracting for these services, O3A has developed a partnership with the Clallam and Jefferson Accountable Community of Health – Olympic Community of Health. Additional funds and partnerships with health care providers are emerging to build a more robust sustainable CDSM program.

O3A also partners at the state level to promote a systematic and sustainable approach towards funding and delivery of evidence based programs throughout the state, with a goal of increasing funding, program capacity and consumer engagement in these life changing programs.

[41] https://www.powerfultoolsforcaregivers.org/
[42] https://www.caregiver.org/savvy-caregiver-program

C – 1: GOALS & OBJECTIVES – HEALTHY AGING

Problem/Needs Statement:

Healthy aging is a goal all older adults hope to achieve. However, older adults with complex chronic illnesses require specialized medical and social support to age well in place. Social determinants of health like poverty, inadequate housing, lack of access to healthy food and exercise, all contribute to a decrease health status, the impacts of which compound as we age. Increasing demand for services will require continued development and support of a variety of resources. O3A will continue to seek to expand the network and variety of resources and contract with local providers to meet individual client needs, and coordinate client services across systems. O3A's focus is to start where the older adult or the adult with disabilities presents themselves, and help them to access the resources they need and want in the most effective way possible.

C – 1.1 - Goal: Older adults and adults with disabilities are able to meet basic needs for food, transportation, and housing.

Objective 1: Provide OAA Senior Nutrition and Senior Farmer's Market Nutrition Programs.
Key Activities:

- Ensure OAA service contracts prioritize home delivered meals, and that Senior Nutrition providers offer congregate meals services that are within their capacity to sustain.
- Implement Senior Farmers Market program with existing Senior Nutrition providers.
- Encourage contractors to connect with local food networks.

  Complete by 12/2023

Objective 2: Support volunteer transportation options for older adults to access health, shopping, and other essential services.
Key Activities:

- Procure local volunteer transportation services through O3A contracts with local agencies to provide transport for medical services and essential shopping.
- Advocate at state and local levels to improve coordination of transportation services.
- Work to expand transportation resources, especially in remote rural areas.

  Complete by 12/2023

Objective 3: Advocate for housing options for homeless and at-risk seniors.
Key Activities:

- Share information about, and help older adults to access programs to reduce costs associated with housing (e.g., property tax relief, utility subsidies, maintenance, and safety modifications).

- Develop and implement a homelessness / affordable housing advocacy plan for O3A.
- Partner with other housing advocates to promote resources for senior housing needs.

  Complete by 12/2023

Objective 4: Maintain regional coverage in Long-Term Care Ombudsman Program.

Key Activities:

- Ensure current level of effort/staff/volunteer capacity is maintained, and as capacity allows, expanded.

  Complete by 12/2023

C – 1.2 Goal: Older adults and adults with disabilities are able to access necessary health care services including primary, specialty, behavioral, oral, hearing, vision health care, and reasonably priced prescriptions.

Objective 1: Advocate for resources to fund dental and vision services for both the Medicare and Medicaid populations.

Key Activities:

- Develop/implement an advocacy plan for oral, hearing and vision care access.
- Continue to refer clients to known resources for oral health services.
- Partner on local oral health coalition efforts.

Complete by 12/2023

Objective 2: Support increased access to medical specialty care services.

Key Activities:

- Support volunteer and other transportation services to distant communities where specialty care is located.
- Partner with local medical institutions to develop local solutions for accessing specialty care.

  Complete by 12/2023

Objective 3: Support increased access to behavioral health services

Key Activities:

- Implement Trauma Informed Care Training for entire O3A staff; inviting community partners as staffing allows.
- Consider / Implement other trainings for staff and /or community partners e.g., Mental Health First Aid, SAFEtalk, self-protection training for O3A direct service staff.
- Develop community resources / partnerships to address emerging behavioral health issues.

  Complete by 12/2023

C – 1.3: Goal: Older adults and their families have the knowledge and support to make informed choices about chronic disease prevention and management.

Objective 1: Facilitate implementation of evidence-based wellness programs in communities throughout the PSA.

Key Activities:

- As funding allows, facilitate implementation of evidence-based programs, such as Chronic Disease Self-Management workshops; Staying Active and Independent for Life (SAIL) fitness program for older adults; Powerful Tools for Caregiving, Tai Ji Quan Moving for Better Balance, Aerobic, Balance and Coordination for those with Parkinson's Disease, Savvy Caregivers and/or other evidence-based wellness programs in the service region.
- Provide information to older adults on medication management through Senior Drug Education Program.
- Advocate for additional funding and partnerships to support evidence-based programs.
  Complete by 12/2023

C – 1.4: Goal: Older adults have adequate information so that they can adequately plan for end of life health and care needs that pair with their values

Objective 1: Coordinate with state-level palliative care committee and with local advance care planning efforts.

Key Activities:

- Work with Advisory Council member serving on this newly forming Palliative Care committee.
- When produced, market the Palliative Care Roadmap to the community at large.
  Complete by 12/2023

Objective 2: Promote awareness of the benefits of palliative care, hospice, and advance care planning to providers and the general public.

Key Activities:

- Partner with local organizations like Olympic Medical Center to promote palliative care, hospice and advanced care planning.
- Identify whether other medical centers in PSA are similarly focused and encourage engagement in this work.
  Complete by 12/2023

C – 2: Access to Resources (Delay Entry into Long Term Services and Support System)

Older Adults and Adults with Disabilities

Older adults and Adults with disabilities need one stop access to understand the aging and long-term care system. Too often they have not planned for their needs and do not know where to seek help. Often, just one conversation with Information and Assistance can offer the reassurance and the planning to help give them guidance to pursue planning on their own.

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 housekeeping, 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, and even great-grandparents, may also find themselves as the primary caregivers to their grandchildren. Caregiving can take a heavy toll on the 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; they are often unaware that services exist, or only seek help when a crisis occurs.

Persons with Alzheimer's Disease and Other Dementias and Their Caregivers

Alzheimer's Disease is a slowly progressive, degenerative disorder that attacks the brain's nerve cells and neurons, resulting in loss of memory, thinking and language skills, and behavioral changes. The disorder progresses through seven stages that can take decades.

- Alzheimer's Disease (AD) is the 6th leading cause of death in the United States
- 82% of seniors report that it is important to have their thinking or memory checked yet only 16% report regular cognitive assessments
- Every 65 seconds someone in the US is diagnosed with some form of dementia
- 5.8 million Americans are living with some form of dementia - by 2050 that number (above) is expected to rise to 14 million
- More than 16 million Americans provide unpaid care to someone with dementia
- In 2019, dementia will cost the nation $290 billion – by 2050 - **$1.1 TRILLION!!!!**[43]

[43] https://alz.org/media/Documents/alzheimers-facts-and-figures-infographic-2019.pdf

There are currently 117,332, people aged 65 and older in Washington State living with some form of dementia. **The number of persons in the O3A region aged 65 and older with any type of dementia is estimated at 5,464.**

Alzheimer's prevalence increases with age, and as the older adult population grows, state governments and local communities will need to identify and invest in interventions to support both the individual with dementia and their caregivers.

In 2014, legislation established an Alzheimer's Disease Working Group (ADWG) to create the first Washington State Plan to Address Alzheimer's Disease and Other Dementias. The plan includes action planning, next steps, and policy changes. Members of the ADWG called for the formation of a next generation workgroup to implement it. This group is now known as the Dementia Action Collaborative (DAC) - a voluntary statewide collaboration of partners committed to preparing our state for the future.

The DAC has established a very broad set of goals outlined below:

- Increase public awareness, engagement and education
- Prepare communities for significant growth in the dementia population
- Ensure well-being and safety of people living with dementia and their family caregivers
- Ensure access to comprehensive supports for family caregivers
- Identify dementia early and provide dementia-capable evidence-based health care
- Ensure dementia-capable long-term services and supports are available in the setting of choice
- Promote innovation and research related to causes of and effective interventions for dementia

Specific problems, needs, recommended action steps and timeframes for each strategy are included in the full DAC report www.dshs.wa.gov/altsa/stakeholders/alzheimers-state-plan. In addition, the DAC has developed the Dementia Road Map which is a helpful tool for families, which can be located online by clicking on the above link, searching for Dementia Road Map, or calling O3A for a copy.

Drawing from these broad goals and strategies, O3A is focused on efforts to support many of the DAC goals, namely increasing public awareness, preparing communities and supporting the development of caregiver services.

Particularly Vulnerable Caregivers

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

- Limited English-speaking and ethnic caregivers, including Native American caregivers
- Caregivers who are in the greatest economic and social need
- 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; LGBTQ (Lesbian, Gay, Bisexual, Transgender or Questioning) partners and individuals who are not legally married
- Grandparents and relatives, age 55 and older, and relatives over the age of 18, raising children are eligible for services provided by Kinship Caregivers Support Program and Relatives as Parents
- Older individuals caring for people, including children (of all ages), with severe disabilities (including developmental disabilities)
- Caregivers providing care to adults under the age of 60

All caregivers may experience exhaustion, guilt that they are not doing enough, physical injury from lack of training, etc. But the impact on these particularly vulnerable caregivers can be more extreme. Just a few examples of the significant impacts that can occur are listed below:

- For immigrants, even if legally in the country, the caregiver may not seek help out of fear for themselves or family members and put themselves, their own health and the health of their loved one at risk.
- Caregivers with fewer financial resources may be at risk for losing housing or inadequate housing, or having utilities shut off or living with food instability,
- Caring for individuals with dementia has a huge array of risks, including a loved one who becomes angry, combative, fearful, not recognizing their care provider, lack of sleep due to night time wandering, etc.
- When a caregiver is a member of a marginalized population, they themselves may not be recognized and supported in their role, for example an LGBTQ spouse, may not be recognized or valued in this role, and potential could even be barred from serving in the role by non-accepting family members.

The bottom line is that we all lose when a caregiver becomes unable to deliver care and often the result is two individuals who now need services. Imagine if suddenly our health systems, our long-term care systems, home care agencies, nursing home facilities, meal delivery programs, etc., were inundated with double the numbers listed below.

Caregivers Statistics[44]

- Approximately 43.5 million caregivers have provided unpaid care to an adult or child in the last 12 months.

[44] https://www.caregiver.org/caregiver-statistics-demographics

- About 34.2 million Americans have provided unpaid care to an adult age 50 or older in the last 12 months. The majority of caregivers (82%) care for one other adult, while 15% care for 2 adults, and 3% for 3 or more adults.
- Approximately 39.8 million caregivers provide care to adults (aged 18+) with a disability or illness or 16.6% of Americans.
- About 15.7 million adult family caregivers care for someone who has Alzheimer's disease or other dementia.
- The value of services provided by informal caregivers has steadily increased over the last decade, with an estimated economic value of $470 billion in 2013, up from $450 billion in 2009 and $375 billion in 2007.
- At $470 billion in 2013, the value of unpaid caregiving exceeded the value of paid home care and total Medicaid spending in the same year, and nearly matched the value of the sales of the world's largest company, Wal-Mart ($477 billion).
- The economic value of the care provided by unpaid caregivers of those with Alzheimer's disease or other dementias was $217.7 billion in 2014.
- 9% of caregivers self-identify as.
- There are at least 3 million LGBTQ persons aged 55+ in the U.S. This number is expected to double in the next two decades.
- LGBTQ male caregivers report providing more hours of care than female caregivers. The average weekly hours of care provided by females from both the LGBTQ and general population samples is similar—26 vs. 28 hours—but LGBTQ males provide far more hours of care than males from the comparison sample (41 hours vs. 29). This reflects that about 14% of gay males indicate that they are full-time caregivers, spending over 150 hours per week in this capacity, compared to 3% of lesbian and 2% of bisexual respondents.

Other issues related to the LGBTQ aging population:

- LGBTQ individuals are more likely to be very concerned about having enough money (51% vs. 36%), experiencing loneliness in old age (32% vs. 19%), declining physical health (43% vs. 33%), not being able to take care of themselves (43% vs. 34%) or not having anybody to take care of them (30% vs. 16%) compared to non-LGBTQ.
- 20% of older LGBTQ individuals and 44% of older transgender individuals feel their relationship with their healthcare provider would be adversely affected if their health provider knew their sexual orientation/gender.
- LGBTQ older adults are twice as likely to age as a single person, twice as likely to reside alone, and three to four times less likely to have children.

State and National Family and Kinship Caregiver Support Programs

The State and National Family Caregiver Support Program (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 Medicaid system.

O3A's Family Caregiver Support and Relatives Programs

O3A provides both Family Caregiver Support and Relatives as Parents (Kinship Caregiver) programs. O3A has Family Caregiver Support Coordinators in each service county. Presently, there are five staff assigned to FCSP; one in Grays Harbor, three in Clallam & Jefferson Counties, and on in Pacific County. O3A FCSP coordinators are trained to implement the T-CARE screening, assessment and care planning protocol's, enabling them to identify the caregiver's needs and provide tailored support and services.

The T-CARE program helps FSCP coordinators 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;

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's role.

Outreach to Vulnerable Caregivers

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

- Health and hospital fairs, including O3A-sponsored events. Tribal health fairs and outreach to Native Americans
- News media, including newspaper columns, and radio
- Outreach to and referrals from local physicians' offices (builds awareness in other providers in practices)
- Outreach to local schools resulting 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
- Presentations to providers

Core Family Caregiver Support Services

Family Caregiver Support services available in each county include:

- Information about long-term care and caregiver support
- Assistance in gaining access to supportive services
- Evidence-based assessment of caregivers' needs and care planning
- Caregiver support groups
- Caregiver training, consultation and education (increasing skill building and self-care)
- Counseling services to cope with challenges
- Respite care services (in and out of home settings, e.g. Memory Care and Wellness Services) to provide breaks

- Supplemental Services such as assistive technology, home safety features like grab bars incontinence supplies, etc.
- Health and wellness referrals to cope with depression and medical issues

Information Services are provided by:

- O3A FSCP coordinators, in person and by telephone (including a toll free number)
- Information & Assistance staff, who provide information on legal services and benefits
- Written materials, including brochures and pamphlets created by O3A and other agencies, such as the Family Caregiver Alliance[45], specifically written for family caregivers; materials from Alzheimer's and dementia support agencies; videos; books, web resources, many of which are linked on the O3A website
- Newspaper columns, articles, and radio presentations by O3A staff
- O3A social networking and websites

Group Activities with outreach to Caregivers include:

- Health and hospital fairs
- Caregiver support groups
- Presentations about both FCSP and Relatives As Parents (see outreach to Vulnerable Caregivers, above)
- FSCP and KCSP support groups
- Referrals to the Alzheimer's Association Dementia Support groups (not available in all areas.

One-on-one specialized family caregiver information and assistance, including T-CARE screening and assessment/care planning.

- Caregivers receive TCARE screening/ assessment and care planning provided by O3A FCSP coordinator
- In response to the caregivers' needs identified by the T-Care screening protocol O3A FSCP staff have developed a menu of services that can be provided through contracts with local providers.
- 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 can feel isolated and sink into depression before they know it, caused by the stressful situation they are facing. This information assists O3A FCSP coordinators to develop a responsive care plan, which may include:

[45] https://www.caregiver.org/

- Encouraging caregivers to speak to their doctors about the T-CARE results showing 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.
- Coordinating individualized counseling. If the caregiver does not have a health insurance plan that covers 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, and workshops for caregivers.

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 Disease and other dementias.

- **One-to-one training**-----for example, how to communicate with someone who is cognitively impaired; how to effectively communicate with medical providers; how to recognize possible depression; and other self-help tools that are available in the O3A resource library and online; and
- **Caregiver Conferences –** occur regionally around the state periodically and focus on enhancing tools and resources available to caregivers.
- **Savvy Caregiver training & Powerful Tools for Caregivers** – Caregivers can be referred for these workshops when they occur.

Support Groups

O3A FCSP carries out ongoing support groups for family caregivers in Clallam, Grays Harbor, and Jefferson counties, as well as referral to support groups offered by other community agencies, such as hospice and local Alzheimer's Association service providers. However, there is still a significant unmet need throughout the region for support groups for caregivers and especially those providing care for persons with Alzheimer's Disease or other dementias.

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. In-home care is provided through O3A – contracted home care providers in each county; out-of-home respite care is currently available only in Clallam County from "'Encore," a program of OlyCAP, and presently the only Adult Day Care service that O3A contracts with in the region. Jefferson Healthcare has planning efforts underway for an Adult Day Service.

The need for safe, out-of-home respite options is largely unmet in the service region; the single Adult Day Care program in the region is unable to serve persons with dementia who are at-risk of wandering, or persons with incontinence.

Supplemental Services

The O3A FCSP also provides durable medical equipment & assistive technology, as well as minor and limited emergency home modifications; ”wander guard” technology, such as Lifeline (paid via contracted providers 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 Kinship Caregivers

The O3A Kinship Caregiver Program (KCSP), serving adult caregivers (age 18+) to children, and including Relatives as Parents (RAP) program serving older adults over age 55, is especially active within impoverished communities in Grays Harbor and the West End (Clallam County); and in several tribal communities, where older relatives raising children often lack the resources to meet even basic needs for the children in their care. Unfortunately, both funds sources are fairly limited, which limits the number of clients O3A is able to serve.

The FCSP coordinators 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
- **Support group** (in Grays Harbor County and in Jefferson County)
- **Supplemental Services** provided directly by FCSP coordinators to help caregivers with urgent basic needs such as housing, food, clothing, and essential supplies
- The needs for these services generally exceeds O3A’s capacity to meet it

Medicaid Transformation Project Demonstration – Medicaid Alternative Care & Tailored Services for Older Adults[46]

Washington State has already created a rebalanced system where more individuals receive Long-Term Services and Supports (LTSS) in their homes than in long-term care facilities. Our LTSS system has been ranked 1st in the nation by AARP for its high performance while at the same time ranking 34th in cost. **Washington is building on the successes of our current system and create a “next generation” system of care** focused on outcomes supporting families in caring for loved ones, delaying or avoiding the need for more intensive Medicaid-funded LTSS where possible and creating better linkage to a reformed healthcare system and continuing its commitment to a robust Medicaid LTSS system for those that need it. The demonstration project has two main LTSS components:

Medicaid Alternative Care (MAC) – Creation of a benefit package for individuals who are eligible for Medicaid but not currently accessing those services and supports. This benefit package provides services to unpaid caregivers designed to assist them in getting supports necessary to continue to provide high-quality care and to focus on their own health and well-being.

[46] https://www.dshs.wa.gov/altsa/stakeholders/medicaid-transformation-demonstration

Tailored Supports for Older Adults (TSOA) – This category has created an eligibility category and benefit packages for caregivers and individuals without a caregiver who are "at risk" of future Medicaid use who currently do not meet Medicaid financial eligibility criteria. This is designed to help caregivers/individuals avoid or delay impoverishment and the need for Medicaid-funded services.

Medicaid Alternative Care (MAC) & Tailored Services for Older Adults (TSOA) includes the following benefits

- **Caregiver Assistance Services:** Services that take the place of those typically performed by unpaid caregiver
- **Training and Education:** Assist caregivers with gaining skills and knowledge to care for receiver.
- **Specialized Medical Equipment & Supplies:** Goods and supplies needed by the care receiver
- **Health maintenance & therapies:** Clinical or therapeutic services for caregivers to remain in role or care receiver to remain at home
- **Personal Assistance Services:** Supports involving the labor of another person to help recipient (TSOA only)

O3A Medicaid Alternative Care (MAC) & Tailored Services for Older Adults (TSOA) Program

O3A has had great success in implementing the MAC & TSOA program utilizing and augmenting the skills of the FCSP Coordinators, hiring specialists in MAC & TSOA, and working to expand the network of contractors. The largest focus of work thus far, similar to all other Area Agencies on Aging in the state has been serving TSOA individuals without caregivers. Although not the stated focus of the program which is on caregivers, this population of individuals in need of services but not eligible for them has helped Washington State identify a systemic gap. That gap is now being filled by this program and thus delaying entry into the Medicaid LTSS system, which has been a stated goal of the demonstration project.

Caregivers slowly become more and more immersed in the act of caregiving so that they believe they do not have the time to address their own needs. They may not self-identify as caregivers, and may not recognize the need or availability for/of additional help and resources. Thus, again like other Area Agencies on Aging, outreach to caregivers has been a challenge. O3A is pleased that this component of the program seems to be slowly gaining ground as community knowledge of these programs grow.

Network Adequacy similarly presents challenges in small, rural areas where providers may be hesitant to embrace a program which includes the complexity of Medicaid contracting and billing. O3A Program Managers continue working to expand the network of providers, but

locally and with the assistance of HCS Resource Development Program Managers. This work benefits MAC & TSOA, FCSP, and TXIX clients as well.

The three areas presenting the biggest network needs and at the same time, the greatest challenges, are:

1. Access to in-home respite services - There is a national paid caregiver shortage.[47] It is difficult for home care agencies to staff shorter respite hours, when clients with greater needs do not have an assigned caregiver.
2. Out-of-home respite services - O3A has spent the last 4 years exploring options for expanding Adult Day Services with few solutions surfacing. In order to utilize limited resources wisely, the development focus in this are must be to increase the number of Adult Day Care programs which are the most economical.
3. Need for additional FCSP and Kinship Care funding.

Quality Assurance

O3A supports quality assurance through several mechanisms:

- A family caregiver satisfaction survey is conducted annually of all family caregivers enrolled in FCSP, MAC & TSOA, with results reviewed by the program managers and coordinators for improvement that can be made to the program services
- A Kinship caregiver support satisfaction survey is also carried once a year
- T-CARE assessments are regularly reviewed by the program supervisors for quality and completeness
- Contracts with service providers are monitored using the same criteria as contracts for TXIX service providers

Long Term Care Trust Act

Fewer than 1 in 10 people have long-term care insurance. Most people do not think they will need this and furthermore, cannot afford it. However, 7 out of 10 will need long-term care. Currently, without insurance, each person pays for these long-term care services themselves, until they can no longer afford to and then they may qualify for Medicaid services. Often, a family member will provides care, transportation and all other needed services, sometimes to the detriment of their own health and financial wellbeing; for example when a daughter reduces work hours or quits working to care for her father. On average, family caregivers spend 20% of their income on caregiving expenses.

Some older adults allow themselves to decline because they do not want to spend their retirement savings on these kinds of services. When they do finally begin receiving long-term care services, it is often precipitated by a crisis, such as a fall, and they may be in much worse condition because of this delayed care.

[47] https://homehealthcarenews.com/2019/01/caregiver-shortage-could-mean-7-8-million-unfilled-jobs-by-2026/

In 2019, Washington State passed ground breaking legislation to create the first Long Term Care Trust Act (LTCTA). This legislation had a majority of voter support of all ages even as a taxing initiative.

- An August 2018 poll of Washington voters showed that 73% support the concept of a long-term care trust
- 83% of voters ages 18-34 support the concept
- The tax will collect .58 on every $100 of income (approximately $24 per month for an annual salary of $50,000)
- The LTCTA is expected to save taxpayers $34 million annually in the very first year of possible usage, (2025); and, will save $3.9 billion in Medicaid costs by 2052.

This is a payroll tax similar to Social Security which will yield a lifetime benefit of $36,500 for long-term care services for all contributing Washingtonians. This may not seem like much but it will pay for:

- 25 hours per week of in-home care for a year
- 9 to 18 months in a residential care such as an adult family home or assisted living
- Five to six months in a nursing home
- Five years of family caregiver support that includes respite, caregiver counseling and education, home modification, adaptive equipment

Area Agencies on Aging were some of the key partners in developing this effort, along with AARP, and Washingtonians for a Better Future. Washington now has a number of years to develop an implementation plan that serves the general population efficiently and effectively. Since Area Agencies on Aging serve in the front line of this work every day, our input will be key in common sense development of this plan and how the public will access these benefits.

C – 2: GOALS AND OBJECTIVES – ACCESS TO RESOURCES

Problem/ Need(s) Statement:

As aging occurs, older adults, and adults with disabilities are at risk of losing their ability to live independently. Unpaid Family and Kinship Caregivers are at continuous risk of being unable to continue their loving and important work. In order to strengthen services and support to unpaid family and kinship caregivers in the O3A service region, O3A needs to conduct outreach, expand referral relationships, and provide targeted services responsive to the needs of family and kinship caregivers; expand options for training and group support for caregivers; and develop options for in home and out of home respite care.

C – 2.1: Goal: Family Caregiver Support (FCSP), Kinship Caregiver Support (KCSP) and Relatives as Parents (RAP) programs support more family & kinship caregivers to care for their family members.

