Area Plan

2016 - 2019

Update – 2018-2019

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, 2017

Dear Friend:

It is my pleasure to present the Olympic Area Agency on Aging 2016 - 2019 Area Plan Update. 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 updated 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;
- Provide support for family caregivers;
- Make informed decisions about the support they need to remain independent and access the appropriate services;
- Access quality in home services that support consumer engagement and provide choice;
- Coordinate with services for Older Native Americans.
- Access to additional Family Care Giver Supports through the Medicaid Transformation Project Demonstration (New in 2017)

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

To the Council of Governments County Commissioners:

- David Sullivan, 2017 Chair, Jefferson
- Wes Cormier, 2017 Vice Chair, Grays Harbor
- Randy Johnson, Clallam
- Bill Peach, Mark Ozias, Clallam alternates
- Vickie Raines, Grays Harbor alternate
- Lisa Olsen, Pacific
- Frank Wolfe, Pacific alternate

And To:

- Joanne Levine, 2017 Advisory Council Chair
- Denny Evans, 2017 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 remaining two 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

Appendices:

A. Organizational Chart
B. Staffing Plan
C. Emergency Response Plan
D. Advisory Council roster
E. Statement of Public Process
F. Statement of Assurances
G. 2018 – 2019 Area Plan Issue Area Goals, Objectives, Key Activities, Accomplishments and Updates

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
CCM	Chronic Care Management
CCO	Care Coordination Organization
CDC	Center for Disease Control
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
FCSP	Family Caregiver Support Program
FEMA	Federal Emergency Management Assistance
HAP	Health Action Plan
HC	Home Care
HCS	Home and Community Services
HCRR	Home Care Referral Registry
HH	Health Home
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
LGBT	Lesbian, Gay, Bisexual or Transgender, also GLBT
LIS	Low Income Subsidy Program
LTC	Long Term Care
LTCOP	Long Term Care (Volunteer) Ombudsman Program
MAC	Medicaid Alternative Care
MB	Management Bulletin
MCO	Managed Care Organization
MTPD	Medicaid Transformation Project Demonstration
MH	Mental Health
MIPPA	Medicare Improvements for Patients and Providers Act
MPC	Medicaid Personal Care
N4A	National Association of Area Agencies on Aging
NCOA	National Council on Aging
NICOA	National Indian Council on Aging
NS	Nursing Services
NSIP	Nutrition Services Incentive Program
OAA	Older Americans Act
O3A	Olympic Area Agency on Aging (OAAA)
PERS	Personal Emergency Response System; also Professional Emergency Response Services
PSA	Planning and Service Area
RCW	Revised Code of Washington
RFI	Request for Information
RFOC	Revised Fundamentals of Caregiving
RFQ	Request for Qualifications
RFP	Request for Proposals
RSVP	Retired Senior Volunteer Program
SAIL	Stay Active & Independent for Life
SCOA	State Council on Aging
SCSA	Senior Citizens Service Act
SCSEP	Senior Community Service Employment Program
SFMNP	Senior Farmers Market Nutrition Program
SHIBA	Senior Health Insurance Benefit Advisors
SLAC	Senior Legal Advice Clinic
SNF	Skilled Nursing Facility
SSA	Social Security Administration
SSPS	Social Service Payment System
SSA	Social Security Administration
T-CARE	Family caregiver assessment tool
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 2016 -2019

Update: 2018-2019

This is a two-year update to the four year 2016-2019 Area Plan. The updated sections are highlighted in yellow. These sections explain what has changed, what has been accomplished to date on the goals and objectives, and changes planned over the next two years.

Significant changes for the 2018 - 2019 period include:

- Implementation of the State Medicaid Transformation Project Demonstration resulting in increased eligibility / services for Family Care Givers; retooling of contracts and staff training for this purpose, as well as potential additional resources for evidence-based programs.
- O3A added additional goals around Alzheimer's Disease / Dementia
- Several programs have been suspended due to lack of resources/staff capacity to support them (Powerful Tools and the Gatekeeper programs).
- Tailoring of 7.01 plans detailing O3A's services to specific tribes' needs has been ongoing.
- Over the past year, there has been significant leadership turnover, which has entailed hiring and orientation of a new Chief Financial Officer and a new Director of Contracts Management & Planning.
- Other significant efforts in the past 2 years include investing management planning and staff training related to Individual Provider overtime, implementation of Community Living Connections, and as noted above the launching of Medicaid Alternative Care/Tailored Services for Older Adults, and Medicaid Transformation Project Demonstration - Initiative 1 planning efforts.

The Olympic Area Agency on Aging (O3A) is pleased to present its Area Plan for 2016 – 2019 with 2018-2019 Updates. 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 fiscal and human capital investments for the next four years, and was developed through broad-based community consultation, qualitative and quantitative field research, and public input. The area plan document serves as the foundation for work plans, funding priorities and planning efforts to provide services for persons who are older or need long term care in Clallam, Grays Harbor, Jefferson, and Pacific Counties.

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

Service Region

O3A's primarily rural service area comprises **198,500[1] *(an increase of 650)*** people dispersed over 1,442 square miles of rugged mountainous terrain 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 **69,500 adults[1] with a predicted increase to 73,945[2] adults age 60 and older by 2020,** adults age 18 and older with disabilities **(28,361[3])**, native elders from nine Tribes **(1,539[4])**, and a small but growing Hispanic population (**1,095[5]** over 60), as well as other non Native American or Hispanic minority populations.

The Olympic Area Agency on Aging

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

To overcome the difficult geographic barriers in its service region, O3A relies on decentralized field office placement, with direct service and support staff situated in the communities they serve; a communications system supported by information technology; and a provider network of contracted and cooperating partners offering support and care to older adults. The provider network includes family and paid caregivers; individual and agency providers of in-home and respite care and support; community action programs providing senior nutrition, transportation and adult day care services; contracted legal services; mental health service providers, and local contractors providing home safety modifications and personal emergency response services. Cooperating partners include local area hospitals and clinics as well as local health departments and legal and law enforcement agencies.

O3A direct service staff provides nursing and case management services to approximately **1,650** Medicaid-eligible adults age 18 and older. O3A's Senior Information & Assistance program provides community outreach with information about health insurance, legal issues, long term care options, and other senior service programs and benefits to thousands of local residents each year.

---

[1] ***April 1 2016 official population estimates,*** Washington State Office of Financial Management, Forecasting Division, 2016, http://www.ofm.wa.gov/pop/asr/default.asp

[2] ***Selected populations and aging service utilization forecast, Olympic AAA***, in *Forecasts ofthe Aging Population, Dementia Prevalence and Use of Long-Term Care Services Through 2020 in Washington State*. DSHS Research and Data Analysis Division, Olympia, WA. Mancuso, David, PhD., June 2015

[3] *U.S. Census Bureau,* ***2011-2015 American Community Survey Fact Finder, 2015***

[4] *U.S. Census Bureau,* ***2011-2015 American Community Survey Fact Finder,*** *2015*

[5] *WA St Office of Financial Management, Estimates of April 1 population by age, sex, race and Hispanic origin, 2016*

Governance

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

Operational Capacity

Approximately 70 direct service, technical, and administrative personnel are based in seven offices - one in Grays Harbor, and two each in Clallam, Jefferson and Pacific counties. An administrative office, located in Port Hadlock, houses executive, financial, human resource, planning, and contract management staff. Two larger offices in Aberdeen (Grays Harbor) and Sequim (Clallam) comprise direct service provision staff, and senior management for Information and Assistance, Care Management, Family Caregiver Support, Nursing Services and Information Technology.

Two offices in Pacific County, one office in the West End of Clallam County, and one in Port Townsend (Jefferson County) serve as satellite offices for Information and Assistance () and Care Management Program staff. O3A receives federal and state funding to administer 20 programs, as well as foundation grants and local resources, and has an average annual operating budget with total revenue of $6.8 million dollars.

O3A supports its direct and contracted service provision with contract management, technical assistance and monitoring, financial oversight, and IT support. O3A maintains a website (www.o3a.org), and access to media publicity through weekly radio programs and weekly columns in local newspapers. These two outreach efforts have the potential to reach significant numbers of the population in the 4 county region. Below is a list of the potential audiences. O3A also provides outreach through social media outlets including increased use of Facebook, Pinterest and Twitter.

- Chinook Observer - weekly: GH=50, P=4542, 58,387 unique web hits/month
- Pacific County Press - weekly: P=2000
- Willapa Harbor Herald - weekly: P=5775
- Daily World - 1x/week: GH=6804, P=505, 145,000 hits/month
- Senior Events" – 1x/week: GH=6804, P=505, 145,000 hits/month
- Peninsula Daily News - 1x/week: C=9135, J=1790, 141,285 hits/month
- Senior Sunset Times - monthly: C=12,150, J=250, GH=1000. 21,000 hits/month
- Beach-To-Beach Edition (of SST) - monthly: GH=14,000, P=1,200. 28,352 hits/month
- Living Well Magazine (resource directory) - annual: C=8800, J=4500, GH=8800, P=2800
- Radio shows on KMUN - 1x/month: GH=3000, P=400
- Radio shows on KPTZ - 4x/month. = C,J & Puget Sound region=20,000
- Radio shows periodically – GH – KBKW & KXRO = 6,000 ea
- Radio shows on KSQM – C – NEW! – 4,000

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

A – 2 Mission, Vision and Values:

MISSION

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

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

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

VISION

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

VALUES

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

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

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

A – 3 Planning and Review Process 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 84% is considered "nondiscretionary" and is designated for specific services like Medicaid Title XIX Case Management and Home Care, the United States Department of Agriculture meals program, and state funded respite care.

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

The Advisory Council, through the work of two committees, recommends criteria for evaluation and allocation of discretionary funding to service areas. The Planning Committee recommends service funding priorities based on community assessment data; the Allocations Committee recommends s allocation levels based on available resources. Both committees have representation from each of O3A's four counties. With life spans increasing, the baby boom cohort advancing, and a service region that is a significant retirement destination, as well as economically distressed, a major challenge for O3A is the determination of vulnerability in a growing population of older adults, in order to prioritize services in a relatively resource-scarce environment.

RESOURCE ALLOCATION GUIDELINES FOR DISCRETIONARY FUNDS

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

FUNDING GUIDELINES

Funds must be allocated in accordance with mandates from each funding source. Services/support must be responsive to the current operating environment. Critical elements to focus on for 2016 -2019:

- Ensuring O3A maintains the capacity and flexibility to respond to emerging local needs through O3A programs (e.g., its I&A and Family Caregiver Support services);

- Prevention services and health promotion programs aimed at reducing the burden of chronic disease and injury in the service population;
- Greater coordination and support for local service delivery at the community, county, and at regional levels (e.g., leveraging with health providers for opportunities within the Affordable Care Act);
- Strengthening the safety net for vulnerable adults through support for traditional (e.g., professional and family caregivers) and non-traditional stakeholders,(e.g., engaging businesses and faith-based organizations in developing services and support);
- 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 are not and cannot reasonably expect funding by other entities;
- Services will be funded at a level sufficient to make the program viable and responsive to consumer needs. O3A will encourage providers to "leverage" additional funds for joint funding of services and may assist providers to secure funds from grants and other sources;
- O3A will generally avoid allocating funding to services in which the O3A contribution is less than 15% of the total for that particular service, and it appears likely that other funding, or fundraising, could be used to cover the service cost;
- In the case of new services and/or initiatives for which other funding sources may be anticipated, O3A funding may be allocated and considered "seed" money, for a time-limited period; 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 allocated for program development, quality initiatives, training, coordination, and advocacy efforts that support the agency mission and statement of values and vision for 2016 - 2019.
- Staff resources will be allocated first for those activities that are necessary to support and improve the quality of services funded directly by O3A.
- Staff resources will be allocated next for those efforts for which the agency can expect to have a high level of impact and likelihood of success in achieving the agency's mission, vision, and objectives.
- Staff resources will be allocated to take advantage of opportunities that arise during the course of the next four years, and which will serve to move the agency toward achieving the goals stated in its mission, values, and vision statements.
- O3A's staffing model will remain flexible in order to sustain capacity by training and rededicating staff with appropriate skill sets as funding, programs, and

services change.

- Additional staffing resources needed for Medicare Alternative Care (MAC) and Tailored Services for Older Adults (TSOA) implementation will be assessed over time and added incrementally. It is anticipated that there will be a minimum of 2 additional Family Care Giver Support FTEs added within the next 2 years and potentially as many as 4 across the PSA.

PRIORITIZATION OF PROGRAMS & SERVICES

Services planned for 2018-2019 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 Health Home Services Family Caregiver Support Information & Assistance In-home Personal Care Nursing Services Home-delivered meals	Congregate Meals Home Repair & Maintenance LTC Ombudsman Senior Community Service Employment Program – Title Transportation	Kinship Caregiver Support Living Well with Chronic Conditions (1) Senior Legal Services ~~In Person Assister program~~

Notes

1. Some activities in the Living Well with Chronic Conditions program (Chronic Disease Self Management) are subject to grant funding and will phase out in early 2016, unless funding is continued. ***Chronic Disease Self Management has continued on a limited basis with a small contract in Clallam through OAA Title IIID Evidence Based Program funding.***

Section B – Planning and Service Area Profile

There has been a slight increase in the population O3A serves since 2015

B – 1 Population Profile:

O3A's service area is home to approximately **198,500** people widely dispersed over the rugged mountainous terrain of the Olympic peninsula. Of these, **35%, or 69,500** are 60 years old and over. The entire service region is considered to be rural[3], with an average of 30 people per square mile.

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

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

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

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

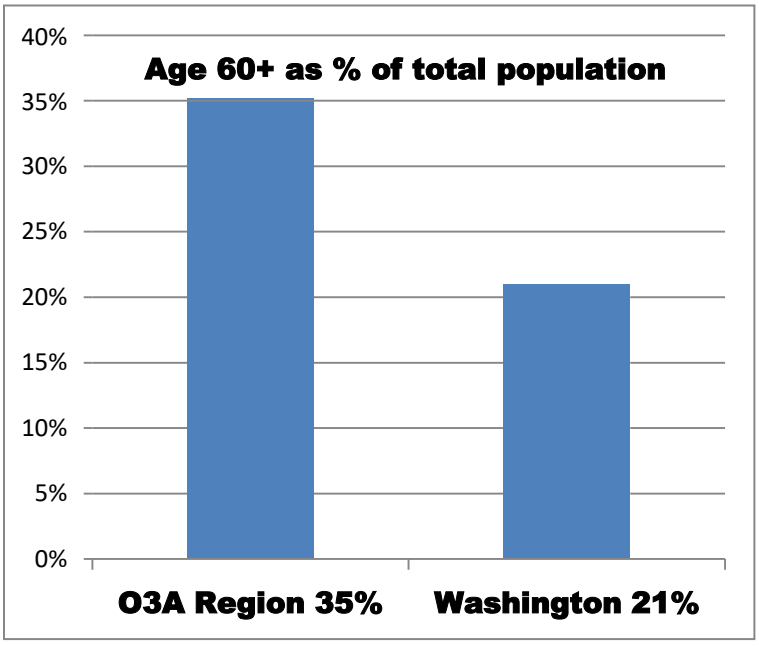
[3] *For the sake of consistency and reporting, the Administration on Aging's definition for rural is used: Any area that is not defined as urban. Urban areas comprise (1) urbanized areas (a central place and its adjacent densely settled territories with a combined minimum population of 50,000) and (2)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

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

DEMOGRAPHIC SUMMARY

Demographic[6]	Total
Total population	**198,500** ▲
60+	**69,500** ▲
60+ at or below poverty level	**4,787**
60+ Minority	**3,709**
60+ Minority below poverty level	**527**
60+ Rural Areas	**69,500** ▲
Adults w/ Disabilities(age 18 +)	**28,361** ▲
60+ Limited English Proficiency	**2,079**
Tribal Elders (estimated)	**1,539** ▲
Number of Tribes	**9**
Tribal Nations	Chehalis, Chinook, Hoh, Jamestown S'Klallam, Lower Elwha Klallam, Quileute, Makah, Quinault, and Shoalwater Bay.
Tribes with Title VI (OAA) programs	Chehalis, Jamestown S'Klallam, Lower Elwha Klallam, Quileute, Makah, Quinault, and Shoalwater Bay.

Percent of O3A Service Region Population Age 60 and over



60 and older

Throughout the O3A service region, 35% of the population is 60 or older, compared to Washington State, with 21%[7].

[6] ***Selected populations and aging service utilization forecast, Olympic AAA***, in *Forecasts of the Aging Population, Dementia Prevalence and Use of Long-Term Care Services Through 2020 in Washington State*. DSHS Research and Data Analysis Division, Olympia, WA. Mancuso, David, PhD., June 2015

[7] www.factfinder2.census.gov; Profile of General Population and Housing Characteristics: 2010

The proportion of adults aged 60 years or over in Jefferson is **45%**; in Pacific County at **40%**; with Clallam at **36.7%** ; and, Grays Harbor at **27.4%**. All of these percentages have increased since the 2016 – 2019 Area Plan was written, and Jefferson County has moved into the lead position for the greatest percentage of the aging population. That means that the 60+ age group already represents over a third of the population in three of the four O3A service counties. As adults continue to age in place and retire to the peninsula, growth in the number of 60+ residents will continue to outpace the rest of the state and nation.

Elders living alone

In a recent O3A survey of the region, 47% of respondents reported living alone; 39% reported living with a spouse or partner, and 14% reported living with a friend or relative[8].

Minority Populations

Within the O3A service region, 92.5% of the total population is white. Persons identifying themselves as Hispanic or Latino amounted to 6.87% of the population, the largest minority in the region recorded by 2015 Census data. American Indian/Alaskan Natives comprise the second largest 'minority' community at 5.6% of total population[9].
As of 2016, approximately 4.1% of American adults identify as lesbian, gay or bisexual, while 0.3% are transgender—approximately 10,052 million Americans. Washington State is one of ten U.S. States with the highest number of adults identifying as lesbian, gay or bisexual, at 4.6% of the total state population.[10]

O3A PSA: White, Native American and Hispanic Populations

County	% White	% American Indian/ Alaska Native	% Hispanic or Latino
Clallam	91.7 ▲	7.1 ▼	5.7 ▲
Grays Harbor	90.8 ▲	6.7 ▼	9.6 ▲
Jefferson	94.2	4.3 ▲	3.4 ▲
Pacific	93.4 ▲	4.3 ▼	8.8 ▲
PSA Average	**92.5%** ▲	**5.6%** ▼	**6.87%** ▲

Adults with Disabilities

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

[8] O3A Consumer Survey, conducted from May – July, 2015 n=>500.

[9] www.factfinder2.census.gov; Profile of General Population and Housing Characteristics: 2010, 2015

[10] http://www.lgbtmap.org/equality-maps/lgbt_populations: 2016.

Seniors with Disabilities

The percent of the 65+ population with disabilities is higher in Grays Harbor and Pacific Counties than the state percentage (42.3%), at 48.6% and 47.8%, respectively. Both Clallam and Jefferson County are below the state average, at 38.4% and 33.9%, respectively.

B – 2 Targeting Services:

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

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

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

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

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

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

In addition, O3A provides case management to approximately **1,625** ***(an increase of 150)*** clients. The following table indicates current services being provided and the geographic location of each. Service descriptions follow.

O3A Direct and Contracted Services	Clallam	Grays Harbor	Jefferson	Pacific
Adult Day Care Services	X			
Case Management ❖ COPES / Medicaid Personal Care	X	X	X	X
Elder Abuse Prevention • Long-Term Care Ombudsmen **1**	X	**1**	X	**1**
Family Caregiver Support Program ❖ Unpaid caregiver support services ❖ Kinship Caregiver Support (incl. *Relatives as Parents*) ❖ Caregiver training; ❖ ~~Powerful Tools for Caregivers Classes~~ **2** ❖ Respite Services, Assessment & Coordination ❖ Respite Care ❖ MAC & TSOA services **3**	X	X	X	X
Employment Support/Title V Services	X	X	X	X
~~Gatekeeper Training~~ 4				
Home Care Referral Registry ❖ Independent Provider procurement/placement	X	X	X	X
Information and Referral Services	X	X	X	X
~~In Person Assister Program~~ 5				
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 6	X	X	X	X
Statewide Health Insurance Benefits Advisors (SHIBA)	X	X	X	X

1. The Long Term Care Ombudsmen Program expanded to Grays Harbor and Pacific Counties on 7/1/2016.
2. O3A no longer offers staff led Powerful Tools for Care Giver classes due to budget constraints; other organizations continue to offer training outside of O3A
3. MAC and TSOA programs expand services to additional family caregivers and to provide support to qualified individuals who do not have a caregiver
4. Due to budget constraints, O3A no longer has a formal Gatekeeper training program; staff encourages community members to serve in gatekeeper role and presents on topic.
5. O3A no longer provides contracted In Person Assister services although will continue to provide assistance on request.
6. Senior Drug Education Program launched an expanded program in June – see Long Term Service & Supports for details.

O3A Direct and Contracted Services:

Adult Day Services

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

Adult Day Care is currently the only *Adult Day 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 therapy), and psychological or counseling services. *There are presently no Adult Day Health services available in the O3A service region.*

Caregiver Information, Support, and Training

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

Case Management

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

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

Screening and referral for case management services are provided through the O3A

Information & Assistance program, and DSHS Home & Community Services.