Objective 1: Conduct outreach and provide support and services to family caregivers.

Key Activities:

- Promote FCSP with appropriate local community organizations, and tribes via presentations & contacts to schools, medical service providers, discharge planners, churches, 7.01 plans and visits to tribes, etc.
- Support/facilitate referrals from hospitals, discharge planners, physicians' offices, schools, churches, etc. Develop new referral resources as they are identified in each county.
- Provide T-CARE assessments & customized care plans for family caregivers.
- Provide services & supports to FCSP (e.g., respite, counseling, training, support groups).
- Identify and contract sufficient providers to facilitate efficient and timelyservice provision.

  Complete by 12/2023

Objective 2: Provide support and services to kinship caregivers.

Key Activities:

- Share information about KCSP & RAP (as limited KCSP/RAP resources allow).
- Provide services & supports to Kinship / RAP caregivers (e.g., help with emergent supplies, car seats, cribs, children's school supplies, etc.).

  Complete by 12/2023

Objective 3: Work towards expansion of out of home respite options for caregivers

Key Activities:

- Survey local facilities to ascertain their interest / capacity to provide out of home respite through an O3A contract.
- Provide technical support and assistance to facilities interested in contracting to provide out of home respite care.

Complete by 12/2023

Objective 4: Develop more local resources supporting families impacted by dementia.
Key Activities:

- In partnership with the local Alzheimer's Association, facilitate increased training opportunities for support group leaders at community level.
- In partnership with the local Alzheimer's Association, facilitate increased training opportunities to help O3A staff recognize dementia and appropriately assist clients and their families.
- Refer caregivers from MAC, TSOA and FCSP to Alzheimer's Disease support groups.
- Publicize dementia support groups through local, on-line and social media.
- Explore methods/strategies to encourage our region to become a Dementia Friendly PSA, including supporting expansion of the Memory Café model, and "Meet me at the Movies".
  Complete by 12/2023

C – 2.2: Goal: Continue to build supports through MAC and TSOA programs for family caregivers and individuals without a caregiver.

Objective 1: Conduct robust outreach to community partners about these programs to encourage referrals.
Key Activities

- Develop/implement an annual outreach plan, refine as needed.
  Complete by 12/2023

Objective 2: Continue to develop network adequacy.
Key Activities

- Develop a network adequacy profile each year.
- Identify potential contractors and provide technical support throughout the Medicaid enrollment process, the initial client service period and beyond.
  Complete by 12/2023

C - 2.3: Goal: Older Adults and adults with disabilities and unpaid caregivers are assisted to make informed decisions about access services they need to remain independent and in their own homes.

Objective 1: Inform older adults, families, other consumers about existing health and long-term care options and provide assistance to access.

Key Activities:

- Offer ongoing, high quality Information and Assistance (I&A) program throughout the region according to standards.
- Support I&A services and staff with training to maintain AIRS and CIR-S certification.
- Coordinate with local community partners to provide coverage with responsive services and current information on alternatives.

  Complete by 12/2023

Objective 2: Participate in local and regional community coordination activities leading to stronger service networks for vulnerable clients.

Key Activities:

- Continue participation in Accountable Communities of Health regional networks.
- Continue participation in local and regional program coordination efforts, e.g., Regional Transportation Providers Organizations; regional home care agency coordination meetings.
- Continue to support local Senior Provider meetings to share information.

  Complete by 12/2023

Objective 3: Increase utilization of Community Living Connections program for support services, resources, and data.

Key Activities:

- Train and support staff in utilization of CLC tracking options.
- Enter local resources into Listing Manager.
- Data Manager will explore options for using CLC effectively.
- Complete annual NAPIS report in a timely manner.

  Complete by 12/2023

Objective 4: Collaborate on developing the Long Term Care Trust Act implementation Plan

Key Activities:

- Identify emerging issues as details for this program are developed, collaborating with frontline staff to understand program impacts on O3A work, and provide feedback to ALTSA and LTCTA Planning Commission.
- Work with Washington Association for the Area Agencies on Aging (W4A) to provide feedback on ideas which emerge from the Planning Commission.
- Participate on subcommittees as requested.

  Complete by 12/2023

C – 3: Aging in Place (Person-Centered Home and Community-based Services)

Supporting People to Age in Place in their Homes[48]

Washington is a national leader in offering home-and community-based Long Term Services and Supports (LTSS) for people with significant disabilities under the Medicaid program. Washington residents can choose to receive support in adult family homes, assisted living, their own homes, or a nursing home. As would be expected, about 72% choose to receive care in their homes, either from an agency or an individual provider of their choosing. To make that choice viable it has been essential that Washington's in-home program has grown in its capacity to support people with moderate to severe physical limitations as well as those who are medically complex, and often accompanied by significant behavioral and cognitive challenges.

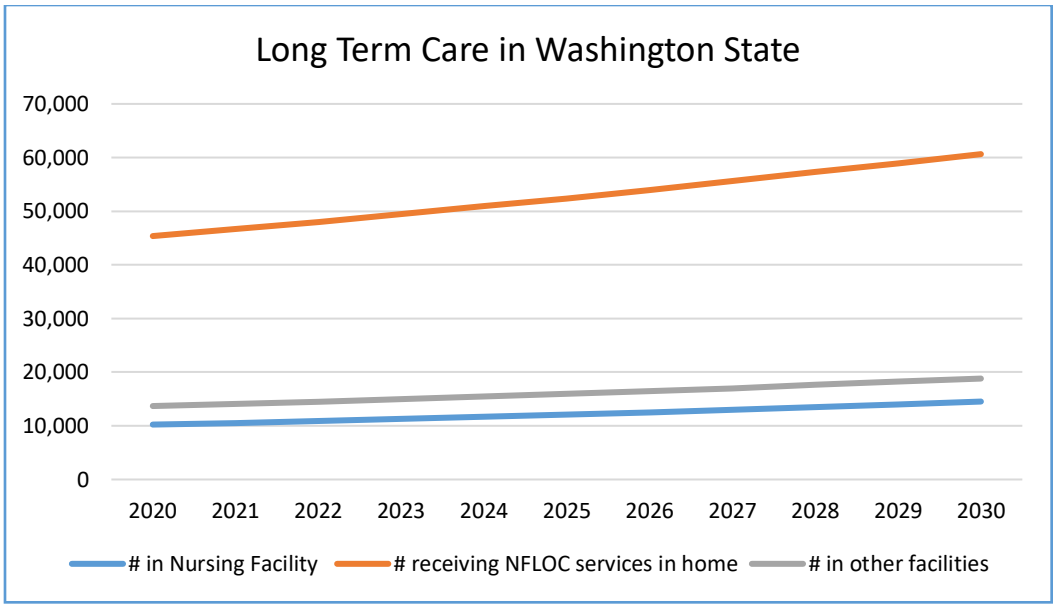
Not only is in-home care the preferred LTSS option, it is the most cost-effective. There is a wide range of services and hours of service authorized for individuals receiving care in their homes. However, the costs for home care services are significantly lower compared to over $5,000 to $9,000 or more per month for care in a nursing facility. In-home care makes more efficient use of funding over the cost of full 24/7 complete care; it supplements what individuals and families can do for themselves with intermittent, paid, gap filling services supports. To ensure success and safety, plans of care are tailored to each situation because each individual and family differs widely in what they can do for themselves.

As the following chart demonstrates, statewide there are over 45,000 people in the in-home and community-based portion of Washington's Medicaid LTSS system who face a broad range of challenges to their health and independence. All need assistance to accomplish daily activities such as bathing, dressing, preparing meals, personal hygiene, and moving around the home.

In the O3A service region, there are approximately 2,351 people receiving services through the Medicaid LTSS system. Of these, approximately 1,703 receive services in their homes; 398 are receiving services in a skilled nursing facility, and 250 in other community residential facilities.

The number of facilities that accepts Medicaid clients in the service region is limited, which in turn limits the option for people who wish to remain in their communities when their need for services cannot be met through in home care.

[48] David Mancuso, PhD., Jingping Xing, PhD., Forecasts of the Aging Population, Dementia Prevalence and Use of Long-Term Care Services through 2030 in Washington State; Office of Financial Management, WA State, 2019. (includes chart on next page).



Washington State Long-Term Care Assessment by Setting and Acuity

Supporting people of all acuity levels in community- based settings is key to accommodating the growing population.

In-Home Care

Community-based in-home care services effectively support people with disabilities and self-care limitations, regardless of income, who wish to remain in their own homes. Approximately 80% of care provided in the home is performed by 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 completely. These people often receive additional home care from paid home care workers.

On a monthly basis, O3A manages Medicaid LTSS services for about 1,700 people receiving in home care. On an annual basis, with turnover, O3A supports about 2,150 people over the course of a year. After assessment, they receive an individual plan that authorizes personal care help with activities of daily living, including personal care tasks such as bathing, toileting, and personal hygiene, mobility, such as encouragement walking, transferring from bed to wheel chair; housekeeping, laundry, and meal preparation; and trips to the doctor or for essential shopping.

Beyond what is directly authorized for payment, the case management team (which includes nursing and social services professionals) helps people access healthcare and other services in the community. To monitor care and maintain safety of this very vulnerable population, the case manager does home visits and maintains contact with family and providers to monitor the effectiveness of the plan of care.

Once the client has received an assessment and the case manager has authorized services, home care workers are engaged to support clients in their homes with the activities of daily living. Some qualified home care workers are trained to perform medical tasks such as insulin injection or wound care under the supervision of a registered nurse. In addition, clients may receive other supportive services, such as nutritional counseling to help a diabetic client learn to make better food choices; or a walker to support safer ambulation.

Within the O3A service region, paid home care is available from about 2,200 caregivers employed as individual providers (1,400) or as an agency home care workers (over 760) from seven agencies. Individual providers are contracted by O3A on behalf of the state, though the O3A Home Care Referral Registries, which recruit and support paid caregivers to receive health insurance benefits, training and certification.

Referral Registries also provide support for family caregivers who wish to transition to a paid career in caregiving.

Increasing caseloads & impact on the case management system

The O3A in-home service caseload is increasing in size, complexity, and acuity, consistent with the state-wide trends and reflecting pressures from the regional demographic shift towards proportionately more older adults.

Within the O3A Medicaid caseload, the number of younger adults with disabilities (aged 18 and over) is similarly increasing. Younger clients tend to need more support from the case manager to deal with "quality of life" needs such as increased mobility and communication needs. In addition, younger clients rely on LTSS for longer periods due to increased longevity.

Increasing clients' clinical complexity

The increasing medical, cultural, and health complexity of client care will present even more challenges in the future, requiring successfully blending medical, behavioral health and social supports within available funding limits. Currently, O3A combines case management and nursing service expertise in order to respond to individual client situations requiring more complex chronic care support planning, coordination, and more attentive ongoing management.

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.

The proportion of people with disabilities who also have self-care limitations increases in the 65-plus age groups, and the prevalence of these limitations increases sharply for people who are 75-and older. 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 disabilities for older adults have declined overall, the older adult population with less education and lower income generally has not yet experienced these improvements.

As funding for mental health services has been reorganized and/or reduced state-wide over the last few years, case management staff has reported that the number of people with disabilities related to mental health issues has increased. Western State Hospital losing its CMS accreditation and federal funding has only exacerbated the issue. They report that although these clients generally qualify for fewer in-home service hours than other clients, they present with behavioral needs that tend to require more time care planning from case management staff.

Workforce and Provider Constraints

Not surprisingly, the work force on the Olympic Peninsula is older than many other areas in the state with many providing care for many years; younger workers are leaving the Peninsula to pursue education, employment, and housing. In addition, many older workers also find themselves providing care to an elder parent, spouse, sibling, or even an adult child. With younger adults leaving the area there is a concern about who will provide the care needed by older adults and people with disabilities.

The lack of qualified home care workers can be a challenge to service provision in some difficult-to-serve areas within the O3A service region. Agencies often struggle with having enough staff available, plus finding staff who will drive to far rural areas, and the small volume of clients in these areas makes it costly for agencies to provide the required supervision and to ensure that sufficient substitute caregivers are available when needed. The O3A home care contract requires agencies to serve at least a two-county region, for example an agency cannot elect to just provide service in Grays Harbor, with a higher client volume, but must also serve clients in Pacific county, with a lower number of clients. It is difficult, however, for agencies to serve an area if they cannot get workers there.

Individual Providers

Even with the support provided by the Home Care Referral Registries, finding individual providers able to qualify for an IP contract can also be an issue, whether because of background checks or to the lack of training and testing opportunities available to home care workers in rural areas during their first 200 days.

Individual providers must pass a thorough, criminal background check, which further limits the pool of available providers. This can have a significant impact on paid family caregivers who give up their jobs to provide care to a family member, and need some form of compensation to make up for the lost wages.

Once a person has been deemed eligible to receive Medicaid-funded in-home care, services must begin within 30 days, or the enrollment process repeats. If a suitable agency or individual caregiver is not available to provide home care, the client risks going without care in the home, having to repeat the enrollment process, or having to move from the area. Individuals who are not eligible to receive Medicaid services can pay privately for an agency caregiver, if that is an option for them.

Agency Providers

In recent years, home care agencies have experienced significant challenges in providing in-home services with an end result of reimbursement rates not keeping pace with increasing costs. This is due to a number of factors:

- The dramatic increase in transportation costs for service providers, especially in our rural region where it is not unusual for clients to have to travel more than 100 miles in a month for services and medical appointments
- Changes in federal regulations and state payment systems are making it difficult for smaller agencies and providers to afford the contract requirements, thus further limiting client choice
- Lack of economies of scale (e.g., caseload size in large rural areas in relation to required administrative structure)
- 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
- Insurance coverage for service providers has become more expensive as insurance companies have associated higher risks with providing services to an aging population

Contracting for Home Care Services

O3A presently contracts with a variety of local providers for services tailored to meet individual client needs, for example, with behavioral health issues, including coaching and development of coping skills, nutritional counseling, and skilled nursing. However, the pool of qualified providers is limited within the region, and increasingly complex contract requirements combined with a relatively low volume of clients dispersed over a wide geographic region significantly constrains more providers from pursuing contracts.

O3A contract managers work with case management personnel from Home and Community Services (HCS) and within O3A to recruit and contract with providers for services. O3A contract managers and case management staff meet regularly to discuss concerns, issues, or questions regarding home care and other services. O3A meets at least annually with other case

management staff and home care agencies throughout the region to discuss issues affecting service to clients.

O3A staff also provide technical assistance to contractors as they prepare and navigate new databases, payment systems, and changes in contract or service requirements. For smaller providers in particular, this is an essential service that helps them to be able to continue to provide services to our clients.

O3A contract managers participate in meetings convened by ALTSA program staff, and other AAAs, to work on the home care statement of work, discuss implementation of new requirements, e.g., training and certification for home care workers, and share information.

Ensuring Compliance

O3A undergoes performance reviews both internally and externally in order to provide quality assurance and ensure compliance with contract requirements.

O3A case management services are assessed annually for quality assurance by ALTSA staff, and O3A collects and submits metrics approved by the Washington Association of Area Agencies on Aging and mandated by the legislature to measure service delivery outcomes.

O3A contract management staff monitor performance of each contracted home care agency in annual, on-site visits, to ensure compliance with contract requirements. In addition to the on-site visit, staff carry out routine desk monitoring, and provide regular technical assistance.

Contracted providers for other client services provided through Medicaid Waiver programs are also assessed against contract requirements, which include routine desk monitoring and can include annual site visits. As compliance and/or service issues arise throughout the contract period, O3A communicates with the provider to resolve the issue. Desk monitoring is carried out throughout the year for all contracts by O3A staff.

O3A contract managers also participate in ALTSA working groups in the development of revised contract monitoring requirements and contract statements of work as necessary.

Community First Choice

As increasing caseloads continue to exert pressure on available funding, how and what services are delivered to clients will be affected as the case management model is streamlined. The Community First Choice (CFC) program emphasizes client self-management and prevention, and shifts more responsibility to the client; outcomes measures will include an emphasis on client self-efficacy, in addition to service utilization indicators.

To meet CFC service requirements for person-centered planning, case managers need to coordinate services for individual clients across service systems, e.g., with behavioral health and chemical dependency service agencies.

Health Homes

With funding from the centers for Medicare and Medicaid Services (CMS) Washington State implemented a plan that integrated care for beneficiaries who are eligible for both Medicaid and Medicare services, often referred to as 'dual eligible' or 'duals'. The plan is designed to reduce the fragmentation and complexity of the current system and streamline the process for eligible clients to access appropriate health care when they need it.

The Washington Health Home program to improve cross-sector care coordination is modeled on a pilot that was shown to have positive effect on health (including mortality) while at the same time lowering inpatient hospital costs and overall health costs in general. The pilot (in which O3A participated) provided frequent face-to-face contact with cost-high risk clients, facilitated exchange of information among the wide range of their providers, connected them to the community social service supports, and used patient education and behavior changing techniques such as motivational interviewing to empower clients to take better charge of their health and use of healthcare series.

The Health Home program is targeted to individuals enrolled in Medicaid or dually eligible for Medicare and Medicaid and who constitute the top 20% of high-health risk, high-cost, clients who could benefit from care coordination services across multiple provider types.

Health Homes Coordination

Between 2005 and 2012, the Olympic Area Agency on Aging participated Washington State Chronic Care Management (CCM) pilot program which resulted in statewide savings of $2.5 million in medical costs with an intervention cost of only $1.7 million (DSHS Research and Data Analysis Division, February 2014). The current Health Homes program model builds on the success of the CCM pilot and expands access to all high-risk Medicaid beneficiaries.

Health Home Services

As defined by CMS, a Health Home provides six specific services beyond the clinical services offered by a typical primary care provider. The Washington Health Home network offers:

- Comprehensive care management;
- Care coordination and health promotion;
- Comprehensive transitional care and follow-up;
- Patient and family support;
- Referral to community and social support services; and
- Use of information technology to link services, if applicable.

The Health Home program emphasizes person-centered care that places the beneficiary in a pivotal role. The beneficiary is involved in improving their health through the development of an individualized Health Action Plan (HAP). Beneficiaries may choose to include their families, caregivers, or others as part of their Health Team. Each beneficiary is assigned a Care

Coordinator (CC) who provides health coaching, community and health care service referral assistance, and care coordination to link efforts of the medical, behavioral health, substance abuse, long-term services and supports, and community social service delivery systems together to meet the beneficiary's identified healthcare needs in a coordinated manner. CCs help the beneficiary to establish health goals and then work with them to assume greater levels of responsibility and confidence in the management of their own healthcare conditions which is critically important for individuals with chronic illness.

Health Homes Lead

The Health Homes program is an important building block in Washington State for innovation models promoting health, preventing and managing chronic disease, and controlling health care costs. As a Health Homes CCO, O3A coordinates services for individual clients including behavioral health specialists, local community-based providers and community health centers.

In February 2019, when a managed care organization discontinued serving as a Health Homes Lead, O3A became a Health Homes Lead to both provide care coordination for eligible long-term care clients within the O3A service region; and to also recruit and contract with other organizations willing to serve as a Health Homes Care Coordination Organizations (CCOs) throughout a five county region (O3A's four county service region plus Kitsap County). As a Health Homes Lead entity, O3A has the responsibility to expand this program to other high medical need populations such as those with Substance Use Disorders and those with Behavioral Health Disorders. As of August 2019, O3A has contracted with two organizations and one tribe, and is working to contract with three to five more organizations across the five counties.

C – 3: GOALS AND OBJECTIVES – AGING IN PLACE

Problem/Needs Statement: Older adults with complex chronic illnesses require specialized medical and social support to age in place while maintaining client choice and dignity. Coordination of these multidimensional services is critical to their success. Increasing demand for services will require continued development and support of a workforce of professional and unpaid caregivers, a robust network of contracts, as well as O3A staff to support coordination of those services. Multiple pressures impact this work including increasing complexity of care needs, population growth of older adults, lack of an adequate caregiver workforce, lack of contract resources in rural counties, and need for training.

C – 3.1: Goal: To provide person centered coordination of health and community supports for increasing numbers of people who face significant health challenges in a manner that improves their health and reduces avoidable care costs.

Objective 1: Maintain O3A staffing and service capacity to provide a personally designed (person-centered) care plan and care coordination services to clients throughout the region that achieves service levels and high quality of service delivery.

Key Activities:

- Recruit and contract local agencies & providers to meet client needs for Medicaid-funded services identified by case managers.
- Implement all staff training programs required during 4 year cycle
- Procure contracted services that meet needs identified for Medicaid clients by case managers.
  Completed by 12/2023

Objective 2: Build Health Home program.

Key Activities

- Deliver quality services as a CCO to long-term care clients, including expanding program as resources allow.
- Develop expanded Care Coordinating Organization network contracts for improved network adequacy.
  Completed by 12/2023

Objective 3: Implement training for O3A staff and community partners to promote better understanding for personalized (person-centered) services.

Key Activities:

- Implement Trauma Informed Care Training for entire O3A staff and potentially community partners as staffing allows.
- Consider / implement other trainings for staff and /or community partners e.g., Mental Health First Aid, SAFEtalk, maintaining personal safety with higher risk clients.

- Provide logistics and coordination for training venues.
  Completed by 12/2023

C – 3.2: Goal: At risk populations including Native American, Hispanic, other minorities, LGBTQ, low income, & more elders living in more remote conditions have equitable access to services. (Equity goals)

Objective 1: Promote access to services in remote areas.
Key Activities:

- Advocate for adequate resources and programs in rural areas and for at risk populations.
- Identify at risk populations and effective mechanisms to reach them, share information about O3A with them, and remove barriers in serving them.
  Completed by 12/2023

C – 3.3: Goal: Adequate workforce available to serve the aging population.

Objective 1: Advocate for training programs in local educational institutions.
Key Activities:

- Contact local high schools and community colleges to encourage implementation of Home Care Aid (HCA) training/certification program, and develop partnerships for this program with Home Care Agencies and Home Care Referral Registry/Consumer Directed Employers.
- Until the Consumer Directed Employer (CDE) program is launched, continue to recruit and contract with individual providers through the O3A Home Care Referral Registries; ensure caregiver requirements are met, including certification and training.
  Completed by 12/2023

Objective 2: Continue to advocate for sufficient support for provision of services across the AAA network in the state and particularly in the remote, rural areas.
Key Activities:

- Advocate for issues affecting rural areas related to new initiatives on the horizon and emerging issues in the future including Electronic Visit Verification and Consumer Directed Employer.
- Ensure that revenue from case management and care coordination contracts adequately supports O3A level of effort.
  Completed by 12/2023

C – 4: PARTNERSHIPS WITH TRIBES

Within the O3A region, there are 8 federally recognized tribes. While Chinook is not a federally recognized tribe, O3A works with the community of Bay Center to address needs of elders in that community.

O3A has historically focused on building a good relationship with the tribes in our region. O3A staff are often invited to elders' luncheons, Wellness Fairs, and other events. This has helped to build positive relationships so that tribal staff and elders are comfortable calling O3A for information and seeking services through O3A.

The proximity of the tribe can also have an impact on the relationship. When the tribe is located further away from O3A office locations, frequent visits are more difficult and other mechanisms to build partnership may work better. For example, establishing one trusted O3A staff person identified to receive all referrals, who then arranges to introduce the elder to the most appropriate direct services staff, as is done with the Chehalis Confederated Tribes. Sometimes this referral process also includes a tribal staff member further helping to reassure the tribal elder.

Following are the eight most current 7.01 plans for each tribe in our region.