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

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

- 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 homes of clients;
- Home-delivered meals for housebound clients who lack the ability to prepare meals and do not have help;
- Home health aide services to provide intermittent health and other incidental services beyond what a regular caregiver can provide;
- PERS (professional emergency 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 wheelchairs, special shoes, flashing light doorbells, and aids to assist with standing).

Elder Abuse Prevention

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

Employment (Title V Senior Community Service Employment Program)

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

Information and Assistance

Information and 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[11] specialists screen clients to determine their need for more

[11] Alliance of Information and Referral Systems is a professional credentialing program for individuals working within the I&R sector of human services. Certification is a measurement of documented ability reflecting specific competencies and related performance criteria,

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 wills clinics, Medicare Part D presentations, and other activities designed to reach out to older persons who need services and link them with the most appropriate resources.

~~In Person Assister Services~~

Staff will assist clients to sign up for insurance but no longer serves in the contracted In Person Assister role.

Legal Services

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

Minor Home Repair and Maintenance

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

Nursing Services

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

Medication Management

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

Nutrition Services

The *Congregate Nutrition* program helps meet dietary needs of older people by providing nutritionally sound lunches in a group setting, along with nutrition education. Two contracted agencies manage nutrition sites located throughout the service region,

which describe the knowledge, skills, attitudes and work-related behaviors needed by I&R practitioners. The AIRS Certification Program is operated in alignment with national standards for credentialing organizations.

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 5days/week rule due to financial constraints as follows:

- Meals are provided 3 days per week in Forks
- Meals are provided 4 days per week in Chimacum, Port Angeles and Sequim

Home-Delivered Meals, often referred to as "Meals on Wheels", provides nutritious 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 services may also receive meals at home. Clients receive hot meals delivered to their homes, as well as frozen meals for weekends and days that hot meals are not scheduled for delivery.

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 market (Grays Harbor and Pacific Counties).

Respite Services

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 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

Senior Drug Education (6088) provides adults age 60 and over education and information on safe and effective use of medication (prescription drugs, vitamins and herbs) through seminars and presentations in classroom settings. In May/June 2017, O3A began sending a quarterly emailed newsletter with medication education information included. Initially this has been sent to providers and staff, with a goal of increasing the mailing list to include clients. Staff are encouraged to forward and share newsletter with clients/others. This information has also been shared on O3A's website and Facebook page.

Statewide Health Insurance Benefits Advisors (SHIBA)

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

Transportation

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

Olympic Area Agency on Aging Coordination Services

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

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

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

Services Provided	Clallam	Grays Harbor	Jefferson	Pacific
Adult Day Care	1	-	-	-
Alzheimer's / Dementia Services & Facilities	5	3	1	1
Case Management Programs	3	-	3	1
Community Action Programs	1	1	1	1
Councils on Aging or other significant senior organizations	1	1	1	1
Dental Health Programs & Services	1	1	1	1
Department of Social and Health Services (DSHS)	1	1	1	1
• Adult Protective Services (APS)	1	1	1	1
• Community Services Offices (CSO)	1	1	1	2
• Developmental Disabilities Offices (DD)	1	1	1	1
• Special Nutrition Assistance Program	1	1	1	1
• Home & Community Services (HCS)	1	1	1	2
• Information & Referral	1	1	1	2
Disability Access Programs	-	1	1	-
Disability Services & Programs (see DSHS Developmental Disabilities)				
Elder Abuse Programs (see DSHS Adult Protective Services)				
Health & Medical Care				
• County Health Departments	1	1	1	1
• Home Health Agencies	4	1	1	1
• Home Care Agencies	9	3	5	3
• Hospice Services	2	1	2	1
• Hospitals	2	2	1	1
• Community Health Clinics	5	3	4	4
Housing				
• Public Housing Authority	1	1	1	1
• Public Housing Facilities	9	8	1	5
• Boarding Homes & Contracted Assisted Living Facilities	11	7	3	4
• Adult Family Homes	6	3	0	6
• Nursing Homes	4	3	1	1
• Home Repair, Energy Assistance, Weatherization Services	1	1	1	1
• Housing for the Homeless Services	2	3	1	-

Services Provided	Clallam	Grays Harbor	Jefferson	Pacific
Information & Referral Services (private or non-profit) (includes 2-1-1)	2	2	2	2
Legal Services				
• Senior Legal Advice Clinics	2	1	1	2
Behavioral Health Services				
• Behavioral Health Regional Support Network (crisis services)	1	1	1	1
• Behavioral Health Centers (community)	3	1	1	3
• Substance Abuse Treatment Programs	5	6	3	1
Native Elder & Minority Services				
• OAA Title VI American Elder Nutrition / Cultural Programs	5	2	-	1
• Tribal Health Clinics	5	2	-	1
• Other	5	2	-	1
Nutrition				
• Food Banks (public)	20	17	4	9
• Women-Infant-Children (WIC) Offices	1	1	1	1
Peer Counseling	-	-	-	-
Primary Care Physicians	25	125	13	15
Retired Senior Volunteer Program, other volunteer programs	3	3	2	2
Senior Centers	4	6	6	1
Senior Fitness and Social / Cultural Programs	3	18	3	4
Social Security Offices	1	1	-	-
Spiritual / Faith-Based Organizations (churches, temples, synagogues)	80	120	38	35
Transportation (includes public transit and Para Transit)	6	3	5	3

SECTION C – ISSUE AREAS, GOALS AND OBJECTIVES

C –1 LONG TERM SERVICES AND SUPPORTS

Long Term Services and Supports (LTSS)

Washington is a national leader in offering home- and community-based LTSS for people with significant disabilities under the Medicaid program. Washington residents can choose to receive support in adult family homes, in assisted living, in their own homes, or in a nursing home. As would be expected, about 75% 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, often accompanied by significant behavioral and cognitive challenges.

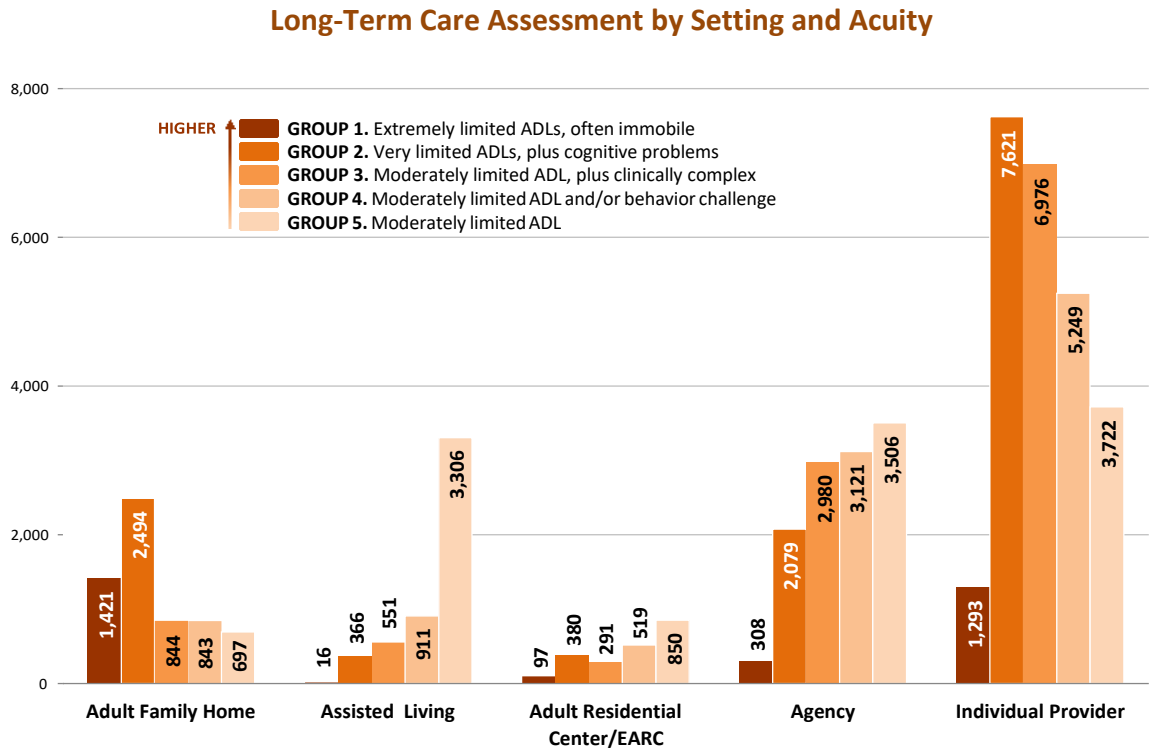
Not only is in-home care the preferred LTSS option, it is the most cost-effective. It costs less than $2,000 per month, on average, for in-home care compared to over $5,000 per month for care in a nursing home. In-home care makes efficient use of funding rather than assuming the cost of full, 24/7 complete 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 must be 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 approximately 38,000 people in the 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 about. About 30% (11, 300 people) of those have very little ability to accomplish daily activities in combination with cognitive limits and extremely limited mobility. That is roughly equal to the number of Washington's nursing home residents with similar conditions who are covered by Medicaid.

In the O3A service region, there are approximately 2,250 people receiving services through the Medicaid LTSS system. Of these, approximately 1,650 receive services in their homes; the remaining 600 receive services in either a residential setting or a skilled nursing home. The number of residential and skilled nursing facilities that accept Medicaid clients in the service region is limited, which in turn limits the options for people who wish to remain in their communities when their need for services cannot be met through in home care.

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 more care from paid home care workers.

On a monthly basis, O3A manages Medicaid LTSS services for about 1,650 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 service plan that authorizes personal care help with activities of daily living.

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', including housekeeping, laundry, and meal preparation; personal care, such as help with bathing, toileting and personal hygiene; mobility, such as help or encouragement walking, transferring from bed to wheel chair; and trips for essential shopping or to the doctor. Some 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 1,925 caregivers employed as independent providers (1,283) or as agency home care workers (642) from eight agencies. Independent providers are contracted by O3A on behalf of the state, through the O3A Home Care Referral Registries, which recruit and support paid caregivers to receive health insurance benefits, training and certification. Registries also provide support for family caregivers who wish to transition to a paid career in care giving.

Increasing caseloads & impact on the case management system

The O3A in-home service caseload is increasing in size, complexity, and acuity, consistent with 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 socialization, education, employment, increased mobility and communication needs. In addition, younger clients rely on LTSS for longer periods due to increased longevity.

Increasing client clinical complexity

The increasing medical, cultural, and health complexity of client care will present even more challenges in the future, requiring successfully blending medical and social support 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, and coordination.

Especially for younger case managed clients with disabilities there is a need to integrate other types of services, such as those provided through 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 disability 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. 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 fewer younger workers owing to limited employment opportunities. In addition, many older workers also find themselves providing care to an elder parent, spouse, sibling or even an adult child. With younger adults leaving the area to secure employment, there is a concern about who will provide the care needed by older adults and people with disabilities.

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; 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.

Independent Providers

Even with the support provided by the Home Care Referral Registries, finding independent providers able to qualify for an IP contract can also be an issue, primarily relating to the difficulty and cost to receive training from the Training Partnership and become certified with the Department of Health.

Independent providers must pass a thorough, criminal background check, which further limits the pool of available providers. This can be an issue with 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 independent 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 agency and other home care providers have experienced significant increases in their cost to provide in-home services due to a number of

factors:

- Insurance coverage for service providers has become more expensive as insurance companies have associated higher risks with providing services to an aging population;
- The dramatic increase in transportation costs for service providers, especially in our rural region where it is not unusual for clients to have to travel more than an hour for services and medical appointments;
- The high costs to develop and support a decentralized, local structure to meet the needs of frail elders and adults with disabilities living in remote service areas,
- reimbursement rates for in-home care services have not kept pace with increasing costs;
- Changes in state payment systems are making it difficult for smaller agencies and providers to afford the contract requirements, thus further limiting client choice; and
- Lack of economies of scale (e.g., caseload size in large rural areas in relation to required administrative structure).

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

O3A contract managers 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 also participate with home care agency representatives in regular Home Care meetings convened by ALTSA program staff 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 case management and contracted service provision undergoes performance review 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 on 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 the Medicaid Waiver program 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 contractors 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.

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. Implementation of the Community First Choice (CFC) program emphasizes client self-management and prevention, and shift more responsibility to the client; outcomes measures will include an emphasis on client self-efficacy, in addition to service utilization indicators.

As CFC service requirements are developed for person-centered planning, case managers will need to coordinate services for individual clients across service systems, e.g., with behavioral health and chemical dependency service agencies. O3A is prepared to respond to these changes with required staff training as requirements are rolled out through CFC.

C –1 Long Term Services and Supports (LTSS)

Problem /Needs Statement:

Older adults with complex chronic illnesses require specialized medical and social support to age in place. Increasing demand for services will require continued development and support of a workforce of professional and unpaid caregivers. O3A will work with the State Unit on Aging and local community partners to provide career options for professional caregivers, contract with local service providers to meet individual client needs, and coordinate client services across service systems.

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

Objective 1: Implement requirements for new service formats with in-service training for direct service staff.

Key Activities:

- Provide logistics and coordination for training venues.
- Implement staff training.

Update:

- The Director of Direct Services is in communication with ALTSA on changes in operations. All new initiatives requiring ongoing or updated training of staff have been or are in process of being implemented strategically, most recently including Person Centered Options Counseling, Independent Provider Overtime changes, Community Living Connections, the Medicaid Transformation Project Demonstration, etc.

Objective 2: Procure contracted services that meet needs identified for Medicaid clients by case managers (average caseload 1,500 clients).

Key Activities:

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

Update:

- Contract Managers engage in ongoing provider recruitment and contracting services for a broad variety of providers.
- Contract Managers regularly seek the help of the HCS Resource Finder for difficult to locate resources.
- O3A works with local Home Care Agencies to encourage training opportunities, encourage partnerships and enhance their work and improve the service their agencies provide.
- O3A's Home Care Referral Registry staff work to find, prepare, and keep a stable corps of Individual Providers and continue to support their ongoing training and work, and to support client choice in who serves them.

Please refer to C –1 Long Term Services and Supports (LTSS) Goals and Objectives Charts in Appendix H.

C. 2 -- Service Integration & Systems Coordination

With funding from the Centers for Medicare and Medicaid Services (CMS), Washington State is implementing a plan that integrates care for beneficiaries who are eligible for both Medicaid and Medicare services, often referred to as 'dual eligibles' 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 high cost/high risk clients, facilitated exchange of information among the wide range of their providers, connected them to 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 statewide to over 50,000 individuals enrolled in Medicaid or dually eligible for Medicare and Medicaid in Washington State constitute the top 20% of high-health risk, high-cost clients who could benefit from care coordination services across multiple provider types.

The following chart on page 28 illustrates the complexity of need among Health Home clients who received services solely funded by Medicaid during the first year of statewide implementation. All are among the top 20% in terms of overall Medical cost. Almost half have evidence of serious mental illness and a quarter have an underlying substance abuse disorder --- which underscores the importance of engagement in and close integration of supports from the medical, mental health, and substance abuse providers. Data for older adults and people with disabilities who are dually eligible for

Medicare and Medicaid are not yet available, but it is expected to show 80% of high cost/high risk duals also have need for LTSS.

Health Home Care Coordination: As noted on the next page, between 2005 and 2012, The Olympic Area Agency on Aging participated in the 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:

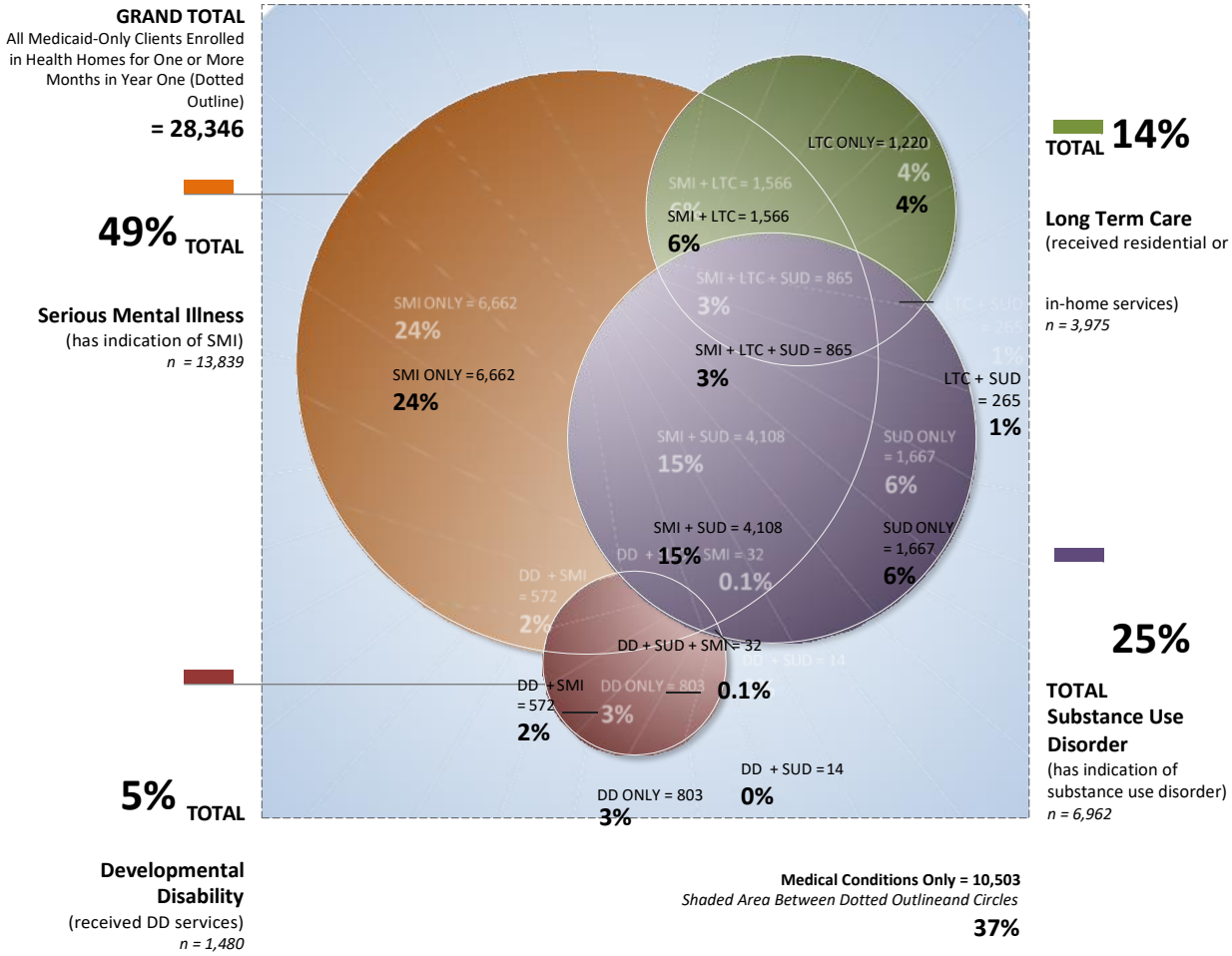
- Comprehensive care management;
- Care coordination and health promotion;
- Comprehensive transitional care and follow-up;
- Patient and family support;
- Referral to community and social support services; and
- Use of information technology to link services, if applicable[10].

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 include their families, caregivers, or others as part of their Health Home 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 medial, mental 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 health care conditions, which is critically important to individuals with chronic illness.

The Health Home program is an important building block in Washington State for innovation models promoting health, preventing and managing chronic disease, and controlling health care costs. O3A contracts with five (5) Health Home lead entities to provide these services within the O3A service region. As a Health Home CCO, O3A coordinates services for individual clients with other providers in the Health Home networks, including mental health specialists, local community-based providers, and community health centers. At the end of June 2015, O3A has engaged over 100 high risk clients and are working with them to implement plans to improve their health.

[10] HealthPath Washington. *Washington State Health Home Fact Sheet.* Visit the Health Care Authority Website at: http://www.hca.wa.gov/health_homes.html.

63% of Medicaid-Only Year One (July 2013-June 2014) Health Home Enrollees have needs beyond Medical Only Services



Transforming lives
DSHS | Research and Data Analysis Division ● OCTOBER 2014

SOURCE: DSHS Research and Data Analysis Division, Integrated Client Outcomes Database, October 2014.
NOTES: - The diagram shows almost all the groups with overlapping needs. 25 of the 28,346 clients (less than 0.1%) had both DD and LTC need flags. One individual of the 29,346 had all four need flags (SMI + SUD + LTC + DD).
- Full-Dual Health Home Enrollees are excluded due to lack of available Medicare claims at the time the diagram was created

Partnerships to Enhance Service Coordination

O3A advocates for better access and health outcomes for vulnerable older adults and adults with disabilities by participating in regional health planning processes, including emerging Accountable Communities of Health (ACH). Accountable Communities of Health are a key component of the Health Care Authority's State Health Care Innovation Plan, and focus on collective impact at the regional level by bringing together multiple communities and community sectors to meet the region's most pressing health needs and challenges. The ultimate goal of the ACH is to achieve the triple aim of better health, better care, and lower health care costs for Washington State residents.

O3A is a participating member of two ACH collaboratives: the Cascade Pacific Action Alliance for Grays Harbor and Pacific counties, and the Olympic Community of Health for Jefferson and Clallam counties. Potential for locally developed ACH priorities may include:

- Palliative care;
- Dementia-capable services;
- Consumer directed services; and
- Robust decision making supports, such as durable power of attorney, conservatorships, and guardianships.

O3A's executive director also participates in the Rural Health Improvement Collaborative (RHIC) and represents the state-wide association of AAAs on the state's stakeholder advocacy team-- HealthPath Advisory Team (HAT).

C-2: Service Integration & Systems Coordination

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 health care costs.

Objective 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.

Key Activities:

- Ensure staff are supported with training, supervision and technology support;
- Ensure service integrity is maintained through adherence to fidelity, reporting requirements; and
- Ensure that revenue from care coordination contracts adequately supports O3A level of effort.

Update:

- Ongoing commitment to staff knowledge, technology, quality of service and fidelity to models, accurate reporting is maintained, and revenue adequately supports services.
- All services adhere to standards or above in 7 offices across 4 counties.
- Dedicated I&A staff provide services that are well known within each community and outreach is supported by newspapers articles and events.
- Unfortunately, revenue does not fully support the Health Homes work, so O3A, like other AAAs has had to limit the numbers served by this important program.

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

Key Activities:

- Continue participation in Accountable Communities of Health regional networks; and
- Continue participation / advocacy in Rural Health Improvement Collaborative and Health Path Advisory Team
- Continue participation in local and regional program coordination efforts, e.g., Regional Transportation Providers Organizations; regional home care agency coordination meetings.

Update:

- Director Chairs the 3 county Olympic Community of Health (OCH); Planning Director serves on the OCH Rural Health Assessment and Planning Committee reviewing applications for funding and encouraging other agency collaboration and application for resources
- Planning Director serves on the Regional Transportation Providers Organization, Jefferson Citizens for Health Care Access, Accessible Communities Committees in Clallam and Jefferson
- Contract Manager coordinates regional home care agency meetings one to two times each year; current focus has been on cross agency coordination during disasters
- Contract Manager serves on the local Bar Association and provides training on SLAC clinics and Advance Care Planning
- O3A convenes well attended Senior Provider Meetings in all counties

Please refer to C-2 Service Integration and Systems Coordination Goal and Objectives in Appendix H.

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

Background

Based on the work of Washington State's Joint Legislative Executive Committee on Aging and Disabilities Issues (JLEC), DSHS in 2014 proposed a set of interventions that support community-dwelling older adults to age safely in place and delay their entry into

Medicaid-funded Long Term Services and Supports. The Governor's office has endorsed the interventions, which include support for family caregivers; information, referral, and counseling for families and individuals on long term care options and resources; and promoting healthy behaviors and managing chronic disease processes. Also in 2014, Washington State undertook the development of a state-wide plan to address Alzheimer's and other dementias.

C.3.1. Community Living Connections (CLC)

Community Living Connections (CLC)

The nation-wide Aging and Disability Resource Center (ADRC) initiative is known in Washington State as Community Living Connections (CLC). The initiative is a collaborative effort of the Administration for Community Living (ACL) and the Centers for Medicare & Medicaid Services (CMS) and is designed to streamline access to home and community supports and services for consumers of all ages, incomes, and disabilities, and their families. The goal for these centers is to help older adults and individuals with disabilities (physical, mental, or developmental) make informed decisions about their service and support options, and serve as a single point of entry into the long term care system. The CLC service menu is designed to provide Washington residents with tools to prevent or delay Medicaid long-term services through person-centered planning and support.

In Washington, CLC centers are operating statewide at AAAs in various levels of implementation. Fully functioning CLCs include:

- Information, referral, and awareness;
- Options counseling;
- Streamlined eligibility screening or determination for public programs;
- Person-centered transition support;
- Consumer, partner, and stakeholder involvement; and
- Quality assurance and continuous improvement.

O3A's Information & Assistance Services and Transition to CLC

O3A's Information and Assistance (I &A) is a trusted place where people of all ages and incomes can find objective, reliable information about long term support options within a framework of a local "continuum of care" that allows older adults to remain in their community as they age. I&A staff are trained to AIRS standards and are CIRS-A certified, which enhances consistent service provision throughout the agency.

O3A's I&A program is a client-based service model with decentralized service staff responsive to local areas, issues, and resources. In addition to serving younger adults with disabilities with case management services, O3A's existing I&A program has achieved broad coverage throughout the region with referral and information about services and benefits for older adults, and has developed solid working relationships with the many state agencies and local community resources providing programs and services to both older adults and younger adults with disabilities.

Most recently, the I&A program has expanded outreach to younger adults by assisting individuals and families to obtain affordable health insurance through Washington State's health benefit exchange portal. The O3A Relatives as Parents program assists grandparents and other older relatives who are raising children, and has established referral relationships with local and regional agencies serving the needs of families and children.

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

O3A is able to reach a wide audience with information on topical issues via:

- A searchable O3A website, www.o3a.org, that lists and / or links to multiple service programs available locally;
- Social networking sites; and
- Access to media publicity through weekly radio programs reaching approximately 14,000 listeners throughout the Olympic peninsula, a weekly television program, and popular weekly newspaper columns in several local newspapers, with a combined audience of over 25,000 readers.

O3A also produces an annual regional resource directory, which has been integrated into the new CLC GetCare on-line directory. As programs for other service populations come on line, O3A will incorporate information on relevant local resources into the CLC GetCare resource directory / database.

O3A Transition to ADRC Format

In line with Washington's goal to implement ADRCs statewide, O3A's I&A program has completed an ADRC readiness assessment and developed a "Transition to ADRC Plan". In 2014, O3A's I&A staff were trained by ALTSA personnel in options counseling protocols for direct line staff of the Community Living Connections network. Options counseling supports families to plan for long-term services that meet their individual needs, in alignment with their preferences, strengths, and values.

In addition, O3A's direct and contracted service staff participated in the development of Washington's CLC-GetCare, a new technology system designed to link consumers and staff to information about services and support. The system is designed to provide robust client management, a resource directory, and an online self-service component. O3A staff worked with CLC-GetCare staff to develop the on-line content for a comprehensive data base of local resources that meet CLC's criteria for inclusion and protocols for updating and maintenance. Consumers will be able to link to the CLC-GetCare Resource Directory from the O3A website, www.o3a.org, as well as access it directly from the ClC-GetCare site.

ADRC Implementation Status

Information, referral and assistance services are currently limited by funding requirements to adults age 60 and over. However, O3A has significant experience serving younger adults with disabilities, and anticipates implementing staff training in protocols and services for people under age 60 when funding becomes available. Similarly, O3A's "Transition to ADRC Plan" outlines key service components that will be initiated as services are expanded to an under age 60 population.

O3A's "Transition to ADRC Plan" includes the following ADRC key service components:

Information, Referral & Awareness (including self-service)

- Marketing to all ages; income levels and disability types, as well as marketing to private paying populations;
- Systematic information and referral processes;
- Follow-Up on I&R/A Services; and
- Online comprehensive resource database that is public and searchable.

Options Counseling and Assistance

- Formal standards and protocols guiding delivery to all income levels and disabilities; and
- Options counseling and assistance

Streamlined Eligibility Determination for Public Programs

- Although staff now assist people to apply for public programs, O3A is not authorized to determine eligibility or enroll people in public service programs. O3A is prepared to take on a larger role in this area, as streamlined processes are developed.

Person-Centered Care Transitions Supports

- O3A staff are experienced in supporting people during various transitions, including hospital to home; nursing facility to community; and home to residential facility.

C.3.1. Community Living Connections (CLC)

Problem / Need Statement(s):

Information & Assistance and ADRCs

Presently, O3A staff are funded to provide information and referral services to adults age 60 and over only, precluding O3A from embarking on any full scale realignment into an ADRC that could serve younger adults until funding for this becomes available. O3A's priority is to sustain regional coverage with existing I&A services by maintaining the staffing expertise and capacity that will be essential for transition to an ADRC service format when funding becomes available.

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

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

Key Activities:

- Support I&A staff with training to maintain AIRS and CIR-S certification;
- Implement Information & Assistance program throughout the region according to program requirements; and
- Coordinate with local community partners to provide coverage with responsive services and current information on alternatives.

Update:

- staff are all AIRS certified or if new on staff, on the training path towards certification.
- work is well recognized within the community and actively sought out.
- staff host Senior Provider meetings to expand community outreach and to learn about new programs.

Objective 2: When funding becomes available, expand services to younger adults with disabilities and children.

Key Activities:

- With new funding, fully implement the O3A Transition to ADRC / CLC Plan; and
- Update and integrate local information and resources for younger adults and children into CLC GetCare on line directory.

Update:

- Funding has not become available - limited movement in this area. Despite lack of funding, all callers to receive thoughtful help and referral for services
- O3A will continue to devote staff time toward this as capacity allows

Please refer to C.3.1. Community Living Connections (CLC) Goal and Objectives in Appendix H.

C.3.2. Family Caregivers and Kinship Caregivers

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

Millions of caregivers are spouses, siblings, or children who are in their seventies and eighties themselves. Grandparents --and even great-grandparents-- may also find themselves as the primary caregivers to their grandchildren. Care giving can take a heavy toll on caregivers, jeopardizing their health and emotional well-being. The physical demands, emotional stress, and their advanced age increase their risk for health problems.

As a result, it is important to support the caregiver as well as the receiver of care, because caregivers often do not seek medical care, health and wellness activities for themselves. Many are so involved in care giving activities that 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, or neurons, resulting in loss of memory, thinking and language skills, and behavioral changes. The disorder progresses through seven stages that can take decades.

Nearly one in every three older adults who dies each year has Alzheimer's or another dementia. Alzheimer's Disease (AD) is the most common of the 80 causes of dementia (66%), followed by vascular disease (15-20%); dementia with Lewy Bodies (8-15%), and Parkinson's Disease. Alzheimer's Disease is the third leading cause of death in Washington State, which has the fourth highest Alzheimer's death rate in America.[11] There are currently 108,218 people in Washington State living with Alzheimer's Disease[12]. **The number of persons in the O3A region aged 70 and older with any type of dementia is estimated at 5,229[13].** Regional data on deaths from AD are not available for the Olympic Peninsula, however, neighboring Kitsap County has recorded a death rate from Alzheimer's Disease that is even higher than the state average[14].

[11] For more information, view the *2014 Alzheimer's Disease Facts and Figures* report at **alz.org/facts**.

[12] Washington State Alzheimer's Disease Working Group, Listening Session, Sequim, WA. May 1, 2015.

[13] ***Selected populations and aging service utilization forecast, Olympic AAA***, in *Forecasts of the Aging Population, Dementia Prevalence and Use of Long-Term Care Services Through 2020 in Washington State*. DSHS Research and Data Analysis Division, Olympia, WA. Mancuso, David, PhD., June 2015

[14] *Alzheimer's Disease: Data for Kitsap County*, S. Kushner, Epidemiologist, August 20, 2014.

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, as well as families who are caring for a person with dementia.

The Washington State Alzheimer's Working Group has identified four main focus areas for the state plan:

- Health and medical care, including the need for early diagnosis / intervention;
- Long term services and supports;
- Public education and awareness; and
- Public health/community health.

Results from a recent state-wide public survey carried out by the AD Working Group prioritized:

- Increased support for home care;
- Family caregiver education and support;
- Financial help with care costs;
- More residential options; and
- Research and prevention.

In addition to support for in home care, survey respondents identified needs for transportation, respite care, and expanded day programs[15].

Alzheimer's Disease Listening Session in Sequim

In one of the regional Listening Sessions conducted by the AD Working Group and held in Sequim (Clallam County), in May, 2015, participants were caregivers who identified issues they had faced or are facing as they provide care for a family member with AD or dementia.

Among them are legal challenges in caring for a family member who is no longer competent to make decisions, including barriers to obtaining medical information imposed by HIPAA regulations. This makes it difficult for responsible family members with power of attorney for the person with dementia to evaluate and approve medical interventions and treatment plans.

Caregivers at the Listening Session shared that the financial costs to provide care for a person with dementia are most difficult for "people in-between", i.e., not "low income" and not wealthy. Caring for a spouse with dementia impoverishes the surviving spouse, leaving insufficient assets for the surviving spouse's eventual care needs.

The caregivers discussed how the "stigma" carried by a diagnosis of dementia is prevalent among both the general public as well as medical care providers. This can

[15] Washington State Alzheimer's Disease Working Group, Listening Session, Sequim, WA. May 1, 2015.

lead families and individuals to delay seeking treatment, preventing early diagnosis and intervention, and leaving families with less time to plan.

Caregivers shared how difficult it can be to deal with a person with dementia who insists on driving, as well as the need for inexpensive transportation options for people with dementia and their older caregivers who do not drive.

Many caregivers reported how they had benefited from participation in an Alzheimer's Support Group, but added that support groups are not available in all communities, reflecting that training for support group facilitators is only available in Seattle. Local training for support group facilitators might increase the potential for more support groups that are convenient for families caring for loved ones with dementias.

Particularly Vulnerable Caregivers

Vulnerable caregivers[16] 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. [17]
- Caregivers who provide care to persons (any age but those over 60 are high priority) with Alzheimer's disease and other dementias;
- Caregivers who provide care to persons at risk for institutionalization;
- Non-traditional family caregivers who may not be recognized as family; GLBT (Gay, Lesbian, Bisexual or Transgender) partners and individuals who are not legally married;
- Grandparents and relatives raising children: age 55 and older are eligible for services provided by the National Family Caregiver Support Program and relatives who are adults (age 18 and older) are eligible for the Kinship Caregivers Support Program and the Kinship Navigator Program;
- Older individuals caring for people, including children (of all ages), with severe disabilities (including developmental disabilities); and
- Caregivers providing care to adults under the age of 60.

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

[17] The term, "greatest social need", means the need caused by non-economic factors, which including: physical and mental disabilities; language barriers; and cultural, social, or geographical isolation, including isolation caused by racial or ethnic status, that restricts the ability of an individual to perform normal daily tasks; or threatens the capacity of the individual to live independently.

Caregivers in the O3A Service Region[18]

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

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

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

State and National Family and Kinship Caregiver Support Programs

The State and National Family Caregiver Support Programs (FCSP), along with the Kinship Caregivers Support Program and Kinship Navigator Programs provide critical services to unpaid caregivers caring for adults with functional disabilities or relatives who are raising children. These services help delay or avoid entry into the Medicaid system[19].

O3A's Family Caregiver Support and Relatives as Parents Programs

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

The T-CARE program helps FCSP 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: [20]

1. Performance of initial care giving task;
2. Self-definition as a caregiver;
3. Provision of personal care;
4. Seeking out or using assistive services;
5. Consideration of institutionalization;
6. Actual out-of-home placement; and
7. Termination of the caregiver role.

[18] www.doh.wa.gov/brfss Behavioral Risk Factor Surveillance System: 2007 Survey; Washington State.
[19] DSHS/ADSA/HCS Management Bulletin: H11-024-Procedure; May 17, 2011; Attach. A.; pg .8.
[20] Montgomery, R.J. & Kosloski, K.D. "Change, Continuity and Diversity Among Caregivers," Sept. 2001.

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, radio and television
- Referrals from local physicians' offices
- Outreach to local schools has resulted in referrals for the Relatives As Parents services
- Word of mouth –caregivers who have received assistance spread the word to their friends and family
- Outreach to churches to publicize Powerful Tools classes
- Presentations to providers, including presentations specific to Gay, Lesbian Bisexual or Transgender caregiver issues (by an O3A Advisory Council member)

Core Family Caregiver Support Services

Family Caregiver Support services available in each county include **Information services and Group Activities**

Information services are provided by:

- O3A FCSP coordinators, in person and by telephone (including a toll free number);
- Information and Assistance staff, who provide information on legal services and benefits;
- Written materials, including brochures and pamphlets created by O3A and other agencies, such as National Institutes on Health /Aging, specifically written for family caregivers; materials from Alzheimer's and dementia support agencies; videos; books, and web resources, many of which are linked on the O3A website;
- Caregiver Lending Libraries located in the O3A's Sequim, Raymond and Aberdeen offices, where caregivers can borrow books and reference materials;
- newspaper columns, articles, and radio ~~and TV*~~ presentations by O3A staff; and
- O3A social networking and web sites.

Group Activities with outreach to Caregivers include:

- Health and hospital fairs
- Caregiver support groups;
- Presentations about both FCSP and Relatives As Parents (see Outreach to Vulnerable Caregivers, above)
- FCSP and KCSP support groups

*TV Presentations are no longer being provided due to changes in local television programing options and staff capacity.

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

- Caregivers receive TCARE screening / assessment and care planning provided by O3A FCSP coordinators.
- In response to the caregivers' needs identified by the T-Care screening protocol, O3A FCSP staff have developed a menu of services that can be provided through in-place 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, based on the stressful situation they are facing. This information assists O3A FCSP coordinators to develop a responsive care plan, which may include:

- 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.
- Receiving 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, workshops, and conferences for caregivers.

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

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 dementia; and the Chronic Disease Self Management workshops.

- **One-to-one training**—for example, how to communicate with someone who is cognitively impaired; how to effectively communicate with medical providers; how to recognize possible depression; and other self help tools that are available in the O3A resource library and online; and

- **Annual Caregiver Conference** O3A Senior I&A and FCSP staff support the Caregiver Coalition of Clallam County to host an annual Caregiver Conference, which focuses on enhancing tools and resources available to caregivers. Similar conferences take place in Jefferson County.

Support Groups

O3A FCSP carries out ongoing support groups for family caregivers in Grays Harbor and Clallam counties, as well as referral to support groups offered by other community agencies, such as hospice and local Alzheimer's Associations. 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 care giving responsibilities. In-home respite 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", presently the only Day Care service available in the region.

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. O3A staff are presently participating in an Adult Day Services working group with a goal of establishing an Adult Day program in Jefferson County.

Supplemental services

The O3A FCSP also provides durable medical equipment & assistive technology, as well as emergency home repair; "wander guard" technology, such as lifeline (paid via 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 Caregiver

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.

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

Quality Assurance

O3A supports quality assurance through several mechanisms:

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

C.3.2. Family Caregivers and Kinship Caregivers

Problem / Need(s) Statement:

In order to strengthen services and support to 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 new options for out of home respite care.

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

Objective 1: Conduct outreach and provide customized support and services to family & kinship caregivers responsive to their needs.

Key Activities:

- Promote FCSP & Relatives as Parents as Parents programs with appropriate local community agencies, via presentations & contacts to schools, medical service providers, discharge planners, churches, etc.;
- 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 customized services & supports to FCSP & Kinship caregivers (e.g., respite, counseling, support groups, help with children's school supplies); and
- Identify and contract sufficient providers to facilitate efficient and timely service provision.

Update:

- Ongoing services as noted above form the core of work provided by FCSP.
- This area has received special focus for training with the implementation of Medicaid Transformation Project with enhanced services for the Medicaid Alternative Care and the Tailored Services for Older Adults Programs.

Objective 2: Strengthen capacity to provide Powerful Tools training for caregivers & make available to wider community.

Key Activities:

- Update Powerful Tools training for FCSP staff;
- Provide Powerful Tools training sessions for caregivers in all counties;
- Train staff from local community based organizations to provide Powerful Tools training in their communities; and
- Offer Powerful Tools for Caregiving to Tribes.

Update:

- O3A no longer offers Powerful Tools training for staff or for caregivers due to funding and capacity constraints.
- O3A does contract with outside providers to provide this program as funding and contractors are available and makes referrals to Powerful Tools programs when courses are being offered.
- This program may be considered in the future, as a train the trainer program should funding permit.

~~**Objective 3: Facilitate the development of more local Alzheimer's Association support groups for caregivers who provide care for persons with Alzheimer's disease or other dementias.**~~

Objective 3: 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 O3A staff to recognize dementia and appropriately assist clients and their families;
- Refer caregivers from the FCSP to Alzheimer's Disease support groups; and
- Publicize support groups through local, on-line and social media.
- Explore methods/strategies to encourage our region to become a Dementia Friendly PSA.

Update: Based on the State Alzheimer's Plan, O3A has broadened our goals around dementia.

- Working with Linda Whiteside of the Alzheimer's Association, and FCSP to identify needs and capacity for new Alzheimer's Support groups
- FCSP does refer caregivers to Alzheimer's Disease support groups if they exist
- Publicize support groups through local, on-line and social media. Still in development
- Exploring cross training for current Care Giver Support Group Facilitators
- Exploring training opportunities for O3A staff
- Exploring options for FCSP to utilize Medicaid Transformation Project funds to support caregivers in this population
- O3A has become a "Dementia Friend" https://www.dementiafriends.org.uk/, with a goal of promoting dementia friendly organizations and communities; currently exploring strategies for accomplishing this goal
- Executive Director serving in a leadership role locally on the regional advisory board and at state level on the WA State Alzheimer's Association Board.

Objective 4: Expand out-of-home respite options for caregivers.

Key Activities:

- Survey assisted living and memory care 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; and
- Issue and monitor contracts; provide technical assistance to provider on contract requirements.