Policy 7.01 Confederated Tribes of the Chehalis Reservation

Olympic Area Agency on Aging (O3A)

Biennium Timeframe: January 1, 2018 to December 31, 2019

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 October 2018
1) Goals/Objectives	**(2) Activities**	**(3) Expected Outcome**	**(4) Lead Staff & Target Date**	**(5) Current Status**
1. Continue outreach to the Chehalis Tribe	○ Meet with tribe's representatives to develop / update 7.01 policy plan. ○ Ensure current outreach assistance is continued & explore expanding support and coordination assistance with the Chehalis Tribe as available O3A resources allow. ○ Meet with tribal representatives to discuss elder issues as requested. ○ Ensure tribal issues are considered in agency planning, training and project development. ○ Ensure tribal elders and staff are aware of access to resources and planning by visiting or calling local O3A Information and Assistance Office; calls can be made by elder or others on behalf of elder.	○ Tailored updated 7.01 plan in place between O3A and Chehalis Tribe ○ Enhanced access to culturally relevant services for tribal elders. ○ Increased collaboration with local tribes and community partners to assure access to appropriate services. ○ Elders, family members and staff are able to more easily identify resources and plan for elders' needs.	Roy Walker, Executive Director, 360.379.5064 walkerb@dshs.wa.gov Mark Harvey, Regional Director, 360. 461.5230 harvemb@dshs.wa.gov Jody Moss, Contracts Management & Planning Director, 360.379.5064 mossjm1@dshs.wa.gov José Caywood, Chehalis Director, jcaywood@chehalistribe.org 360.709.1777 Roxanne Dreier, Social Worker for Adult Protective Services rdreier@chehalistribe.org 360 810-1350 O3A Advisory Council (AC) Tribal Rep I&A Offices–call for address: Aberdeen 360.532.0520 800.801.0060 Raymond 360.942.2177 888.571.6557 Long Beach 360.642.3634 888.571.6558 Timeline: 1/1/2018–12/31/19	1. Met with Chehalis staff on 3/9/18. Draft 7.01 Plan completed and subsequently approved. Between 3/9 and 9/30/18, O3A has had multiple contacts with Chehalis, discussing potential contract opportunities, including a phone call meeting to discuss, adult day care, environmental modification and home care contracting. Chehalis tribe has reached out to O3A to link members with services and to request O3A staff participate in Health Fair, and provide a SHIBA Clinic. O3A routinely shares multiple tribal / other grant opportunities with tribes via tribal contact list.

2. Improved caregiver training and support options for unpaid family caregivers and for paid caregivers serving tribal members for interested tribes. (While Chehalis does not have a formal caregiver program, O3A would want to connect any caregivers needing support to services.)	○ Improve coordination between AAA Title III and Tribal Title VI Caregiver Support Programs ○ Identify unpaid family caregivers through family caregiver support programs* and tribal social service referrals and support Tribal caregivers to obtain respite, training and other forms of support. ○ Through partnerships with tribal staff, Identify tribal members interested in becoming paid caregivers and provide referrals for training** and becoming an independent provider or for working for a home care agency. ○ Include Tribal caregivers in Home Care Referral Registry (HCRR)*** training and referral activities.	○ Coordinated Title III and VI resources are maximized, resulting in improved dissemination of best practices, available resources, information sharing and provision of technical assistance. ○ Increased resources for and capacity of family caregivers to support their loved ones in their homes for as long as possible. ○ Tribal capacity for accessing and/or providing training to Tribal members interested in becoming caregivers. Tribal caregivers are able to access training and potential employment in a timely manner. ○ Increased number of Tribal caregivers	O3A Planning & Program Mgmt. staff Jody Moss Contact Mark Harvey to link to services (360) 461-5230 harvemb@dshs.wa.gov *Family Caregiver Support Program – Eric Nessa 360.538.2450/866.582.148, nessaem@dshs.wa.gov *Renee Iverson MAC/TSOA services (360) 538-2447 sheflrm@dshs.wa.gov **Catholic Community Services – Caregiver Training - Robin Gibson; robing@ccsww.org; 360.417.5420 *** Ann Peterson, Supervisor, Home Care Referral Registry, peteram@dshs.wa.gov, 360-538-2449 Timeline: 1/1/2018 – 12/31/2019	3/1/18: Shared Nisqually Caregiver training conference opportunities with tribal contact list. O3A continues to provide resources to all tribal caregivers/family members/others who call for assistance. 5/3/18: Met via phone call with Chehalis Social Service Staff to discuss process for developing a home care contract Provided information and an introduction between O3A and Robin Gibson regarding Home Care agency caregiver training. Provided information about MAC and TSOA programs to staff. Over course of spring/summer 2018, Chehalis staff and O3A staff and Hillarie Hauptmann had several conversations/email on developing a process for encouraging and supporting unpaid family caregivers to seek services through O3A.
3. Enhanced services / support for Tribal grandparents / other elders raising children	○ Increase outreach efforts, particularly for remote communities and Tribal reservations, to inform families of the resources available for relatives raising children.	○ a. Tribal grandparents & other elders raising children gain additional and often critical support through Relatives as Parents/Kinship Care Support programs.	Mark Harvey/ Eric Nessa, O3A Kinship Care Support Program and Relatives as Parents Delivery staff, 360.538.2450/866.582.148 nessaem@dshs.wa.gov Timeline: 1/1/2018 – 12/31/2019	Provided information about KCSP and RAP programs to Chehalis staff. Over course of spring/summer 2018, Chehalis staff and O3A staff and Hillarie Hauptmann had several conversations/email on developing a process for encouraging and supporting unpaid family caregivers to seek services through O3A. Chehalis Tribe developed a

				process utilizing tribal staff to help tribal members make connections for KCSP/RAP services.
4. Improved Tribal access to health and nutrition education and program services to the extent resources allow.	○ Through nutrition contracts with local providers, promote inclusion of local tribal elders in nutrition education programs. ○ Share useful resources between tribes and nutrition providers such as printed education material and 1/3 RDA approved menus.	○ Tribal elders participate in programs implemented by local health / nutrition education providers. ○ Capacity for local tribes and regional nutrition providers is increased by sharing ideas and material; more elders receive better information around health and nutrition.	O3A Planning & Program Mgmt staff Tribal Nutrition Providers Coastal Community Action Program, Nutrition Services, Staff TBD 360.500.4530, Timeline: 1/1/2018 – 12/31/2019	Two staff members attended Chehalis Health Fair and presented information regarding O3A resources. Shared menus from Community Action Program Nutrition contractor with tribal email list. SHIBA Clinic provided for Chehalis in October 2017. Shared menus from CAP nutrition contractor with tribal email list.
5. Improved access to health and support services for Tribal elders.	○ Increase coordination between the Area Agency on Aging and Tribal representatives to facilitate access to local services—especially health care-- for Tribal Elders. ○ As funding opportunities permits, Jody Moss will coordinate with Chehalis staff to access to prevention program funding (Savvy Caregivers, Powerful Tools for Caregivers, Wisdom Warriors, fall	○ Tribal issues are represented in local community, county planning efforts. ○ Tribal needs are considered and addressed by local service providers, resulting in increased access to services.	Mark Harvey; Regional Director Jody Moss, Planning Director O3A Planning & Program Mgmt staff 2018 - 2019	Shared information on available O3A Evidence Based grants, including Powerful Tools, CDSMP and SAIL Leadership training opportunities through tribal email contact list. This resulted in 3 members of Chehalis staff/tribe attending a SAIL training and an application for an Evidence Based Grant which has just been awarded.

	prevention programs), etc. for elders.			
6. Strengthened O3A and tribal partnerships.	○ Notify tribal staff when recruiting tribal representation on O3A Advisory Council. ○ Notify tribes when O3A staff positions are open. ○ Routinely consult with tribal outreach (O3A direct service) staff re: O3A response to tribal issues. ○ Ensure contracting mechanisms support productive tribal partnerships.	○ Partnerships between O3A and region tribes result in more responsive service and program development. ○ Tribal members have opportunities for employment; O3A becomes more diverse and representative of the community we serve ○ Contract instruments are responsive to tribal administration capacity.	AC Tribal Representative Designated O3A Program Management and Service Delivery staff O3A leadership 2018- 2019	O3A is in the beginning stages of recruiting a new tribal representative. This will be marketed to all tribes in our region via tribal contact email list. Tribal staff is routinely notified of O3A staff openings.
7. Improved access to transportation for Tribal Elders with special needs.	○ Facilitate Tribal representation in local planning and coordination efforts and regional transportation coalitions (RTPO & local transportation initiatives if known). ○ Volunteer Transportation program is accessible to all members over age 60. ○ Tribes can identify a tribal volunteer driver(s) if they wish who would become a volunteer with the volunteer transportation program and could be reimbursed per mile driven for	○ Local planning efforts are responsive to transportation needs of Tribes. Promote increased options for transportation for Tribal Elders with Special needs. ○ Volunteer transportation provider will complete a resource presentation to the Tribe if requested. ○ Tribal volunteer drivers expand transportation capacity for Elders over 60. (note that this age limitation is determined by fund source – Older Americans Act)	Jody Moss – O3A Planning Director Tribal Social Services Director Tribal Elders Liaison Grays Harbor Jennyk@coastalcap.org, 360.500.4524 Pacific Abbi Quigg, Volunteer Chore Services AbbiQ@ccsww.org 360.637.8563.ext113 Timeline: March 2018 By December 2018 (if requested by Chehalis Tribe)	RTPO has not yet met since fall 2016. Contacted Jenny Knutson, CCAP to verify her willingness to work with tribes to develop tribal transportation volunteers. Jenny responded that she would love to work with tribal volunteer drivers.

	qualified transport services.			
8. Assist Chehalis Tribe if interested, to develop contracts available in 2018 (for example, Adult Days Services, Home Care Agency, Environmental Modification and others).	○ Notify tribe of option to contact O3A to help develop services/contracts ○ Provide technical assistance as needed ○ Assist with first series of contract monitoring visits as needed.	○ Communication between O3A and tribe results in awareness of new service options, and strengthens O3A's relationship with Chehalis Tribe ○ Expands culturally relevant services to tribal elders ○ Strengthens and improves the quality and cultural relevancy of services provided through tribal contracts.	AC Tribal Representative Jody Moss Mark Harvey Designated O3 Program Manager, and O3A Services Delivery staff 2018-2019	3/9/18 and 5/9/18: Met with Chehalis social service staff about developing elder social service programs for which they may want to become tribal contractors with O3A. Discussed Environmental Modification, Adult Day Care, Caregiving and other contracts for services they may already be providing without payment. Chehalis is interested in pursuing contracts, and has a grant funded staff member working closely on this.

Policy 7.01 Hoh Plan – Draft ***December 2018***

Olympic Area Agency on Aging (O3A)

Biennium Timeframe: January 1, 2018 to December 31, 2019

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Implementation Plan				Progress Report October 2018
(1) Goals/Objectives	**(2) Activities**	**(3) Expected Outcome**	**(4) Lead Staff & Target Date**	**(5) Current Status**
1. Continue current outreach assistance to tribal members; develop updated tailored 7.01 plans with the Hoh Tribe.	○ Meet with tribe's representatives to clarify/ update 7.01 policy plan. ○ Ensure current outreach assistance is continued & explore expanding support and coordination assistance with Hoh Tribe as available O3A resources allow. ○ Meet with tribal representatives to discuss elder issues as requested. ○ Ensure tribal issues are considered in agency planning, training and project development. ○ Ensure tribal elders and staff are aware of access to resources and planning by visiting or calling local O3A Information and Assistance Office; calls can be made by elder or others on behalf of elder.	○ O3A and Hoh Tribe's relationship is strengthened leading to better communication and more opportunities for partnerships. ○ Enhanced access to culturally relevant services for tribal elders. ○ Increased collaboration with the Hoh Tribe and community partners to assure access to appropriate services. ○ Elders, family members and staff are able to more easily identify resources and plan for elders' needs.	Roy Walker, Executive Director, 360.379.5064 walkerb@dshs.wa.gov Mark Harvey, Regional Director, 360. 461.5230 harvemb@dshs.wa.gov Jody Moss, Contracts Management & Planning Director, 360.379.5064 mossjm1@dshs.wa.gov O3A Forks office staff: Char Carte - 360.374.9496 carteci@dshs.wa.gov, Susie Brandelius - 360.374.9496, brandcs@dshs.wa.gov Hoh Tribe Representatives: Bob Smith, ED, bob.smith@hohtribe-nsn.org, 360.374.6501, 360.780.0280-c Lola Moses, Family Services Dir. lola.moses@hohtribe-nsn.org, 360.374.5037 O3A Advisory Council Tribal Rep Brenda Francis Thomas, francBD@dshs.wa.gov, (360) 565-2203	○ Met with Hoh Tribe – Bob Smith and Tara Sexton on 4/30/18 and on October 10/3/18 with Lisa Martinez (360.374.6277) and Eugene Barrigan to develop/ update plan. ○ Assured that Char Carte and Susie Brandelius are aware of plan and context. ○ 2016, 2017, & 2018 – O3A staff attended Money Follows the Person and made contacts with tribes in attendance. ○ O3A staff readily available to meet with Hoh as invited and always available to answer individual or more general resource questions. ○ Over past two years a number of referrals for services for individuals have been made. ○ O3A routinely shares multiple tribal / other grant opportunities with tribes via tribal contact list. ○ O3A has attended the Hoh Health Fair whenever invited. ○ O3A attended the Hoh Elder Center Grand Opening and gave a short presentation on O3A services.

			I&A Offices–call for address: Sequim 360.452.3221 800.801.0070 Forks 360.374.9496, 888.571.6559 Timeline: Review Annually	
2. Improved caregiver training and support options for unpaid family caregivers and for paid caregivers serving tribal members (if interested/requested).	○ Improve coordination between AAA Title III and Tribal Title VI Caregiver Support Programs ○ Identify unpaid family caregivers through family caregiver support programs and tribal social service referrals and support caregivers to obtain respite, training and other forms of support. ○ Provide information and support for tribal members to access the Medicaid Alternative Care and Tailored Supports for Older Adults (MAC & TSOA) Programs ○ With help from Hoh Tribe staff, identify tribal members interested in becoming paid caregivers and provide referrals for training to become an independent provider or a home care agency worker.	○ Coordinated Title III and VI resources are maximized, resulting in improved dissemination of best practices, available resources, information sharing and provision of technical assistance. ○ Increased resources for and capacity of family caregivers to support their loved ones in their homes for as long as possible. ○ Hoh Tribe capacity for accessing and/or providing training to Tribal members interested in becoming caregivers. Hoh Tribe caregivers are able to access training and potential employment in a timely manner. ○ Unpaid family caregivers of elders receive additional services to support them in caregiving and help sustain services in the home for as long as possible.	O3A Planning & Program Mgmt. staff Mark Harvey Susie Brandelius Timeline: On Demand	○ Shared Nisqually Caregiver training conference opportunities with tribal contact list. ○ O3A continues to provide resources to all tribal caregivers/family members/others who call for assistance.

	○ Include Tribal caregivers in Home Care Referral Registry training and referral activities.	○ Increased number of Tribal caregivers available to deliver home care services to elders		
3. Enhanced services / support for Tribal grandparents / other relatives raising children	○ Increase outreach efforts to inform families of the resources available for relatives raising children.	○ Tribal grandparents & other relatives raising children gain additional and often critical support through Relatives as Parents/Kinship Care Support programs.	O3A Kinship Care Support Program and Relatives as Parents program staff: Susie Brandelius Timeline: On Demand	○ O3A provided an overview of services during 7.01 meetings and at other times and will continue to provide these resources as clients call or are referred. In fact, the majority of O3A's KCSP and RAP services are provided to tribal families. ○ At Hoh Elder Center Grand Opening, shared several free passes to Seattle Aquarium to be given to grandparents raising grandchildren.
4. Improved Hoh Tribe access to health and nutrition education and program services to the extent resources allow.	○ Through nutrition contracts with local providers, promote inclusion of local tribal elders in nutrition education programs. ○ Share useful resources between Hoh Tribe and nutrition providers such as printed education material and 1/3 RDA approved menus.	○ Tribal elders participate in programs implemented by local health / nutrition education providers. ○ Capacity for Hoh Tribe and regional nutrition providers is increased by sharing ideas and material; more elders receive better information around health and nutrition.	O3A Planning & Program Management staff Tribal Staff Kim Redmond, OlyCAP – (360) 301-6394 kredmond@olycap.org Timeline: Review Annually	○ Shared information about Senior Farmers Market Program. At time, no local site for produce was available. ○ Note: new site is available in 2018 at Sarge's Place Farmers Market in Forks. ○ Shared information on available O3A Evidence Based grants, including Powerful Tools, CDSMP and SAIL Leadership training opportunities through tribal email contact list. ○ Shared menus from Community Action Program Nutrition contractor with tribal email list.
5. Improved access to health and support services for Tribal elders.	○ Increase coordination between the Area Agency on Aging and Tribal representatives to facilitate access to local services—especially health care-- for Tribal Elders.	○ Tribal issues are represented in local community, county planning efforts. ○ Tribal needs are considered and addressed by local	Mark Harvey; Regional Director O3A Planning & Program Mgmt staff Timeline: Review Annually and On Demand	○ August 2017 – Attended Hoh Health Fair and spoke with 28 individuals about services available through O3A.

	○ Invite the Hoh Tribe to engage in the O3A Prevention programs	service providers, resulting in increased access to services.		
6. Strengthen O3A and tribal partnerships.	○ Notify tribal staff when recruiting tribal representation on O3A Advisory Council. ○ Notify the Hoh Tribe when O3A staff positions are open. ○ Routinely consult with tribal outreach (O3A direct service) staff re: O3A response to tribal issues.	○ Partnerships between O3A and the Hoh Tribe results in more responsive service and program development. ○ Tribal members have opportunities for employment; O3A becomes more diverse and representative of the community we serve	AC Tribal Representative Designated O3A Leadership, Program Management and Service Delivery staff Carol Ann Laase, O3A Human Resources – 360.379.5064, Lasseca@dshs.wa.gov Brenda Francis Thomas, DSHS Timeline: Review Annually	○ O3A staff met with Tara Sexton at the Hoh Tribe and shared numerous resources with her. Tara will take advantage of them as needed ○ O3A is recruiting a new tribal representative. This will be marketed to all tribes in region via tribal contact email list. ○ Tribal staff is routinely notified of O3A staff openings.
7. Improved access to transportation for Tribal Elders with special needs.	○ Facilitate Tribal representation in local planning and coordination efforts and regional transportation coalitions (RTPO & local transportation initiatives if known). ○ Volunteer Transportation program is accessible to all members over age 60. ○ The Hoh Tribe can identify a tribal volunteer driver(s) if they wish who would become a volunteer with the volunteer transportation program & could be reimbursed	○ Local planning efforts are responsive to transportation needs of The Hoh Tribe. Promote increased options for transportation for Tribal Elders with Special needs. ○ Volunteer transportation provider will complete a resource presentation to the Tribe if requested. ○ Tribal volunteer drivers expand transportation capacity for Elders over 60. (note that this age limitation is determined by fund source – Older Americans Act)	Jody Moss – O3A Planning Director Clallam Teri Wensits, Volunteer Chore Services, TeriW@ccsww.org, 360.417.5640 Jefferson Nancy Budd-Garvin, ECCHO, director@echhojc.org, 360.379.3246 Grays Harbor Jennyk@coastalcap.org, 360.500.4524 Pacific Abbi Quigg, Volunteer Chore Services AbbiQ@ccsww.org 360.637.8563.ext113 Timeline: 3/18 to 12/18 (if requested)	○ Spoke with Teri Wensits who stated she would be very happy to be able to serve tribal members if she had volunteer drivers who wanted to become trained/qualified to provide this service in the west Jefferson region.

	mileage for qualified transport services.			
8. Assist the Hoh Tribe if interested, to develop contracts (for example, Adult Days Services, Home Care Agency, Environmental Modification Transportation and others).	○ Notify Hoh Tribe of options to contact O3A to help develop services/contracts ○ Provide technical assistance as needed ○ Assist with first series of contract monitoring visits as needed.	○ Communication between O3A and the Hoh Tribe results in awareness of new service options, and strengthens O3A's relationship with the Hoh Tribe ○ Expands culturally relevant services to tribal elders ○ Strengthens and improves the quality and cultural relevancy of services provided through tribal contracts.	AC Tribal Representative Designated O3 Program Manager, and O3A Services Delivery staff Timeline: On Demand / Review Annually	○ Discussed contracting options with Bob Smith and Tara Sexton. There may be some interest in the Environmental Modification Contract as Hoh Tribe is currently helping elders with repair efforts.

Policy 7.01 Plan - Lower Elwha Klallam Tribe *(Draft - may not have been approved by LEKT Council)* *February 2018*

For Olympic Area Agency on Aging (O3A)

2018-19

Plan and Progress Report Due Dates: April 2 (Regional Plan submitted to Assistant Secretary
April 30 (Assistant Secretary Plan submitted to the Office of Indian Policy) of each year.

Implementation Plan			Progress Report	
(1) Goals/Objectives	**(2) Activities**	**(3) Expected Outcome**	**(4) Lead Staff and Target Date**	**(5) Status Update October 2018**
1. Continue current outreach assistance to the Lower Elwha Klallam Tribe.	○ Ensure current outreach assistance is continued and explore expanding support and coordination assistance as available resources allow. ○ Hold regular meetings with Lower Elwha to discuss Elder issues at least biannually. ○ Expand activities in this area through grants available. ○ Include Tribal Outreach staff agency planning, training and project development, and regular emails related to programs. ○ Ensure tribal elders and staff are aware of access to resources and planning by visiting or calling local O3A Information and Assistance Office; calls can be made by elder or others on behalf of elder.	○ Enhanced access to culturally relevant services for Tribal Elders ○ Increased collaboration with Lower Elwha and community partners to assure appropriate services for tribal elders. ○ Elders, family members and staff are able to more easily identify resources and plan for elders' needs.	Roy Walker, Executive Director, 360.379.5064 walkerb@dshs.wa.gov Mark Harvey, Director I&A/CM, 360. 461.5230 harvemb@dshs.wa.gov Jody Moss, Contracts Management & Planning Director, 360.379.5064 mossjm1@dshs.wa.gov Kelly Bradley, LEKT Social Services Director / Elders 360.565.7257 x. 7451 Kelly.Bradley@elwha.org TBD, LEKT Elders Liaison, 360.565.7257 x. 7466 xxx@elwha.org I&A Offices–call for address: Sequim 360.452.3221 800.801.0070 Forks 360.374.9496 888.571.6559 Pt Townsend 360.385.2552 800.801.0050 Timeline: Bi-annual Meetings – February and August 2018	○ Met on 2/21/18 to revise plan. ○ 2016 & 2017 – O3A staff attended Money Follows the Person and made contacts with tribes in attendance. ○ O3A staff readily available to meet with Lower Elwha Tribe as invited and always available to answer individual or more general resource questions. ○ Over past two years a number of referrals for services for individuals have been made. ○ O3A routinely shares multiple tribal / other grant opportunities with tribes via tribal contact list.

			Emails – Jody has developed an email list of tribal contacts; will include in ongoing emails Review Annually	
2. Improved caregiver training and support options for unpaid family caregivers and for paid caregivers serving tribal members for interested tribes	○ Improve coordination between AAA Title III and Tribal Title VI Caregiver Support Programs ○ Identify unpaid family caregivers through family caregiver support programs* and tribal social service referrals and support Tribal caregivers to obtain respite, training and other forms of support. ○ Through partnerships with tribal staff, identify tribal members interested in becoming paid caregivers and provide referrals for training and becoming an independent provider or for working for a home care agency; utilize new Caregiver Training protocols of the Training Partnership available through Catholic Community Services** ○ Include tribal caregivers in Home Care Registry Resource (HCRR)*** training and referral activities. Registry staff will come to Lower Elwha	○ Coordinated Title III & VI resources are maximized, resulting in improved dissemination of best practices, available resources, information sharing, and provision of technical assistance. ○ 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. ○ Increased number of tribal caregivers.	Mark Harvey Jody Moss Kelly Bradley LEKT Elders Liaison Fran Koski, Family Caregiver Support Program, 360.3417.8549, koskiff@dshs.wa.gov **Catholic Community Services - Caregiver Training - Robin Gibson; robing@ccsww.org; 360.417.5420 ***Aida Crumb, 360.417.8553, crumbaf@dshs.wa.gov Timeline: a. Using email address list, Jody will apprised LEKT staff of training opportunities b. Facilitate communication with CCS Training partnership by April 2018 c. On request from LEKT On Request & Review Annually	○ 3/1/18: Shared Nisqually Caregiver training conference opportunities with tribal contact list. ○ O3A continues to provide resources to all tribal caregivers/family members/others who call for assistance.

	and meet with tribal staff and caregivers at the request of the LEKT. Contact Mark Harvey.			
3. Enhanced services/support for Tribal grandparents / other relatives raising children	Increase outreach efforts, Fran Koski to introduce herself to Lower Elwha to inform families of resources available for relatives raising children.	Kinship Care Support Program and Relatives As Parents will benefit tribal grandparents and other relatives raising children.	Mark Harvey Fran Koski, Kinship Care Coordinator, 360.417.8559 koskiff@dshs.wa.gov Kelly Bradley & LEKT Elders Liaison Timeline: On Request	O3A provided an overview of services during 7.01 meetings and at other times and will continue to provide these resources as clients call or are referred. In fact, the majority of O3A's KCSP and RAP services are provided to tribal families.
4. Improved access to health and nutrition education and program services to the extent resources allow.	○ Through nutrition contracts with OlyCAP, promote inclusion of local Tribal Elders in nutrition programs. ○ More elders access fresh local foods through the Senior Farmers Market Nutrition Program.	○ Tribal Elders may participate in programs implemented by OlyCAP who are the health/nutrition education providers. ○ Jody Moss will coordinate with OlyCAP to contact Lower Elwha and market program to elders.	Jody Moss Kim Redmond, OlyCAP – (360) 301-6394 kredmond@olycap.org Kelly Bradley Timelines: a. By December 2018 b. June – October 2018	○ The Tribe received Senior Famers Market Nutrition vouchers in 2017 & 2018 from OlyCAP. ○ Shared menus from Community Action Program Nutrition contractor with tribal email list. ○ Shared information on available O3A Evidence Based grants, including Powerful Tools, CDSMP and SAIL Leadership training opportunities through tribal email contact list. ○ At LEKT's invitation, O3A provided a "Welcome to Medicare/Medicare Getting Started" training for Lower Elwha Tribe in fall 2017 with a goal of developing tribal Health Insurance Assisters. LEKT invited Jamestown, Makah, Port Gamble and Quileute Tribes to attend.