Update:

- Meet with HCA Resources Development Managers to discuss need for additional respite options - July
- Meet with Case Managers and Long Term Care Ombudsman staff to identify possible providers (August)
- Meet with possible providers to discuss providing out of home respite options including Adult Day Care, Adult Day Health, and Skilled Nursing Facility day services.
- Provide technical assistance and initiate contracts as needed

Please refer to C-2 Family Caregivers and Kinship Caregivers Goal and Objectives in Appendix H.

C .3.3. HEALTH PROMOTION, DISEASE PREVENTION

O3A Healthy Aging programs and services

O3A dedicates Older Americans Act and grant funds to support the implementation of evidence-based wellness programs, including: promoting influenza and pneumonia vaccination for older adults; powerful tools for caregiving; chronic disease management workshops and programming, and facilitating evidence-based fitness programs for older adults, such as Staying Active and Independent for Life (SAIL).

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 estimates that nationally about 80% of older adults have at least one chronic condition, and 50% have at least two, straining a healthcare system that is not prepared to address the geriatric needs that currently exist[21]. The situation on the peninsula, with 34% of the population age 60 and older, is made worse by the shortage of primary care providers and inadequate transportation options.

Medical and 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 the region face long wait times to access the limited, non-emergency care options provided by local community health providers.

In particular, residents in Grays Harbor and Pacific Counties face a significant lack of primary care providers: roughly one provider to every 2,300 residents, compared with the Washington State average of 1,200 residents to every provider[22]. As a result, residents without a local primary care provider tend to delay seeking treatment and / or call 9.1.1, contributing to an overuse of local EMS services for non- emergency care.

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

Living Well with Chronic Conditions Workshops

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

O3A has carried out, or supported local community partners to carry out, *"Living Well"* workshops throughout the four county service region: Clallam, Grays Harbor, Jefferson and Pacific Counties; and within Tribal communities in three counties. Since

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

[22] http://www.countyhealthrankings.org/

2012, Diabetic Self Management and Chronic Pain Self Management workshops are also available.

Several local community partners in Grays Harbor and Pacific Counties have integrated the Chronic Disease Self Management program and workshop implementation into their community outreach and education programs; in these counties the CDSM workshops are more likely to be sustained in the absence of dedicated funding for CDSM.

Availability of mental health care is limited

Currently, mental health services available on the Olympic Peninsula offer limited outpatient therapy, consultation, client evaluation, and education.

Within O3A's four county service region population of 197,890, the number of persons age 18 and over with cognitive impairment is projected at 12,037; of these, 6,408 are age 60 and older, or approximately 10% of adults age 70 and older in the O3A service region. The number of persons age 60 and older with dementia is projected at 5,229[23], nearly 8% of adults age 60 and over in the PSA.

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

Depression affects 10-20% of individuals 65 and older,[24] however, less than 3% of Medicare reimbursement is for psychiatric care. The onset of chronic illness for people 50 and over often leads to depression, the most common mental health concern for older adults. Many primary care physicians are not trained to screen for mental illness in older people, and, unfortunately, may attribute psychiatric symptoms to 'normal aging' or to chronic physical illness. As a result, close to 90% of depressed older patients in primary care get no treatment or inadequate treatment, despite the availability of effective treatments. Only 3% receive treatment for mental disorders from a mental health specialist.[25]

If left untreated, mental disorders can have significant consequences, including increases in disease, disability, and mortality. In fact, men age 85 and older currently have the highest rates of suicide and depression is the foremost risk factor identified. Evidence suggests that up to 75% of older adults who commit suicide have visited a primary care professional within 30 days of their death.

Excessive consumption of alcohol and prescription drugs

Substance abuse by older adults often goes undetected, and effective treatment for alcohol and drug abuse in older adults has not been well-studied. Older adults the,

[23] ***Selected populations and aging service utilization forecast, Olympic AAA***, in *Forecasts of the Aging Population, Dementia Prevalence and Use of Long-Term Care Services Through 2020 in Washington State*. DSHS Research and Data Analysis Division, Olympia, WA. Mancuso, David, PhD., June 2015

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

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

aging experience. Some will choose to self-medicate in attempts to cope with loss physical experience many changes, both physically and emotionally, as they progress through 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.[26] 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.

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

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

Access to prescription drugs and assistive devices

Many older adults lack medical insurance with sufficient drug coverage; this is true even for adults age 65 and older receiving Medicare. For Medicare recipients, there is a coverage gap (also known as the “doughnut hole”) for most Medicare prescription drug plans, which impose a temporary limit on what the drug plan pays for. The high cost of medications, coupled with the large number of medications taken by older adults, make appropriate use of prescribed medications extremely challenging, and frequently unmet.

Assistive devices, such as hearing aids, glasses, and walkers are unaffordable to many older adults; Medicaid does not cover all the devices needed, and older adults who are ineligible for Medicaid simply do not have access. Older adults are often faced with making difficult choices between food, rent, medications, or other health needs.

In the O3A consumer survey conducted in 2015[27] almost half (47%) of the older adult respondents reported they often skipped paying for essentials:

Dental Care	23%
Vision or glasses	17%
Food	10%
Housing or utilities	11%
Insurance	8%
Medicine	6%

[26] Widlitz, Michelle and Marin, Deborah B. 2002. Substance abuse in older adults. Geriatrics, Vol 57 (12), p 29-34.
[27] O3A consumer survey, conducted from May to July, 2015; n= >500.

Palliative Care, Palliative Care for Dementia & Hospice Care

Palliative care is specialized medical care for people with serious illnesses. It is focused on addressing what curative treatment may not, including providing people with relief from the 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 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, e.g., 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.

Palliative Care for Dementia

Because dementia is a progressive, terminal illness that is today without a cure, palliative care can be an appropriate approach to meeting the needs of persons diagnosed with a 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 medical problems can play a big role.

The needs of a person with dementia are often poorly addressed, symptoms are often under-treated, and intensive medical treatments 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, for example, with an individualized treatment plan that balances disease, modifying therapy (e.g., antibiotics to treat infection, dementia-specific drugs) and palliative support that focuses on

- The quality of life,
- Symptom management,
- Psychosocial support to patient and family,
- Communication; and
- Coordination of care.

Because of the progressive nature of dementia, early intervention is important for clear medical directions in the early stages, when patients may be able to express their wishes. Palliative care can provide critical support to caregivers, who tend to get used to “the new normal” as the disease progresses, gradually doing more and more until they become exhausted and at high risk for illness themselves.

Early intervention with palliative care also supports longer range planning and preparation for later decisions that can be difficult for families, including understanding the trajectory of the disease process and preparing for a time when it may no longer be possible to safely care for the person with dementia at home.

Hospice Care

Palliative care is an important component of hospice care. Like palliative care, hospice care is provided by an interdisciplinary team and includes provision of medical care and pain management. However, though palliative care can be provided at any stage of life, hospice care is reserved for the last six months of a person's life. Hospice will also include emotional and spiritual support expressly tailored to the patient's needs and wishes. Support is provided to the patient's family and loved ones as well.

Hospice care in most cases is provided in the patient's home. Hospice care also is provided in hospice centers, hospitals, and nursing homes and other long-term care facilities, and is covered under Medicare, Medicaid, most private insurance plans, HMOs, and other managed care organizations.

Members of the hospice staff make regular visits to assess the patient and provide additional care or other services. The hospice team develops a care plan that meets each patient's individual needs for pain management and symptom control. The team usually consists of:

- The patient' s personal physician;
- Hospice physician (or medical director);
- Nurses;
- Home health aides;
- Social workers;
- Clergy or other counselors
- Trained volunteers; and
- Speech, physical, and occupational therapists, if needed.

Hospice services include:

- Managing the patient’s pain and symptoms;
- Assisting the patient with the emotional and psychosocial and spiritual aspects of dying;
- Providing needed drugs, medical supplies, and equipment;
- Coaching the family on how to care for the patient;
- Delivering special services like speech and physical therapy when needed;
- Making short-term inpatient care available when pain or symptoms become too difficult to manage at home, or the caregiver needs respite time; and
- Providing bereavement care and counseling to surviving family and friends.

End of Life Planning

Although hospice care is available through Medicare and Medicaid, and palliative care interventions provided by medical care teams are often covered by insurance, neither type of care is well understood. Older adults are generally unaware of all that is involved in planning for end-of-life. Older adults may have a 'living will', but be unaware that palliative services, which are not limited to 'terminally ill' people, can also be an effective way to manage chronic pain.

Sensitively facing the reality of dying and making a plan for the final stage of life is important, but is often omitted, resulting in a tendency towards reactive, crisis-led care that does not always meet the needs or wishes of dying patients. Most of the final year of life is spent at home, and most people would choose to die there. Although more people are choosing hospice care, most people still die in hospital. A hospital death is more likely to occur in groups such as the poor, the elderly, solitary women and those with a long illness.

Increased advanced care planning—supporting more people to cope well at home and improving the quality of palliative care provided by medical practitioners in the community, in hospitals and other care settings, would increase the number of people who are able to die where they choose, support their quality of life, and prevent unnecessary hospital admissions.

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 now 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 are available through End of Life Washington (www.endoflifewa.org, info@endoflifewa.org or 206.256.1636.)

C .3.3. HEALTH PROMOTION, DISEASE PREVENTION

Problem / Need Statement:

The rapid growth in the older adult population on the Olympic peninsula is associated with an increase in the burden of chronic disease and increasing pressure on available medical and health care services. Preventing health problems and managing chronic illness can help older adults remain independent, improve their quality of life and delay the need for costly long-term care. Disease prevention and effective self-management is important in O3A's rural setting, where healthcare services are relatively scarce and unaffordable to many.

People now live longer with serious illness, with most of the time spent living "normally" at home. They need the knowledge, support and tools to make informed decisions about their care and treatment and how it affects both the quality and longevity of life, and may need support to effectively communicate their wishes to family members and

medical providers. The quality of life for people with progressive serious illness is enhanced when their medical and other service providers support person-centered care and treatment, including palliative and hospice care services provided in the community.

GOALS:

1. 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.

2. 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.

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; 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; and
- Provide information to older adults on medication management.

Update: O3A has contracted with:

- A provider in Port Angeles and Sequim leading a very popular Tai Ji Quan, Movement for Better Balance programs. With additional funds and more trained leaders could easily be expanded. The current classes have long waiting lists.
- OlyCAP is leading a Chronic Disease Self-Management Programs in Clallam. Jefferson Healthcare is leading a workshop in East Jefferson (self-funded).
- Long Beach Hospital, contracted to offer a CDSMP, was unable to do so.
- Grays Harbor did not apply for the Evidence Based funding opportunity; O3A plans to focus some recruitment efforts in those areas for these programs in the future. O3A has submitted an application with other partners for Medicaid Transformation Project 1 funding in the north counties

Objective 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.

Key Activities:

- 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.
- Identify (local) technical resources to provide education and training.

Update:

- Researched tools and developed a resource guide with links on website.
- Conducted a survey seeking community members' thoughts, feelings and readiness on this topic.
- Next step is to use the data to plan education/technical assistance options.
- Identified a partner in Olympic Medical Center, which is launching a project using the Honoring Choices tool (a WA State branded program supported by the Washington State Medical Society that encourages providers to engage with their patients to have honest conversations about end of life preferences and help providers understand what is important to patients.)

Objective 3: Engage local medical service providers (hospital, clinic physicians) in dialogue regarding the current status of palliative and hospice care options available in the community.

Key Activities:

- Meet with local medical service providers re availability of palliative & hospice care, and how to access in each county.
- Develop follow up activities based on initial conversations in each county.

Update:

- O3A Advance Care Planning Committee developed a list of questions to begin engaging medical providers.
- Developing a plan for contacting providers.
- Olympic Medical Center in Clallam is launching Honoring Choices – a WA State Medical Society branded program that engages medical providers in having conversations with patients about their preferences; plan collaboration/learning from one another's experiences.

Please refer to C .3.3. Health Promotion, Disease Prevention Goals and Objectives in Appendix H.

C – 4 Basic Needs

The ability to "age in place" 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.

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 reasons they work are varied, but for many it's a matter of necessity to remain financially secure and independent. Others work to stay active and engaged in their communities.

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

Although the rate of unemployment among mature workers is lower than younger populations, older workers who do become unemployed spend more time searching for work. (Bureau of Labor Statistics, 3/10). Older workers also are unemployed for a longer time —11 months on average in July 2010 compared to 8 months for younger workers. (Bureau of Labor Statistics, 9/3/10).

Part-Time & Multiple Jobs

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

In August 2010, almost 4% of workers aged 55+ held more than one job. Doing so may indicate an inability to find a job that provides sufficient paid hours. Two of O3A's service counties, Grays Harbor and Pacific counties meet the persistent unemployment threshold, indicating that the unemployed older worker "lives in an area with persistent unemployment and has severely limited employment prospects. [28]"

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

Senior Community Services Employment Program (SCSEP)

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

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

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

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

Title V wages play an important role in the economic viability of the low-income participant and his or her family. Participants also receive supportive services such as eyeglasses, a health exam, tuition and supplies for classes such as computer training, resume development, interview clothing, etc. The community also benefits from the program as the enrolled participants are performing community service in their Host Agencies, and spend their Title V wages locally.

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 one community-- Port Townsend-- the Food Bank has implemented "Senior Saturday" services, in order to allow older adults age 65+ 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 include 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 nutrient 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.

Although available to everyone age 60 and over, the average congregate meal participant is 76 years old. About two-thirds (69%) of participants are female.

In O3A's service region, the home-delivered meals program **(Meals on Wheels)** is an important part of the safety net for frail, homebound elders, and it serves as a referral mechanism to other services, notably Senior and in-home care 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 farms 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. Anecdotal evidence from emergency first responders indicates that an increasing number of people are relying on 911 response teams for transportation to emergency facilities for non-emergency care. This includes older adults and adults with disabilities who do not drive; do not have access to a private vehicle; and either cannot afford or may be too frail to access public transportation.

Supporting these older adults to age in place and live independently in their own homes requires an infrastructure that enables access to medical and health care, and supporting services.

The rugged geography and rural nature of the service region present significant

challenges, including access to adequate medical care -- many older adults with chronic or complex medical conditions must now travel to other counties or states for specialized care that does not exist in the service region. These older adults and people with disabilities are often unable to tolerate multiple transfers and long waits to access the public transit system; may be unable to drive or without access to private transportation. They can easily become isolated and dependent on emergency services and transportation.

Linking older people with goods, supports, services, and activities in the community becomes a greater challenge as people outlive their ability to drive. On average, men will live an average of six years and women an average of 11 years after they stop driving.[29] Furthermore, only 3% of older people use public transit[30] due to concerns about safety, schedules, and connections to needed destinations.

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

Preventing Elder Abuse & Exploitation

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

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

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

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

---

[29] 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.

[30] 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.

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

Elder abuse can include verbal abuse, physical aggression and beatings, psychological trauma (such as being isolated from others or being severely criticized), sexual and financial exploitation and abuse, and self-neglect. Women and the very elderly are at greatest risk: two-thirds (66%) of elder abuse victims were female. Of the victims aged 60+, 43% were 80 years of age and older.

Neglect

Neglect can be defined as the failure of a caretaker to provide goods or services necessary to avoid physical harm, mental anguish or mental illness, for example, abandonment, denial of food or health related services.[32]

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

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

Gatekeeper Training for Contractors & Long Term Care Ombudsman Programs

Gatekeeper Training for Contractors

Gatekeeper training is designed to educate personnel who have regular contact with older adults to recognize signs and symptoms that an older person is in need of assistance, and to refer that person to appropriate local resources. Gatekeepers are not expected to assume the role of social workers or counselors. All that is requested of Gatekeepers is to keep a watchful eye while conducting daily work activities and make a simple referral for those people in need.

Within the O3A service region, O3A Information and Assistance staff provides Gatekeeper training to volunteers and employees of O3A contractors for home delivered meals and volunteer transportation services, especially meals on wheels and volunteer transportation drivers. These programs serve home bound older adults, who may experience isolation or lack other social support as a result of their home bound status. These Gatekeepers are trained in how to refer at-risk older adults to the O3A Information and Assistance specialists, as well as to their own agencies, in order for them to receive further services.

[32] Administration on Aging, *Fact Sheets, Elder Abuse Prevention*.

Long-Term Care Ombudsman

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

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

The following people can use the Ombudsman Program:

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

Safe and Affordable Housing

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

Despite an overall increase in the number of subsidized rental units throughout the region, currently, about 35% of senior renters live in housing that costs more than 30% of their annual income.

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

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

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

Many times, people have to move because their homes are no longer safe or user friendly. Looking at how homes are designed and adapting universal design features, intended for all ages and designed for a lifetime, can go a long way in allowing people to live independently in their own homes as long as possible.

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

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

Emergency Preparedness

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

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

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

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

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

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

C – 4 Basic Needs

Problem / Needs Statement:

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

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

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

Key Activities:

- Provide employment support through SCSEP for 12 participants in 2016;
- Retain current host agencies (presently 10 agencies throughout region); and
- Coordinate with local service agencies to provide training, job skills development for older adults.

Update: This program continues to be highly successful at O3A. Unfortunately, the increase in minimum wage O3A has necessitated a decrease in numbers served from 12 – to 9-10. With additional funds we could serve additional clients.

Objective 2: Provide OAA Senior Nutrition & Senior Farmers Market programs; refer older adults at high nutritional risk to I&A.

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

Key Activities:

- Ensure OAA service contracts prioritize home delivered meals & Senior Nutrition providers offer congregate meals services that are within their capacity to
- sustain; and
- Implement Senior Farmers Market program with existing Senior Nutrition providers.

Update:

- Congregate and Home Delivered Meals continue to offer substantial nutrition to seniors across 4 county region in accordance with new 2016 Nutrition Standards. (Diners Choice, a meal voucher program in partnership with restaurants is offered in Forks, WA in partnership with the Forks Community Hospital.)
- The very popular Senior Farmers Market program offers vouchers to eligible seniors in the north counties and through bulk purchase and delivery to eligible seniors in the south counties. Bulk purchased produce is bagged and distributed at congregate meal sites and through home delivered meals and caregiver picks ups in south counties.

Objective 3: 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; and
- Advocate at state and local levels to improve coordination of transportation services.

Update:

- Issued RFQ resulting in 3 new 4 year contracts for Transportation Services in PSA
- Planning Director serves on the Regional Transportation Providers Organization, Jefferson Citizens for Health Care Access, Accessible Communities Committees in Clallam and Jefferson

Objective 4: Provide annual Gatekeeper training for personnel of O3A subcontracted Senior Nutrition and Volunteer Transportation programs, specifically volunteer drivers.

Key Activity:

- Train contractor staff (especially volunteer drivers for Meals on Wheels, volunteer transportation) on signs of self-neglect and elder abuse, where to report, and how to refer to O3A Information & Assistance.

Update: Gatekeeper program has been discontinued internally due to lack of staffing capacity. O3A continues to educate community members about their role as gatekeepers in their communities/neighborhoods/work places and encouraging elders and adults with disabilities who appear to need assistance to contact Information and Referral Services. O3A encourages other agencies to take on leadership of this program as interest is expressed.

Objective 5: Maintain current coverage in LTC Ombudsman Program.

Key Activity:

- Ensure current level of effort /staff capacity is maintained.

Update: O3A's very effective LTC Ombudsman program has been expanded to the South Counties, and continues with 2 staff and 22 volunteers throughout the region.

Objective 6: Publicize programs to reduce costs associated with housing (e.g., property tax relief, utility subsidies, maintenance, safety modifications).

Key Activity:

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

Update: Continued marketing through multiple media opportunities (TV, radio, newspaper, Facebook, Pinterest, Twitter), including regular meetings of local provider networks throughout 4 county region. Because of O3As visibility in these efforts, many other groups contact O3A to share news, and O3A staff mines news media to share programs.

Objective 7: Coordinate w/local emergency preparedness efforts regarding needs of elders & ensure structure exists to assist frail, home bound persons in emergency; maintain O3A emergency plan, with contingency systems developed and staff trained.

Key Activities:

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

Update:

- O3A planning staff has developed an updated emergency management plan
- Working with Emergency Management staff from north counties to align plan with county disaster planning
- Will be working with north and south counties to secure signed MOUs with Emergency Management
- Working with Home Care Agencies to develop plan for cross agency client access for welfare checks and services in emergency circumstances
- Launched staff training in system to identify frail client

Please refer to C – 4 Basic Needs Goal and Objectives in Appendix

Section C – Older Native Americans
7.01 Plans

C - 5 Older Native Americans

7.01 plans include recent updates. We continue to work with the 9 tribes in our region to develop plans tailored to their needs and within O3A's capacity to deliver.