5. Improved access to transportation for Tribal Elders with special needs.	○ Facilitate Tribal representation in local planning and coordination efforts and regional transportation coalitions (RTPO & Clallam County Transportation Coalition). ○ Volunteer Chore Transportation program is accessible to all members over age 60. ○ Tribes can identify a tribal volunteer driver(s) if they wish who would become a volunteer with the Volunteer Chore program and could be reimbursed per mile driven for qualified transport services.	○ Local planning efforts are responsive to transportation needs of Tribes. Promote increased options for transportation for Tribal Elders with Special needs. ○ CCS Volunteer Chore Transportation will complete a resource presentation to the Tribe if requested. ○ Tribal volunteer drivers expand Lower Elwha transportation capacity for Elders over 60. (note that this age limitation is determined by fund source – Older Americans Act)	Jody Moss Kelly Bradley, Social Services Director LEKT Elders Liaison Teri Wensits, Volunteer Chore Services, 360.417.5640 TeriW@ccsww.org, Timeline: March 2018 By December 2018 (if requested by LEKT)	○ Learned Lower Elwha is interested/actively pursuing training to have a number of staff trained as Paratransit drivers, so they can transport members. They still need resources for a bus. ○ Shared transportation grant information with contacts over 2018.
6. Improved access to health and support services for Tribal Elders.	○ Increase coordination between the Area Agency on Aging and tribal representatives to facilitate access to local services – especially health care—for Tribal Elders. ○ As funding opportunities permits Jody will coordinate with LEKT staff to access to prevention program funding (Powerful Tools for Caregivers, Wisdom Warriors, fall prevention programs), etc. for elders.	○ Tribal issues are represented in local community, county planning efforts. ○ Tribal needs are considered and addressed by local service providers, resulting in increased access to services.	Mark Harvey, Jody Moss Clinic staff Ellen Charles 360.452.6252, ext 7630 Ellen.charles@elwha.org Timeline: a. 2018-2019 –health improvement programs occur throughout the year – J. Moss and M. Harvey will include LEKT staff in messaging about programs b. Quarterly, 2018	○ Shared information on available O3A Evidence Based grants, including Powerful Tools, CDSMP and SAIL Leadership training opportunities through tribal email contact list. ○ O3A provided a SHIBA clinic for Lower Elwha Tribal Elders in fall 2017.

7. Strengthen O3A and Lower Elwha Klallam Tribe's partnerships.	○ Notify LEKT staff when recruiting tribal representatives for Advisory Council. ○ Notify LEKT when O3A positions are open. ○ Train outreach staff in culturally appropriate communication.	○ Partnerships between O3A & LEKT result in responsive service / program development. ○ LEKT members have opportunities for employment; O3A becomes more diverse. ○ As schedules permit, Brenda or others will make Cultural Competency Training available to O3A.	LEKT Elders Liaison Designated O3A Leadership, Program Management and Service Delivery staff Carol Ann Laase, O3A Human Resources – 360.379.5064, Lasseca@dshs.wa.gov Brenda Francis Thomas, DSHS Timeline: a. March – June 2018 b. 2018 – 2019 c. December 2018 d. Review Annually	○ O3A is in the beginning stages of recruiting a new tribal representative. This will be marketed to all tribes in our region via tribal contact email list. ○ Tribal staff is routinely notified of O3A staff openings.
8. Assist the Lower Elwha Klallam Tribe if they are interested, to develop contracts.	○ Notify tribe of option to use O3A to help develop services/contracts ○ Provide technical assistance as needed ○ Assist with first series of contract monitoring visits as needed.	○ Communication between O3A and the Lower Elwha Tribe results in awareness of some options, and strengthens O3A's relationships with tribe ○ Expands services available to tribal elders ○ Strengthens and improves the quality of services provided through tribal contracts.	AC Tribal Representative Designated O3 Program Manager, and O3A Services Delivery staff Lower Elwha Tribe staff Ann Dahl, Marietta Bobba – ALTSA Tribal Liaison Staff Timeline: Review Annually	Shared contracting options with Lower Elwha Tribal staff during 7.01 planning meeting. They would love to develop an adult family home. Offered technical assistance if they move forward with this or other projects.

Completed or Tabled Items

Goal/Activity/Outcome	Date	Status
Goal: Improved access to potential employment training and hosting opportunities for the Title V Senior Community Service Employment Program.	6/30/18	This project was transferred to a statewide contractor, AARP. AARP and Good Will still have Senior employment programs and O3A refers interested host agencies as well as interested seniors to programs.

Activity: Share information with LEKT when openings are available in the Title V Senior Community Service Employment Program should this program continue as an O3A service **Outcome:** Increased employment and job skills of elder who wish to work.		

Policy 7.01 Makah Tribe – O3A Plan – DRAFT *(may not have been approved by Tribal Council)*
December 2018

Olympic Area Agency on Aging (O3A)
Biennium Timeframe: January 1, 2018 to December 31, 2019

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 October 2018
(1) Goals/Objectives	**(2) Activities**	**(3) Expected Outcome**	**(4) Lead Staff and Target Date**	**(5) Current Status**
1. Continue current outreach assistance with staff and tribal members; work to develop/update tailored plans with the Makah Tribe.	○ Meet with tribe's representatives to develop / update 7.01 policy plan. ○ Ensure current outreach assistance is continued & explore expanding support and coordination assistance with Makah Tribe as available O3A resources allow. ○ Meet with Makah tribal representatives to discuss elder issues as requested. ○ Ensure tribal issues are considered in agency planning, training and project development. ○ Ensure tribal elders and staff are aware of access to resources and planning by visiting or calling local O3A Information and Assistance Office; calls can be made by elder or others on behalf of elder.	○ Tailored and regularly updated 7.01 plan in place between O3A and the Makah Tribe. ○ Enhanced access to culturally relevant services for tribal elders. ○ Increased collaboration with the Makah Tribe and community partners to assure access to appropriate services. ○ Elders, family members and staff are able to more easily identify resources and plan for elders' needs.	Target: 7.01 plan in place based on Makah Tribe's preferences; goal would be for plan to be in place by December 2018. Roy Walker, Executive Director, 360.379.5064 walkerb@dshs.wa.gov Mark Harvey, Regional Director, 360. 461.5230 harvemb@dshs.wa.gov Jody Moss, Contracts Management & Planning Director, 360.379.5064 mossjm1@dshs.wa.gov Maureen Woods Maureen.woods@makah.com 360-645-3027 Glenda Butler, Makah Wellness, Glenda.butler@makah.com O3A Forks office staff: Char Carte - 360.374.9496 carteci@dshs.wa.gov, Susie Brandelius - 360.374.9496 brandcs@dshs.wa.gov	Winter 2017, met with Makah Tribe in Neah Bay related to a discussion on Health Homes, and shared other options for their consideration. Met with Makah Tribal staff and Council member on 11/26/18 to develop current draft 7.01 Plan O3A staff Char Carte and Susie Brandelius routinely connect with the Makah Tribe as requested. 2016, 2017 & 2018 – O3A staff attended Money Follows the Person and made contacts with tribes in attendance. Over past two years a number of referrals for services for individuals have been made. O3A routinely shares multiple tribal / other grant opportunities with tribes via tribal contact list. O3A has attended the Makah Health Fair for a number of years.

			O3A Advisory Council Tribal Rep To Be Filled Brenda Francis Thomas, francBD@dshs.wa.gov, (360) 565-2203 I&A Offices–call for address: Sequim 360.452.3221 800.801.0070 Forks 360.374.9496 888.571.6559 Pt Townsend 360.385.2552 800.801.0050 Timeline: Review Annually	
2. Improve caregiver training and support options for unpaid family caregivers and for paid caregivers serving tribal members.	○ Improve coordination between AAA Title III and Tribal Title VI Caregiver Support Programs ○ Support development of a high school Home Care Aid program ○ Include Tribal caregivers in Home Care Referral Registry* training and referral activities. ○ Provide information and support for tribal members to access the Medicaid Alternative Care and Tailored Supports for Older Adults (MAC & TSOA) Programs	○ Coordinated Title III and VI resources are maximized, resulting in improved dissemination of best practices, available resources, information sharing and provision of technical assistance. ○ Increased resources for and capacity of family caregivers to support their loved ones in their homes for as long as possible. ○ The Makah Tribe capacity for accessing and/or providing training to Tribal members interested in becoming caregivers. Tribal caregivers are able to access training and potential employment in a timely manner. ○ Increased number of Tribal caregivers available	O3A Planning & Program Mgmt. staff Mark Harvey *Jaci Hoyle, O3A Sequim Direct Services Supervisor 360-41708540, 800-801-0070; hoylejl@dshs.wa.gov Susie Brandelius *Aida Crumb 360-417-8583 crumbaf@dshs.wa.gov Timeline: On demand	3/1/18: Shared Nisqually Caregiver training conference opportunities with tribal contact list. O3A continues to provide resources to all tribal caregivers/family members/others who call for assistance.

		to deliver home care services to elders		
3. Enhanced services / support for Tribal grandparents / other relatives raising children	○ Increase outreach efforts to inform families of the resources available for relatives raising children.	○ Tribal grandparents & other relatives raising children gain additional and often critical support through Relatives as Parents/Kinship Care Support programs.	O3A Kinship Care Support Program and Relatives as Parents Delivery staff: Susie Brandelius Timeline: On demand	O3A staff routine provides outreach to Makah to for KCSP and RAP services and serves clients who contact any of the O3A offices. O3A suggested and planned with Maureen Woods a Kinship/Grandparents Day in the Makah Senior Center in September, 2018
4. Improved Tribal access to health and nutrition education and program services to the extent resources allow.	○ Through nutrition contracts with local providers, promote inclusion of local tribal elders in nutrition education programs. ○ Share useful resources between tribes and nutrition providers such as printed education material and 1/3 RDA approved menus.	○ Tribal elders participate in programs implemented by local health / nutrition education providers. ○ Capacity for local tribes and regional nutrition providers is increased by sharing ideas and material; more elders receive better information around health and nutrition.	O3A Planning & Program Mgmt staff Tribal Nutrition Providers Kim Redmond, OlyCAP – (360) 301-6394 kredmond@olycap.org Jessica Herndon, Makah Timeline: On Demand & Review Annually	Shared information about Senior Farmers Market Program. At time, no local site for produce was available. Note: new site is now available at Sarge's Place Farmers Market in Forks. Shared information on available O3A Evidence Based grants, including Powerful Tools, CDSMP and SAIL Leadership training opportunities through tribal email contact list.
5. Improved access to health and support services for Tribal elders.	○ Engage Makah Tribe in the prevention programs (Areas of interest include Powerful Tools for Caregivers, Savvy Caregivers, and possibly others)	○ Tribal issues are represented in local community, county planning efforts. ○ Tribal needs are considered and addressed by local service providers, resulting in increased access to services.	Mark Harvey; Regional Director O3A Planning & Program Mgmt staff, Margaret Taylor, 360.379.5064 taylomh@dshs.wa.gov Jan Li Hanson, janet.hanson@makah.com, (206) 651-6707 Glenda Butler, Makah Wellness Timeline: As requested	

6. Strengthened O3A and tribal partnerships.	○ Notify tribal staff when recruiting tribal representation on O3A Advisory Council. ○ Notify tribes when O3A staff positions are open. ○ Routinely consult with tribal outreach (O3A direct service) staff re: O3A response to tribal issues.	○ Partnerships between O3A and region tribes result in more responsive service and program development. ○ Tribal members have opportunities for employment; O3A becomes more diverse and representative of the community we serve	AC Tribal Representative Designated O3A Program Management and Service Delivery staff O3A leadership - Carol Ann Laase, O3A Human Resources – 360.379.5064, Lasseca@dshs.wa.gov Brenda Francis Thomas, DSHS Review Annually	O3A is in the beginning stages of recruiting a new tribal representative. This will be marketed to all tribes in our region via tribal contact email list. Tribal staff is routinely notified of O3A staff openings.
7. Improved access to transportation for Tribal Elders with special needs.	○ Facilitate Tribal representation in local planning and coordination efforts and regional transportation coalitions (RTPO & local transportation initiatives if known). ○ Volunteer Transportation program is accessible to all members over age 60. ○ If Makah Tribe can identify tribal volunteer driver(s), coordinate training with the Catholic Community Services Volunteer Transportation program so drivers can support elder transportation needs and can be reimbursed for mileage for qualified elders. ○ Facilitate communication	○ Local planning efforts are responsive to transportation needs of Tribes. Promote increased options for transportation for Tribal Elders with Special needs. ○ Volunteer transportation provider will complete a resource presentation to the Tribe if requested. ○ Tribal volunteer drivers expand transportation capacity for Elders over 60. (note that this age limitation is determined by fund source – Older Americans Act)	Jody Moss – O3A Planning Director Maureen Woods, Tribal Social Services Director Glenda, Butler, Makah Wellness Director Clallam Teri Wensits, Volunteer Chore Services, TeriW@ccsww.org, 360.417.5640 Jefferson Nancy Budd-Garvin, ECCHO, director@echhojc.org, 360.379.3246 Grays Harbor: Jenny Knutson, CCAP, Jennyk@coastalcap.org, 360.500.4524 Pacific: Abbi Quigg, Volunteer Chore Services, AbbiQ@ccsww.org 360.637.8563.ext113 Ann Dahl, DSHS, Tribal Initiative Project Manager, (Contracting for some Transportation services), 360.725.3489, DahlA@dshs.wa.gov Timeline:	Spoke with Teri Wensits who stated she would be very happy to be able to serve tribal members if she had volunteer drivers who wanted to become trained/qualified to provide this service

	between Clallam Connect and Makah Tribe ○ Support developing Transportation Contracts if tribe is interested		Target June to August 2019 for CCS Volunteer Transportation training On Demand & Review Annually	
8. Assist Makah Tribe as interested, to develop contracts. Areas of interest include Environmental Modification, Transportation,	○ Notify tribes of option to contact O3A to help develop services/contracts ○ Provide technical assistance as needed ○ Assist with first series of contract monitoring visits as needed.	○ Communication between O3A and tribes results in awareness of new service options, and strengthens O3A's relationship with tribes ○ Expands culturally relevant services to tribal elders ○ Strengthens and improves the quality and cultural relevancy of services provided through tribal contracts.	AC Tribal Representative Designated O3 Program Manager, and O3A Services Delivery staff On Demand & Review Annually	Shared contracting options with Makah Tribe. They would love to develop services including home care, and Environmental Modification. Offered technical assistance if they move forward with these or other projects.
9. Assist Makah Tribe to be able to access more grant resources	○ Notify Makah Tribe about grant opportunities for Tribe only funds.	○ Tribe enabled to expand capacity for providing services to members.	Jody Moss, O3A staff	

Policy 7.01 Quileute Nation Plan **Updated January 2019**

Olympic Area Agency on Aging (O3A)
Biennium Timeframe: January 1, 2018 to December 31, 2019

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 October 2018
(1) Goals/Objectives	**(2) Activities**	**(3) Expected Outcome**	**(4) Lead Staff and Target Date**	**(5) Current Status**
1. Continue current outreach assistance and work to develop a more tailored plan for the Quileute Nation	○ Meet with tribe's representatives to clarify/ update 7.01 policy plan. ○ Ensure current outreach assistance is continued & explore expanding support and coordination assistance with Quileute Nation as available O3A resources allow. ○ Meet with tribal representatives to discuss elder issues as requested. ○ Ensure tribal issues are considered in agency planning, training and project development. ○ Ensure tribal elders and staff are aware of access to resources and planning by visiting or calling local O3A Information and Assistance Office; calls can be made by elder or others on behalf of elder.	○ O3A and Quileute Nations' relationship is strengthened leading to better communication and more opportunities for partnerships. ○ Enhanced access to culturally relevant services for tribal elders. ○ Increased collaboration with the Quileute Nation and community partners to assure access to appropriate services. ○ Elders, family members and staff are able to more easily identify resources and plan for elders' needs.	Roy Walker, Executive Director, 360.379.5064 walkerb@dshs.wa.gov Mark Harvey, Regional Director, 360. 461.5230 harvemb@dshs.wa.gov Jody Moss, Contracts Management & Planning Director, 360.379.5064 mossjm1@dshs.wa.gov O3A Forks office staff: Char Carte - 360.374.9496 carteci@dshs.wa.gov, Susie Brandelius -360.374.9496, brandcs@dshs.wa.gov Nicole Earls, Human Services Director Nicole.earls@quileutenation.org, 360.640.8795 Lisa Hohman-Penn, Senior Cook, Lisa.hohman@quileutenation.org, 360.374.6040 Timeline: Review Annually	○ Met Nicole Earls at Consolidated Tribal Meetings on 1/4/17, approved by council on 3/27/17 and again on October 2, 2018. ○ 2016 & 2017 – O3A staff attended Money Follows the Person and made contacts with tribes in attendance. ○ O3A staff visits Quileute staff and elders monthly for Elder's Luncheons and other events. ○ O3A staff continues to be available to answer individual or more general resource questions. In July 2017, attended the Quileute Resource Fair. ○ June 2018 - Provided new Living Well resource guide to elder's at Senior Luncheon. ○ Over past two years a number of referrals for

				services for individuals have been made. ○ O3A routinely shares multiple tribal / other grant opportunities with tribes via tribal contact list. ○ O3A Routinely attends tribal events like elders' lunches/brunches, health fairs, or events when invited.
2. Support caregiver training and support options as requested by the Quileute Nation.	○ Improve coordination between AAA Title III and Tribal Title VI Caregiver Support Programs ○ Identify Tribal caregivers and support them to obtain training and support.	○ Coordinated Title III and VI resources result in support for caregivers as requested by the Quileute Nation. ○ Tribal caregivers are supported to access training in a timely manner	Mark Harvey, 360. 461.5230 harvemb@dshs.wa.gov Time Line: On Demand and Review Annually	○ 3/1/18: Shared Nisqually Caregiver training conference opportunities with tribal contact list. ○ O3A continues to provide resources to all tribal caregivers/family members/others who call for assistance. ○ Met with elders at a brunch and discussed MAC / TSOA, need for specialized equipment and other O3A programs
3. Enhanced services / support for Tribal grandparents / other elders raising children	○ Increase outreach efforts, particularly with remote communities and Tribal reservations, to inform families of the resources now available for relatives raising children.	○ Relatives as Parents Support Program will benefit Tribal grandparents & other elders raising children.	Mark Harvey, 360. 461.5230 harvemb@dshs.wa.gov Time Line: On Demand	○ O3A provided an overview of KSCP / RAP services during previous 7.01 meetings and at several elder's luncheons, and will continue to provide these resources as clients call or are referred. In fact, the majority of O3A's KCSP and RAP services are provided to tribal families.

				○ 2/27/17 – Met with Kinship Care Navigator/discussed resources and availability to consult regarding client issues. ○ May 2017, O3A staff was honored on Kinship Care Day at an elder's luncheon
4. Improved Tribal access to nutrition program services (such as Senior Nutrition, Meals on Wheels and Senior Farmers Market) through coordination with local nutrition providers.	○ Through nutrition contracts with local providers, promote inclusion of local tribal elders in nutrition programs.	○ Tribal elders are able to participate in programs implemented by local nutrition providers.	Jody Moss mossjm1@dshs.wa.gov; 360.379.5064 Kim Redmond, OlyCAP – (360) 301-6394 kredmond@olycap.org Timeline: Review Annually	○ The Quileute Nation received Senior Famers Market Nutrition applications in 2017 & 2018 from OlyCAP. Note: new site is available in 2018 at Sarge's Place Farmers Market in Forks. ○ Shared menus from OlyCAP with tribal email list. ○ Shared information on available O3A Evidence Based grants, including Powerful Tools, CDSMP and SAIL Leadership training opportunities through tribal email contact list. ○
5. Promote access to health and support services for Tribal elders.	○ Increase coordination between the Area Agency on Aging and Tribal representatives to advocate increased access to local services—especially health care-- for Tribal Elders. ○ Explore options for a Tribal Wills Clinic and/or Senior Legal Advice Clinics for more general civic legal needs ○ Explore options for developing a corps of driving	○ Tribal issues are represented in local community, county planning efforts. ○ Tribal elders receive legal services supporting their aging needs and goals	Mark Harvey, 360. 461.5230 harvemb@dshs.wa.gov Jody Moss mossjm1@dshs.wa.gov; 360.379.5064 Timeline: On Demand and Review Annually	○ Attended Health Resource for Quileute Nation at their invitation. ○ Provided SHIBA Clinics on request for tribes. ○ Shared Medicare Part D enrolment info and other resources at Elders' Luncheon.

	tribal volunteers to help transport elders to necessary activities and medical appointments as part of Catholic Community Services Volunteer Transportation program ○ Engage Quileute Tribe in the prevention programs (e.g., Powerful Tools for Caregivers, Savvy Caregivers, Wisdom Warriors)	○ Tribal elders have greater access to services and greater mobility. ○ Quileute Tribal members gain access to prevention programs and healthy activities for elders	Transportation and Wills Clinic: by October 2019	
6. Strengthened O3A and Quileute partnerships	○ Notify tribal staff when recruiting tribal representation on O3A Advisory Council. ○ Notify tribes when O3A staff positions are open. ○ Routinely consult with tribal outreach (O3A direct service) staff re: O3A response to tribal issues.	○ Partnerships between O3A and region tribes result in more responsive service and program development. ○ Tribal members have opportunities for employment; O3A becomes more diverse and representative of the communities O3A serves.	AC Tribal Representative Designated O3A Program Management and Service Delivery staff O3A leadership Timeline: Review Annually	○ O3A is in the beginning stages of recruiting a new tribal representative. This will be marketed to all tribes in our region via tribal contact email list. ○ Tribal staff is routinely notified of O3A staff openings.
7. Help the Quileute Nation if they are interested, to develop service contracts.	○ Notify tribe of option to use O3A to help develop services/contracts ○ Provide technical assistance as needed ○ Assist with first series of contract monitoring visits as needed.	○ Communication between O3A and the Quileute Nation results in awareness of some options, and strengthens O3A's relationships with tribe ○ Expands services available to tribal elders	AC Tribal Representative Jody Moss mossjm1@dshs.wa.gov; 360.379.5064 Designated O3 Program Manager, and O3A Services Delivery staff Quileute Nation staff Ann Dahl, Marietta Bobba – ALTSA Tribal Liaison Staff Timeline: On Demand & Review Annually	○ Shared contracting options with Quileute Nation staff at 7.01 meeting first week of October 2018. Will offer technical assistance if they move forward with any contracting projects.

		○ Strengthens and improves the quality of services provided through tribal contracts.		

Completed or Tabled Items

Goal/Activity/Outcome	Date	Status
Goal: Improved access to potential employment training and hosting opportunities for the Title V Senior Community Service Employment Program. **Activity:** Share information with Quileute Nation when openings are available in the Title V Senior Community Service Employment Program should this program continue as an O3A service **Outcome:** Increased employment and job skills of elder who wish to work.	6/30/18	This project was transferred to a statewide contractor, AARP. AARP and Good Will still have Senior employment programs and O3A refers interested host agencies as well as interested seniors to programs.

Policy 7.01 Quinault Nation ***March 2018***

The Quinault Nation and the Olympic Area Agency on Aging (O3A)
Biennium Timeframe: January 1, 2018 to December 31, 2019

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 October 2018
(1) Goals/Objectives	**(2) Activities**	**(3) Expected Outcome**	**(4) Lead Staff & Target Date**	
1. Quinault Nation and O3A representatives work together to develop/refine 7.01 policy implementation plan.	○ Representatives from Quinault Nation and O3A meet together to develop/refine 7.01 policy implementation plans. ○ Ensure current O3A outreach assistance is continued & explore expanding support and coordination assistance as available O3A resources allow. ○ O3A Information & Assistance (Grays Harbor) staff schedule meeting(s) with tribal representatives to discuss Elder issues in Taholah. ○ Ensure tribal issues are considered in agency planning, training and project development. ○ Ensure tribal elders and staff are aware of access to resources and planning by visiting or calling local O3A Information and Assistance Office; calls can be made by	○ 7.01 plan guides activities and coordination between O3A and the Quinault Nation. ○ Enhanced access to culturally relevant services for tribal elders. ○ Increased communication with Quinault Nation and community partners to improve access to appropriate services. ○ Elders, family members and staff are able to more easily identify resources and plan for elders' needs.	Roy Walker, Exec Director, O3A walkerb@dshs.wa.gov 360-379-5064 Mark Harvey, Regional Director I&A/CM 360. 461.5230, harvemb@dshs.wa.gov Jody Moss, O3A Planner, 360.379.5064; mossjm1@dshs.wa.gov; Amelia Delacruz, Quinault Nation Social Services Manager, 360.276.8215; Amelia.Delacruz@quinault.org Lanada Mail-Brown, Quinault Nation Elder Programs Marie Natrall, DSHS Office of Indian Policy, 360.725.4880, NATRAMF@dshs.wa.gov I&A Offices–call for address: Aberdeen – 360.532.0520 888.801.0060 Forks 360.374.9496, 888.571.6559 2018 – 2019	3/9/18 – M Harvey and J Moss met with A Delacruz, L Mail-Brown and M Natrall to discuss updates to the Quinault Nation 7.01 Plan. 1/29/18: Met with Quinault social service staff and ALTSA/HCS staff about developing Adult Day Care as well as other programs for which they may want to become tribal contractors with O3A. 2016 & 2017 – O3A staff attended Money Follows the Person and made contacts with tribes in attendance. O3A staff readily available to meet with Quinault as invited and always available to answer individual or more general resource questions. Over past two years a number of referrals for services for individuals have been made. O3A routinely shares multiple tribal / other grant opportunities with tribes via tribal contact list. O3A Staff member, Stacey Michaelson, a Nisqually Tribal member herself, has historically worked very closely with the Quinault Tribe to connect elders to services.

	elder or others on behalf of elder			
2. Improved caregiver training and support options for unpaid family caregivers and for paid caregivers serving tribal members as requested by the Quinault Nation.	○ Improve coordination between AAA Title III and Quinault Nation Title VI Caregiver Support Programs. ○ Identify unpaid family caregivers through family caregiver support programs and tribal social service referrals and support unpaid family caregivers to obtain respite, training and other forms of support. ○ Through partnerships with tribal staff, Identify tribal members interested in becoming paid caregivers and provide referrals for training and becoming an independent provider or for working for a home care agency. ○ Include Tribal caregivers in Home Care Referral Registry* training and referral activities.	○ Coordinated Title III and VI resources are maximized, resulting in improved dissemination of best practices, available resources, information sharing and provision of technical assistance. ○ Increased resources for and capacity of family caregivers to support their loved ones in their homes for as long as possible. ○ Tribal capacity for accessing and/or providing training to Tribal members interested in becoming caregivers. Tribal caregivers are able to access training and potential employment in a timely manner. ○ Increased number of Tribal caregivers available to care for elders.	Mark Harvey, Regional Director I&A/CM Eric Nessa, Family Caregiver Support Program Support Staff, 360.538.2458 or 866.582.1485, NessaEM@dshs.wa.gov Amelia Delacruz, Quinault Nation Social Services Manager Lanada Mail-Brown, Quinault Nation Elder Programs *Ann Peterson, O3A Aberdeen Direct Services Supervisor, 360-538-2449, 866.582.1482, peteram@dshs.wa.gov 2018 – 2019	3/1/18: Shared Nisqually Caregiver training conference opportunities with tribal contact list. O3A continues to provide resources to all tribal caregivers/family members/others who call for assistance.
3. Enhanced services / support for Tribal	○ Increase outreach efforts, particularly with remote communities and Tribal	○ Relatives as Parents Support Program will benefit Tribal	Mark Harvey, Regional Director I&A/CM Amelia Delacruz, Quinault Nation Social Services Manager	3/9/18: Shared resource information about RAP/KCSP programs.

grandparents / other elders raising children	reservations, to inform families of the resources now available for relatives raising children.	grandparents & other elders raising children.	Lanada Mail-Brown, Quinault Nation Elder Programs Eric Nessa, Kinship Care / Relatives as Parents Support Staff, 360.538.2458 or 866.582.1485, NessaEM@dshs.wa.gov 2018-2019	
4. Improved Tribal access to nutrition program services (such as Senior Nutrition, Meals on Wheels and Senior Farmers Market) through coordination with local nutrition providers.	○ Through nutrition contracts with local providers, promote inclusion of local tribal elders in nutrition programs.	○ Tribal elders are able to participate in programs implemented by local nutrition providers.	Amelia Delacruz, Quinault Nation Social Services Manager Lanada Mail-Brown, Quinault Nation Elder Programs Jody Moss, O3A Planner Jason Hoseny, Coastal Community Action Programs (CCAP) – 360.589.9094, jasonh@coastalcap.org 2018 – 2019	Connected Quinault social service staff with Vicky Johnson, CCAP for questions about nutrition resources. 2018 Encouraged signup for Senior Farmer's Market program, by sharing start dates and contact info via email links. Shared menus from Community Action Program Nutrition contractor with tribal email list.
5. Promote access to health and support services for Tribal elders	○ Increase coordination between the Area Agency on Aging and Tribal representatives to advocate increased access to local services - especially health care - for Tribal Elders. ○ Increase coordination with volunteer transportation program in Grays Harbor County.	○ Tribal issues are represented in local community, county planning efforts.	Mark Harvey, Regional Director I&A/CM Amelia Delacruz, Quinault Nation Social Services Manager Lanada Mail-Brown, Quinault Nation Elder Programs Jody Moss, O3A Planner 2018 -2019	Shared information on available O3A Evidence Based grants, including Powerful Tools, CDSMP and SAIL Leadership training opportunities through tribal contact list. O3A staff provided SHIBA Clinics in Grays Harbor region – shared with tribal staff. Linked tribal Social Service Staff to local Transportation resources – Jenny Knutson, CCAP, Grays Harbor County, (360) 500-4524, jennyk@coastalcap.org

6. Strengthened O3A and Quinault tribal partnerships.	○ Notify Quinault staff when recruiting tribal representation on O3A Advisory Council. ○ Notify Quinault staff when O3A staff positions are open. ○ Routinely consult with O3A direct service staff and Quinault staff re: O3A response to tribal issues. ○ Ensure contracting mechanisms support productive tribal partnerships.	○ Partnerships between O3A and region tribes result in more responsive service and program development. ○ Tribal members have opportunities for employment; O3A becomes more diverse and representative of community served ○ Contract instruments are responsive to tribal administration capacity.	AC Tribal Representative Designated O3A Program Management and Service Delivery staff O3A leadership 2018 - 2019	O3A is in the beginning stages of recruiting a new tribal representative. This will be marketed to all tribes in our region via tribal contact email list. Tribal staff is routinely notified of O3A staff openings.
7. Improved access to transportation for Tribal Elders with special needs.	○ Facilitate Tribal representation in local planning and coordination efforts and regional transportation coalitions (RTPO & local transportation initiatives if known). ○ Volunteer Transportation program is accessible to all members over age 60. ○ Quinault Tribe can identify a tribal volunteer driver(s) if they wish to become a volunteer with the volunteer transportation program and could be reimbursed mileage for qualified transport services.	○ Local planning efforts are responsive to transportation needs of Tribes. Promote increased options for transportation for Tribal Elders with Special needs. ○ Volunteer transportation provider will provide a talk for the Tribe if requested. ○ Tribal volunteer drivers expand transportation capacity for Elders over 60. (note - age limit is determined by Older Americans Act fund source.	Jody Moss – O3A Planning Director Amelia Delacruz, Quinault Nation Social Services Manager Lanada Mail-Brown, Quinault Nation Elder Programs Liaison Clallam Teri Wensits, Volunteer Chore Services, TeriW@ccsww.org, 360.417.5640 Jefferson Nancy Budd-Garvin, ECHHO, director@echhojc.org, 360.379.3246 Grays Harbor Jennyk@coastalcap.org, 360.500.4524 Pacific Abbi Quiggg, Volunteer Chore Services, AbbiQ@ccsww.org 360.637.8563.ext113 Timeline: 2018-2019	RTPO has not yet met since fall 2016. Contacted Jenny Knutson, CCAP to verify her willingness to work with tribes to develop tribal transportation volunteers. Jenny responded that she would love to work with tribal volunteer drivers.

8. Help the Quinault Nation if they are interested, to develop contracts available in 2018, (e.g., Adult Days Services, Home Care / Respite Contracting, Environmental Modification and others).	○ Notify Quinault Nation of option to use O3A to help develop services/contracts ○ Provide technical assistance as needed ○ Assist with first series of contract monitoring visits as needed.	○ Communication between O3A and the Quinault Nation results in awareness of new service options, and strengthens O3A's and Quinault Nation's relationships. ○ Expands services available to tribal elders ○ Strengthens and improves the quality of services provided through tribal contracts.	AC Tribal Representative, Designated O3 Program Manager, and O3A Services Delivery staff Quinault Nation, ALTSA Designated staff 2018-2019	1/29/18: Met with Quinault social service staff and ALTSA/HCS staff about developing contracts for services they may already be providing and/or services which they may want to become tribal contractors with O3A. Discussed Adult Day Care, Caregiving and other contracts of services they are already providing without payment. Quinault Nation is redeveloping their Senior Center program and does not have the staff capacity to take ion new projects until after this is completed.

Policy 7.01 Plan with the Shoalwater Bay Tribe Plan

Olympic Area Agency on Aging (O3A)

Biennium Timeframe: January 1, 2018 to December 31, 2019

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 October 2018
(1) Goals/Objectives	**(2) Activities**	**(3) Expected Outcome**	**(4) Lead Staff and Target Date**	**(5) Current Status**
1. Continue current outreach assistance and work to develop and improve the tailored plan for the Shoalwater Bay Tribe.	○ Meet with tribe's representatives to develop / update 7.01 policy plan. ○ Ensure current outreach assistance is continued & explore expanding support and coordination assistance with Shoalwater Bay Tribe as available O3A resources allow. ○ Meet with tribal representatives to discuss elder issues as requested. ○ Ensure tribal issues are considered in agency planning, training and project development. ○ Ensure tribal elders and staff are aware of access to resources and planning by visiting or calling local O3A Information and Assistance Office; calls can be made by elder or others on behalf of elder.	○ Tailored 7.01 plan in place between O3A and each individual Tribe within O3A service region. ○ Enhanced access to culturally relevant services for tribal elders. ○ Increased collaboration with local tribes and community partners to assure access to appropriate services. ○ Elders, family members and staff are able to more easily identify resources and plan for elders' needs.	Roy Walker, Executive Director, 360.379.5064 walkerb@dshs.wa.gov Mark Harvey, Regional Director, 360. 461.5230 harvemb@dshs.wa.gov Jody Moss, Contracts Management & Planning Director, 360.379.5064 mossjm1@dshs.wa.gov Charlene Nelson, cnelson@shoalwaterbay-nsn.gov Kathirine Horne, khorne@shoalwaterbay-nsn.gov O3A Advisory Council Tribal Rep I&A Offices–call for address: Aberdeen 360.532.0520 800.801.0060 Raymond 360.942.2177 888.571.6557 Long Beach 360.642.3634 888.571.6558 Timeline: 1/1/18–12/31/19	1. 1. Met with Shoalwater Bay Tribe on March 12, 2018. Draft Plan developed and sent to Shoalwater Bay Tribe. 12016 & 2017 – O3A staff attended Money Follows the Person and made contacts with tribes in attendance. O3A staff readily available to meet with Hoh as invited and always available to answer individual or more general resource questions. Over past two years a number of referrals for services for individuals have been made. O3A routinely shares multiple tribal / other grant opportunities with tribes via tribal contact list. O3A Routinely attends tribal events like health fairs, or elders' luncheons when invited.

2. Improved caregiver training and support options for unpaid family caregivers and for paid caregivers serving tribal members for interested tribes.	○ Improve coordination between AAA Title III and Tribal Title VI Caregiver Support Programs ○ Identify unpaid family caregivers through family caregiver support programs* and tribal social service referrals and support Tribal caregivers to obtain respite, training and other forms of support. ○ Through partnerships with tribal staff, Identify tribal members interested in becoming paid caregivers and provide referrals for training** and becoming an independent provider or for working for a home care agency. ○ Include Tribal caregivers in Home Care Referral Registry*** training and referral activities.	○ Coordinated Title III and VI resources are maximized, resulting in improved dissemination of best practices, available resources, information sharing and provision of technical assistance. ○ Increased resources for and capacity of family caregivers to support their loved ones in their homes for as long as possible. ○ Tribal capacity for accessing and/or providing training to Tribal members interested in becoming caregivers. Tribal caregivers are able to access training and potential employment in a timely manner. ○ Increased number of Tribal caregivers	O3A Planning & Program Mgmt. staff Mark Harvey Jody Moss *Bob Powell, Family Caregiver Support Program staff360.214.9622, powelrm@dshs.wa.gov **Robin Gibson, Catholic Community Services - Robin Gibson; robing@ccsww.org; 360.417.5420 *** Ann Peterson, Supervisor, Home Care Referral Registry, peteram@dshs.wa.gov, 360-538-2449 Timeline: 1/1/2018 – 12/31/ 2019	3/1/18: Shared Nisqually Caregiver training conference opportunities with tribal contact list. O3A continues to provide resources to all tribal caregivers/family members/others who call for assistance.
3. Enhanced services / support for Tribal grandparents / other elders raising children	○ Increase outreach efforts, particularly for remote communities and Tribal reservations, to inform families of the resources available for relatives raising children.	○ a. Tribal grandparents & other elders raising children gain additional and often critical support through Relatives as Parents/Kinship Care Support programs.	Bob Powell, O3A Kinship Care Support Program and Relatives as Parents Delivery staff, 360.214.9622, powelrm@dshs.wa.gov Timeline: 1/1/18–12/31/19	O3A provided an overview of services during 7.01 meetings and at other times and will continue to provide these resources as clients call or are referred. In fact, the majority of O3A's KCSP and RAP services are provided to tribal families.

4. Improved Tribal access to health and nutrition education and program services to the extent resources allow.	○ Through nutrition contracts with local providers, promote inclusion of local tribal elders in nutrition education programs. ○ Share useful resources between tribes and nutrition providers such as printed education material and 1/3 RDA approved menus.	○ Tribal elders participate in programs implemented by local health / nutrition education providers. ○ Capacity for local tribes and regional nutrition providers is increased by sharing ideas and material; more elders receive better information around health and nutrition.	O3A Planning & Program Mgmt staff Tribal Nutrition Providers Coastal Community Action Program, Nutrition Services, Vicky Johnson, 360.500.4530, vickyj@coastalcap.org Timeline: 1/1/2018 – 12/31/2019	The Tribe received Senior Famers Market Nutrition program information Shared menus from Community Action Program Nutrition contractor with tribal email list. Shared information on O3A Evidence Based grants, including Powerful Tools, CDSMP and SAIL Leadership training opportunities through tribal contact list.
5. Improved access to health and support services for Tribal elders.	○ Increase coordination between the Area Agency on Aging and Tribal representatives to facilitate access to local services—especially health care-- for Tribal Elders. ○ Engage tribe as local community partners in the prevention programs	○ Tribal issues are represented in local community, county planning efforts. ○ Tribal needs are considered and addressed by local service providers, resulting in increased access to services.	Mark Harvey; Regional Director O3A Planning & Program Mgmt staff 2018 - 2019	Offered to attended future Health Fairs at Shoalwater Bay Tribe's invitation. Available to provide SHIBA Clinics on request for tribes.
6. Strengthened O3A and tribal partnerships.	○ Notify tribal staff when recruiting tribal representation on O3A Advisory Council. ○ Notify tribe when O3A staff positions are open. ○ Routinely consult with tribal outreach (O3A direct service) staff re: O3A response to tribal issues. ○ Ensure contracting mechanisms support	○ Partnerships between O3A and Shoalwater Bay Tribe results in more responsive service and program development. ○ Tribal members have opportunities for employment; O3A becomes more diverse and representative of the community we serve	AC Tribal Representative Designated O3A Program Management and Service Delivery staff O3A leadership 2018- 2019	O3A is in the beginning stages of recruiting a new tribal representative. This will be marketed to all tribes in our region via tribal contact email list. Tribal staff is routinely notified of O3A staff openings.

	productive tribal partnerships.	○ Contract instruments are responsive to tribal administration capacity.		
7. Improved access to transportation for Tribal Elders with special needs.	○ Facilitate Tribal representation in local planning and coordination efforts and regional transportation coalitions (RTPO & local transportation initiatives if known). ○ Volunteer Transportation program is accessible to all members over age 60. ○ Tribe can identify a tribal volunteer driver(s) if they wish to become a volunteer driver with the transportation program; could be reimbursed for mileage for qualified services.	○ Local planning efforts are responsive to transportation needs of Tribe. Promote increased options for transportation for Tribal Elders with Special needs. ○ Volunteer transportation provider will complete a talk for the Tribe if requested. ○ Tribal volunteer drivers expand transportation capacity for Elders over 60. (note that this age limitation is determined by fund source – Older Americans Act)	Jody Moss – O3A Planning Director Tribal Social Services Director Tribal Elders Liaison <u>Pacific</u> Abbi Quigg, Volunteer Chore Services abbiq@ccsww.org, 360.637.8563.ext113 <u>Timeline:</u> March 2018 By December 2018 if requested by tribe	Spoke with Teri Wensits, Shelley Plemons and Jenny Knutson, who stated they would be very happy to be able to serve tribal members if they had volunteer drivers who wanted to become trained/qualified to provide this service in their region.
8. Assist Shoalwater Bay Tribe who are interested, to develop contracts available in 2018 (for example, Adult Days Services, Home Care Agency, Environmental Modification and others).	○ Notify tribe of option to contact O3A to help develop services/contracts ○ Provide technical assistance as needed ○ c. Assist with first series of contract monitoring visits as needed.	○ Communication between O3A and tribe results in awareness of new service options, and strengthens O3A's relationship with Shoalwater Bay Tribe ○ Expands culturally relevant services to tribal elders	AC Tribal Representative Designated O3 Program Manager, and O3A Services Delivery staff 2018-2019	Shared contracting options with tribal staff during 7.01 planning meeting and at other times. Many tribes have expressed interest in providing personal care services, environmental modification services, and Adult Day Care, even Adult Family Homes. Offered technical assistance if tribes move forward with any projects.

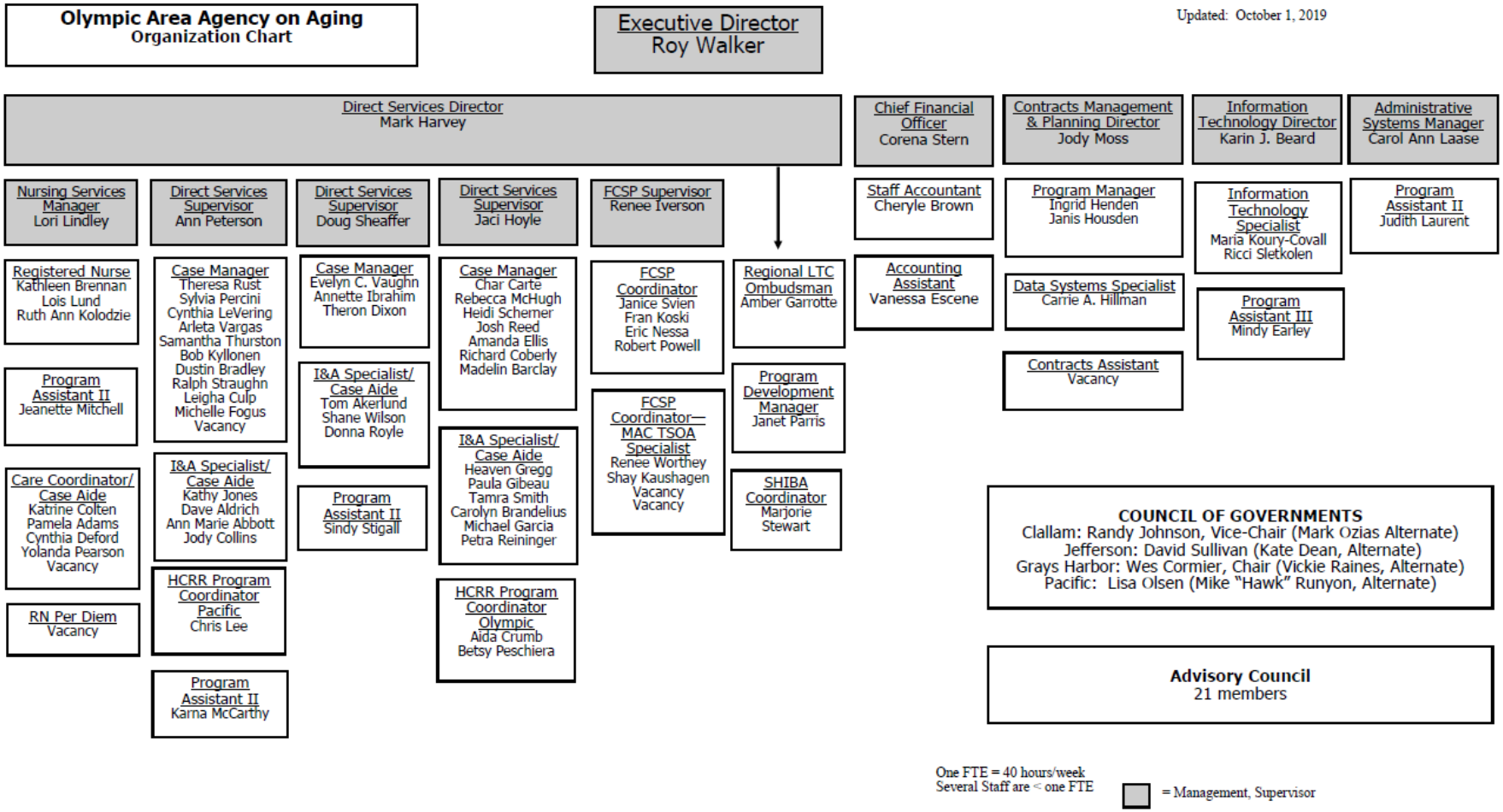
		○ Strengthens and improves the quality and cultural relevancy of services provided through tribal contracts.		

SECTION D – AREA PLAN BUDGET & COST ALLOCATION PLAN

Please see separate attachment.

APPENDICES

APPENDIX A – OLYMPIC AREA AGENCY ON AGING ORGANIZATION CHART



OLYMPIC AREA AGENCY ON AGING

2020 Staffing Plan

POSITION TITLE	TOTAL STAFF	POSITION DESCRIPTION
*^Executive Director R. Walker	1 FTE	Directs all activities, programs and services provided by O3A; works at state level to have voice in policy and funding decisions; carries out policies set by governing body, advises the board on community needs and strategic development. Advocacy (federal, state, local).
*^Direct Services Director M. Harvey	1 FTE	Directs in-house direct services programs in all four counties; program development and improvement; planning; quality assurance; community leadership; state relations; supervises CM/I&A Supervisors, Nurse Manager, designated direct service personnel.
*^Information Technology Director K. Beard	1 FTE	Maintains and improves technology and communication systems; develops data management systems, provides training, works with other managers to create technology tools that better serve clients.
*Chief Financial Officer C. Stern	1 FTE	Directs all of the fiscal operations of the agency. Prepares all budgets, agency contract/grant billings, and financial statements.
*^Contracts Management & Planning Director J. Moss	1 FTE	Supervisor for all planning & program management activities. Grant preparation & program development. Coordinates community-based planning/needs assessment process, monitors progress towards plan goals. Coordinates Advisory Council activities. Develops community and tribal partnerships. Lead on subcontract management & monitoring; subcontractor training & technical assistance.
*^Program Manager I. Henden J. Housden	1 FTE 1 FTE	Manage and monitor homecare agency, caregiver training, Older Americans Act, and COPES Ancillary, and other contracted services as assigned; Assist with subcontractor training & technical assistance.
*Administrative Systems Manager C. Laase	1 FTE	Assures integrated office systems are implemented & maintained; external dissemination of business information. Provides advanced administrative and program management support/coordination. Maintains personnel files; performs general human resource functions.
*Direct Services Supervisor J. Hoyle A. Peterson D. Sheaffer	1 FTE 1 FTE 1 FTE	Assist the Direct Services Director in supervising & managing the department; supervise direct service staff in coordinating services & resources to meet long-term care/in-home care needs of older adults & adults with disabilities.
*Nursing Services Manager L. Lindley	1 FTE	Supervises agency nursing staff. Works with Direct Services Director to manage agency's nurse services delivery to meet mandated requirements and provide Health Home services.