Policy 7.01 Implementation Plan (Regional)

Olympic Area Agency on Aging (O3A)Biennium Timeframe: January 1, 2016 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
(1) Goals/Objectives	**(2) Activities**	**(3) Expected Outcome**	**(4) Lead Staff and Target Date**	**(5) Current Status October, 2016**
1. Work together with Tribal representatives from each of the 9 registered tribes in the O3A service region to develop 7.01 policy implementation plans for each Tribe. Chehalis, Chinook Hoh, Jamestown S'Klallam, Lower Elwha Klallam, Makah, Quileute, Quinault Nation, & Shoalwater.	**a. Meet with representatives from each tribe to develop 7.01 policy implementation plans.** b. Ensure current outreach assistance is continued & explore expanding support and coordination assistance with all area Tribes as available resources allow. c. Meet with tribal representatives to discuss elder issues as requested. d. Ensure tribal issues are considered in agency planning, training and project development.	**a. 7.01 plans in place between O3A and each individual Tribe within O3A service region.** b. Enhanced access to culturally relevant services for tribal elders. c. - d. Increased collaboration with local tribes and community partners to assure access with appropriate services.	**Target: 7.01 plans developed w/ 2 of 9 Tribes each year; 7.01 plans w/ all Tribes by 12/19.** Roy Walker, Exec Director, O3A Mark Harvey, O3A Reg. Director Barbie Rasmussen / Jody Moss O3A Planner (8/15/16) Representatives from individual area Tribes	**1a. O3A attended a Regional two day meeting hosted by Jamestown S'Klallam Tribe and attended by all Clallam & Jefferson Tribes, DSHS Agencies and O3A resulting in information sharing about tribal needs, and 7.01 Plan development, February 2016 and January 2017** **1a. Draft 7.01 plan developed with Lower Elwha Klallam Tribe (July 2015). Plan updated March 2017 - attached.** **1a. Quileute and O3A representatives met on Wednesday, February 17, 2016 to discuss possible activities. Final 7.01 Plan with Quileute Tribe, approved by Tribal Council, March 2016 – updated January 2017 - attached.** **1a. Draft 7.01 Plan developed with Quinault Nation, July, 2016 - attached.** **1a. Draft 7.01 Plan developed with Jamestown January 2017 – still in draft form - attached**

			O3A AC Tribal Rep 2016 -2019	**1b. Senior and Case Management staff continued development and nurturing of relationships with tribal staff and tribal members throughout the service area. This ensures that tribes are aware of services and comfortable in asking for help - ongoing 2016. Examples include *1)* a monthly O3A staff member in attendance at Quileute elders luncheon; and, *2)* O3A is one of only 2 outside agencies invited to participate in Makah Health Fair;** **1c. New Contract Management and Planning Director to meet with Brenda Francis – Thomas, DSHS, Regional Manager, Office of Indian Policy Affairs, Sept. 28, 2016.** **1d. Met with three tribes during development of 7.01 plans – other issues emerged and included in ongoing planning and linking to services.** **Other outreach efforts in 2016 have included: and Nursing staff have participated in Chehalis, Makah, & Quileute "Senior Fairs"; continued to provide "Powerful Tools for Caregivers"; provided Medicare training with Chehalis, and engaging in ongoing discussions for training with Lower Elwha Klallam Tribal members in "".**
2. Improved caregiver training and support options for interested Tribes.	a. Improve coordination between AAA Title III and Tribal Title VI Caregiver Support Programs b. Identify Tribal caregivers through O3A individual provider & family caregiver support programs and support Tribal caregivers to obtain training and support. c. Include Tribal caregivers in referral workforce resource center (Registry) training and referral activities	a. Coordinated Title III and VI resources are maximized, resulting in improved dissemination of best practices, available resources, information sharing and provision of technical assistance. b. Increased Tribal capacity for accessing and/or providing training to Tribal members interested in becoming caregivers. Tribal caregivers are able	O3A Planning & Program Mgmt. staff Mark Harvey 2016 -2019	**2a, b, c. FCSP and KCSP staff attends the monthly Quileute Elder's Luncheon, each time leaving with referrals for service and referrals for additional potential tribal caregivers.** **2a. O3A added caregiver support capacity in Jefferson & Pacific Counties with additional staff.** **2b. Notable assistance has been provided by I&A staff to Makah and Quinault members to become trained, contracted Independent Providers.** **2c. O3A's registry staff includes tribes in marketing and outreach efforts to recruit, train and support current and new tribal caregivers.** **2c. "Powerful Tools for Caregiving" presented to/with Makah, Hoh, & Quileute. Extensive use of "Kinship**

		to access training in a timely manner c. Increased number of Tribal caregivers		**Caregiver Support" throughout the PSA, particularly Quin TANF.** **2c. Direct service staff report continued growth and collaboration with Tribes within the PSA on recruiting & training & retaining IP's.**
3. Enhanced services / support for Tribal grandparents / other elders raising children	a. Increase outreach efforts, particularly with remote communities and Tribal reservations, to inform families of the resources now available for relatives raising children.	a. Relatives as Parents Support Program will benefit Tribal grandparents & other elders raising children.	O3A Relatives as Parents Service Delivery staff 2016-2019	**3a. The programs, "Relatives and Parents", "Family Caregiver Support" and "Kinship Caregiver Support" continue to be very popular in supporting all families including tribal families. Grays Harbor in particular benefits from being located in the same facility as Quin TANF** **3a. O3A offers Legal Clinics throughout the PSA, which are often important to grandparents or relatives raising children**
4. Improved Tribal access to health and nutrition education and program services to the extent resources allow.	a. Include tribal elders in nutrition education & training offered by O3A health promotion and education staff. b. Through nutrition contracts with local providers, promote inclusion of local tribal elders in nutrition programs.	a. Tribal nutrition program managers & elders receive education on food safety, menu planning, etc. b. Tribal elders participate in programs implemented by local health / nutrition education providers.	O3A Planning & Program Mgmt. staff 2016 -2019	**4a. The Senior Farmers Market Nutrition program is available to 6 tribes through senior nutrition providers (OlyCAP and CCAP): Hoh, Jamestown, Lower Elwha, Makah, Quileute and Shoalwater Tribes** **4b. Tribal members have access to and are recipients of the O3A Nutrition programs, predominantly Home delivered Meals.** **4b. In 2016, O3A nurses /staff have participated in tribal health fairs with Chehalis, Quileute & Makah.** **4b. O3A nurses/staff provided ongoing education on oral health, fall prevention, medication management, to clients as needed. O3A contracted with two providers to deliver 10 Senior Drug Education workshops across the PSA – with 57 participants. All workshops are marketed broadly including to the tribes.**
5. Improved access to health and support services for Tribal elders.	a. Increase coordination between the Area Agency on Aging and Tribal representatives to facilitate access to local services—especially health care--for Tribal Elders.	a. Tribal issues are represented in local community, county planning efforts. b. Tribal needs are considered and addressed by local service providers,	Mark Harvey O3A Planning & Program Mgmt staff 2016 -2019	**5a. O3A staff participate in annual DSHS/Tribal meetings to explore service coordination and access.** **5b. In 2016, O3A continued to support the CDSMP and Wisdom Warriors program provided by the Lower Elwha health clinic staff, although the funds for this program have now been exhausted.**

	b. Engage tribes as local community partners in the "Living Well with Chronic Conditions" program	resulting in increased access to services.		**5a. /SHIBA has become a resource for Tribal members and staff regarding any health insurance coverage available (excepting their own tribal insurance).**
6. Strengthened O3A infrastructure to respond to tribal needs.	a. Ensure tribal representation on O3A staff & Advisory Council. b. Routinely consult with tribal outreach (O3A direct service) staff re: O3A response to tribal issues. c. Ensure contracting mechanisms support productive tribal partnerships.	a. Communication between O3A and area tribes results in more responsive service and program development. b. Consultation with Tribes results in identification of tribal needs & priorities & possible solutions for incorporation into this plan. c. Contract instruments are responsive to tribal administration capacity.	AC Tribal Representative Designated O3A Program Management and Service Delivery staff O3A leadership 2016 -2019	**6a. The Advisory Council Tribal Representative, a Lower Elwha tribal elder, enhances communication between tribes and O3A.** **6b. The work with tribal members is deeply embedded in O3A – with 9 tribes in our PSA and a long history of delivering services, O3A has carefully built relationships within our tribal communities to enhance the lives of tribal elders and those with disabilities.** **6b. Direct Service staff throughout the Plan Service Area have forged particularly strong relationships with tribe social service staff along with their relationships with tribal members in almost all regions.** **6c. O3A service delivery to tribes is decentralized throughout the region through local case management / outreach staff, providing continuous O3A presence.**

Policy 7.01 Plan and Progress Report
Lower Elwha Klallam Tribe
For Olympia Area Agency on Aging (O3A)
2017 to 2018

Plan and Progress Report Due Dates: April 2 (Regional Plan submitted to Assistant Secretary) and 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 for the Fiscal Year Starting Last July 1**
1. Continue current outreach assistance with expansion to the Lower Elwha Klallam Tribe.	a. Ensure current outreach assistance is continued and explore expanding support	a. Enhanced access to culturally relevant services for Tribal Elders	Roy Walker, Executive Director, 360.379.5064 walkerb@dshs.wa.gov	Met on 2/3/15, 5/4/15 and 5/18/15 Met on 2/17/2016

	and coordination assistance as available resources allow. b. Hold regular meetings with Lower Elwha to discuss Elder issues at least biannually. c. Expand activities in this area through grants available. Include Tribal Outreach staff agency planning, training and project development.	b. Increased collaboration with Lower Elwha to assure appropriate services.	Mark Harvey, Director /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 Serena Antioquia, LEKT Elders Liaison, 360.565.7257 x. 7466 Serena.Antioquia@elwha.org	Met on 1/4/17
2. Improved caregiver training and support options for Lower Elwha	a. Improve coordination between AAA Title III and Tribal Title VI Caregiver Support Programs b. Identify Tribal caregivers through O3A IP & family caregiver support programs and support tribal caregivers to understand and utilize new Caregiver Training protocols of the Training Partnership c. Include tribal caregivers in referral workforce resource center (registry) training and referral activities. Registry staff will come to Lower Elwha and meet with tribal staff and caregivers at the request of the LEKT. Contact Mark Harvey. d. As funding permits Jody will coordinate with Kelly to provide powerful tools for	a. Coordinated Title III & VI resources are maximized, resulting in improved dissemination of best practices, available resources, information sharing, provision of technical assistance. b. Increased Tribal capacity for accessing and/or providing training to tribal members interested in becoming caregivers. Tribal caregivers are able to access training in a timely manner. c. Increased number of tribal caregivers. d. Caregivers will receive skills and support. Tribal Elders will receive better care.	Mark Harvey Jody Moss Kelly Bradley Serena Antioquia	

	6-week caregiver workshops, and work the train the trainer opportunities.			
3. Enhanced services/support for Tribal grandparents / other Elders raising children	Increase outreach efforts, Nancy McCarty to Lower Elwha to inform families of resources now available for relatives raising children.	Kinship Care Support Program will benefit tribal grandparents and other Elders raising children.	Mark Harvey Nancy McCarty, Family Caregiver Support Coordinator, 360.417.8559 mccarnl@dshs.wa.gov Kelly Bradley & Serena Antioquia	OAAA overviewed services and will continue.
4. Improved access to health and nutrition education and program services to the extent resources allow.	a. Through nutrition contracts with OlyCAP, promote inclusion of local Tribal Elders in nutrition programs. b. Senior Farmers Market Nutrition is active. Coordination takes place.	a. Tribal Elders may participate in programs implemented by OlyCAP who are the health/nutrition education providers. b. Jody Moss (via OlyCAP) will send the vouchers to Lower Elwha when they are available.	Jody Moss, Contracts Management & Planning Director, 360.379.5064 mossjm1@dshs.wa.gov Marki Lockhart, OlyCAP – 360-4524726 x 6215, mlockhart@olycap.org Jody Moss Kelly Bradley, Social Services Director	The Tribe received Senior Famers Market Nutrition vouchers in 2015 from OlyCAP.
5. Improved access to transportation for Tribal Elders with special needs.	a. Facilitate Tribal representation in local planning and coordination efforts and regional transportation coalitions (RTC). b. Jody will contact CCS Volunteer Chore Transportation	a. Local planning efforts are responsive to transportation needs of Tribes. Promote increased options for transportation for Tribal Elders with Special needs. b. CCS Volunteer Chore Transportation will complete a resource presentation to the Tribe.	Jody Moss Kelly Bradley, Social Services Director Serena Antioquia	The Tribe did not receive any information from CCS in 2015.

6. Improved access to health and support services for Tribal Elders.	a. Increase coordination between the Area Agency on Aging and tribal representatives to facilitate access to local services – especially health care—for Tribal Elders. b. Engage Lower Elwha as local community partners with the "Living Well with Chronic Conditions" program as funding permits	a. Tribal issues are represented in local community, county planning efforts. b. Tribal needs are considered and addressed by local service providers, resulting in increased access to services. c. Jody will explore potential funding options.	Mark Harvey, Jody Moss Leanna Ray Colby 360.452.6252, ext 7629 LeAnna.Colby@elwha.org Ellen Charles 360.452.6252, ext 7630 Ellen.charles@elwha.org	
7. Strengthened O3A infrastructure to respond to tribal needs.	a. Ensure tribal representative on the O3A staff and Advisory Council. b. Train outreach staff in culturally appropriate communication techniques which will be accessed through the Office of Indian Policy	a. Communication between O3A and Lower Elwha results in more responsive service and program development. b. Brenda will offer Cultural Competency Training to O3A.	Serena Antioquia Jody Moss, Contracts Management & Planning Director, 360.379.5064 mossjm1@dshs.wa.gov Brenda Francis-Thomas, Office of Indian Policy Office 360.565.2203 Cell 360.584.3338 francBD@dshs.wa.gov Mark Harvey	
8. Improved access to potential employment training and hosting opportunities for the Title V Senior Community Service Employment Program	a. Share information with LEKT when openings are available in the Title V Senior Community Service Employment Program	a. Jody / Carol Ann Laase will provide Information about Title V Senior Community Service Employment Program	Jody Moss Carol Ann Laase, Director Human Resources/Office Administrator, O3A, 360.379.5064, laaseca@dshs.wa.gov	

Policy 7.01 Implementation Plan

The Quileute 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
(1) Goals/Objectives	**(2) Activities**	**(3) Expected Outcome**	**(4) Lead Staff and Target Date**	**5) Current Status**
1. Quileute Nation and O3A representatives work together to develop 7.01 policy implementation plan.	**a. Representatives from Quileute and O3A meet together to develop 7.01 policy implementation plans.** b. Ensure current O3A outreach assistance is continued & explore expanding support and coordination assistance as available resources allow. c. O3A Information & Assistance staff (Forks) meet with tribal representatives to discuss elder issues at Friday brunches in La Push. d. Ensure tribal issues are considered in agency planning, training and project development.	**a. 7.01 plan guides activities and coordination between O3A and the Quileute Nation.** b. Enhanced access to culturally relevant services for tribal elders. c. - d. Increased communication with Quileute Nation and community partners to improve access with appropriate services.	**Target: 7.01 plan developed by 12/16.** Roy Walker, Exec Director, O3A walkerb@dshs.wa.gov 360.379.5064 Nicole Earls, Human Services Director Nicole.earls@quileutenation.org, 360.640.8795 Lisa Hohman-Penn, Senior Cook, Lisa.hohman@quileutenation.org, 360.374.6040 Mark Harvey, Regional Director /CM, 360. 461.5230, harvemb@dshs.wa.gov Jody Moss, O3A Contracts Mgt & Planning Director mossjm1@dshs.wa.gov; 360.379.5064 2016 – 2019	**Quileute and O3A representatives met on Wednesday, February 17, 2016 to discuss possible activities.** **Met at Consolidated Tribal Meetings on 1/4/17.** **Notified in April that this plan was approved by the Quileute Tribal Council**

2. Support caregiver training and support options as requested by the Quileute Nation.	a. Improve coordination between AAA Title III and Tribal Title VI Caregiver Support Programs b. Identify Tribal caregivers and support them to obtain training and support.	a. Coordinated Title III and VI resources result in support for caregivers as requested by the Quileute Nation. b. Tribal caregivers are supported to access training in a timely manner	Mark Harvey, 360. 461.5230 harvemb@dshs.wa.gov 2016 - 2019	
3. Enhanced services / support for Tribal grandparents / other elders raising children	a. Increase outreach efforts, particularly with remote communities and Tribal reservations, to inform families of the resources now available for relatives raising children.	a. Relatives as Parents Support Program will benefit Tribal grandparents & other elders raising children.	Mark Harvey, 360. 461.5230 harvemb@dshs.wa.gov 2016 - 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.	a. Through nutrition contracts with local providers, promote inclusion of local tribal elders in nutrition programs.	a Tribal elders are able to participate in programs implemented by local nutrition providers.	Jody Moss mossjm1@dshs.wa.gov; 360.379.5064 2016 -2019	
5. Promote access to health and support services for Tribal elders.	a. Increase coordination between the Area Agency on Aging and Tribal representatives to advocate increased access to local services—especially health care-- for Tribal Elders.	a. Tribal issues are represented in local community, county planning efforts.	Mark Harvey, Jody Moss 2016-2019	
6. Improved access to potential employment training and hosting opportunities for the Title V Senior Community Service Employment Program	b. Share information with the Quileute Tribe when openings are available in the Title V Senior Community Service Employment Program	b. Jody / Carol Ann Laase will provide Information about Title V Senior Community Service Employment Program	Jody Moss Carol Ann Laase, Director Human Resources/Office Administrator, O3A, 360.379.5064, laaseca@dshs.wa.gov	
7. Strengthened O3A infrastructure to respond to tribal needs.	a. Ensure tribal representation on O3A staff & Advisory Council.	a. Communication between O3A and area tribes results in more responsive service and program development.	AC Tribal Representative Designated O3A Program Management	

	b. Meet with Tribal staff re: O3A response to Tribal issues in the context of 7.01 planning.	b. Meetings with Tribes results in identification of tribal needs & priorities & possible solutions, for incorporation into this plan.	and Service Delivery staff O3A leadership 2016 -2019	

Policy 7.01 Implementation Plan

The Quinault Nation and the Olympic Area Agency on Aging (O3A)
Biennium Timeframe: January 1, 2016 to December 31, 2018

Plan Due Dates:
October 1st of each odd numbered year a complete Implementation plan is due for the coming biennium.
October 1st of even numbered years a progress report is due.

Implementation Plan				Progress Report
(1) Goals/Objectives	**(2) Activities**	**(3) Expected Outcome**	**(4) Lead Staff & Target Date**	**Quinault Nation and O3A representatives held the following meetings to discuss possible activities:**
1. Quinault Nation and O3A representatives work together to develop 7.01 policy implementation plan.	**a. Representatives from Quinault Nation and O3A meet together to develop 7.01 policy implementation plans.** b. Ensure current O3A outreach assistance is continued &explore expanding support and coordination assistance as available resources allow. c. O3A Information & Assistance (Grays Harbor) staff schedule meeting(s) with tribal representatives to discuss Elder issues in Taholah. d. Ensure tribal issues are considered in agency planning, training and project development.	**a. 7.01 plan guides activities and coordination between O3A and the Quinault Nation.** b. Enhanced access to culturally relevant services for tribal elders. c.-d.Increased communication with Quinault Nation and community partners to improve access with appropriate services.	**Target: 7.01 plan developed by 12/16.** Roy Walker, Exec Director, O3A walkerb@dshs.wa.gov 360-379-5064 Aliza Brown, Quinault Nation Social Services Manager ABROWN@quinault.org 360-276-8215 Mark Harvey, Regional Director /CM Phone: 360. 461.5230 harvemb@dshs.wa.gov	**Aliza Brown, Barbie Rasmussen, November 19, 2015** **Meeting on January 28, 2016 in Taholah:** **Quinault Nation:** Aliza Brown, Social Services Manager Lanada Mail-Brown, QIN Sr Prog Manager Lynnell Watt-Martin, RN,Community Health, PHN, Discharge Planner Nancy Underwood, QIN Sr Prog Assistant **and O3A:** Roy Walker, O3A Executive Director Mark Harvey, O3A Regional Director, Information & Assistance / Case Management

			Jody Moss, O3A Planner mossjm1@dshs.wa.gov 360-379-5064 2016 -2019	Barbie Rasmussen, O3A Planner Ann Petersen, O3A Supervisor, I&A / CM, Grays Harbor County **Aliza Brown, Barbie Rasmussen, May 25, 2016**
2. Support caregiver training and support options as requested by the Quinault Nation.	a. Improve coordination between AAA Title III and Tribal Title VI Caregiver Support Programs b. Identify Tribal caregivers and support them to • become certified as IPs, or • enroll in the family caregiver support program..	a. Coordinated Title III and VI resources result in support for caregivers as requested by the Quinault Nation. b. Tribal caregivers are supported to access training, support in a timely manner	Mark Harvey, Regional Director /CM Phone: 360. 461.5230 harvemb@dshs.wa.gov Aliza Brown, Quinault Nation Social Services Manager ABROWN@quinault.org 360-276-8215 2016 -2019	Aliza Brown, Katrine Colten, O3A Registry, met on May 26, 2016
3. Enhanced services / support for Tribal grandparents / other elders raising children	a. Increase outreach efforts, particularly with remote communities and Tribal reservations, to inform families of the resources now available for relatives raising children.	a. Relatives as Parents Support Program will benefit Tribal grandparents & other elders raising children.	Mark Harvey, Regional Director /CM Phone: 360. 461.5230 harvemb@dshs.wa.gov Aliza Brown, Quinault Nation Social Services Manager ABROWN@quinault.org 360-276-8215 2016-2019	Aliza Brown, Eric Nessa, O3A FCSP Specialist, met on May 26, 2016.
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.	a. Through nutrition contracts with local providers, promote inclusion of local tribal elders in nutrition programs.	a Tribal elders are able to participate in programs implemented by local nutrition providers.	Aliza Brown, Quinault Nation Social Services Manager ABROWN@quinault.org 360-276-8215 Jody Moss, O3A Planner mossjm1@dshs.wa.gov; 360-379-5064	Barbie Rasmussen email (May 26, 2016) to Stephanie Glover, CCAP Senior Farmers Mkt program & Aliza Brown, re: coordinating with Quinault Nation to facilitate participation of Tribal Elders.