*Positions designated with an (*) are employees whose responsibilities would include disaster planning/management. ^Positions designated with an (^) are employees whose responsibilities include Medicaid Transformation Demonstration activities.

POSITION TITLE	TOTAL STAFF	POSITION DESCRIPTION
*^FCSP Supervisor R. Iverson	1 FTE	Supervises FCSP staff coordinating services and resources to meet the needs of unpaid family care-givers of older adults and people with disabilities. Works with Direct Services Director to manage the agency's FCSP and MAC-TSOA program service delivery to meet mandated requirements.
Case Manager M. Barclay D. Bradley C. Carte R. Coberly L. Culp T. Dixon A. Ellis M. Fogus A. Ibrahim B. Kyllonen C. Levering R. McHugh S. Percini J. Reed T. Rust H. Scherner R. Straughn S. Thurston A. Vargas E. Vaughn Vacancy	 1 FTE	Coordinate services & resources to meet long-term care/in-home care needs of older adults and people with disabilities.
^Information & Assistance Specialist /Case Aide A.M. Abbott T. Akerlund D. Aldrich C. Brandelius J. Collins M. Garcia P. Gibeau H. Gregg K. Jones P. Reininger D. Royle T. Smith S. Wilson	 1 FTE 1 FTE 1 FTE 1 FTE 1 FTE 1 FTE 1 FTE 1 FTE 1 FTE 1 FTE 1 FTE 1 FTE .82 FTE	Assist Case Managers in carrying out their responsibilities; provides information and assistance/referral services to public.

Care Coordinator P. Adams K. Colten C. Deford Y. Pearson Vacancy	 1 FTE 1 FTE 1 FTE 1 FTE 1 FTE	Assist Case Managers in carrying out their responsibilities; provides information and assistance/referral services to public; arranges supports for designated health home clients.
Staff Accountant C. Brown	1 FTE	Manages the agency's accounting functions and automated accounting system. Coordinates the accounts payable, payroll and ledger functions for the agency. Assists with sub-contractor monitoring.
Accounting Assistant V. Escene	1 FTE	Assists the Staff Accountant and CFO with standard accounting functions. Performs complex data entry and clerical tasks.
^*Data Systems Specialist C. Hillman	1 FTE	Ensures varied program data base program entries are accurate, performs reporting and review functions. Technical assistance to staff and contractors for data base platform usage. Coordinate service reporting.
Information Technology Specialist M. Koury-Covall R. Sletkolen	 1 FTE 1 FTE	Collects and reports data for statistical reporting agency-wide. Offers support and training on computerized tasks, troubleshoots and repairs problems, reporting results to IT Director.
Contracts Assistant Vacancy	.75 FTE	Provides mid-level clerical and data entry support within contracts management and administrative departments.
Program Assistant III M. Earley	.75	Provides mid-level clerical support and data entry for direct services (I&A, CM, etc.); IP contract management.
Program Assistant II J. Laurent K. McCarthy J. Mitchell S. Stigall	 .75 FTE 1 FTE .88 FTE .75 FTE	Provides mid-level clerical support for the agency.
SHIBA Coordinator M. Stewart	.75 FTE	Provides senior-level clerical support for the case management and I&A department.
*Program Development Manager J. Parris	1 FTE	Performs all levels of administrative support to direct service with emphasis on special projects & program administration for care management and I&A department. Assist with subcontractor training & technical assistance.
Registered Nurse K. Brennan R. Kolodzie L. Lund	 1 FTE .75 FTE 1 FTE	Per referrals, provides health-related consultation to case management, clients, and caregivers in the development and implementation of community-based long-term care services.
Reg. Nurse – Per Diem Vacancy	.25 FTE	Per referrals, provides health-related consultation to case management, clients, and caregivers in the development and implementation of community-based long-term care services.

Family Caregiver Support Program Coordinator ^S.Kaushagen (MAC-TSOA) F. Koski E. Nessa R. Powell J. Svien ^R. Worthey (MAC-TSOA) ^Vacancy (MAC-TSOA) ^Vacancy (MAC-TSOA)	1 FTE 1 FTE 1 FTE 1 FTE 1 FTE 1 FTE 1 FTE 1 FTE	Coordinate services & resources to meet needs of unpaid family caregivers of older adults and people with disabilities. Staff who work predominately with the MAC-TSOA program within the Family Caregiver Support Program (FCSP) department are marked. These staff persons may also provide general FCSP services to clients.

POSITION TITLE	**TOTAL STAFF**	**POSITION DESCRIPTION**
Regional Long Term Care Ombudsman A. Garrotte	1 FTE	Serves as Regional Long-Term Care Ombudsman in assigned area. Recruits, trains & supervises Certified Volunteer Long term Care Ombudsmen. Advocates for the well-being of long-term care residents. Assists in complaint resolution. May perform community education and legislative advocacy.
HCRR Coordinator A. Crumb C. Lee B. Peschiera	1 FTE 1 FTE 1 FTE	Works in HCRR operation in accordance with ALTSA guidelines. Trained & skilled in use of the HCRR database. Provides support to consumers and IP workers.

Number of full-time equivalents = 78.45 (FTE = 40 hours per week)
Number of Staff = 81
Number of Staff Over 60 = 33
Number of Staff Indicating a Disability = 7
Number of minority staff = 8

APPENDIX C - EMERGENCY RESPONSE PLAN *(The following is the Clallam County Plan – each plan is specific to the County)*

OLYMPIC AREA AGENCY ON AGING DISASTER PLAN

A disaster is defined by the World Health Organization as, "an occurrence disrupting the normal conditions of existence and causing a level of suffering that exceeds the capacity of adjustment of the affected community." In our region, a disaster may affect a small area in one county all the way up to and including the entire PSA. Disasters in our region may be a highly destructive storm, an earthquake, a flood, a multiple structure fire or forest fire, a landslide, an explosion, an epidemic, a structural collapse, environmental pollution, etc. Disasters can be natural or man-made and can include any problem that may require human intervention to assist community members (and specific for O3A), staff and clients to be safe.

The Olympic Area Agency on Aging (O3A) plan is based in part on an actual disaster which took place in 2007 when a windstorm and flooding occurred in the south counties and the O3A building was damaged and declared inoperable until repaired. **Note: Many of these following activities may occur concurrently**

Employee Status - Employees are O3A's greatest resource. In order to assure our clients' safety, we must first assure that our employees are safe and will deploy assistance as needed. Employees are instructed to:

- Contact 911 for any life threatening emergencies
- O3A asks that all employees text and or call their supervisor and leave a message, including any personal disaster issues they may be facing
- If there is limited phone* access – check in once phone access is available again, or if able, drive to work site to check in *Note: some local fire stations may have charging stations for mobile phones
- Employees are instructed NOT to enter a work site until the structural integrity has been verified (subject to the particular disaster)
- Managers should keep a contact list of all employees and begin calling those who have not checked in
- For all other employee needs, managers are asked to work with Emergency Management to deploy resources to help employees

Client Status – O3A clients, given their fragile and more dependent status, are of immediate concern - it may be necessary to contact the most vulnerable clients to determine if they are safe and receiving essential support. O3A has developed a standardized process for identifying and being able to contact prioritized clients. Previously secured client authorization to release records will suffice during disasters.

Disaster preparation is primarily a personal responsibility. O3A Staff who work with clients will encourage them to develop relationships with a neighbor(s) who can assist them during an emergency when no one else may be able to reach them.

Criteria for Assessing Client Risk/Frailty

Following are guidelines for assessing client risk:

The High Priority Client

Solely:

- Is medically fragile and needs daily tasks to survive
- Has critical medical equipment that is dependent on electricity (i.e. oxygen, nebulizer)
- Located in close proximity to disaster (based on some degree of judgement of type and severity of disaster)
- Has cognitive issues
- Has inadequate housing

-OR-

Two or more:

- Lives alone
- Is non-ambulatory
- Is geographically isolated
- Lacks functioning or close informal support systems
- Has a non-family independent provider

The Lower Priority Client

- Lives with family
- Lives in a senior or disabled housing complex
- Has a strong, local informal support system
- Has an Agency Provider

Assessing Priority

There is also a human element in assessing need, based on the case manager's (CM) and/or supervisor's knowledge of a client's specific circumstances. Some High Priority Clients (HPC) may be at less risk based on their support systems – e.g., a medically fragile client living with or near a daughter who is a nurse by training, or a client with oxygen who is known to have an electrical generator. Each CM will provide their own input to determine client risk.

The Client Contact List

O3A Information Technology Director created a tool for identifying the O3A High Risk / Frail Clients. Daily, the Information Technology staff will download O3A client records from the CARE system into an O3A agency database. The contact list includes the following:

- Client Name
- Physical Address
- Phone Number(s)
- A note field for CM to enter data, which will be key to identifying clients' risk/frailty status. CM will enter notes that another O3A staff or First Responder would need to know about the client to assist them (e.g., dementia, fragile diabetic, requires oxygen, etc.) in the event of an emergency/disaster. Any client with notes in this field will be listed on the high priority list.

CMs are responsible for keeping the risk / frailty notes up to date and noting changes in clients' condition as a low risk client deteriorates or high risk gets better. The full list of clients and the High Priority List of clients are accessible from any device in the O3A organization. When clients change to different CMs or cease receiving services their names are automatically transferred or removed through the daily update process. CMs may also use their client list as a tool in day to day work so they are motivated to keep it updated with adequate notes**.**

Master List Process

- O3A will maintain a master list of clients at each site
- This list will be produced using the same tools and sending Directors / Office leads emails
- Master List is always available electronically, on director/lead's device, and accessible for the period that the mobile device is charged

Client Contact Following Employee check-in after a Disaster:

- CMs will contact their high priority clients via telephone (if possible) first to ascertain their status, and will contact low priority clients thereafter
- Needs will be addressed on a case by case basis
- CMs may also wish to contact vendors providing life-sustaining equipment who may also be contacting clients
- CMs may also contact home care agency or individual providers for highest priority clients who may also be contacting clients
- When unable to reach a high priority client either by O3A or by Home Care Agency, contact will be made with local Emergency Management/911 to request a welfare check.
- MOUS are in development with all County Emergency Management Offices identifying need for welfare checks to be completed for uncontacted or High Priority Clients in need of emergent assistance
- No one will have access to the list unless there is an emergency as declared by O3A Executive Director, O3A Direct Services Director or County Emergency Management Departments, and it will be used only to perform health and welfare checks on high priority clients.

When Telephone Communication is Interrupted:

- O3A will determine who in each locale may have access to a ham radio and will use this as a communication tool to contact 911 for a welfare check
- When possible, O3A staff will attempt to arrange visits to high priority clients by nearby staff, realizing that limited communication also impairs this effort
- O3A will work with Home Care Agencies to develop strategies for reaching various clients based on close proximity of home care providers. (e.g., Since Agency X's worker lives near Agency Y's client and needs a welfare check, Agency X's worker will check on client); see attached "HCA DISASTER COLLABORATIVE PLANNING" Document
  - O3A will prepare and share a Home Care Agency contact list for to share for this purpose
  - O3A Case Management will authorize services provided by alternative agencies if not prior to services, then retroactively
- Per Home Care Agencies, approximately 20% of clients do not have telephones or do not have service in their homes – it is critical to have nearby contact information for these clients.

EMERGENCY KITS FOR OFFICES

- A Disaster Kit will be budgeted for each office based on staff size and maintained by the disaster lead. http://www.emergencykits.com/office-emergency-kits/small-office-emergency-kits (approximately $5-6K for all O3A offices)

Preparation Planning for Clients **(Recommended but dependent on Case Management Capacity)**

CMs will review disaster planning with all clients including:

- Encouraging development of a disaster kit
- Who will the client reach out to for help / who is nearby who can help
- A list of important contact numbers
- FEMA has developed a useful handout which may help seniors think and plan for disasters: https://www.fema.gov/media-library-data/1390858289638-80dd2aee624210b03b4cf5c398fa1bd6/ready_seniors_2014.pdf
- American Red Cross developed a Disaster Preparedness for Seniors By Seniors: https://www.redcross.org/images/MEDIA_CustomProductCatalog/m4640086_Disaster_Preparedness_for_Srs-English.revised_7-09.pdf

Business Continuity Policy

Purpose: The purpose of this policy shall be to ensure that the Olympic Area Agency on Aging (O3A) maintains a comprehensive Business Continuity Policy including objectives, assumptions, roles and responsibilities implemented in the event of an emergency resulting in the disruption of operations for any office locality of O3A.

Description: O3A shall maintain a comprehensive Business Continuity Policy, reviewed annually and updated as necessary to keep it current. The Executive Director and/or their designee(s) shall see that the plan is properly maintained and tested periodically. Copies of the plan shall be provided to management team members and direct service supervisors. Copies shall also be maintained at each office location and with other key staff.

O3A's Business Continuity Policy shall include, but not be limited to, the following areas:

1. Employee Safety: Each office shall be equipped with and have procedures regarding emergency supplies, evacuating buildings, securing assets, inspecting the premises, and conducting annual drills.
2. Prevention: The Executive Director and/or their designee shall take preventive measures to minimize the impact of a disaster. It may include, but not be limited:
   a. First aid and CPR (cardiopulmonary Resuscitation) training for employees;
   b. Smoke detectors in each office;
   c. Employee training on fire devices, location and use;
   d. Limited access to sensitive areas;
   e. Limited access to sensitive data;
   f. Offsite records retention as deemed appropriate; and,
   g. Regular inspection of alarms, fire extinguishers and other emergency devices as appropriate in each location.
3. Records Preservation: The Information Technology Coordinator is responsible for electronic records retention. However, this duty may be delegated to another member of the management team or other staff as deemed appropriate by the Executive Director and/or the Information Technology Coordinator. DSHS/ALTSA, HIPPA, and O3A policies shall be the guidelines for offsite records retention. A duplicate of critical electronic records shall be

stored offsite as described in the Business Continuity Policy procedures.

4. Alternate office location sites: In the event of major damage to O3A buildings, a list of possible relocation sites shall be maintained by the O3A Emergency Planning Coordinator named in the Business Continuity Policy. If alternate sites are also damaged, O3A shall make arrangements to operate out of a temporary facility at a safe site located as close as possible to the permanent location.
5. Risk Analysis: A separate risk analysis related to disaster may be performed for each office location/department annually. This shall include the probability and impact of various types of disasters and available resources.
6. Recovery Procedures: Procedures for resuming normal operations shall be maintained for each office location/department. Each office will review the procedures with staff annually.

The procedures shall be established for different types of disasters and shall include a minimum of the following:

a. Emergency communications;
b. Power Failure/fluctuations;
c. Communications systems failure;
d. Computer system or network failure
e. Earthquake, fire/explosion, flooding resulting in loss of building;
f. Data systems security.

Tracking of emergency expenses for possible reimbursement: In the event of an emergency and O3A incurs unanticipated expenditures in response to the emergency, those expenditures will follow normal invoice processing procedures except that a purchase order will not be required due to the urgency of the need. Each invoice will be approved by either the O3A Executive Director, the O3A Emergency Planning Coordinator or the Direct Service's Emergency Coordinator prior to payment. To track the expenditures for possible reimbursement, a separate GL account will be established for such emergency expenditures.

General Info

- Supervisors and Directors from other regions will attempt to travel to involved region to provide addition resources
- One employee will be assigned as key disaster lead for each O3A jurisdiction or office and has the responsibility to have deep knowledge of the O3A disaster plan and ability to help other staff
- Suggest employee selection be based on their interest and whether they have the respect of their colleagues (since they may be giving directions).
- Depending on availability, these employees are encouraged to periodically attend local prep meetings and share feedback with unit at monthly safety meeting – note: the limited capacity of direct service staff may limit this
- O3A Units will conduct one practice drill each year and provide feedback to plan based on practice learnings as part of agency Safety Programs.
- Conduct an after event feedback loop, adjust plan.
- Identify public disaster shelters and notify staff of each unit

FIRST RESPONDERS

Emergency Management & Ambulance

Clallam County Emergency Management

223 E 4th St # 6,
Port Angeles, WA 98362
clallam.net/EmergencyManagement/emcontact.html
360.417.2483

Olympic Ambulance

General Contact: 550 W Hendrickson Rd, Sequim, WA 98382
olympicambulance.com
Operations:
601 West Hendrickson Road
Sequim, WA 98382
Business – **360.681.4882**
Fax – 360.683.3381

FIRE DEPARTMENTS

Port Angeles Fire Department

102 E 5th St, Port Angeles 98362
360.417-4655 Fax: 360.417.4659
pafire@cityofpa.us
Fire Chief, **Ken Dubuc,**
kdubuc@cityofpa.us

Forks: Clallam County Fire District 1

11 Spartan Ave & Division, PO Box 118
Forks 98331
360.374.5561 Fax: 360.374.5613
ccfpd1@centurytel.net
Fire Chief **Bill Paul**: 360.374.5561

Port Angeles: Clallam County FD 2

102 E Fifth St, PO Box 1391
Port Angeles, 98362
360.417.4790 Fax: 360.452.9235
www.clallamfire2.org
www.facebook.com/clallamfire2

Sequim: Clallam FD 3

Provides service to City of Sequim & Jefferson 8
Clallam County Fire District 3
323 N Fifth Ave, Sequim 98382
360.683.4242 Fax: 360.683.6834
www.clallamfire3.org

Joyce: Clallam County FD 4

51250 Hwy 112, Port Angeles 98363
Mailing: PO Box 106, Joyce 98343
360.928.3132 Fax: 360.928.9604
station1@clallamfire4.org
Fire Chief **Alex Baker** . 360. 928.3132

Clallam Bay/Sekiu: Clallam County FD 5

60 Eagle Crest Way, PO Box 530; Clallam Bay 98326
360.963.2371
cclallam@centurytel.net; www.clallamfire5.org

La Push/Three Rivers: Clallam County FD 6

Three Rivers Fire Station
PO Box 2385, Forks 98331
360.374.2266

FEDERAL, INDUSTRIAL, MUNICIPAL & PRIVATE FIRE DEPARTMENTS

Neah Bay

Neah Bay Fire Department
PO Box 115, Neah Bay 98357
360.645.2701 Fax: 360.645.2941
Brian Parker, *Fire Chief*

Quileute

Quileute Fire Department
FDID: 05S03
PO Box 279, La Push 98350
360.374.6605
Chris Morganroth IV, *Fire Chief*

U. S. Coast Guard Air Station

Sector Field Office, Ediz Hook, Port Angeles 98362
360.417.5840

LAW ENFORCEMENT

State Patrol

District 8 Headquarters/ Bremerton Detachment
4811 Werner Road; Bremerton, WA 98312
Phone: **360.473.0300**
Port Angeles Detachment Office: **360.417.1738**

Clallam County Sheriff's Office

223 East 4th Street, Suite 12
Port Angeles, WA 98362
360.417.2262, 360.417.2459

Forks Police Department

500 East Division Street, Forks, Washington, 98331
360.374.2223, Fax: 360.374.2506

Port Angeles Police Department

Port Angeles City Hall; 321 E 5th St, Port Angeles
360.452.4545, Fax: 360.417.4556

Sequim Police Department

152 West Cedar Street, Sequim, Washington, 98382
360-683-7227; Fax: 360-683-4556

O3A / CCEM MEMORANDUM OF UNDERSTANDING

BETWEEN

OLYMPIC AREA AGENCY ON AGING

AND

CLALLAM COUNTY DEPARTMENT OF EMERGENCY MANAGEMENT

This MEMORANDUM OF UNDERSTANDING is hereby made and entered into by and between the Olympic Area Agency on Aging, hereinafter referred to as O3A, and Clallam County Department of Emergency Management, hereinafter referred to as CCDEM.

1. Purpose:
   The purpose of this agreement is to promote a partnership between O3A and CCDEM to help coordinate assistance efforts for O3A clients during an emergency.

2. Problem:
   A. Each individual client is first and foremost responsible for him or herself. However, high priority clients (already frail) may be particularly vulnerable in the event of an emergency and may need special assistance to meet their needs.
   B. O3A and the CCDEM will need to have points of contact in order to facilitate emergency communications about the extent of the emergency and urgent, crisis needs of vulnerable clients in the impacted areas.

3. Rules:
   A. On an ongoing and regular basis,

      O3A SHALL:

      a) Maintain current point of contact lists of the designated O3A staff to be able to communicate with the command centers of the counties during emergencies including staff names, titles, cell phones, email addresses, work phones, home phones, and any other means of communication with the CCDEM.

      CCDEM SHALL:

      a) Maintain and deliver current point of contact lists of the designated CCDEM staff to communicate with O3A including their names, titles, cell phones, email addresses, work phones, home phones, and any other means of communication to the points of contact for O3A.
      b) Respond as necessary during emergencies and disasters to the assigned O3A staff to coordinate with the client contact health and safety checks as needed.

   B. During an event, the role of each entity in performing health and welfare checks will largely be dependent upon the available resources, priorities and direction of the overall response. Health and welfare checks should, as appropriate, follow the suggested general structure of questions as attached to this agreement.

4. Responsibilities of the parties. O3A and CCDEM and their respective agencies and offices will handle their own activities and utilize their own resources, including the expenditure of their own funds, in pursuing these objectives. Nothing in this agreement

shall obligate O3A or CCDEM to obligate or transfer any funds. Each party will carry out its separate activities in a coordinated and mutually beneficial manner.

5. Commencement/Expiration/Termination. This agreement is in effect from _____ 2017 until amended or terminated by written request of either party and the subsequent written concurrence of the other. Either O3A or CCDEM may amend or terminate this agreement with a 30-day written notice to the other party.

6. Principal Contacts. The principal contacts for this agreement are:	
Olympic Area Agency on Aging	**Clallam County Department of Emergency Management**
Executive Director: Roy Walker walker@dshs.wa.gov; (360) 379-5064 Mobile – (360) 301-1506	
Planning Unit Director: Jody Moss mossjm1@dshs.wa.gov; (360) 379-5064 Mobile – (360) 460-4199	
Direct Services Director: Mark Harvey harvemb@dshs.wa.gov; (360) 538-8876 Mobile: (360) 461-5230	
Case Management Supervisor: Jaci Hoyle hoylejl@dshs.wa.gov; (360) 379-4427 Mobile: (360) 301-1052	

Authorized Representatives. By signature below, the parties certify that the individuals listed in this agreement as representatives of the parties are authorized to act in their respective areas for matters related to this agreement. THE PARTIES HERETO have executed this agreement.

Organization	**Printed Name / Title**	**Signature**	**Date**
Olympic Area Agency on Aging	Roy Walker Executive Director		
Care Givers Home Health, Inc.			
Catholic Community Services			
Korean Women's Association			
Olympic Community Action Programs			

ATTACHMENTS INCLUDED:

- Attachment #1 – Prioritization of O3A Case Management Clients
- Attachment #2 – O3A Health and Safety Welfare Check Questions for Clients

Attachment 1: O3A PRIOTIZATION of CLIENTS IN DECLARED EMERGENCIES

Client Status – O3A clients, given their fragile and more dependent status, are of immediate concern - it may be necessary to contact the most vulnerable clients to determine if they are safe and receiving essential support. O3A has determined that it is necessary to develop a standardized process for identifying and being able to contact prioritized clients.

Criteria for Assessing Client Risk The following are guidelines for each of the classifications:

High Priority Client Lists

Solely:

- Is medically fragile and needs daily tasks to survive
- Has critical medical equipment that is dependent on electricity (i.e. oxygen, nebulizer)
- Located in close proximity to disaster (based on judgement of type and severity of disaster)
- Has cognitive issues
- Has inadequate housing

-OR-

Two or more:

- Lives alone
- Is non-ambulatory
- Is geographically isolated
- Lacks functioning or close informal support systems
- Has a non-family independent provider

Lower Priority Client for Contact

- Lives with family
- Lives in a senior or disabled housing complex
- Has a strong, local informal support system
- Has an Agency Provider

Assessing Client Frailty: There is a human element in assessing need, based on the case manager's (CM) and/or supervisor's knowledge of a client's specific circumstances. Some High Priority Clients (HPC) may be at less risk based on their support systems – e.g., a medically fragile client living with or near a daughter who is a nurse by training, or a client with oxygen who is known to have an electrical generator. Each CM will provide their own input to determine client risk.

The contact list includes **Client Name, Physical Address, Phone Number(s), and a note field for CM to enter data, key to identifying clients' risk/frailty status.** CM will also enter notes that another O3A staff or First Responder would need to know about the client to assist them (e.g., dementia, fragile diabetic, requires oxygen, etc.) in the event of an emergency/disaster. Any client with notes in this field will be listed on the high priority list. Contact lists will be available to Case Managers on agency devices; full lists will be stored on Directors' devices

Contact Process

- O3A will make every attempt to contact frail clients first followed by all other clients

- If unable to reach high priority client, O3A staff will contact supervisor followed by Emergency Management to request a welfare check.

HOME CARE AGENCY DISASTER COLLABORATIVE PLANNING
MEMORANDUM OF UNDERSTANDING BETWEEN
HOME CARE AGENCIES & OLYMPIC AREA AGENCY ON AGING

This MEMORANDUM OF UNDERSTANDING is hereby made and entered into by Care Givers Home Health, Inc., Catholic Community Services, Concerned Citizens, Korean Women's Association, Olympic Community Action Programs, and ResCare HomeCare, Inc., (Home Care Agencies involved), hereinafter referred to as HCAs and with Olympic Area Agency on Aging, hereinafter referred to as O3A.

Purpose:

The purpose of this agreement is to promote collaboration between all HCAs in O3A's north region (Clallam and Jefferson Counties) and the south region (Grays Harbor and Pacific Counties) and with O3A to coordinate assistance efforts with clients during an emergency.

Problem:

1. Each individual client is first and foremost responsible for him or herself. However, high priority clients (already medically fragile) may be particularly vulnerable in the event of an emergency and may need special assistance to meet their needs
2. Depending on the type of disaster, O3A Case Managers / HCA workers may not be able to reach clients by phone or vehicle
3. Different agencies may need to ask other agencies if they have nearby staff who can perform a welfare check and/or deliver home care services to clients
4. HCAs / O3A will need to have points of contact in order to facilitate emergency communications between different agency care givers and difficult to reach clients

Rules:

HCAs SHALL:

a) Immediately contact 911 if client is experiencing life threatening problems (realizing that in the event of a large scale natural disaster, first responders may not be able to respond quickly to these situations)

b) Encourage clients to develop a personal disaster plan. A useful tool developed by the American Red Cross is Disaster Preparedness for Seniors By Seniors: https://www.redcross.org/images/MEDIA_CustomProductCatalog/m4640086_Disaster_Preparedness_for_Srs-English.revised_7-09.pdf

c) Previously secured client authorization to release records will suffice during disasters

d) Maintain contact lists of the designated HCA lead staff to communicate with one another during disasters

e) Commit to help one another's clients during disasters

f) Respond to all requests received by email, phone or SMS text as follows:
   1. Respond that message has been received
   2. Check to determine if a care giver is in the area and can perform a welfare check/deliver services

3. Provide feedback if worker is available to perform welfare check/deliver services, and provide feedback once the check has been completed
4. Provide feedback to the client's contracted agency on outcome/disposition
5. Provide feedback to O3A if an O3A client, to HCA, and to DDA (if applicable)
6. Document services in writing
7. Contact O3A (if an O3A client) after the disaster with back up documentation to arrange P1 billing/payment for services in a timely manner
8. Agree to meet after the disaster for an after event review process

O3A SHALL:

a) Immediately contact 911 if client is experiencing life threatening problems (realizing that in the event of a large scale natural disaster, first responders may not be able to respond quickly to these situations)

b) O3A will ask all clients to create their own disaster plan by identifying someone nearby who can help in times of disaster prior to a disaster; FEMA has developed a useful handout which may help seniors think and plan for disasters: https://www.fema.gov/media-library-data/1390858289638-80dd2aee624210b03b4cf5c398fa1bd6/ready_seniors_2014.pdf

c) O3A shall have previously secured client authorization to release records as part of routine care coordination

d) O3A has developed a tool to identify O3A's most fragile clients and will try to reach frail clients to assess their status

e) O3A will try to reach their clients using other available resources, i.e.,
   a) contact assigned home care agencies to see if they reached client
   b) if not, ask client's agency to contact other HCAs to determine if they have nearby available workers
   c) if not able to reach client through above means, contact Personal Emergency Response System (PERS) provider (if client has PERS unit) to try and make contact client or perform a safety check
   d) contact oxygen providers if needed
   e) contact 911 if unable to contact client, (realizing that in the event of a large scale natural disaster, first responders may not be able to respond quickly to these situations)

During an event, the role of each entity in performing welfare checks will largely be dependent upon the available resources, priorities and direction of the overall response.

Health and welfare checks should follow the suggested general structure of questions, as appropriate, attached to this agreement.

Responsibilities of the parties:

O3A, HCAs and their respective offices will handle their own activities and utilize their own resources, including the expenditure of their own funds, in pursuing these objectives. Nothing in this agreement shall obligate O3A or HCAs to obligate or transfer any funds. Each party will carry out its separate activities in a coordinated and mutually beneficial manner.

Commencement/Expiration/Termination:

This agreement is in effect from _____ 2018 until amended or terminated by written request of either party and the subsequent written concurrence of the other. HCA's may amend or terminate this agreement with a 30-day written notice to the other party.

Principal Contacts: The principal contacts for this agreement are: Efforts to contact shall include calling local contacts first, and next closest office second and working way out.

Organization	Person if known/Title	Contact #1	Contact #2
Olympic Area Agency on Aging - Clallam	Jaci Hoyle, Supervisor Mark Harvey Regional Dir		
Olympic Area Agency on Aging – Jefferson	Jaci Hoyle, Supervisor Mark Harvey Regional Dir		
Olympic Area Agency on Aging – Grays Harbor	Ann Peterson, Supervisor Mark Harvey, Regional Dir		
Olympic Area Agency on Aging – Pacific	Doug Sheaffer, Supervisor Mark Harvey, Regional Dir		
Home & Community Services	Michelle Cook, HCS Supervisor		
Developmental Disabilities Administration	Tobias Clawson, DDA Supervisor		
Care Givers Home Health, Inc.	Rhonda Carrell, CEO		
Catholic Community Services	Robin Gibson, Service Director, Long Term Care		
Concerned Citizens	Emma Noble, Personal Care Manager		
Korean Women's Association	JoEl James, IHC Regional Manager		
Olympic Community Action Programs	Sheila Rand, Homecare Manager		

Authorized Representatives: By signature below, the parties certify that the individuals listed in this agreement as representatives of the parties are authorized to act in their respective areas for matters related to this agreement. THE PARTIES HERETO have executed this agreement:

Organization	Printed Name / Title	Signature	Date
Olympic Area Agency on Aging	Roy Walker, Executive Director		
Care Givers Home Health, Inc.			
Catholic Community Services			
Korean Women's Association			
Olympic Community Action Programs	Sheila Rand, Homecare Manager		

Attachment #1
HCA Process for Disaster Cross Agency Collaboration

Scenario

- A Disaster has occurred and O3A and the HCA has instituted their own disaster plan
- There are client(s) the O3A and HCA have been unable to reach and/or provide care

Agreements

- Agencies agree to participate in phone tree
- Agencies create a master phone list / email list / text list and share with one following initiation of this MOU
- Agencies agree to respond to all contacts that they receive

Actions

- Agencies will create a phone tree / email tree / SMS text tree for connecting with other HCA agencies and caregivers
- Following disaster, HCA or O3A provides client address and brief description of locale to the phone/email/SMS tree, asking for care givers located nearby / possibly able to perform a welfare check.
- All agencies respond to these requests
- Once/if help is located, details are provided to particular caregiver
- Caregiver performs a welfare check and determines needs of client
- Caregiver provides care required which may include connecting client to neighbors, securing food/medication, and or arranging for client to be transported to a disaster shelter site.
- Caregiver provides feedback to own HCA and supervisor or worker provides feedback to original HCA
- Following incident, HCA providing services contacts O3A about payment for services.
- O3A submits a back dated authorization for payment of services

After Actions

- Meet with agencies and O3A to discuss what worked, what didn't
- Refine planning

Attachment #2
HEALTH AND WELFARE CHECK QUESTIONS FOR CLIENTS
(Move from general to specific)

1. Are you OK?
2. Do you have electricity? Heat? Water?
3. If the electricity is out, do you have medical equipment that isn't working that is essential for your health and care?
4. Do you have alternative options if your heat is out?
5. Do you have alternative options if your water supply is not working?
6. Do you have enough food to eat and liquids to drink?
7. Can you prepare the food?
8. Do you have friends/family that have been there to help you? If no, can you call friends/family for assistance?
9. Has your caregiver been there to help you? If no, have you been in touch with your caregiver?
10. How many more days' worth of accessible food/water do you have?
11. Do you have enough essential medication? How many more days' worth do you have?
12. Do you have any other concerns or needs at this time?

If a client is in immediate danger, call 911, (realizing that in the event of a large scale natural disaster, first responders may not be able to respond quickly to these situations).

If there is a need, but less imminent, call

County	**Phone**
Jefferson County Emergency Management Department	360-385-3831, Ext. 7
Clallam Emergency Management Department	360-417-2525
Grays Harbor County Emergency Management Department	360-964-1575
Pacific County Emergency Management Department	360-875-9340

APPENDIX D - ADVISORY COUNCIL

O3A ADVISORY COUNCIL MEMBERSHIP

Membe	Geographic Representation
Carolyn Lindley	Clallam County
Elizabeth Pratt	Clallam County
Charla Wright	Clallam County
Joseph Sharkey	Clallam County; State Council on Aging Rep./liaison, all counties
Ginny Adams	Jefferson County
Kris Kiesel	Jefferson County
Rebecca Knievel	Jefferson County
Patricia Smith	Jefferson County
Tobi Buckman	Grays Harbor County
Jane Lauzon	Grays Harbor County
Pam Tuttle	Grays Harbor County
Vicki Schmidt	Grays Harbor County
Darlene Smith	Pacific County
Denny Evans – 2019 Vice Chair	Pacific County
Eldred Gilpin	Pacific County
Dale Jacobson	Pacific County
Vacant	Tribal Rep., all counties.
Joanne Levine – 2019 Chair	Disabilities Rep, all counties.
Vacant	Elected Official, all counties
Vacant	Minority Rep., all counties

Number of Advisory Council Members 60+years of age = 14
Number of Advisory Council Members self-indicating a disability = 2
Number of Advisory Council Members of minority descent = 1

APPENDIX E - PUBLIC PROCESS

Description of the O3A 2020 -2023 Area Plan Work plan and Activities:

1. A Customer Satisfaction Telephone Survey was conducted in March and April, 2019 by Advisory Council Members
2. A regional survey of older adults was distributed via O3A's website, Advisory Council Members, stakeholder and provider network, via a newsletter, Trending Health and advertised in local media in paper format.
3. An online Provider Survey was marketed to all Senior Providers through the regular provider networks, contractor lists and O3A supervisors.
4. O3A staff organized a conference call and conferred with colleagues across the state to share ideas, research sources, and other pertinent information.
5. O3A staff reviewed current research on aging issues; recent information published by various local sectors (civic planners, public health, hospitals, transportation, social services, community action programs, etc.); national data sources (census, county health rankings, family caregiver data sources, etc.), and county and regional demographic projections.
6. Planning meetings occurred with ALTSA, with the Advisory Council to review the Area Plan requirements, last Area Plan goals and accomplishments, and changes in requirements from ALTSA.
7. Developed goals and sought input from Direct Service leadership staff, Advisory Council, and through Public Hearing process.
8. The Advisory Council reviewed the draft plan and approved the draft copy for presentation at a series of public hearings.
9. Public Hearings were held in each of O3A's four service counties: Clallam, Jefferson, Grays Harbor, and Pacific counties.
10. A Senior Provider Forum and a O3A Staff Forum were held in September, 2019
11. The Advisory Council accepted the plan and recommended that the Council of Governments approve the plan for submission to the Aging and Long Term Support Administration on September 17, 2019.
12. The Council of Governments approved the plan on October 3, 2019.
13. The 2020 – 2023 Area Plan was submitted to Aging and Long Term Support Administration on October 4, 2019

Surveys:

2019 Area Plan Survey →

Number of respondents – 433

← **2019 Client Satisfaction Phone Survey**

2019 Senior Provider Survey →

Senior Provider Forum:

One Senior Provider Forum was held in Port Angeles on September 11, 2019 with 25 in attendance. An overview on the Area Plan and goals for the next four years was presented.

Topics discussed following the presentation included:

- Paratransit – Will not transport clients seeing a specialist who does not accept Medicaid to appointments (in Poulsbo). Clients paying difference between Medicare and Medicaid but wants to stick with this trusted specialist for medical problems. We recommended they follow up with Volunteer Transportation in Clallam.
- Brianne Stewart has been working with Betsy Warden at the Port Angeles High School to begin teaching more components of the HCA training at the high school. They use to have a CAN program but discontinued that during budget cuts. (Pairs with one of the Area Plan Goals).
- Renee Worthey shared information about Medicaid Alternative Care & Tailored Services for Older Adults, (MAC & TSOA), and that these programs have a relatively generous income level qualification and can offer valuable supports for caregivers and individuals without a caregiver, who do not quite qualify for Medicaid services.
- Discussed that O3A planning is prioritized as
    - Level I - by critical services that are funded
    - Level II – less critical funded services & critical needs that are non- funded
    - Level III – Important needs, non-funded, and/or other agencies may be primary in leading these efforts.
    - Noted that most funded services are delivered by a combination of direct service staff and contracted agencies. Non-funded goals will be responsibility of Contracts Management & Planning staff

O3A Staff Forum:

Port Townsend & Sequim staff requested a presentation on the draft Area Plan on September 17, with 25 present. Staff was interested in how the plan was developed, what the goals were, and particularly interested in some of the data presented. They noted that the Prioritization page omitted SHIBA, which has since been added in.

Public Hearings:

A Public Hearing was held in each of the four counties in O3A's service area; the local county commissioner serving on the O3A Council of Governments convened each hearing in three of the four counties. Two weeks in advance of the first hearing, O3A:

- Published legal notice in local newspapers, and posted the notices on the O3A website.
- Mailed a copy of the draft Area Plan document to all persons who requested a copy in advance of the hearings.

Public Hearings were held in:

- Pacific County on August 22, 2019, 10:00 p.m., at the Pacific County Courthouse Annex in South Bend

- Grays Harbor County on August 22, 2019 at 2:00 a.m., at the Grays Harbor County Administration Building in Montesano;
- Clallam County on August 28, 2019, 10:00 a.m., at the Clallam County Courthouse in Port Angeles
- Jefferson County on August 29, 2019, 9:00 a.m., at the Jefferson County Courthouse in Port Townsend.

Local county representatives to the O3A Advisory Council County attended each hearing. Executive Director Roy Walker and Planning Unit Director Jody Moss attended each hearing to provide summary information about the Area Plan, and take comments. At each hearing:

- An attendance sign-up sheet was circulated;
- People attending were invited to comment verbally or in writing on a comment sheet;
- Full copies of the 2020-2023 Draft Area Plan were available at each hearing;
- A summary document with area plan goals and objectives and overview and plan highlights were distributes to all interested parties

A summary of each Public Hearing follows:

Clallam County Public Hearing

August 28, 2019: Clallam County Court House, Port Angeles

Commissioner: Randy Johnson, 2019 Council of Governments Vice Chair

O3A Advisory Council: Beth Pratt, Port Angeles; Charla Wright, Sequim

O3A Staff: Roy Walker, Jody Moss

Members of the Public: Penny Sanders, Elder Advocate/Guardian; Tammy Gallagher, Life Transition Services; Nancy Krieg, Laurel Place; Cindy Kazlauskas, Sequim Rehab; Kathy Morgan, OlyCAP

Summary: Copies of handouts and plan were distributes to all interested parties. Commissioner Johnson opened the Public Hearing and welcomed the attendees. Jody Moss presented an overview of the plan. Goals, Objectives and Activities were shared and a summary document of the high lights of the plan were reviewed. Questions were raised or discussion/suggestions ensued about:

- Recognition of the large geographic area and the challenges presented in delivering services, combined with the lack of recognition of these challenges in the I5 Corridor.
- Differences even within other rural areas for example comparing Kitsap to Clallam.
- Rural addresses may be poorly signed and unmarked and lack of connectivity makes way finding challenging “turn right at the big rock and into the dirt track by the large cedar tree.”
- Question was voiced on whether O3A is finding many Health Home clients with behavioral health issues. Explained the 3 sectors being served with Health Homes and that O3A is recruiting / contracting with other Care Coordinating Organizations for Behavioral Health and Substance Use Disorder Health Home Clients. In addition, O3A is general seeing increases in behavioral health issues in the population.
- Lack of specialty care services and limited numbers of gerontologists in region is a big issue.
- Providers are not familiar with the frail elder’s experience in a long term care facility or in their home is so that the provider’s treatment recommendations may be unrealistic.

- There is a need to address issues for the middle income individual facing the same challenges in aging and the high costs of long term care services. Information was shared on what is available to this middle income population.
- Cost of care is significant – Tammy mentioned the benefits of a Health Savings Plan.
- Discussion around housing and rise in homelessness for elderly women. There is an increase in the number of women living in their cars. Cathy Morgan noted the shelter residents include a number of elderly women who are no longer able to support themselves in housing once a spouse passes away.
- Commissioner Johnson described an affordable housing strategy he is pursuing using a public private partnership and may ask for support for the strategy in the future.
- Generally participants agreed that we cannot build our way out of housing issues and will need a new paradigm, for example Naturally Occurring Retirement Communities where individuals share housing; or building housing with shared kitchen / bathroom facilities. All of these options will need a culture shift in acceptance that it is honorable to live in a more shared social way.
- Noted that these options do address social isolation which is a significant elder issue.
- The need for oral health care access is critical as well as vision and hearing access for elders in the future. Discussed options for midlevel practitioners perhaps addressing the oral health care, but this is an issue the oral health care providers will need to embrace.
- Need for legislative advocacy for Medicare to cover oral, vision and hearing services.
- Need for advance care planning with entire family. Discussed work Olympic Medical Center is doing with Honoring Choices.
- Other issues – lack of adult day care and transportation options, abandonment of elders by their families.

Jefferson County Public Hearing

August 29, 2019: Jefferson County Court House, Port Townsend

Commissioners: David Sullivan

O3A Advisory Council: Joanne Levine, Port Townsend; Beth Pratt, Port Angles

O3A Staff: Roy Walker, Jody Moss

Members of the Public: Brian Jackson, Home Instead

Summary: Copies of handouts and plan were distributes to all interested parties. Commissioner Sullivan opened the Public Hearing and welcomed the attendees. Given the smaller number of attendees the process was slightly less formal with discussions of aging issues more generally. Questions were raised or discussion/suggestions ensued about:

- Brian talked about the various needs to assure stability for elders which include:
  - Financial stability
  - Safe showering
  - Making adjustments within the home to improve senior safety
  - Transportation access – getting to and from appointments

    - Food stability and improved home delivered meals
    - Medication Management and Durable Medical Equipment in place
    - Addressing Social Isolation (Adult Day care services)
    - Smart discharge planning to avoid readmission that addresses things like home safety evaluations, ability to manage a care plan independently or need for other services in place
    - Contracting more broadly with the health care system to keep frailer seniors stable.
- Home Instead has been investing in the GrandPad which is modeled after the iPad
    - With this a care giver can monitor the client from afar, checking on medications, asking questions and triggering face to face visits as needed in between those that are routinely scheduled.
    - The Elder and family can link to one another with this system – just by pressing a picture, the elder can call a family member or friend in the network.
    - The care provider leaves a voice note on the device which family can also listen to (in the "Family "Room function).
    - It has risk factors that trigger a "red, yellow and green flag". Brian is talking with Eric Lewis about a means of getting the important alert info to providers.
- Concerns were voiced over the manner in which people who have some form of dementia have on occasion been treated by staff at a medical facility – example given was when a client was sent back to the assisted living facility with the instructions in the same bag as soiled clothing.
- Other topics that were discussed were the impact of minimum wage and benefits increases on small businesses for home care aids, the cost of training, low reimbursement from Medicaid, future potential health payment models, the cluster care delivery model in Snohomish County; HCA training in schools for students.

Grays Harbor Public Hearing

August 22, 2019: Grays Harbor County Courthouse, Montesano

Commissioner(s): Wes Cormier, 2019 Council of Governments Chair

O3A Advisory Council: Tobi Buckman, Aberdeen, Jane Lauzon, Aberdeen, Vicki Schmidt, Ocean Shores, Pam Tuttle, Ocean Shores

O3A Staff: Roy Walker, Jody Moss

Members of the Public: Bob Nakutin, Hoquiam; Moira Connor, Channel Point, Village Concepts; Suzette Tamlin, Coastal Community Action Programs

Summary: Copies of the Area Plan were shared with the Commissioner and with Moira Connors, at their request. Commissioner Cormier opened the Hearing and welcomed the attendees. Jody Moss presented an overview of the plan. Goals, Objectives and Activities were shared and a summary document of the high lights of the plan were reviewed. Questions were raised or discussion/suggestions ensued about:

- Housing Issues in Grays Harbor; increasing housing costs are pushing people, especially those on fixed incomes, into homelessness or residential placement; there are increasing numbers of homeless older women who are often victims of domestic violence.

- The values of Advance Care planning, Hospice and the Honoring Choices program in the north counties.
- Lack of resources for vision services and hearing aids – with potential coverage for hearing aids coming through Medicare in the future.
- Helping community members better link to our services and that our organization title (O3A and even I&A may be confusing – suggested rebranding as "Healthy Aging."
- Health Homes – explained program and benefits;
- Lack of Adult Day Care services, especially for those with dementia;
- Transportation is a real issue.
- Workforce training; caregiver training partnerships at schools; expressed support for training for young people to see a path forward.
- Discussion on our work with tribes.
- Need more resources for dementia care, adult day care, telehealth, technology impacts.
- Comments about the need for senior defensive driving training in Grays Harbor;
- Questions about the use of interpreter services; and;
- Comments voiced about the high value of Senior Provider Meetings.

Pacific County Public Hearing

August 22, 2019: Pacific County Courthouse Annex, South Bend

Commissioner: Lisa Olsen

O3A Advisory Council: Dale Jacobsen, Long Beach

O3A Staff: Roy Walker, Jody Moss

Members of the Public: Suzette Tamlin, Coastal Community Action Programs

Summary: Copies of the Area Plan were shared with the Commissioner and with Suzette Tamlin, at their request. Goals, Objectives and Activities were shared and a summary document of the high lights of the plan were reviewed. Questions were raised or discussion/suggestions ensued about:

- Question about the reduction of client hours for home care services when the client requests home delivered meals.
- Access to Specialty Care and Transportation are significant issues.
- Discussed the possibility of Dementia telemedicine / grand rounds model for local Primary Care providers to be able to call in to a University of Washington program and get diagnosis/ treatment/ other questions answered.
- Housing issues for seniors.
- CCAP has a new respite program for homeless people discharged from the ED but too sick to go back to the street.
- Long Term Care trust Act.
- Substance use.
- Dementia.

Advisory Council Meeting:

The Advisory Council met to conduct a final review of the Area Plan, Goals, and Public Hearing details. During that meeting there was a robust discussion on measuring outcomes to prove that the investments are making a difference. Some input on that topic are as follows:

- Much of the outcomes study work has been done at the federal or state level (for example – Health Homes, Family Caregiver Support Evidence Based Programs, and In Home Long Term Care Supports).
- The cost of measuring outcomes is expensive and much more likely to be a more efficient use of funding if done at the state and local level rather than having each Area Agency on Aging hire and evaluator.
- There was an appreciation of the need to move in this direction given the use of federal and state dollars to fund services.
- There was some concern expressed on the potential for reduction of critical resources or having budgets reduced for programs that are already not well funded. The example given was Nutrition program, funded at $6.80 per meal, already a poorly compensated program requiring investments on the part of the agencies running it.
- There is an opportunity to create some of this during the Request for Proposal process which will be conducted next year for the Older Americans Act Nutrition and Transportation contracts.