			2016 -2019	
5. Promote access to health and support services for Tribal elders.	a. Increase coordination between the Area Agency on Aging and Tribal representatives to advocate increased access to local services—especially health care-- for Tribal Elders. b. Increase coordination with volunteer transportation program in Grays Harbor County.	a. Tribal issues are represented in local community, county planning efforts.	Mark Harvey, Regional Director /CM Phone: 360. 461.5230 harvemb@dshs.wa.gov Aliza Brown, Quinault Nation Social Services Manager ABROWN@quinault.org 360-276-8215 Jody Moss, O3A Planner mossjm1@dshs.wa.gov; 360-379-5064 2016 -2019	
6. Strengthened O3A infrastructure to respond to tribal needs.	a. Ensure tribal representation on O3A staff & Advisory Council.	a. Communication between O3A and area tribes results in more responsive service and program development.	O3A Advisory Council Tribal Representative: Serena Antioquia, Lower Elwha Klallam Tribe Designated O3A Program Management and Service Delivery staff O3A leadership 2016 -2019	

Policy 7.01 Implementation Plan

Jamestown S'Klallam Tribe (JST) and the Olympic Area Agency on Aging (O3A)
Draft Timeframe: January 1, 2017 to December 31, 2019

O3A 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.
JST Due Dates: Plan and Progress Report Due Dates: April 1 (Regional Plan submitted to Assistant Secretary) and 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) Current Status (date)**
1. Jamestown S'Klallam Tribe and O3A representatives work together to develop 7.01 policy implementation plans.	**a. Representatives from O3A and JST meet together to develop 7.01 policy implementation plans.** b. Ensure current outreach assistance is continued & explore expanding support and coordination assistance as available resources allow. c. O3A and I&A staff meet with JST tribal representatives to discuss elder issues as requested. (could recommend a particular regular meeting, like elders luncheon 1/month) d. Ensure tribal issues are considered in agency planning, training and project development. Could also include items such as an annual I&A presentation to elders / staff about available services.	**a. 7.01 plan guides activities and coordination between O3A and Jamestown S'Klallam Tribe.** b. Enhanced access to culturally relevant services for tribal elders. c. - d. Increased collaboration and communication with JST and community partners to assure access with appropriate services.	**Target: 7.01 plan developed with JST by 4/1/17** Roy Walker, Exec Director, O3A walkerb@dshs.wa.gov 360.379. Mark Harvey, Regional Director /CM, 360. 461.5230, harvemb@dshs.wa.gov Jody Moss, O3A Contracts Mgt & Planning Director mossjm1@dshs.wa.gov; 360.379.5064 Rob Welch Serena Antioquia, O3A Advisory Council Tribal Representative serena.antioquia@elwha.nsn.us 2017 -2019	**1a. O3A representative met with JST representatives at Consolidated Tribal Meetings on 1/4/17 and reviewed regional plan. JST requested plan development be completed by April 1, 2017.** **O3A and Jamestown made a number of efforts to set up meetings without finding a date that worked for both parties. Will continue to work with Jamestown to develop a tailored plan.**
2. Improved caregiver training and support options for interested Tribes.	a. Improve coordination between AAA Title III and Tribal Title VI Caregiver Support Programs	a. Coordinated Title III and VI resources are maximized, resulting in improved dissemination of best practices, available resources,	Mark Harvey, 360. 461.5230 harvemb@dshs.wa.gov	

	b. Identify Tribal caregivers through O3A individual provider & family caregiver support programs and support Tribal caregivers to obtain training and support. c. Include Tribal caregivers in referral workforce resource center (Registry) training and referral activities	information sharing and provision of technical assistance. b. Increased Tribal capacity for accessing and/or providing training to Tribal members interested in becoming caregivers. Tribal caregivers are able to access training in a timely manner c. Increased number of Tribal caregivers	2017 - 2019	
3. Enhanced services / support for Tribal grandparents / other elders raising children	a. Increase outreach efforts to inform families of the resources now available for relatives raising children.	a. Relatives as Parents Support Program will benefit Tribal grandparents & other elders raising children.	Mark Harvey, 360. 461.5230 harvemb@dshs.wa.gov 2017 - 2019	
4. Improved Tribal access to health and nutrition education and program services to the extent resources allow.	a. Include tribal elders in nutrition education & training offered by O3A health promotion and education staff. b. Through nutrition contracts with local providers, promote inclusion of local tribal elders in nutrition programs. Could add info here on Senior Farmers Market Program	a. Tribal nutrition program managers & elders receive education on food safety, menu planning, etc. b. Tribal elders participate in programs implemented by local health / nutrition education providers.	Jody Moss mossjm1@dshs.wa.gov; 360.379.5064 2017 -2019	
5. Improved access to health and support services for Tribal elders.	a. Increase coordination between the Area Agency on Aging and Tribal representatives to facilitate access to local services—especially health care-- for Tribal Elders. Could add a section on transportation here	a. Tribal issues are represented in local community, county planning efforts.	M Mark Harvey, 360. 461.5230 harvemb@dshs.wa.gov Jody Moss mossjm1@dshs.wa.gov; 360.379.5064 2017-2019	
6. Improved access to potential employment training and hosting	c. Share information with JSTwhen openings are available in the Title V Senior Community Service Employment Program	c. Jody Moss / Carol Ann Laase will provide Information about Title V Senior Community Service Employment Program	Jody Moss, mossjm1@dshs.wa.gov; Carol Ann Laase, Director Human Resources/Office Administrator, O3A, 360.379.5064, laaseca@dshs.wa.gov	**Color = new**

opportunities for the Title V Senior Community Service Employment Program	Only 10 slots available, currently all filled		2017-2019	
7. Strengthened O3A infrastructure to respond to tribal needs.	a. Ensure tribal representation on O3A staff & Advisory Council. b. Routinely consult with tribal outreach (O3A direct service) staff re: O3A response to tribal issues. c. Ensure contracting mechanisms support productive tribal partnerships.	a. Communication between O3A and area tribes results in more responsive service and program development. b. Consultation with Tribes results in identification of tribal needs & priorities & possible solutions for incorporation into this plan. c. Contract instruments are responsive to tribal administration capacity.	Serena Antioquia, O3A Advisory Council Tribal Representative serena.antioquia@elwha.nsn.us Designated O3A Program Management and Service Delivery staff O3A leadership 2017 -2019	

C – 6: MEDICAID TRANSFORMATION PROJECT DEMONSTRATION

Washington State has already created a rebalanced system where individuals have a community care entitlement for Long-Term Services and Supports. Our LTSS system has just been ranked 1st in the nation by AARP for its high performance while at the same time ranking 34th in cost. ***Washington will build 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, creating better linkages to a reformed healthcare system and continuing its commitment to a robust Medicaid LTSS system for those that need it.

The Medicaid Transformation Waiver, part of Healthier Washington, will transform the delivery system for the 25% of Washington's population served by Medicaid, engaging and supporting Apple Health clients, providers, and communities in achieving improved health, better care, and lower costs.

The demonstration has two main LTSS components

1. **Medicaid Alternative Care (MAC)** - Creation of a benefit package for individuals who are eligible for Medicaid but not currently accessing Medicaid-funded LTSS. This benefit package will provide 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.
2. **Tailored Supports for Older Adults (TSOA)** - Establishment of a new eligibility category and benefit package for individuals "at risk" of future Medicaid LTSS use who currently do not meet Medicaid financial eligibility criteria. This is designed to help individuals avoid or delay impoverishment and the need for Medicaid-funded services.

MAC and TSOA include 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 recipient.
- **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).

Problem / Needs Statement:

The ability to "age in place" has been a particular challenge for family caregivers who have not qualified for help, or because they did not wish to deal with the Medicaid Estate Recovery requirements. None-the–less, these caregivers encountered the same limitations of lack of knowledge, resources, time, and increased stress.

The new MAC and TSOA Benefits will help support these families to provide services for their loved ones and maintain their health and wellbeing.

Goal: MAC and TSOA Benefits support additional caregivers to care for their family members and provide supports to qualified individuals who do not have a caregiver.

Objective 1: Conduct outreach and provide customized client centered support and services to family caregivers and clients without a caregiver.

Key Activities:

- O3A Staff participates in training
- Promote MAC & TSOA programs with appropriate local community agencies, via presentations & contacts to schools, medical service providers, discharge planners, churches, 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/clients;
- Provide customized services & supports to newly identified caregivers/clients (e.g., respite, counseling, support groups)
- Develop and implement an Outreach Plan

Update:

- Education about and promotion of MAC & TSOA has occurred with the entire staff, with Advisory Committee and COG Members, through provider networks and at other public groups such as Jefferson Citizens for Health Care Access
- O3A leadership has been meeting with and briefing local providers about MAC & TSOA opportunities for over a year.
- Frontline staff and FCSP staff have attended relevant training
- Beginning in August, the relevant staff members are prepared to begin

offering these services to clients.
- Outreach Plan is copied below

Objective 2: Assure systems alignment and provider network adequacy.

Key Activities:

- Develop additional contract tools
- Identify and contract with sufficient providers to facilitate efficient and timely service provision.
- Provide technical assistance and encouragement to current FCSP and new small contract providers who may be reluctant to commit to the Medicaid contracting requirements.

Update:

- Contracting staff have been working on updating contracts and addressing network issues
- Staff will be using "blended and braided" funding sources (meaning to utilize several different sources of funds to serve families as seamlessly as possible to assure services are available to new MAC and TSOA clients to assure that our systems work for clients, rather than wait until clients arrive and then look for services. For example: A caregiver in need of respite services can be served by current in home caregiving agencies, and the charges are billed through Medicaid. The same caregiver would like some counseling for depression and anxiety; however the counselor has not yet completed a contract with Medicaid, so Older Americans Act Funds and State Senior Citizens Service Act funds are used for funding these services.

Outreach Plan

Olympic Area Agency on Aging Outreach Plan for Medicaid Transformation Project Demonstration Initiative 2, MAC and TSOA		
Outreach Messaging Principles: Keep it simple, avoid jargon / acronyms / keep effort focused on caregiver / client choice		
Target	**Date Range**	**Responsible Party/ies**
Care Givers / Clients	Present / Ongoing	FCSP, I&A, other O3A Staff
Message: These are resources to expand caregiver/client support throughout our region.		

Non-Medicaid Providers:	Present / Ongoing	CMP, other O3Astaff
Message: 1) Some clients and their caregivers and clients without caregivers that you are currently serving may be eligible for additional services. 2) There may be options for partnering and contracting with Provider One for your agency to provide services to caregivers. 3) Contact O3A for more information		
Current O3A Medicaid Providers	Present / Ongoing	CMP, FCSP and other staff
Message: There are new resources for caregivers and for clients without caregivers and O3A wants to work with you to help facilitate serving additional caregivers/clients.		
Process/Tools for Outreach*: Outreach will utilize the communication vehicles we currently have available.		
Target	**Date Range**	**Responsible Party/ies**
Staff Training	5.1.17 - 8.31.17	Direct Service, CMP, other
Activity: Training/outreach to all O3A/I&A offices/staffs		
Outreach to Senior Providers	4.1.17 - 8.31.17	O3A Staff facilitating Senior Provider Meetings
Present about MAC/TSOA at meetings with providers serving the senior population		
Social Media Messaging	8.1.17 - Ongoing	CMP, Designated O3A staff
Activity: Post messages about new resources for caregivers on Website, Constant Contact Newsletter “Trending Healthy”, Facebook page, Pinterest, and Twitter		
Caregiver / Client Review	6.1.17 - 8.31.17	FCSP staff
Activity: Review existing FCSP clients for potential eligibility		
Outreach to existing, potentially eligible FCSP clients	7.1.17 - 10.30.17	FCSP staff
Activity: Contact caregivers and initiate conversion to TSOA/MAC as appropriate and based on caregiver/client preference		
New Incoming Clients	8.1.17 - Ongoing	I & A, FCSP staff
Activity: Review new I&A clients for eligibility for MAC/TSOA services		

Reminders to referral sources	7.1.17 - Ongoing	FCSP, I&A, CMP, Other staff
To reinforce previous efforts, provide outreach to existing FCSP referral sources		
Outreach/Community Education	5.1.17 - Ongoing	DS, I&A, FCSP, CMP, O3A Staff
Activities: Identify selected community groups, e.g. Forks Elder Luncheon, Willapa Community Network, "Feed the 5,000," other interested groups such as Services Clubs, Faith Communities, etc.		
Tribal Outreach	5.1.17 - Ongoing	I&A, FCSP, DS
Activity: Communication/consultation to/with selected Tribal staff representatives		
Media Including Print and Radio Programming	4/17 - Ongoing	
Activity: Radio show on KMUN, KONP, KSQM, KPTZ, KBKW, & KXRO; Columns in: Peninsula Daily News, The Daily World, Chinook Observer, Pacific Press, Willapa Harbor Herald, South Beach Bulletin, Clallam Senior Sunset Times/Senior Sunset Times-Beach-To-Beach edition		
Letters to Current Providers	8.1.17 - Ongoing	CMP
Develop letters describing program in more detail to be mailed to providers serving seniors to reinforce other outreach efforts		
*Note – Many of these activities have already begun.		

Olympic Area Agency on Aging

2016-2019 Area Plan with Updates 2018-2019

APPENDICES

Olympic Area Agency on Aging

APPENDIX A:

Organizational Chart

Olympic Area Agency on Aging
Organization Chart

Updated: September 12, 2017

Executive Director
Roy Walker

Direct Services Director
Mark Harvey

Chief Financial Officer
Paul Scott

Contracts Management & Planning Director
Jody Moss

Information Technology Director
Brenda Parks

Administrative Systems Manager
Carol Ann Laase

Nurse Manager
Lori Lindley

Registered Nurse
Kathleen Brennan
Mike Thompson
Lois Lund
Ruth Ann Kolodzie

Program Assistant II
Jeanette Mitchell

Care Coordinator /Case Aide
Katrine Colten

RN Per Diem
Vacancy

Direct Services Supervisor
Ann Peterson

Case Manager
Annette Ibrahim
Theresa Bodi
Renee Iverson
Delores Swanson
Sylvia Percini
Cynthia LeVering
Arleta Vargas
Karin Beard
Samantha Thurston
Bob Kyllonen
Vacancy

I&A Specialist Case Aide
Kathy Jones
Dave Aldrich
Ann Marie Abbott

HCRR Program Coord. Pacific
Chris Lee
Yolanda Pearson

Direct Services Info. Specialist
Mindy Early

CM/I&A Support Specialist
Vacancy

Direct Services Supervisor
Doug Sheaffer

Case Manager
Colleen Vaughn
Kimberly Cook
Sarah McBride

I&A Specialist
Jolene Manuel
Tom Akerlund
Shane Wilson

FCSP Coordinator
Eric Nessa
Robert Powell
Vacancy

Program Assistant II
Karna McCarthy
Sindy Theofelis

Direct Services Supervisor
Jaci Hoyle

Case Manager
Char Carte
Joshua Reed
Sandra Moore
Marnie Raelene
Rebecca McHugh
Heidi Scherner
Vacancy

I&A Specialist / Case Aide
Heaven Gregg
Paula Gibeau
Tamra Smith
Carolyn Brandelius
Aida Crumb
Renee Worthey

HCRR Program Coordinator — Olympic
Ricci Sletkolen
Donna Bankston

Care Coordinator / Case Aide
Pamela Adams

Program Development Manager
Janet Parris

Regional LTC Ombudsman
Jane Meyer
Amber Garrotte

SHIBA Coordinator
Marjorie Stewart

Family Caregiver Support Program
Nancy McCarty
Janice Siven
Vacancy

Staff Accountant
Cheryle Brown

New Fiscal Clerical Position
Vacancy

Program Manager
Ingrid Henden
Margaret Taylor

Data Specialist
Rebecca Knievel

Information Technology Specialist
Maria Koury-Covall
Vacancy

Program Assistant I
Ann Winningham

Program Assistant II
Judith Laurent
Averil Lawson

COUNCIL OF GOVERNMENTS
Clallam: Randy Johnson (Bill Peach, Mark Ozias, Alternates)
Jefferson: David Sullivan, Chair (Kate Dean, Alternate)
Grays Harbor: Wes Cormier, Vice Chair (Vickie Raines, Alternate)
Pacific: Lisa Olsen (Frank Wolfe, Alternate)

Advisory Council
21 Members

One FTE = 40 hours/week
Several Staff are < one FTE

= Management or Supervisor

Olympic Area Agency on Aging

2018 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; includes program development and improvement; planning; quality assurance; community leadership; state relations; supervises CM/I&A Supervisors, Nurse Manager and some direct service personnel.
*^Information Technology Director B. Parks	1 FTE	Maintains and improves technology and communication systems; provides training, develops data management systems and works with other managers to create technology tools to better serve clients.
*Chief Financial Officer P. Scott	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 M. Taylor	1 FTE .63 FTE	Manage and monitor homecare agency, caregiver training, Older Americans Act, and COPES Ancillary 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 & program management support/coordination. Title V program management. Maintains personnel files; performs general human resource functions.
*I&A/ CM 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.
*Nurse Manager L. Lindley	1 FTE	Supervises agency nursing staff. Works with Direct Services Director to manage the 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
Case Manager K. Beard T. Bodi C. Carte K. Cook A. Ibrahim R. Iverson B. Kyllonen C. Levering S. McBride R. McHugh S. Moore S. Percini M. Raelene J. Reed H. Scherner D. Swanson S. Thurston A. Vargas E. Vaughn Vacancy Vacancy	 1 FTE 1 FTE 1 FTE 1 FTE .75 FTE 1 FTE 1 FTE 1 FTE 1 FTE 1 FTE 1 FTE 1 FTE 1 FTE 1 FTE 1 FTE 1 FTE 1 FTE 1 FTE 1 FTE 1 FTE 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 A. Crumb P. Gibeau H. Gregg K. Jones J. Manuel T. Smith S. Wilson R. Worthey	 1 FTE .81 FTE 1 FTE 1 FTE 1 FTE 1 FTE 1 FTE 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.
Care Coordinator / Case Aide P. Adams K. Colten	 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.
Case Management / Information & Assistance Support Specialist Vacancy	 1 FTE	Provides high-level administrative support to direct services supervisors to support Case Management /CORE program/components. Provides oversight/ retrieval of statistical/service reporting; liaison to O3A's IT dept. for data, reporting, monitoring. Supports supervisors within other programs as assigned.
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.

POSITION TITLE	TOTAL STAFF	POSITION DESCRIPTION
New fiscal clerical Vacancy	.75 FTE	Assists the Staff Accountant and CFO with standard accounting functions. Performs complex data entry and clerical tasks.
^*Data Specialist R. Knievel	1 FTE	Ensures varied program data base program entries are accurate and 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 Vacancy	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 Coordinator.
Direct Services Information Specialist M. Earley	.63 FT	Provides mid-level clerical support and data entry for direct services (I&A, CM, etc.);IP management.
^Program Assistant I A. Winningham	.50 FTE	Provides entry level clerical support for the agency.
Program Assistant II J. Laurent A. Lawson K. McCarthy J. Mitchell S. Theofelis	.50 FTE .50 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 M. Thompson	1 FTE .75 FTE 1 FTE .81 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	.20 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 N. McCarty R. Powell E. Nessa J. Svien 2 Vacancies	1 FTE 1 FTE 1 FTE 1 FTE 1 FTE 2 FTE	Coordinate services & resources to meet needs of unpaid family caregivers of older adults and people with disabilities.
Regional Long Term Care Ombudsman J. Meyer A. Garrotte	1 FTE 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.

POSITION TITLE	TOTAL STAFF	POSITION DESCRIPTION
HCRR Coordinator D. Bankston C. Lee Y. Pearson R. Sletkolen	 1 FTE 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.
Title V (SCSEP) Trainee None currently assigned	0 FTE	Provides support within the agency as part of a training program; participants are seeking work while in the program and are expected to transition to unsubsidized employment after a certain period of time.

Number of full-time equivalents = 73.90 (FTE = 40 hours per week)
Number of Staff = 79
Number of Staff Over 60 = 35
Number of Staff Indicating a Disability = 5
Number of minority staff = 5

Olympic Area Agency on Aging

APPENDIX C*:

Emergency Response Plan

*The Emergency Response Plan (EMP) copied below as Appendix C is the a newly revised plan that is what O3A is using as a guiding document although some sections are still in development. Each county in the O3A PSA has a similar plan listing equivalent First Responders' Contact Information

Olympic Area Agency on

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

OLYMPIC AREA AGENCY ON AGING

EMERGENCY MANAGEMENT PLAN FOR CLALLAM COUNTY

Table of Contents

OLYMPIC AREA AGENCY ON AGING EMERGENCY MANAGEMENT PLAN *DRAFT*

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 that happened 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
- 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 determined that it is necessary to develop a standardized process for identifying and being able to contact prioritized clients.