Tobi Buckman made the following motion: The Olympic Area Agency on Aging Advisory Council recommends that the Council of Governments approve the Olympic Area Agency on Aging 2020-2023 Area Plan draft to be presented to the Aging and Long-Term Support Administration as required.

Second was made by Rebecca Knievel. Motion carried.

Council of Governments

The Council of Governments met on October 3, 2019, and reviewed final changes to the Area Plan.

Clallam County Commissioner Mark Ozias (Alternate Clallam Commissioner) made a motion: The Olympic Area Agency on Aging Council of Governments approves the Olympic Area Agency on Aging 2020-2023 Area Plan to be presented to the Aging and Long-Term Support Administration as required.

Second was made by Pacific County Commissioner Lisa Olsen. Motion carried.

APPENDIX E - PUBLIC PROCESS

O3A Area Plan (AP) Work Plan for 2020 - 2023

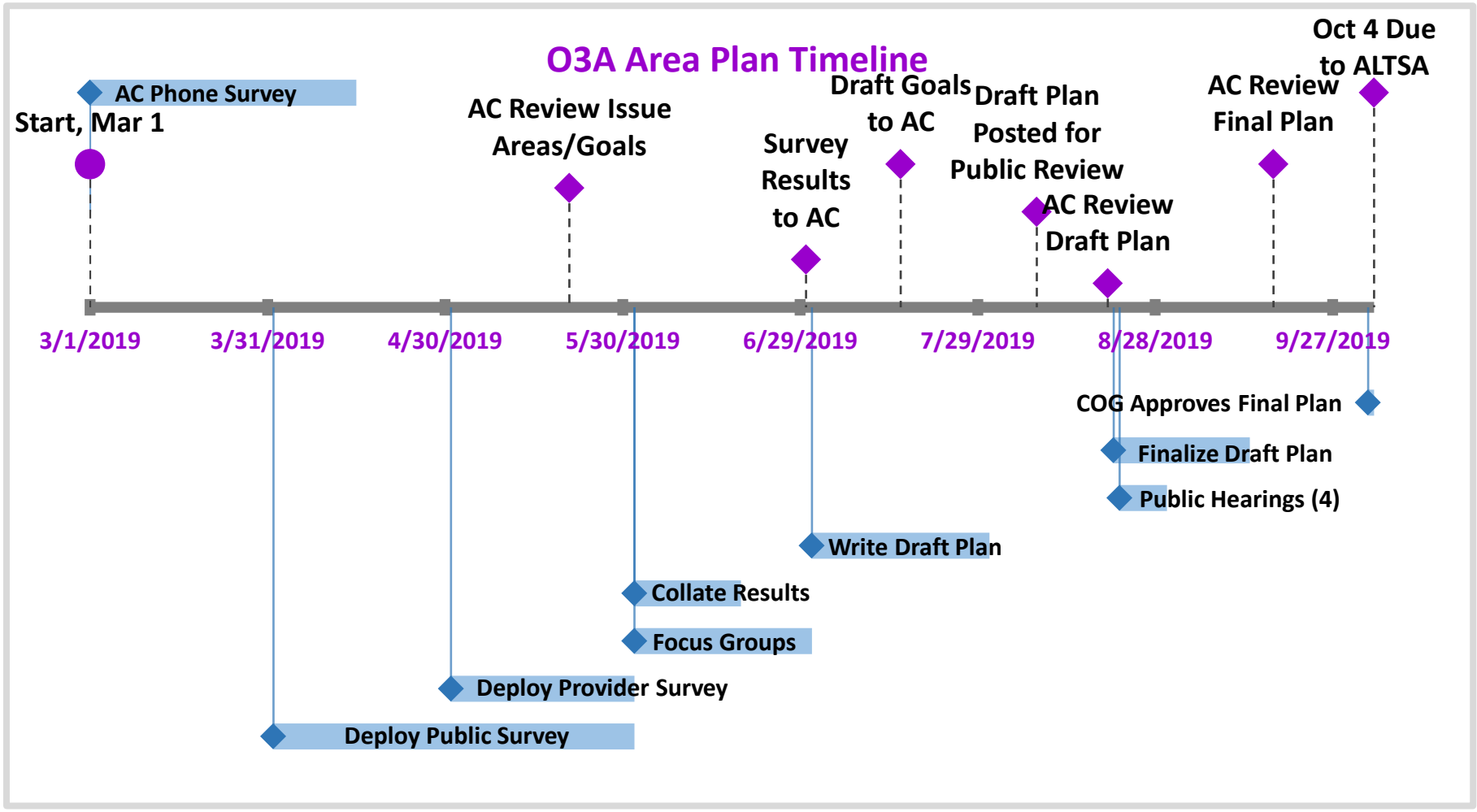
Key:

Jody	Carol Ann	Ingrid	Margaret
Carrie	Roy	Advisory Council	Mark
Brenda	ALTSA	Kim	Other

Actions	Person Responsible	Time Line[49]
ALTSA Issues AP instructions – See Attached	ALTSA	April ✓
7.01 Meetings	Jody, Roy, Mark	Jan-Apr✓
Issue Areas & Background Narrative Review		
Develop 2016-2019 Plan Review PowerPoint and present to AC	Jody & staff	Sept 18 ✓
Instructions / Issue Areas Goals / Objectives / Targets Reviewed w/AC	Jody & staff, AC	5/21
Discuss Issue Areas, Goals, Objectives & Activities with AC and seek input	JM, IH, JH, RW, AC	5/21
Present draft very preliminary goals to AC	Jody, AC	7/16
Refine goals based on local data/survey/focus groups/other community input	JM, IH, JH, CH	July Aug
Profile Research		
Search web sites for county and regional data	Carrie	May-Jun
Field Research		May/June
Phone Survey by AC	Jody, AC	3-4/19 ✓
Deploy Public Survey	Jody & staff, AC	4/16✓
Deploy Provider Survey	JM, Janet, Heaven, Shane, Karna, JH, IH	5/1
Collate results	Carrie, Brenda	6/30
Feedback on all survey results to AC	Jody	July
Share instructions with AC	Jody	May
Write and Edit Area Plan		

[49] If date is listed , it is the end date

Write Sections A – C, Appendix C, E, F - Jody	**Jody**			**May-Aug**
Write Staffing Plan, Appendix A, B, D, G - Carol Ann	**Carol Ann**			**Jul-Sept**
Write Budget – Kim/Corena Carol Ann	**Kim, Carol Ann**			**Jul-Sept**
Review/Edit Section A – C or more– Mark/Sups	**Mark/Sups**			**Aug**
Review/Edit Section A – C – or more Roy	**Roy**			**Aug**
Review/Edit Section A – C – or more Kim /Corena	**Kim**			**Aug**
Review/Edit Section A – C – Brenda / Karin	**Brenda**			**Aug**
Review/Edit Section A – C– Ingrid	**Ingrid**			**Aug**
Review/Edit Section A – C – Margaret and / or Janis	**Margaret/Successor**			**Aug**
Review/Edit Section A – C – Members of AC Planning Committee	**AC**			**Aug**
Send draft to interested staff for input	**Jody**			**Jul-Aug**
Make edits from input	**Jody**			**Jul-Aug**
Present Draft Area Plan to AC	**Jody**			**August**
Make any suggested AC draft edits	**Jody**			**August**
7.01 Meetings	**Jody**	**Mark**	**Roy**	**Jan-Apr ✓**
Public Hearings				
Schedule Public Hearings (each county) Between 8/20and 9/17	**Carol Ann**			**May**
Prepare Power Point for Public Hearings	**Jody**			**Jul-Aug**
Advertise Public Hearings 2-weeks prior to each hearing	**Carol Ann**			**Aug-Sep**
Draft Summary Available for Public Review 2 weeks before 1st hearing	**Jody**	**Carol Ann**		**8/10/19**
Hold Public Meetings	**Jody**	**Roy**		**8/22-28-29/19**
Complete notes from Public Meetings	**Jody**			**Sep**
Submit Final Area Plan to Advisory Council	**Jody**			**9/17/19**
Finalize and submit to COG for Approval	**Jody**			**10/3/19**
SUBMIT TO ALTSA				**OCT 4**


O3A Area Plan Timeline
AC Phone Survey
Start, Mar 1
AC Review Issue Areas/Goals
Survey Results to AC
Draft Goals to AC
Draft Plan Posted for Public Review
AC Review Draft Plan
AC Review Final Plan
Oct 4 Due to ALTSA
3/1/2019
3/31/2019
4/30/2019
5/30/2019
6/29/2019
7/29/2019
8/28/2019
9/27/2019
COG Approves Final Plan
Finalize Draft Plan
Public Hearings (4)
Write Draft Plan
Collate Results
Focus Groups
Deploy Provider Survey
Deploy Public Survey

APPENDIX F - REPORT ON ACCOMPLISHMENTS OF 2018-2019 AREA PLAN UPDATE

ISSUE AREA: C-1 LONG TERM SERVICES AND SUPPORTS (LTSS)					C = Continued in Next Area Plan
GOAL C.1.: Older adults & people w/ disabilities are able to remain in their own homes w/ maximum independence as long as possible.					
Measurable Objectives	**Key Activities**	**Responsible**	**Timeframe**		**Accomplishment or Update**
			Start	**End**	
1. Implement requirements for new service formats with in-service training for direct service staff. **C**	1.a. Provide logistics and coordination for training venues	Regional Director	1/2016	12/2016 & ongoing	1a/1b. All required training was provided to O3A staff.
	1b. Implement staff training.				
2. Procure contracted services that meet needs identified for Medicaid clients by case managers (average caseload 1,500 clients). **C**	2a. Recruit and contract local agencies & providers to meet client needs for Medicaid-funded services identified by case managers.	Program Manager; Case Managers	1/2016	12/2019	2a. Contract Managers engaged in ongoing provider recruitment and contracting for a broad variety of providers. 2a. Contract Managers routinely seek the help of the HCS Resource Development Manager for difficult to locate resources. 1a/2a. O3A worked with Home Care Agencies to develop stronger partnerships/opportunities for information sharing that enhance /improve service.
	2b. Recruit and contract with individual providers (IPs) through the O3A Home Care Referral Registries; ensure caregiver requirements are met for background check, training and certification. **C until CDE is in place**	Regional Director; Case Managers; Registry staff	1/2016	Ongoing	2b. O3A's Home Care Referral Registry staff worked to contract with, and track training, background checks and certification requirements for Individual Providers in PSA.
ISSUE AREA: C-2 SYSTEMS INTEGRATION AND SERVICES COORDINATION					

GOAL C-2: To provide person-centered coordination of health and community supports for increasing numbers of people who face significant health challenges in a manner that improves their health and reduces avoidable health care costs.					
Measurable Objectives	**Key Activities**	**Responsible**	**Timeframe**		**Accomplishment or Update**
			Start	**End**	
1. Maintain O3A staffing capacity to provide person-centered care coordination services to clients throughout the region that achieves service levels and quality of service delivery required by health home contracts. **C**	1a. Ensure dedicated staff are supported with training, supervision, and technology support.	O3A Exec Director; Regional Director; Nursing Services Manager	1/2016	Ongoing	1a, 1b, 1c. O3A has maintained an ongoing commitment to staff knowledge, technology, quality of service, fidelity to models, accurate reporting is maintained, and working towards assuring that revenue adequately supports services. In February 2019, O3A became a Health Homes Lead in a 5 county region when an MCO left the region. Lead function is covering expenses. Need to add staffing capacity to CCO work.
	1b. Ensure service integrity is maintained through adherence to fidelity, reporting requirements.				
	1c. Ensure that revenue from Health Home Care Coordination Contracts adequately supports O3A level of effort.				

2: Participate in local and regional readiness coordination activities leading to stronger service networks for clients. C	2a. Continue participation in Accountable Communities of Health networks.	O3A Exec Director O3A Director, Planning & Program Management O3A Program Mgr	1/2016	Ongoing	2a. O2A Executive Director Chaired 3 county Olympic Community of Health (OCH); Planning Dir. Active with Natural Communities of Care, and advising OCH staff regarding Social Service Nonprofit organization issues.O3A received a small annual grant to fund some CDSMP & staff training work. 2. Contract Manager coordinated regional home care agency meetings with current focus on cross agency disaster coordination 2. Contract Manager served on the local Bar Association and provided SLAC Clinic training and Advance Care Planning development 2. O3A Offices convened well attended monthly Senior Provider Meetings in all four counties
	2b. Continue participation / advocacy in Rural Health Improvement Collaborative (RHIC) and Health Path Access Team (HPAT).			Ongoing if active	Discontinued as neither organization is currently active
	2c. Participate in local and regional program coordination efforts, e.g., Regional Transportation Providers Organizations; regional home care agency coordination meetings.				2c. Planning Director serves on the Regional Transportation Providers Organization, Clallam County Transportation Coalition

ISSUE AREA: C –3 HEALTH PROMOTION, DISEASE PREVENTION AND DELAY OF MEDICAID-FUNDED LONG TERM SERVICES AND SUPPORTS (AKA PRE-MEDICAID)

GOAL C.3.1. Community Living Connections (CLC) Program: 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.

Measurable Objectives	Key Activities	Responsible	Timeframe		Accomplishment or Update
			Start	End	

1. Inform older adults, families, other Consumers about existing health and long- term care options, and assistance to access. **C**	1a. Support I&A staff with training to maintain AIRS and CIR-S certification.	Regional Director	1/2016	Ongoing	1a. I&A staff are AIRS certified or on the training path towards certification. 1b I&A Work is well recognized within the community and actively sought out and referred to. 1c.Staff host Senior Provider meetings to expand community outreach and to learn about new programs.
	1b. Implement Information & Assistance program throughout the region according to program requirements.				
	1c. Coordinate with local community partners to provide coverage with responsive services and current information on alternatives.				
2. When funding becomes available, expand services to younger adults with disabilities and children. **NC**	2a. With new funding, fully implement the O3A Transition to ADRC/CLC Plan.	Regional Director	TBD	TBD	2a. Funding not available. Although O3A does not market to the adults with disability population, all clients receive thoughtful help and referral for services.
	2b. With new funding, update and integrate local information and resources for younger adults with disabilities and children into CLC GetCare on line directory.	O3A IT Coordinator	TBD	TBD	2b. Funding not available - O3A will continue to devote staff time toward this as capacity allows

GOAL C.3.2.: Family Caregiver Support (FCSP); Kinship Caregiver Support (KCSP) and Relatives as Parents (RAP) Programs support more family and kinship caregivers to care for their family members.

Measurable Objectives	Key Activities	Responsible	Timeframe		Accomplishment or Update
			Start	End	
1. Conduct outreach to identify and enroll caregivers into support programs & provide targeted support to family & kinship caregivers responsive to their needs.	1a. Promote & facilitate referrals to FCSP; KCSP & RAP with appropriate local community agencies, via presentations & contacts to schools, medical service providers, discharge planers, churches, etc. Develop new referral resources as they are identified in each county.	Regional Director	1/2016	Ongoing	1a. Ongoing services provided by FCSP staff. FCSP has seen a significant increase in cases since beginning of MAC/TSOA and will need to advocate for additional resources in the future.
	1b. Provide T-CARE assessments & customized care plans for family caregivers.	FCSP Staff	1/2016	Ongoing	1b. Ongoing services form the core of work provided by FCSP.

C	1c. Provide customized services & supports to family & kinship caregivers (e.g., respite, counseling, support groups, help with children's school supplies, etc.)	FCSP Staff	1/2016	Ongoing	1c. Ongoing services form the core of work provided by FCSP.
	1d. Identify and contract sufficient providers to facilitate efficient and timely service provision.	Program Manager; FCSP Staff	1/2016	Ongoing 12/2019	1c. Ongoing services provided by Contract Managers.
2. Strengthen capacity to provide Powerful Tools for Caregivers & make available to wider community **Will continue as an T3D funded Evidence Based program**	2a. Update Powerful Tools training for FCSP staff.	Regional Direct Services Director; FCSP Coordinators	NA	NA	2a. O3A no longer offers Powerful Tools training for staff or for caregivers due to funding constraints.
	2b. Provide Powerful Tools training sessions for caregivers in all counties.	Regional Direct Services Director; FCSP Coordinators	NA	NA	2b. O3A does contract with outside providers to provide this program as requested if staffing capacity or funding available.
	2c.Train staff from local community-based organizations to provide Powerful Tools training in their communities.	Regional Direct Services Director; FCSP Coordinators	NA	NA	See above

Goal(s) C.3.3. Health Promotion, Disease Prevention

Older adults, adults with disabilities and their families have the knowledge and support to make informed choices about chronic disease prevention and management, and person-centered treatment and care options.

Medical service providers and the general public are aware of and appreciate the benefits of person-centered care and treatment, including the roles and benefits of palliative and hospice care as options for people facing severe chronic illness and/or end-of-life.

Measurable Objectives	Key Activities	Responsible	Timeframe		Accomplishment or Update
			Start	End	

1. Facilitate implementation of evidence-based wellness programs in communities throughout the PSA. C	1a. As funding allows, facilitate implementation of evidence based programs, such as Chronic Disease Self-Management (CDSM) workshops; Stay Active and Independent for Life (SAIL) fitness program for older adults; Powerful Tools for Caregiving, and/or other evidence-based wellness programs in the service region.	O3A Planning Director Program Manager	1/2016	Ongoing	1a. Contracted: Tai Ji Quan, Movement for Better Balance in Port Angeles and Sequim, a very popular and over- subscribed program. Chronic Disease Self-Management Programs in Clallam County. Jefferson Healthcare is leading workshops in East Jefferson (self-funded, and O3A offers scholarships for eligible seniors). Ocean Beach Hospital has contracted to offer CDSMP and SAIL Grays Harbor agencies did not apply for the Evidence Based funding opportunity – we will focus additional recruitment efforts in GH in the future. O3A has applied for Medicaid Transformation Project 1 funding in the north counties.
	1.b. Provide information to older adults on medication management.	O3A Planning Director	1/2016	12/31/2019	1b. O3A contracted with 2 pharmacists in north and south counties to present programs on drug education. In addition, O3A has invested in a project to create more social media and emailed newsletters with drug education material included. This project will also boost marketing pharmacist programs.

2. Promote end-of-life planning, using available resources and tools such as The Five Wishes, through existing public education mechanisms, e.g., www.o3a.org, feature articles in local newspapers. **Continuing in a limited fashion**	2a.Survey available tools and resources available to individuals for end of life planning, including legal and medical tools, as well as educational tools for communicating with family and loved ones. 2b. Identify (local) technical resources to provide education and training.	O3A Advisory Council Task Force O3A Planning Director	1/2016	12/31/2019	2a. Researched tools and developed a resource guide with links on website. 2a. Conducted a survey seeking community members' thoughts, feelings and readiness on this topic. 2b. Identified a partner in Olympic Medical Center which is launching a project using the Honoring Choices tool. Partnered to expand reach.
3. Engage local medical service providers in dialogue regarding palliative and hospice care options available in the community**.** **Continuing in a limited fashion**	3a Meet with local medical service providers re availability of palliative & hospice care, and how to access in each county. 3b. Develop follow up activities based on initial conversations in each county.	O3A Advisory Council Task Force O3A Planning Director	1/2016	12/31/2019	3a. O3A Advance Care Planning Committee developed a list of questions to begin engaging medical providers. 3a. Olympic Medical Center in Clallam County has launched a county wide and beyond effort to develop this work. Jefferson Healthcare has a Palliative Care Department

ISSUE AREA: C.6: MEDICAID TRANSFORMATION PROJECT DEMONSTRATION

C.6.1 GOAL: Medicare Alternative Care (MAC) and Tailored Services for Older Adults (TSOA) Benefits support additional caregivers to care for their family members.

Measurable Objectives	Key Activities	Responsible	Timeframe		Accomplishment or Update
			Start	Finish	

1: Conduct outreach and provide customized client centered support and services to family caregivers. **C**	1a. Train FCSP I&A and other O3A staff 1b. Promote MAC & TSOA programs with appropriate local community agencies, via presentations & contacts to schools, medical service providers, discharge planners, churches, etc.; 1b. Support / facilitate referrals from hospitals, discharge planners, physicians' offices, schools, churches, etc. Develop new referral resources as they are identified in each county; 1c. Provide T-CARE assessments & customized care plans for family caregivers; 1d. Provide customized services & supports to newly identified caregivers (e.g., respite, counseling, support groups) 1.e. Develop and implement an Outreach Plan	Regional Direct Services Director, FCSP Staff, CMP staff	1/1/17	Ongoing	1a.Ongoing – staff performing at a high level 1b. Multiple presentations given throughout region, articles published in many different markets and papers, programs presented on radio shows. 1b.Connected with hospitals, discharge planners, tribes, medical providers offices etc., throughout region. 1c. Routine part of MAC &TSOA services now. 1d. Routine part of MAC & TSOA services now. 1e. Outreach plan developed annually and implemented with increasingly positive results.
2. Assure systems alignment and provider network adequacy. **C**	2a. Learn about and develop contract tools 2b. Identify and contract with sufficient providers to facilitate efficient and timely service provision. 2c. Provide technical assistance and encouragement to current FCSP and new small contract providers who may be reluctant to commit to the Medicaid contracting requirements	CMP Staff	4/2017	Ongoing	2a. Contracting staff have completed updating contracts. 2b Addressing network issues (ongoing) 2c. Community and tribes are aware of program and making referrals.

APPENDIX G - STATEMENT OF ASSURANCES AND VERIFICATION OF INTENT

For the period of January 1, 2020 through December 31, 2023, the Olympic Area Agency on Aging accepts the responsibility to administer this Area Plan in accordance with all requirements of the Older Americans Act (OAA) (P.L. 114-144, 42 USC 3001-3058ff) and related state law and policy. Through the Area Plan, Olympic Area Agency on Aging shall promote the development of a comprehensive and coordinated system of services to meet the needs of older individuals and individuals with disabilities and serve as the advocacy and focal point for these groups in the Planning and Service Area. The Olympic Area Agency on Aging assures that it will:

Comply with all applicable state and federal laws, regulations, policies and contract requirements relating to activities carried out under the Area Plan.

Conduct outreach, provide services in a comprehensive and coordinated system, and establish goals objectives with emphasis on: a) older individuals who have the greatest social and economic need, with particular attention to low income minority individuals and older individuals residing in rural areas; b) older individuals with significant disabilities; c) older Native Americans Indians; and d) older individuals with limited English-speaking ability.

All agreements with providers of OAA services shall require the provider to specify how it intends to satisfy the service needs of low-income minority individuals and older individuals residing in rural areas and meet specific objectives established by the Olympic Area Agency on Aging for providing services to low income minority individuals and older individuals residing in rural areas within the Planning and Service Area.

Provide assurances that the Area Agency on Aging will coordinate planning, identification, assessment of needs, and provision of services for older individuals with disabilities, with particular attention to individuals with significant disabilities, with agencies that develop or provide services for individuals with disabilities.

Provide information and assurances concerning services to older individuals who are Native Americans, including:

A. Information concerning whether there is a significant population of older Native Americans in the planning and service area, and if so, an assurance that the Area Agency on Aging will pursue activities, including outreach, to increase access of those older Native Americans to programs and benefits provided under the Area Plan;

B. An assurance that the Area Agency on Aging will, to the maximum extent practicable, coordinate the services the agency provides with services provided under title VI of the Older Americans Act; and

C. An assurance that the Area Agency on Aging will make services under the Area Plan available, to the same extent as such services are available to older individuals within the planning and service area, to older Native Americans.

Provide assurances that the Area Agency on Aging, in funding the State Long Term Care Ombudsman program under section 307(a)(9), will expend not less than the total amount of Title III funds expended by the agency in fiscal year 2000 on the State Long Term Care Ombudsman Program.

Obtain input from the public and approval from the AAA Advisory Council on the development, implementation and administration of the Area Plan through a public process, which should include, at a minimum, a public hearing prior to submission of the Area Plan to DSHS/ADS. The Olympic Area Agency on Aging shall publicize the hearing(s) through legal notice, mailings, advertisements in newspapers, and other methods determined by the AAA to be most effective in informing the public, service providers, advocacy groups, etc.

Date	Roy Walker, Executive Director Olympic Area Agency on Aging
Date	Joanne Levine, Advisory Council Chair Olympic Area Agency on Aging
Date	Wes Cormier, Grays Harbor County Commissioner Chair, Council of Governments Olympic Area Agency on Aging