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.

*mobile phones may be able to be charged at a local fire department

Criteria for Assessing Client Risk/Frailty

The 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 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 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.

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 can both be downloaded to all agency devices, printed, or 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 update process. CMs will 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 and a second master list of frail 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 will also contact vendors providing life sustaining equipment who may also be contacting clients.
- CMs may also contact 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 to request a welfare check.**
- MOUS will be developed with the four 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 Emergency Management 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.)
    - O3A will prepare and share a contact list for Home Care Agency management to share for this purpose
    - O3A Case Management will authorize services provided by alternative agencies if not prior to services, then after the fact
- Per the 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.

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 members or Council of Governments as the Executive Director may deem appropriate.

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.

7. 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

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 that will include
- 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
- 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 - Home care agencies are also encouraged to use this tool with their clients.

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

SAMPLE 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.

_____ _____

Olympic Area Agency on Aging Date
Roy Walker, Executive Director

_____ _____

Clallam County Emergency Management Department Date
Printed name: _____

Title: _____

ATTACHMENTS INCLUDED:

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

Attachment 1: PRIOTIZATION OF O3A CASE MANAGEMENT CLIENTS FOR USE 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, which will be 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.

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

1. Are you OK?
2. Do you have friends/family that have been there to help you? If no, can you call friends/family for assistance?
3. Has your caregiver been there to help you? If no, have you been in touch with your caregiver?
4. Do you have electricity? Heat? Water?
5. If the electricity is out, do you have medical equipment that isn't working that is essential for your health and care?
6. Do you have alternative options if your heat is out?
7. Do you have alternative options if your water supply is not working?
8. Do you have enough food to eat and liquids to drink?
9. Can you prepare the food?
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.

If there is a need, but less imminent, call:

County	**Phone**
Clallam Emergency Management Division	360-417-2525

HCA DISASTER COLLABORATIVE PLANNING

MEMORANDUM OF UNDERSTANDING BETWEEN HOME CARE AGENCIES AND OLYMPIC AREA AGENCY ON AGING

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

7. Purpose:

The purpose of this agreement is to promote collaboration between all HCAs in Grays Harbor and Pacific Counties / Clallam and Jefferson Counties and with O3A to coordinate assistance efforts clients during an emergency.

8. 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

9. Rules: On an ongoing and regular basis,
   1. HCAs SHALL:
      b) Immediately contact 911 if client is experiencing life threatening problems
      c) 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 -
      d) Previously secured client authorization to release records will suffice during disasters
      e) Maintain contact lists of the designated HCA lead staff to communicate with one another during disasters
      f) Commit to help one another's clients during disasters
      g) 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
         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
8. Agree to meet after the disaster for an after event review process

2. O3A SHALL:
   a) Immediately contact 911 if client is experiencing life threatening problems
   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 has developed a tool to identify our most fragile clients and will try to reach frail clients to assess their status
   d) O3A shall have previously secured client authorization to release records as part of routine care coordination
   e) O3A will try to reach their clients using other available resources, i.e.,
      1. contact assigned home care agencies to see if they reached client
      2. contact assigned agency to see if they have a different worker in the neighborhood who can reach client
      3. if not, ask client's agency to contact other HCAs to determine if they have nearby available workers
      4. contact Personal Emergency Response System (PERS) provider if client has PERS unit
      5. contact Lincare /other oxygen providers if needed
   d) Contact 911 if unable to contact client

3. 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.

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

10. 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.

11. 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. HCA's may amend or terminate this agreement with a 30-day written notice to the other party.

12. Principal Contacts. The principal contacts for this agreement are:

Organization	**Person**	**Contact Numbers**
Olympic Area Agency on Aging		
Catholic Community Services		
Coastal Community Action Programs		
Korean Women's Association		

Personal Service Providers		
ResCare HomeCare, Inc.		
Care Givers Home Health, Inc.		
Concerned Citizens		
Olympic Community Action Programs		

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.

_____ _____
Agency Director Date

_____
Printed Agency / Name of Director

_____ _____
Agency Director Date

_____
Printed Agency / Name of Director

_____ _____
Agency Director Date

_____
Printed Agency / Name of Director

_____ _____
Agency Director Date

_____
Printed Agency / Name of Director

_____ _____
Agency Director Date

_____
Printed Agency / Name of Director

ATTACHMENTS INCLUDED:
Attachment #1 - HCA Process for Disaster Cross Agency Collaboration
Attachment #2 – O3A Health and Safety Welfare Check Questions for Clients

Attachment #1
HCA Process for Disaster Cross Agency Collaboration

Scenario

- A Disaster has occurred and the HCA Agency has instituted their own disaster plan
- There are client(s) the agency has been unable to reach

Agreements

- Agencies agree to participate in phone tree and sign MOUs to that effect
- Agencies create a master phone list / email list / text list and share with one another
- Agencies agree to respond to all contacts that they receive as follows:

    1. received the contact and are checking
    2. are not able to assist the client(s) in the message
    3. are able to assist the client in that area
    4. provide feedback to HCA who requested assistance

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 initiates any care plans 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 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

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

13. Are you OK?
14. Do you have friends/family that have been there to help you? If no, can you call friends/family for assistance?
15. Has your caregiver been there to help you? If no, have you been in touch with your caregiver?
16. Do you have electricity? Heat? Water?
17. If the electricity is out, do you have medical equipment that isn't working that is essential for your health and care?
18. Do you have alternative options if your heat is out?
19. Do you have alternative options if your water supply is not working?
20. Do you have enough food to eat and liquids to drink?
21. Can you prepare the food?
22. How many more days' worth of accessible food/water do you have?
23. Do you have enough essential medication? How many more days' worth do you have?
24. Do you have any other concerns or needs at this time?

If a client is in immediate danger, call 911.

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

Olympic Area Agency on Aging

APPENDIX D:

Advisory Council

O3A ADVISORY COUNCIL MEMBERSHIP

Member	Geographic Representation
Vacancy	Clallam County
Bonnie Hurd	Clallam County
Carolyn Lindley	Clallam County
Joseph Sharkey	Clallam County
Patricia Smith	Jefferson County
Kris Kiesel	Jefferson County
Patti Reynolds	Jefferson County
Nancy Jamieson	Jefferson County
Jane Lauzon	Grays Harbor County
Pam Tuttle	Grays Harbor County
John Shannon	Grays Harbor County
Vicki Schmidt	Grays Harbor County
Natalie Jacobson	Pacific County
Denny Evans – 2017 Vice Chair	Pacific County
Amy Kredlo	Pacific County
Dale Jacobson,	Pacific County
Serena Antioquia	Tribal Rep., all counties.
Joanne Levine – 2017 Chair	Disabilities Rep, all counties.
Vacant	Elected Official, all counties
Martha (Marti) Anthony	Minority Rep., all counties
Joseph Sharkey	State Council on Aging Rep./liaison, all counties

Number of Advisory Council Members 60+ = 18
Number of Advisory Council Members self-indicating a disability = 1
Number of Advisory Council Members of minority descent = 2

Olympic Area Agency on Aging

APPENDIX E:

Public Process

In order to develop the 2016-2019 Area Plan, O3A carried out:

1. A regional survey of older adults distributed via O3A's website, stakeholder and provider network, and advertised in local media;
2. Meetings and interviews to solicit input from service providers, community leaders, members of O3A's Council of Governments, and Advisory Council; O3A direct service staff, and tribal elders, and
3. Public Hearings in each of O3A's four service counties: Clallam, Jefferson, Grays Harbor, and Pacific counties.

In addition, O3A staff reviewed current research on aging issues; recent information published by various local sectors (civic planners, public health, transportation, social services, community action programs, etc.), as well as U.S. census-based county and regional demographic projections.

Public Hearings:

A Public Hearing was held in each of the four counties in O3A's service area; local county commissioners 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, and
- Mailed a copy of the draft Area Plan document to all persons who requested a copy in advance of the hearing.

Public Hearings were held in:

- Grays Harbor County on July 28, 2015, 10:00 a.m., at the Grays Harbor County Administration Building in Montesano;
- Pacific County on July 28, 2015, 1:00 p.m., at the Pacific County Courthouse Annex in South Bend;
- Clallam County on July 30, 2015, 10:00 a.m., at the Clallam County Courthouse in Port Angeles, and in
- Jefferson County on August 4, 2015, 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 Barbie Rasmussen 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 in writing on a comment sheet;
- A summary document with area plan goals and objectives and plan highlights was available, and
- Anyone who requested a copy of the full plan was later mailed a copy of the draft document and invited to provide feedback.

A summary of each Public Hearing follows:

Clallam County Public Hearing

July 30, 2015: Clallam County Court House, Port Angeles
Commissioner: Bill Peach
O3A Advisory Council: Annette Lindemood; Allen Ruble
O3A Staff: Roy Walker, Barbie Rasmussen

Commissioner Peach opened the Hearing at 10:00 a.m. O3A staff presented a summary of the 2016 – 2019 Area Plan. General discussion following the presentation focused on workforce issues, including both local unemployment following the closure of several mills, and shortages of caregivers especially in isolated, remote communities. Ms. Lindemood spoke about the value of the *Powerful Tools for Caregiving* training, an element of the Plan that is available to support family caregivers. Commissioner Peach commented on the lack of access to services, especially dental care, and difficulty in accessing primary care in some areas. He mentioned that the 'pioneer spirit' of the local populace can make it difficult for people to ask for help. The group briefly discussed the need for and potential benefits of palliative care services in adjunct to medical care. Mr. Ruble observed that participation on the O3A Advisory Council provides a good, ground level perspective into the needs of older adults in the community. Commissioner Peach closed the Hearing at approximately 11:30 am.

Jefferson County Public Hearing

August 4, 2015: Jefferson County Court House, Port Townsend
Commissioners: David Sullivan, Phil Johnson
O3A Advisory Council: Joanne Levine, Patti Reynolds
O3A Staff: Roy Walker, Barbie Rasmussen, Ingrid Henden

Commissioner Sullivan opened the Hearing at 9:00 a.m. O3A staff presented a summary of the 2016 – 2019 Area Plan. General discussion focused on the critical role of family caregivers and how the O3A Area Plan supports family –and other unpaid caregivers through the Family Caregiver support program. Ms. Reynolds spoke about the importance of palliative care services in providing support especially to adults with chronic, progressive illness, and mentioned that Jefferson HealthCare may be developing new palliative care services based in the primary care clinics. Ms. Levine spoke about the benefits of support groups for caregivers of persons with dementia, and how training can be made more accessible to group leaders on the peninsula. The group discussed transportation needs, especially for older adults who may be too frail to access public transportation; Ms. Levine spoke to some of the limits of Para Transit, as well as the work the State Council on Aging is doing on transportation, including her participation in conversations with the Governor. Commissioner Johnson discussed 'age-friendly' housing concepts and modifications that can support older adults to age safely in their homes, and there followed brief discussions about caregiver workforce adequacy, as well as strategies to engage consumers to take a more active role in managing their health. Commissioner Sullivan closed the Hearing at approximately 10:30 am.

Grays Harbor Public Hearing

July 28, 2015: Grays Harbor County Courthouse, Montesano
Commissioners: None
O3A Advisory Council: Joann Balmer
O3A Staff: Roy Walker, Barbie Rasmussen
Members of the Public: Bob Nakutin, Hoquiam; Pam Tuttle, Ocean Shores

In the absence of a Commissioner, Mr. Walker opened the Hearing at approximately 10:10 a.m. and invited discussion of the Area Plan, following presentation by staff. Mr. Nakutin had requested, and received a draft plan to review prior to the Hearing, and made a number of suggestions to clarify concepts and terms in the Plan, including his suggestion of including a Glossary of Terms, which he volunteered to provide. Several issues were discussed, including recent constraints experienced by the home delivered meals program in recruiting and retaining sufficient volunteer drivers. Mr. Nakutin suggested investigating whether Americorps volunteers could be used to provide yard work for older adults to help them maintain their homes, and mentioned the value of linking the recent North Beach television programs featuring Kathy Jones on the O3A website, and making them easy to access. Ms. Balmer and Ms. Tuttle spoke about the work the North Beach Senior Resource Center is doing to support older adults and people of all ages in Ocean Shores, including the homeless family of young boy who was recently cited for his volunteer work. The Hearing adjourned at approximately 11:30 am.

Pacific County Public Hearing

July 28, 2015: Pacific County Courthouse Annex, South Bend
Commissioner: Steve Rogers
O3A Advisory Council: Dale Jacobsen, Chair; Denny Evans
O3A Staff: Roy Walker, Barbie Rasmussen

Commissioner Rogers opened the Hearing at 1:00 p.m., and invited discussion. He observed that in Pacific County the housing authority is currently looking at housing needs for older adults, and is considering developing an independent project in South Bend for low income older adult residents. Mr. Jacobsen described a coordinated housing effort in a neighboring municipality that was making good use of the tax credit option for developing subsidized housing in that community. Commissioner Rogers mentioned that homelessness is increasing on the peninsula, and discussed some of the related issues facing the County. Mr. Evans spoke briefly about the shortage of caregivers in the Raymond area. Ms. Rasmussen provided a brief summary of the O3A programs and services supported by the Area Plan. Commissioner Rogers adjourned the Hearing at 2:00 p.m.

Advisory Council Review and Area Plan Meeting Chronology:

O3A's Advisory Council and the Advisory Council Planning Committee each worked on the development of the area plan in meetings this year. The full Advisory Council meets monthly at the Shelton Civic Center; all meetings are also open to the public. Meetings of the Advisory Council and Planning Committee are included in the following list of meetings that informed the development of the area plan.

Area Plan Meeting Chronology

Date	Meeting	Meeting Topic
February 1-3	7.01 Planning Meeting, regional tribes & agencies	Meeting provided opportunity for O3A staff to discuss 7.01 plan development with individual representatives from several area tribes.
March 17	O3A Advisory Council	Reviewed area plan timeline and existing area plan goals, and discussed a new draft issue area addressing Palliative Care
April 8	O3A Planning Committee Co-Chairs	Planning Committee Co-Chairs met with staff to discuss issue areas and process, identify tasks, make tentative assignments.
April 29	O3A staff & Representative from Office of Indian Policy	Plan meetings with local area tribes to develop 7.01 plans; discussed expectations of tribes, process to develop plans and potential content.
May 1	Alzheimer's Disease Listening Session, Sequim	O3A staff, Planning Committee Co-Chair attended meeting to learn about local caregiver experience caring for a person with dementia.
May 4	Lower Elwha & O3A Staff	Meeting to discuss and draft 7.01 plan between Lower Elwha and O3A.
May 5	Aberdeen Sr Center	O3A staff met with Aberdeen Sr Nutrition Staff to distribute surveys to all Senior Centers in Grays Harbor & Pacific Counties
May 12	O3A Planning Committee	Planning Committee members met by conference call to discuss 'homework' assignments, i.e., review individual issue area draft narratives & provide feedback to staff, either by phone, email or in person.
May 13	O3A Provider Meeting, Port Angeles	O3A staff solicited input on area plan issues from local providers of services to older adults at this monthly meeting.
May 15	Port Angeles Sr Center	
May 19	O3A Advisory Council	Reviewed progress to-date; discussed public hearing attendance and expectations.
May 20	O3A Provider Meeting, Aberdeen	O3A staff solicited input on area plan issues from local providers of services to older adults at this monthly meeting.

May 28	Brinnon, Quilcene & Sequim Community / Senior Centers	O3A staff met with community center staff to explain about the plan and distribute surveys.
June 3	Willapa Connections (Pacific County Provider Group)	O3A staff solicited input on area plan issues from local providers of community services at this monthly meeting.
June 16	O3A Advisory Council	Reviewed draft area plan goals and objectives; members received copies of the goals/objectives and were requested to provide feedback to staff.
July 21	O3A Advisory Council	Reviewed Area Plan summary for presentation at Public Hearings; Council agreed by consensus to recommend the summary for review at Public Hearings.
August 18	O3A Advisory Council	Reviewed a power point summary of final draft area plan highlights. The Council voted unanimously to recommend the final draft 2016-2019 Area Plan to the O3A Council of Governments for their approval.
September 3	O3A Council of Governments	O3A's Council of Governments met in person with approval of the 2016-2019 Area Plan as an advertised agenda item. This meeting was advertised in service area newspapers, on the agency's website (www.o3a.org) and was open to the public. At this meeting, the COG reviewed the final draft of the plan and draft budget, and approved submission of the plan to the Aging and Long-Term Support Administration.
June 26, 2017		

Area Plan Update Meetings & Hearings Chronology

Date	Meeting	Meeting Topic
May 23, 2017 10-12:30 pm	Advisory Council Meeting	Meeting with Advisory Council to present initial draft and took comments – noted below.
June 19, 2017 10-12:30 pm	Advisory Council Meeting	Met with Advisory Council who approved draft of the Area Plan Update – Approved Area Plan Update Draft
June 26, 2017 2-3:00 pm	Clallam County Public Hearing	Met with Clallam County Commissioners and public; presented overview of plan updates and took comments.
July 7, 2017 9-10:00am	Jefferson County Public Hearing	Met with Jefferson County Commissioners and pubic; presented overview of plan updates, and took comments.
July 11, 2017 10-11 am	Pacific County Public Hearing	Met with Pacific County Commissioners and pubic; presented overview of plan updates, and took comments.
July 11, 2017 2-3:00 pm	Grays Harbor County Public Hearing	Met with Grays Harbor County Commissioners and pubic; presented overview of plan updates, and took comments.
September 7, 2017, 10-11:00 am	Council of Governments Meeting	Presented Final Draft of the Area Plan Update to the Council of Government (COG) representatives. COG approved the Area Plan Update.

Area Plan Update Handout:

Area Plan Update Highlights

- **Implementation of the State Medicaid Transformation Project Demonstration**

- A**dditional goals around Alzheimer's Disease**
  - Training for O3A staff
  - Facilitator Training tailored to dementia for support groups
  - Becoming a "Dementia Friend"
  - Encouraging communities, organizations and businesses to adopt dementia friendly strategies

- **Several programs have been suspended** due to lack of resources and capacity to support them
  - **Powerful Tools** – O3A supports other groups who may want to lead these programs for example a faith group in Sequim has continued to offer this program.
  - **Gatekeeper programs** – O3A continues to share in presentations to the community, through articles and other work, how individuals with frequent contact with seniors may notice worrisome changes and how to help and make referrals to I&A.

- **New Tribal 7.01 Plans have been created and/or updated**

- **New Draft O3A Emergency Management Plan**

- **Significant leadership turnover**, bringing **new talent and ideas to Olympic Area Agency on Aging**

- **Implementation of Community Living Connections**

- **Individual home care provider overtime**

Area Plan Public Hearing

Welcome and thank you for attending this public review of the required two-year update to the 2016-2019 area plan of the Olympic Area Agency on Aging. We invite your comments and suggestions to this plan update, which is still in a draft stage and will be finalized in early September.

Some background on the Olympic Area Agency on Aging:

- **The Olympic Area Agency is one of 13 area agencies on aging –or triple AAAs --in Washington, and each of them are developing similar plans for their service regions.**
- **AAAs were established by the federal government in 1974 to provide support and assistance to the aging population. AAAs are found throughout the country, in every state and in rural, urban and suburban communities.**
- **In Washington, AAAs focus on the needs of elders and people with disabilities, as well as people with chronic care needs and family members who may be caring for a relative.**

- **O3A**
  - Is governed at the local level by county commissioners,
  - is mandated to advocate for issues important to older people
  - works with other agencies to coordinate local services, and
  - receives federal and state funding, along with local support, to provide a wide range of senior services and support throughout a four county region, including Clallam, Grays Harbor Jefferson, and Pacific Counties.

- **Some of the services that O3A provides in our county include**
  - Information and Assistance, to help people solve their own problems;
  - Meals on Wheels and congregate meals, to improve senior nutrition;
  - Health education on topics such as how to manage chronic illness, prevent falls, and manage your medications;
  - Insurance counseling, for example, Medicare Part D;
  - In home care, family caregiver support, and respite;
  - Legal assistance on issues such as wills, credit counseling, health care directives, and;
  - Volunteer transportation to medical appointments.

~~~~~~

ADVISORY COUNCIL REVIEW:

On **May 23, 2017**, O3A presented the initial draft of the Area Plan Update to the Advisory Council members. Feedback from the Advisory Council included the following:

- Spell out all acronyms the first time
- Voiced questions about out of home respite options for the PSA
- Provided feedback on numbers and availability of Alzheimer Support Groups
- Asked for a review of the non O3A service list
- Voiced questions about why the Gatekeeper program was discontinued and encouraged staff to look for options for continuing this program – possibly a train the trainer program if funding and capacity became available

On **June 19, 2017**, presented Advisory Council members with updated draft and described next steps.

~~~~~~

The Olympic Area Agency on Aging
2018 – 2019 Area Plan Update
Summary—Public Hearings

<u>Clallam County</u>

June 26, 2017: Clallam County Court House

Commissioner: Bill Peach

O3A Advisory Council: Not Available

O3A Staff: Roy Walker, Carol Ann Lasse

At 2:06 pm the Public Hearing was called to order by Commissioner Peach.

Roy Walker reviewed major updates to the plan including

- The new Medicaid Transformation Project Demonstration Initiative 2 – Medicaid Alternative Care, and Tailored Services for Older Adults (MAC & TSOA), which expands services for unpaid caregivers
- The addition of several new goals around Alzheimer's Disease and Dementia including training for O3A staff; facilitator training tailored to dementia for O3A support group facilitators; O3A becoming a "Dementia Friend"; and, encouraging communities, organizations and businesses to adopt dementia friendly strategies
- Several programs have been suspended due to lack of resources and capacity to support them including Powerful Tools for Caregivers and the Gatekeeper program
- New Tribal 7.01 Plans have been created and/or updated for 4 tribes – work continues to meet the needs of O3A's 9 tribes within the PSA.
- O3A has developed a new Emergency Management Plan still in draft form
- In the last year there has been significant leadership turnover, bringing new talent and ideas to Olympic Area Agency on Aging
- Implementation of Community Living Connections which is the Aging and Long Term Support Administrations Branding for Information and Referral Services and the data management system for tracking resources with a goal of eventually becoming outward facing so the public can search for resources.
- Implementing new requirements for tracking and managing individual home care

provider overtime

Commissioner Peach spoke about the importance of oral health access especially for the very low income. Roy Walker shared the work the Olympic Community of Health in the area of oral health.

At 2:46 the public hearing was closed.

~~~~~~

Jefferson County Public Hearing

July 7, 2017: Jefferson County Courthouse

Commissioner: Unavailable to be present

O3A Advisory Council: Marti Anthony, Joanne Levine, Nancy Jamieson

Public: Evelyn Zimmerman

O3A Staff: Roy Walker, Jody Moss, Ingrid Henden

At 9:05 am the Public Hearing was called to order by Roy Walker.

Staff shared a handout summarizing the areas in which the plan has been updated, subsequently reviewed by Roy Walker as noted in the Clallam Summary

Advisory Council Members asked about 7.01 plans, which is a tailored description of how O3A will deliver services to tribal members and which is developed working with both O3A and tribal representatives. O3A is continuing to develop tailored plans for each of the 9 tribes in our PSA (the most statewide).

The group discussed that Kinship Care and Kinship Care Navigation is a big focus of work for O3A with the tribes. There was encouragement to advocate at the state level for resources to establish a dedicated O3A Kinship Care Navigator position.

O3A talked about potential additional resources which will be available through the Medicaid Transformation Project Demonstration (MTPD) through MAC/TSOA and the MTPD Initiative 1 which may bring additional Chronic Disease Self Management services to the northern region.

Advisory Council members noted how much the update highlights how much interconnection there is with O3A and other organizations and appreciated the leadership role O3A has taken with the Olympic Community of Health.

At 10:30 am the Public Hearing was closed.

~~~~~~

Pacific County Public Hearing

July 11, 2017: Pacific County Courthouse Annex, South Bend

Commissioners: Lisa Olsen; Frank Wolfe;

O3A Advisory Council: Amy Kredlo

O3A Staff: Roy Walker, Jody Moss

At 10:05 the Public Hearing was called to order.

Staff shared a handout summarizing the areas in which the plan has been updated, subsequently

reviewed by Roy Walker as noted in the Clallam Summary

No questions were asked.

~~~~~~

Grays Harbor County

July 11, 2017: Montesano Municipal Courthouse, Montesano

Commissioners: Wes Cormier

O3A Advisory Council: Jane Lauzon

Public: Bob Nakutin

O3A Staff: Roy Walker, Jody Moss

At 2:05 pm the Public Hearing was called to order by Commissioner Wes Cormier.

Following presentation by staff, Mr. Nakutin asked the following questions or made comments:

- Would unpaid caregivers also include neighbors or friends who are stepping in to help? - Yes
- Suggested adding two radio stations, KBKW, and KXRO where O3A staff have presented to the list on page 3.
- What is CLC? Is it like CILS or ILC? Also, it does not appear on the acronym list. CLC is Community Living Connections and unrelated to CILS or ILC. This is the Aging and Long Term Support Administrations branding for Information and Referral Services and the data management system for tracking resources with a goal of eventually becoming outward facing so the public can search for resources.
- What is Honoring Choices? Answer: This is a WA State branded program supported by the Washington State Medical Society that encourages providers to engage with their patients to have honest conversations about end of life preferences and help providers understand what is important to patients.
- Is the Senior Community Service Employment program for 24 months or 48 months. Answer: Roy Walker noted that it has been 48 months although a participant may have left the program and returned to complete only a remaining 24 month period. Unfortunately, this program, may be cut in the federal budget. Staff will verify time length of the current program and get back to Mr. Nakutin.
- Asked if information should be included about the need for couples to divorce to preserve assets in cases where Alzheimer's is draining resources. Roy Walker responded that this may still be a public perception but many years ago this was addressed legislatively allowing the transfer of assets to the spouse. There is still a financial drain and there is a participation fee but it is much more reasonable that previously.
- What is Diners Choice? Answer: Diner's Choice is an option for the Senior Nutrition Congregate Meal program where seniors are issued a voucher and can select participating restaurants and meal facilities for their meals – currently Forks Senior Congregate Meals are managed in this fashion. The meal is a set menu with a registered Dietitian approved 1/3 Recommended Daily Amount. This program allows
~~~~~~

members who may not feel comfortable in current Senior Congregate Meals to participate. Participants can go whenever the restaurant is open rather than at a set time. The restaurant offers options for donations and many Diners Choice programs find they collect more donations from the general public in this model.

- Mr. Nakutin noted a typo on page 85 – Bulleting should be bulletin
- Suggested adding a description of the Death with Dignity Act and Resources on the relevant page
- Asked if the issue of Food preparation at the Elma Senior Center was ever resolved. For a period of time the Senior Center was having food prepared in Raymond and delivered to Elma. Jody Moss reported this had been resolved.

Hearing adjourned at 3:18.

Olympic Area Agency on Aging
Appendix F:

Mid-cycle Report on Accomplishments for the 2016-2017 Area Plan Years

ISSUE AREA: C-1 LONG TERM SERVICES AND SUPPORTS (LTSS)					
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.	1.a. Provide logistics and coordination for training venues 1.b. Implement staff training.	Regional Director	1/2016	12/2016 & ongoing	1a./ 1.b. The Dir. Of Direct Srvc is in contact with ALTSA on changes in Operations. All new initiatives requiring ongoing / updated staff training have been strategically implemented, including PCOC, CLC, new MAC/TSOA training and IP Provider OT training, etc.
2. Procure contracted services that meet needs identified for Medicaid clients by case managers (average caseload 1,500 clients).	2.a. 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	2.a. Contract Managers engage in ongoing provider recruitment and contracting services for a broad variety of providers. 2.a. Contract Managers routinely seek the help of the HCS Resource Development Manager for difficult to locate resources. 1.a./2.a. O3A works with local Home Care Agencies to encourage training opportunities, encourage partnerships that enhance their work and improve the service agencies provide.

	2.b. 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.	Regional Director; Case Managers; Registry staff	1/2016	12/2019	2.b. O3A's Home Care Referral Registry staff work to find, prepare, and keep a stable corps of Individual Providers and continue to support their ongoing training and work, and to support client choice in who serves them.

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.	1.a. Ensure dedicated staff are supported with training, supervision, and technology support. 1.b. Ensure service integrity is maintained through adherence to fidelity, reporting requirements. 1.c. Ensure that revenue from care coordination contracts adequately supports O3A level of effort.	O3A Exec Director; Regional Director; Nursing Services Manager	1/2016	12/2016 & ongoing	1.a, 1.b, 1.c. Ongoing commitment to staff knowledge, technology, quality of service and fidelity to models, accurate reporting is maintained, and revenue adequately supports services. Revenue does not fully support the Health Homes work, so O3A has had to limit the numbers served by this important program.

2: Participate in local and regional readiness coordination activities leading to stronger service networks for clients.	2.a. Continue participation in Accountable Communities of Health networks.	O3A Exec Director O3A Director, Planning & Program Management O3A Program Mgr	1/2016	12/2016 & ongoing	2a. O2A Executive Director Chairs 3 county Olympic Community of Health (OCH); Planning Dir. serves on the OCH Rural Health Assessment and Planning Committee reviewing applications for funding / encouraging other agency collaboration and application for resources 2. Contract Manager coordinates regional home care agency meetings 1-2 times each year; current focus on cross agency coordination during disaster 2. Contract Manager serves on the local Bar Association and provides training on SLAC clinics and Advance Care Planning 2. O3A Offices convene well attended Senior Provider Meetings in all four counties
	2.b. Continue participation / advocacy in Rural Health Improvement Collaborative (RHIC) and Health Path Access Team (HPAT).				2.b. O3A Executive Director serves as a team member for both the RHIC and HPAT, although both groups have been inactive.
	2.c. Participate in local and regional program coordination efforts, e.g., Regional Transportation Providers Organizations; regional home care agency coordination meetings.				2.c. Planning Director serves on the Regional Transportation Providers Organization, Jefferson Citizens for Health Care Access, Accessible Communities Committees in Clallam and Jefferson

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.	1.a. Support I&A staff with training to maintain AIRS and CIR-S certification.	Regional Director	1/2016	12/2016 & ongoing	1a. staff are all AIRS certified or if new on staff, on the training path towards certification. 1b. Wwork is well recognized within the community and actively sought out. 1c. Staff host Senior Provider meetings to expand community outreach and to learn about new programs.
	1.b.Implement Information & Assistance program throughout the region according to program requirements.				
	1.c. 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. .	2.a. With new funding, fully implement the O3A Transition to ADRC/CLC Plan.	Regional Director	TBD	TBD	2.a. Funding not available - limited movement in this area. Despite lack of funding, all callers to receive thoughtful help and referral for services
	2.b. 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	2.b. Funding not available - limited movement in this area. 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.	1.a. 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	12/2019	1.a. Ongoing services form the core of work provided by FCSP. This area has received special focus for training with the implementation of MTP Initiative 2.
	1.b. Provide T-CARE assessments & customized care plans for family caregivers.	FCSP Coordinators FCSP Staff	1/2016	12/2019	1.b. Ongoing services form the core of work provided by FCSP.
	1.c. Provide customized services & supports to family & kinship caregivers (e.g., respite, counseling, support groups, help with children's school supplies, etc.)	FCSP Coordinators & FCSP Staff	1/2016	12/2019	1.c. Ongoing services form the core of work provided by FCSP.
	1.d. Identify and contract sufficient providers to facilitate efficient and timely service provision.	Program Manager; FCSP Coordinators & FCSP Staff	1/2016	12/2019	1.c. Ongoing services provided by Contract Managers.
2. Strengthen capacity to provide Powerful Tools for Caregivers & make available to wider community	2.a Update Powerful Tools training for FCSP staff.	Regional Direct Services Director; FCSP Coordinators	1/2016	12/2016	2a. O3A no longer offers Powerful Tools training for staff or for caregivers due to funding constraints.
	2.b. Provide Powerful Tools training sessions for caregivers in all counties.	Regional Direct Services Director; FCSP Coordinators	1/2017	12/2017	2b. O3A does contract with outside providers to provide this program as requested if staffing capacity or funding available.
	2.c. Train staff from local community based organizations to provide Powerful Tools training in their communities.	Regional Direct Services Director; FCSP Coordinators	1/2017	12/2017	See above

	2.d. Offer Powerful Tools for Caregiving training to Tribes.	Regional Direct Services Director	1/2017	12/2017	2b. O3A does contract with Tribes to provide this program as funding is available.
3. ~~Facilitate the development of more local Alzheimer's Association caregiver support groups for caregivers who provide care for persons with Alzheimer's Disease and other dementias~~. Develop more local resources supporting families impacted by dementia.	3.a. In partnership with the local Alzheimer's Association, facilitate increased training opportunities for support group leaders at community level.	O3A Planner	1/2016	12/2017	3a. Working with the Alzheimer's Association, and FCSP to identify needs and capacity for new Alzheimer's groups Exploring cross training for current Care Giver Support Facilitators
	3.b. In partnership with the local Alzheimer's Association, facilitate increased training opportunities O3A staff to recognize dementia and appropriately assist clients and their families	O3A Planner, O3A staff	10/2017	12/2019	3.b. Exploring training opportunities for O3A staff;
	3.c. Refer caregivers from the FCSP to Alzheimer's Disease Support Groups	FCSP Coordinator & FCSP staff	1/2016	12/2019	3.c. Making referrals for services which caregiver wants is part of core role / ongoing.
	3.d. Publicize support groups through local, on-line and social media.	O3A Planner; FCSP Coordinators; O3A IT Coordinator	1/2016	12/2019	3.d. Publicize support groups through local, on-line and social media. Website lists multiple types of support groups for caregivers including Alzheimer's groups.

	3.e. Explore methods/strategies to encourage our region to become a Dementia Friendly PSA.	O3A Director, O3A Planner, O3A Staff,	5/2017	12/2019	3.e. O3A has officially became a "Dementia Friend;" currently exploring strategies for accomplishing this goal; Executive Director serving in a leadership role locally on the regional advisory board and at state level on the WA State Alzheimer's Association Board.
4. Expand out-of-home respite options for caregivers in each service county.	4.a. Survey assisted living and memory care facilities to ascertain their interest / capacity to provide out of home respite through an O3A Adult Day Care contract.	O3A Program Manager; O3A Planner	1/ 2016	12/2017	In process with Program Manager
	4.b. Provide technical support and assistance to facilities interested in contracting to provide out of home respite care.	O3A Program Mgr.; O3A Planner	1/2016	12/2017	Not started
	4.c. Issue and monitor contracts; provide technical assistance to provider on contract requirements.	O3A Program Mgr.; O3A Planner	1/2016	12/2019	Not started

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.	1.a. 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	1/2016	12/31/2019	1.a. 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). Long Beach Hospital has contracted to offer CDSMP, although have not launched program to date. 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	1.b. 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.	2.a. 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. Identify (local) technical resources to provide education and training.	O3A Advisory Council Task Force O3A Planning Director	1/2016	12/31/2019	2.a. Researched tools and developed a resource guide with links on website. 2.a Conducted a survey seeking community members' thoughts, feelings and readiness on this topic. 2.b. Next step is to use the data to plan education/technical assistance options. 2.b. Identified a partner in Olympic Medical Center which is launching a project using the Honoring Choices tool.

3. Engage local medical service providers in dialogue regarding palliative and hospice care options available in the community.	3. a Meet with local medical service providers re availability of palliative & hospice care, and how to access in each county. 3.b. Develop follow up activities based on initial conversations in each county.	O3A Advisory Council Task Force O3A Planning Director	1/2016	12/31/2019	3.a. O3A Advance Care Planning Committee developed a list of questions to begin engaging medical providers. 3.a. Developing a plan for contacting providers. Olympic Medical Center in Clallam County is launching a plan to engage with their medical staff through Honoring Choices; plan collaboration/learning from one another's experiences. 3.b. In planning stage.

ISSUE AREA: C.4. BASIC NEEDS

C.4. GOAL: Older adults & adults with disabilities are able to meet basic needs for employment, food, transportation, housing, and safety.

Measurable Objectives	Key Activities	Responsible	Timeframe		Accomplishment or
			Start	End	
1. Provide employment options for adults 55 & older each year.	1.a. Provide employment support through SCSEP to 12 participants in 2016.	O3A SCSEP Coordinator	1/2016	12/2016	1.a. This program continues to be highly successful at O3A. Unfortunately, the increase in minimum wage O3A has necessitated a decrease in numbers served from 12 – to 9-10. With additional funds we could serve additional clients.
	1.b. Retain current host agencies (currently 10 agencies throughout service region).		1/2016	12/2016	1.b Current agencies retained

	1.c. Coordinate w/ local service agencies to provide training, job skills development for older adults.		1/2016	12/2016	1.c Ongoing.
2. Provide Older Americans Act Senior Nutrition and Farmers Market Programs.	2.a.Ensure OAA service contracts prioritize home delivered meals & Senior Nutrition providers offer congregate meals services that are within their capacity to sustain.	O3A Planner	1/2016	12/2019	2.a. Congregate and Home Delivered Meals continue to offer substantial nutrition to seniors across 4 county region in accordance with new 2016 Nutrition Standards.
	2.b. Implement Senior Farmers Market program according to guidelines with existing Senior Nutrition providers.	O3A Planner	1/2016	12/2019	2.b.The Senior Farmers Market Nutrition Program offers vouchers to eligible seniors in the north counties and bulk purchase /delivery in the south counties. Bulk produce is bagged and distributed at congregate meal sites and through home delivered meals and caregiver pick ups in south counties.
3. Support volunteer transportation options for older adults to access health, shopping and other essential services.	3.a. Procure local volunteer transportation services through O3A contracts with local agencies to provide transport for medical services and essential shopping.	O3A Planner	1/2016	12/2019	Issued RFQ resulting in 3 new 4 year contracts for Transportation Services in PSA
	3.b. Advocate at state, local levels to improve coordination of transportation services.	O3A Planner O3A SCOA Rep	1/2016	12/2019	3.b.Planning Director serves on the Regional Transportation Providers Organization, Jefferson Citizens for Health Care Access, Accessible Communities Committees in Clallam and Jefferson

4. Provide Gatekeeper training to personnel in O3A subcontracted programs.	4.Train contractor personnel for senior nutrition and volunteer transportation on signs of self-neglect and elder abuse, where to report and how to refer.	O3A Program Development Manager	1/2016	12/2019	4.Gatekeeper program has been discontinued internally due to lack of staffing capacity. O3A continues to educate community members about their role as gatekeepers in their communities/neighborhoods/work places and encouraging elders and adults with disabilities who appear to need assistance to contact Information and
5. Maintain current coverage in LTC Ombudsman program.	5. Ensure current level of effort / staff capacity is maintained.	Exec Dir; CFO; I&A Director	1/2016	12/2019	5. O3A's very effective LTC Ombudsman program has been expanded to the South Counties, and continues with 2 staff and 22 volunteers throughout the region.
6. Publicize programs to reduce costs associated with housing.	6. Maintain current level of effort to provide information via O3A media outlets (newspaper, O3A web site, including Facebook, & radio) & staff about programs offered through local providers and state/federal programs related to housing, maintenance, safety & security.	Regional I&A Director	1/2016	12/2019	6. Continued marketing through multiple media opportunities (Radio, newspaper, Facebook, Pinterest, Twitter, Constant Contact Newsletter), including regular meetings of local provider networks throughout 4 county region. Because of O3As visibility in these efforts, many other groups contact O3A to share news, and O3A staff mines news media to share programs.

7. a. Coordinate w/local emergency preparedness efforts re: needs of elders & ensure structure exists to assist frail, home bound in emergency 7.b . O3A emergency plan is in place, w/ contingency systems developed & staff trained.	7.a.. Designated staff in each service county participate in local emergency preparedness efforts, with designated O3A & contractor staff assigned to follow up with frail, home bound persons in emergencies.	Regional I&A Director; Home Care Program Mgr	1/2016	12/2019	7.a. O3A planning staff has developed an updated emergency management plan 7.a. Working with Emergency Management staff from north counties to align plan with county disaster planning 7.a Will be working with north and south counties to secure signed MOUs with Emergency Management
	7.b. Update /revise O3A emergency preparedness plan as necessary; implement system backups & train staff in emergency system contingencies.	O3A IT Coordinator	1/2016	12/2019	7.b Launched staff training in system to identify frail clients 7.b. Working with Home Care Agencies to develop plan for cross agency client access for welfare checks and services in emergency circumstances

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.	1.a. Train FCSP I&A and other O3A staff 1.b. Promote MAC & TSOA programs with appropriate local community agencies, via presentations & contacts to schools, medical service providers, discharge planners, churches, etc.; 1.b. Support / facilitate referrals from hospitals, discharge planners, physicians' offices, schools, churches, etc. Develop new referral resources as they are identified in each county; 1.c. Provide T-CARE assessments & customized care plans for family caregivers; 1.d. Provide customized services & supports to newly identified caregivers (e.g., respite, counseling, support groups)	Regional Direct Services Director, FCSP Staff, CMP staff	1/1/17	Ongoing	1.a.Ongoing 1.b. presentations have begun generally, and will become more detailed as audience needs develop 1.b.Not yet begun 1.c. Not yet begun 1.d. Not yet begun 1.e. Outreach plan developed and initial

2. Assure systems alignment and provider network adequacy.	2.a. Learn about and develop contract tools 2.b. Identify and contract with sufficient providers to facilitate efficient and timelyservice provision. 2.c. 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	2.a. Contracting staff have been working on updating contracts and addressing network issues 2.b & 2.c. Introducing FCSP and other contractors to MAC/TSOA program generally. O3A leadership has been meeting with and briefing local providers about MAC & TSOA opportunities for over a year.

Olympic Area Agency on Aging

Appendix G:

Statement of Assurances and Verification of Intent

Appendix G Statement of Assurances and Verification of Intent

For the period of January 1, 2016 through December 31, 2019, 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. 106-510) and related state law and policy. Through the Area Plan, the 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	David Sullivan, Jefferson County Commissioner Chair, Council of Governments Olympic Area Agency on Aging